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Becoming a Caring Mental Health Nurse:
A Phenomenological study of student mental health nurses narratives, of developing
caring during their pre-registration nursing education.

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ABSTRACT

“Becoming a Caring Mental Health Nurse:

A Phenomenological study of student mental health nurses narratives, of developing caring during their pre-registration nursing education”.

Angela Hall

This research is located within the current debate surrounding a ‘crisis in care’ within the nursing profession. Caring has been considered at the foundation of nursing practice since the days of Florence Nightingale. However the contemporary healthcare environment with increasing nursing workloads and a focus on productivity measures is creating real barriers for nurses who wish to be caring. Nurse education is at the centre of this debate regarding its location within Higher Education and the move to an all graduate profession across all fields of nursing.

The aim of this study was to acquire a deeper understanding of how their development of caring was experienced within the pre-registration nursing mental health programme. A total of 9 second year student mental health (MH) nurses volunteered to participate in the study from a Higher Education Institution in the United Kingdom.

The interviews were analysed using an Interpretive Phenomenological Approach and this uncovered 3 super-ordinate themes. Participant’s identified with caring as an innate characteristic that is central to their ‘being’, and this acted as a key motivator towards becoming a Mental Health Nurse. Several effective pedagogies were identified in the study that enhance and enrich the participant’s innate caring qualities during their educational programme. The value of mental health practice placements and the role of reflection in their learning whilst acknowledged is also a source of dissonance as they encounter the reality of caring within mental health services.

The findings would indicate that caring within new student (MH) nurses’ is an innate human quality that requires awakening and validating rather than instilling by the appropriate nursing pedagogies grounded in the ethics of caring. The role of nurse educators is clearly to produce competent (MH) nurses who can remain ‘caring human beings’, whilst responding effectively to the social, economic and cultural transformations and contemporary nursing demands. Introducing and embedding approaches that develop resilience and increase emotional intelligence are essential to protect their professional ideals.

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Chapter One: Prelude

1.1 Overview

This study concerns nursing, care, and education. This comes at a crucial time, as it is widely believed that the fundamental values at the core of nursing have been eroded as a result of over-education and 'professionalisation'. This chapter begins with a brief introduction to the concepts of nursing and healthcare with background information relating to the evolution of this study. An examination of the historical context follows, and subsequently a consideration of the impact of global health changes on nursing. Nursing is consequently situated within its complex landscape in order to explore the issue of nurse education. The principles of practical training and theoretical education are considered in opposition, acknowledging the problems encountered within contemporary pre-registration nurse education. I will then outline the research purposes and questions before moving on to describe the nature of this work, explaining the significance of a critical and emancipatory methodology. Finally, I detail the original contribution of this study to existing knowledge and conclude with a description of the thesis organisation.

The International Council of Nurses (ICN) provides the following definition of Nursing:

It [nursing] encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (ICN, 2010).

Nursing, as with any other profession or occupation with human relationships at its core, will be influenced by context and environment, by patients and recipients of care and the resources available. In addition, the interpretation of the role of the 'nurse' will vary depending on the cultural and national context. Nursing does not occur within a vacuum, and social, economic and political contexts necessarily shape its performance and development. It is a

fallacy to imagine that nursing has remained solely at the level of 'interpersonal care' for most of the last century. Nursing and its definitions are dynamic. As a profession, it is constantly evolving and responding to new knowledge and technologies. In addition, nursing is sensitive and responsive to the increasing demands of the care provision arena. Nursing has evolved from its inception as a vocational practice-based occupation to an increasingly professionalised, technical and scientific endeavour.

This study is about 'being caring' as a nurse and has emerged from my many years' experience as a mental health nurse and as a nurse educator. I have grappled with the concept of care and what it means in terms of emotion, attitude, action and deeds. These questions have been central to my self-identity. Mental Health Nursing was never something I ever considered as a career, although as a child I had played the traditional role-playing games around being a nurse, so I was taken by surprise at the age of sixteen and a half to be offered an interview for a Cadet Nursing position by my careers advisor at the local mental health institution. I attended for an interview the following week and was offered the position. I attended a local college two days each week and worked in various hospital departments for 3 days each week. It was not possible to work on any of the wards until aged 18. At this time, I had no idea of what to expect or what I would be doing and was filled with apprehension. After 1½ years as a Cadet Nurse, I then progressed to become a Student Mental Health Nurse for 3 years. During these 3 years (1980-1983), I witnessed a diverse range of nursing care, from excellent caring and professional nursing to poor and abusive practice, which has informed my own value base and caring approach. The influence on my development was by key people both in the placement areas and within the Nursing College which shaped my development and my becoming a nurse educator. As a nurse educator, I now have the possibility and opportunity to explore the experience of learning, in part that I am responsible for. This study has also been a 'transformational' process in itself. There have been periods of self-doubt and a sense of imposter syndrome in academia as I have struggled with my self-worth and self-esteem as a researcher and educator. The transitions I have experienced during this process have played

a significant part in my interpretation and presentation of the findings. My interpretation of the data is connected to my 'evolving' self-identity that inevitably colours my view. This is one of the positive and dynamic assets of the interpretive paradigm adopted.

The idea for this study and thesis was loosely formed 9 years ago as 'caring' was something that I had considered every day in my practice as a nurse educator where I observed a range of interactions between student nurses and nurse educators. Some of these educators were approachable and caring, while others were harsh and uncaring. I was concerned how a nurse educator's values and attitudes could impact on the student nurses' development of a caring approach. The question then evolved over the next couple of years as throughout this time there had been increasing media attention in relation to the standard of caring within nursing and two major inquiries (DH, 2012b; Francis, 2013) into care that reinforced the need for further study in this area.

This re-examination of 'care' is timely in that it has erupted following the much publicised Francis Inquiry (2013), which highlighted the catastrophic failings of care at the Mid Staffordshire National Health Service (NHS) Trust which led to unnecessary deaths and suffering, but also uncovered an institutional culture of defence and deceit where mistakes and bad practice were concealed and suppressed. The Compassion in Practice (DH, 2012a) policy, whilst acknowledging the challenges of current systems of healthcare and new ways of working, reinforced the fundamental requirement for care, dignity, respect and compassion and introduced the 6Cs of "Care, Compassion, Communication, Competence, Courage and Commitment" as a framework for all nurses, midwives and care staff (DH, 2012a). Condemnation such as: "we are as shocked by the failings of care at Mid Staffordshire and Winterbourne View as the public are. Such poor care is a betrayal of what we all stand for" (DH, 2012a, p. 7) and as such has led to a 'crisis in care'. To uncover and appreciate the current landscape in nursing and nurse education it is necessary to trace its historical roots and

development. It also needs to be considered within the current global trends and patterns of health care provision.

1.2 Historical and Global Context of Nursing

Until the Industrial Revolution, nursing in the UK was carried out within charitable or religious orders that served small communities. In urban areas, provision for the sick was either poor or non-existent and was frequently the preserve of landed gentry and aristocracy whose nurses played the dual role of 'bodily function' servants as well as carers (Vern & Bullough, 1993; Hawkins, 2010). The Industrial Revolution brought mass migration to cities, and the explosion of attendant public health problems and new types of injuries amongst workers, all of which demanded larger institutions for hospital treatment and in most cases led to high volume and poor quality care (Hall & Ritchie, 2011). Indeed, for many people, the only access to health care was in workhouses, and there it was provided by prisoners, pardoned criminals, alcoholics, destitute women and prostitutes. The 'nurses' of that time were probably best characterised by Charles Dickens' portrayal of Sarah 'Sairey' Gamp, an elderly prostitute working as a nurse who ate her patient's food and drank whatever alcohol she could get hold of (Summers, 1997). By the introduction of formal registration in the medical profession in 1858, many were calling for a similar scheme of regulation for nursing, both to ensure a base level of competence for all practicing nurses and to regulate practices that may cause more harm than good. As a result, organised nurse training was established in 1860.

Florence Nightingale was opposed to the formal registration of nurses, believing that the essential qualities of the nurse could not be examined nor regulated (Davies & Beach, 2000). Others such as Henry Burdett, founder of the National Pension Fund for Nurses, and Ethel Fenwick, Matron at St Bartholomew's Hospital in London, were keen to make registration a universal requirement for all trained nurses (Williamson, et al., 2008). Lagging behind several countries where legislation to licence and nursing regulations had already been introduced, including the United States (State Licensure Programmes inaugurated 1890-1895), Japan (1899) and New

Zealand (1901), the British Government refused to act and it was not until after the First World War that Parliament passed the Nurses Registration Act in 1919 and established the General Nursing Council, the first regulatory body for trained nurses in the UK (Ibid).

The Nightingale Training School then opened at St Thomas' Hospital, London, which established the basis for professional nurse education in the UK. The training was based on an apprenticeship model, whereby much of the learning was from practical experience in the workplace and learning from more experienced nurses. Nightingale herself, however, felt that nursing schools should be separate from the demands of hospitals. Students were often considered as 'a pair of hands', and their learning became secondary to the running of the wards. Thus, there were few opportunities to develop critical thinking and reflective skills to enhance their practice development. This practical based approach was often located in schools of nursing attached to local hospitals, where students provided patient care services for a minimal allowance (Bullough & Bullough, 1978). It was not until 1922 that the first cohort of mental health students became registered by the General Nursing Council (GNC). Previously psychiatry was not under the remit of the Ministry of Health (1919) and those caring for the mentally ill were known as 'asylum attendants'. The name 'asylum' was not replaced until the 1930's Mental Treatment Act when they were formally deemed 'hospitals'. It is fair to say that until the introduction of Project 2000 (UKCC, 1986), mental health nursing lagged behind the general nursing counterparts.

Despite many benefits of the apprenticeship model it received criticism from nurse educators (Beard, 1920; Goldmark, 1923; Burgess, 1928) who felt that the demands of hospitals were not compatible with the training needs of student nurses and that a university education would ensure the educational needs of the students were prioritised. Although the first Bachelor's degree in nursing was awarded in 1909 in the USA, it was not until 1962 that people could study at degree level in Scotland, 1970 in England, and 1972 in Wales. Throughout the majority of the 20th Century, the core of nursing continued on the path that had been set several hundred years before, but with important

philosophical and practical changes gradually filtering into the training structure. In the 20th Century, nursing remained in essence a relational and 'body-work' (Ruddick, 1998; Tronto, 2006) activity whose professional role was the alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations, in the latter half of the century. During this time, nursing across the West did begin to diversify, and nurse preparation adopted an arguably more medicalised disciplinary core, while still recognising its role in the promotion of health and the prevention of illness and death.

In the UK, nurse education moved into the higher education sector from the former Schools of Nursing located within hospital settings during the 1990s. This followed a wide consultation within the National Health Service and lobbying by the professional nursing body at the time, the United Kingdom Central Council (UKCC) and the support of the government. Project 2000 (UKCC, 1986) was launched in 1989, and in a radical shift from previous nursing curricula, it increased the theoretical input of nursing preparation programmes and changed students to supernumerary status, which moved training from a training programme in hospitals to a university based educational programme. Specifically, nurses were to be exposed to the demands of "*critical thinking* rather than just *doing*" (Morall & Goodman, 2013, p. 935). The aim was to provide an opportunity to increase the professional status of nurses and enhance skills, focusing on a broader community care approach (Davies, et al., 2000) and the supposed need to expand the concept of evidence-based practice within the nursing profession:

The expansion of medical research and specialisation, accompanied by increasing awareness of the right to excellence in nursing care, had produced a burgeoning knowledge base required for nursing practice (Deans, et al., 2003, p146).

The image of the registered nurse under Project 2000, as a "knowledgeable doer" (UKCC, 1986) soon began to come under scrutiny (Davies, et al., 2000), as the blame for failings within the NHS was consigned to Higher Education and its role in nurse training (Clarke, 2000; Phillips, 2003; Sergent,

et al., 2003; Templeton, 2004). Concerns with the quality of patient care, the perception of nurses being removed from front-line healthcare, and the seeming proliferation of administrative roles at the expense of the well-known and traditional 'matrons' were conflated with the erosion of public confidence in health care, which at the same time was being undermined due to reductions in public spending throughout the early 1990's and into the 21st Century. In response to such widespread concerns, the government introduced a new nursing curriculum based on competencies (Bentley, 1996) and amongst these were the compulsory demonstration of reflective practice and continual professional development.

When the Nursing Midwifery Council (NMC) became the new regulatory body for Nursing and Midwifery from April 2002, part of their responsibilities was, and still is, to ensure nurses are prepared as competent and professional practitioners. The increasingly technical role of the nurse has led to a perceived 'gap' in the provision of care (Flanagan, 2004; Templeton, 2004, 2012) where, as a result of staff shortages in many hospitals, work normally carried out by trained and registered nurses has been transferred to less qualified member of care staff, with attendant patient perceptions of lack of care. This is a complex issue, however, and lies at the heart of this research. Although it is clear that the proportion of registered nurses in the workforce has positive outcomes, in improving the pace of recovery, reducing complications and even mortality (Needleman, et al., 2002; Aiken, et al., 2013). These positive effects of nursing care occur in contexts where nurses are practising competently and professionally. Some studies suggest that patients and other healthcare users alike dispute the boundaries of competent practice, and argue either that nurses are improperly deployed, or that their practice is fundamentally wrongly conceived, both in terms of the nursing curriculum, its underpinning philosophy and the means and mechanisms by which nurses are trained (Barton, 1998; Hoyles, et al., 2000, Wakefield, 2000).

There is currently a global crisis of severe shortages and misdistribution of health professionals that is exacerbated by three great global

transitions; demographic changes, epidemiologic shifts and a redistribution of the disability burden (Crisp & Chen, 2014, p. 950).

Populations are aging globally, with the number of people aged 65 or older projected to grow from 524 million in 2010 to nearly 1.5 billion by 2050 (WHO, 2011). Currently, the population of developing countries is still young, and it is within these countries (for example Brazil) that have the most rapidly aging populations, projected to rise by more than 250% compared to a 71% increase in developed nations (Ibid). In regions with quickly ageing populations (for example Europe and Japan), a major challenge is soaring healthcare costs related to chronic diseases and increased demand for care of the elderly. According to the World Health Organisation (WHO), 30-40% of healthcare costs are spent on those over 65 (WHO, 2014), many developing countries will also need to respond to the increased demand for financial resource and social care in order to ensure appropriate and adequate care provision.

In the next two decades there are predictions of major changes in the world's health care needs as a result of epidemiological transition. Due to advances in and access to immunisation, treatment, and improved living conditions in developing countries, non-communicable diseases such as depression, cancer, diabetes, and heart disease, as well as road traffic deaths are quickly replacing the earlier infectious, nutritional, and maternity related causes of death (WHO, 2014). However, the poorest developing countries, for example Zambia, Swaziland, and Ethiopia, will face a triple burden of communicable, non-communicable disease, and socio-behavioural illness and will need to amend their traditional focus on infectious disease (Ibid). Market forces are intrinsically linked to healthcare provision and "health expenditures are now amounting to 10.1% of the world's gross domestic product, and healthcare industry is turning over more than \$6.6 trillion annually" (Crisp & Chen, 2014, p. 953). It is estimated that the population of the UK will increase by 7% between 2012 and 2022 to 68 million with a 30% increase in the number of people with long term conditions. Currently, there are 1.5 million people with a long-term condition accounting for 70% of all health spending (NHS England, 2014).

There is a recognition that with decreasing global resources and a shortage of skilled healthcare workers, not only in less wealthy countries but also in the UK (RCN, 2013), and the growing burden of infectious disease in many countries, the need to maximise the efficacy and efficiency of education and training for healthcare workers has never been greater (Johnson, et al., 2013). It is acknowledged that in order to provide universal and equitable healthcare coverage, strong healthcare systems are required, with adequate, well distributed, appropriately trained, motivated and well supported and managed human resources (Amde et al., 2014). Sound pre-registration education can give individuals entering the workforce the competencies they need in order to make an immediate impact as well as a foundation for future professional growth (Johnson et al., 2013). There is, however, an acknowledgement that few studies make links between pre-qualification education and the impact on health outcomes, but they claim a logical argument can be made that the production of trained and competent staff is required to achieve the required health outcomes (Ibid). The proportion of registered nurses in the workforce clearly has positive outcomes in the pace of recovery, reduced complications and even mortality (Needleman et al., 2002; Aiken et al., 2013).

Nurses have developed skills and practices in hugely demanding and complex public health contexts. For example, in the USA at the turn of the 20th Century, nurses were educated to administer anaesthesia during surgery, leading to the specialty field of nurse anaesthetists. Although the aim of advancing nursing practices continues globally (Duffield et al., 2009) research, patient, public, and professional narratives demonstrate repeatedly that nursing can never seem to escape its original remit of 'caring'. Some of the earliest forms of nursing were provided by religious orders and as such were founded on the concept of *caritas* meaning charity (Hallett, 2007), incorporating virtues of altruism and self-sacrifice, which in turn contributed to the gradual formation of the 'saintly' image of nursing. This image is often used by the media to symbolise the demise of nurses or nursing in news headlines, for example, Channel 4's '*Undercover Angels*' (2005) exposed

nurses as uncaring, disrespectful and neglectful in their care, in other words, depicting nurses as 'fallen angels'.

1.3 The Landscape of Nurse Education

A long-standing and critical debate within nurse education has been whether nurses should receive training in the workplace or undergo education at university. This apprehension continues today, following the introduction of Project 2000 and the idea of the 'knowledgeable doer' (UKCC, 1986). The previous apprenticeship model, of on-the-job training, was replaced by the move into higher education. A curriculum focused on "*critical thinking*" emerged rather than a one focussed on "*just doing*" (Morrall, & Goodman, 2013, p. 935). This has 'turned sour' as a result of managerialism within universities and the major restructuring of funding. In addition, there is "increasing public concern with the state of nursing, so undermining the viability of critical thinking and potentially the acceptability of university education for nurses" (Ibid).

Higher Education Institutions have experienced a period of profound change, driven by political, cultural, economic, and technological factors affecting all aspects of university provision, including the environment in which they operate, what they are required to deliver and how they are structured and funded. These changes have contributed to an expansion of post-compulsory education, particularly higher education, to meet the demands of a transforming economy. As such, employability and vocational preparation are no longer the preserve of particular professional preparation courses, but critical and vital programmes both to sustaining university finance and providing the foundation for an increasingly diverse and demanding national population, as outlined earlier. Translating this to employability means tackling issues of how best to teach particular skills that confer such status on graduates, and in nursing (Meyer & Land, 2003; Clouder, 2005).

A further layer to the foundation of this research is that nursing students are not the stereotypical university student, they are different in several areas: demographically, financially, educationally, and socially. The widening

participation initiatives aim to promote diversity in the student population. For some socially disadvantaged students, this brings in a crucial layer of everyday 'tactics of resilience' (Scheper-Hughes, 2008) which highlights the ability of some students to withstand and flourish in response to social and educational adversity. Resilience is relevant to both personal and professional development and is considered an important attribute (DH, 2013b) when recruiting student nurses to the programme. Student nurses experience challenging and often negative experiences on the journey towards 'becoming a nurse' and in order to manage these stressful situations, they will need to draw on and enhance their resilience.

Research which investigates the preparation of nurses in the university context is scarce and more generically focussed in the UK. Acknowledging these gaps in the literature, lecturer to student caring interactions have been explored in several phenomenological studies (for example: Appleton 1990; Halldorsdottir 1990; Miller et al., 1990; Beck, 1991; Hanson & Smith, 1996; Grams et al., 1997). These have identified how caring is expressed and the positive effects which can be produced for student nurses. Such research, however, has either elicited testimony that considers caring interactions as functions of specific faculty, identified on the basis of their exceptional 'caring', or used instruments to investigate moral orientations or dispositional qualities and infer caring attributes from them. To the researcher's knowledge and through an extensive literature review, the researcher has been unable to locate any studies that focuses specifically on the details of how student mental health (MH) nurses narrate and construct caring-meaning from their nursing programme, and linked to this, how they perceive nurse educators influence in developing values, beliefs, attitudes and practice of the student (MH) nurses with whom they have contact.

Nursing is a complex practice, and nurses themselves have multiple identities and construct their work through multi-layered narratives. Nurses narrate to themselves stories of caring and concern, of satisfaction and isolation, of healing and helping. Since the academicisation of nurse preparation, nurses also generate stories of reflection and reflexivity, of

theoretical conceptualisation and academic refinement, of objectification and subjectivity. Nurse education programmes promote and claim to foster all of these arguably conflicting aims and to do so within a framework of explicit cognisance of caring. But the change that precipitated the move of nurse preparation out of hospitals and into universities was seemingly a double-edged sword: although it provided trainee nurses with a wider context in which to examine more diverse 'case knowledge' other than simply that which the trainee was exposed to in a single hospital previously, and also increased the time available for nurses to engage in critical reflection, it brought the problems of practitioners becoming 'academic educators' to the centre stage and the issue of transmission of the nurse educators' own values and beliefs. Some believe that there is a connection between the values and beliefs, and consequent practices, of the nurses and nurse educators who teach them (Timmins & Neil, 2013). These research findings suggest that as a result of such nurses, once trained, may lack the requisite skills and dispositions to effectively nurse people and respond to their health needs with compassion and sensitivity beyond either their own personal experiences, or those to which the nurse education has exposed them to, during the course of their preparation. In other words, trained nurses may well become in practice, a function of their experience, autobiography and 'subjective warrant' (Lortie, 1975) with, or without, the level of critical reflection and reflexivity that the nurse education programme has developed and fostered within them. In parallel, nurse educator's beliefs influence how they understand and assess the abilities and behaviours of others, what they consider key elements of nursing theory and practice, and thus how they teach and prepare nurses (Peddie et al., 2011).

Public concern regarding the state and preparation of nurses has led to reviews of Registered Nurse Education with the Willis Commission (RCN, 2012) and *Raising the Bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants* (HEE, 2015). The key recommendations of these reviews regarding how to: facilitate the transition for care assistants onto pre-registration nursing programmes using various educational models; to increase the flexibility for

training, such as work-based routes, or increasing flexibility during pre-registration training; to reconsider a generic programme as opposed to specific pathways and the acquisition of advanced skills in pre-registration nursing (Ibid).

Pre-registration nursing programmes are complex and multi-layered in their demands to educate, develop skill, and engender change in people's attitudes, beliefs, and dispositions. Indeed, in nursing programmes, the nurse educators are expected to act both as catalysts for the critical exploration and development of particular dispositions, as well as being arbiters and assessors of caring behaviours and practices. Nonetheless, amongst nurse education providers, there is a lack of agreement as to how and where this should be achieved. Indeed, its prominence in the nursing curriculum at all is not universally accepted or observed. For example, the Open University's nurse education programmes claim:

With the focus on person and family-centred care, you'll develop and demonstrate effective interpersonal skills that meet service user's rights to dignity and privacy in a compassionate and caring manner (Open University, 2013).

In contrast, the Higher Education Institution (HEI) that provides the setting for this study states:

It develops your clinical decision-making and interpersonal skills, and your ability to provide high-quality person centred compassionate nursing in a safe and caring environment (HEI, 2015).

Whilst other institutions emphasise the alternative model of nursing, stressing the theoretical input and the importance of research-based study:

The integration of theory and research-based practice in the classroom and the clinical setting is emphasised throughout the programme. Key benefits include (...) world-class academics, and gifted students, from all walks of life (Kings College London, 2013).

While on other programmes, the professional utility of the programme is more important than its status as an academic subject:

As well as an academic qualification, successful students also receive a Registered Nurse qualification that allows you to practice in a wide variety of healthcare settings (Manchester University, 2013).

But these diverse aims for nursing programmes notwithstanding, the place of caring in health provision in the UK is increasingly concerning as highlighted in the many public inquiries of the last two decades. A number of trends have been identified (Walshe, 2003) in the use of inquiries in the NHS as the volume and scope of inquiries increases. Walshe (2003) notes,

In the last three years there have been five major inquiries: into security and other issues at Ashworth Hospital; pathology services at Alder Hey Hospital; the conduct of gynaecologist Rodney Ledward; paediatric cardiac services at the Bristol Royal Infirmary; and the activities of general practitioner Harold Shipman. Secondly, inquiries have increasingly become concerned with issues to do with the clinical performance of doctors and other health professionals, often in acute care areas (Ibid, p. 1).

Nurses are frequently in the media, portrayed as ‘detached and uncaring’, ‘too posh to wash’ or ‘too clever to care’. In addition, that they have become ‘overeducated’ for their role (Flanagan, 2004; Templeton, 2004, 2012). By contrast, there has never been any suggestion that doctors or teachers are overeducated (Watson, 2000) despite the importance of a caring disposition in their own roles.

This crisis has once again led to questions regarding the effectiveness and appropriateness of degree level preparation and the education of nurses at university. Following on from several critical documentaries (BBC, 2005; Channel 4, 2005) and culminating in the Francis Inquiry (2013), the implication was clear: the low quality of nurse education was the principal reason for such poor care and in particular the change to degree level education. Griffiths et al. (2011) found that service users they interviewed were in tune with the British media in the belief that graduate nurses are not ‘caring’, or perhaps they were just mirroring/echoing the media’s condemnation of nursing. Reports emerged to suggest that there is a sense of asymmetry in nurse preparation, in that the academic and technical approaches override and subsume the caring and compassionate element.

Even nurse academics have been debating whether nursing has become a lost art (Flatley & Bridges, 2007; Corbin, 2008; Griffiths, 2008; Maben, 2008). There have been a series of studies (Aiken et al., 2003; Estabrooks et al., 2005; Tourangeau, 2007) which challenge this view, as there is evidence that the hospitals with graduate nurses had lower patient mortality rates. Yet, at the same time, the Willis Commission (RCN, 2012) was set up to lead an independent inquiry into identifying what excellent pre-registration nursing education in the UK should look like and how it should be delivered. One of the key findings was that they found “no major shortcomings in nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care” (Ibid, p. 7).

But if the aim of nurse education is to produce nurses who are ‘fit for practice’ and ‘fit for purpose’ then caring and culture are two of the major issues that need to be investigated and addressed if nurses are to achieve this aim (Ousey & Johnson, 2007). It could be argued that all nurses care *for* people as in delivering nursing care, but they may not all care *about* people, and this difference is frequently encountered in the practice settings where choices about how to treat patients and decisions made become very visible, and their consequences are felt acutely. The ‘caring’ nurse is able to be “somehow responsive to the person as a unique individual, perceives the others feelings and sets apart one person from another from the ordinary” (Watson, 1999, p. 34), while the ‘uncaring’ nurse will still provide the physical, technical care, they are “insensitive, non-perceptive and do[es] not distinguish one person from another in any significant way” (Ibid).

Often it is the caring personal quality that can define the person, as “caring is a basic way of being in the world, and that caring creates both self and world” (Benner & Wrubel, 1989, p. 398). In the positive caring kind of nursing common humanity can be found, with a sense of affection, love and commitment to others as “loving kindness gives birth to natural compassion. The compassionate heart holds the pain and sorrow of our life and all other beings with mercy and tenderness. It is the tender heart that has the power to transform the world” (Kornfield, 2002, p. 102). If education is to produce

caring nurses, then it needs to seek the appropriate critical pedagogy for this end. But “in a world of empiricism and evidence based practice, the notion of value based practice is less understood and embraced” (Schwartz, 2011, p. 102). This research aims to investigate the student’s lived experience of nurse education, to inquire into how such practice is enacted and embraced.

The location of nurse education within the university lies at the heart of most of these debates and is the basis for this study. The researcher's own Higher Education Institution (HEI) in the UK provides the setting for this research and is a very good site for a study of this nature. The faculty has established an excellent national reputation and has several areas of best practice endorsed by the NMC and through the National Student Survey (NSS) and Quality Assurance Agency (QAA). The researcher has access to participants but is sufficiently removed from the majority of the student intake as they teach predominantly Year 3 Mental Health Nursing students. Notwithstanding, issues of 'insider research' is clearly significant and have formed a major element of the methodological consideration, as did issues of ethics and disclosure. As a result, permission to approach the participants had been granted from the School at the University, in addition to ethical approval granted by the Doctoral Department at Durham University. During the research process, I have had to decide on which questions the research should focus from the many possibilities, which academic avenues to pursue in order to gain a new understanding of the phenomena, and which conceptual and methodological perspectives are compatible to the aim and purpose of the study. This is to aid the clarity and credibility of the social research presented here.

1.4 Research Aim and Objectives

The aim of this study is to explore and examine student mental health nurses’ lived experience of caring in the context of their graduate nurse education programme at an HEI in the UK.

This research has 3 key questions:

- Which particular values and philosophies do student mental health nurses feel stand behind them and their choice of educational programme?
- To what extent do student mental health nurses feel that their programme prepares them to be caring nurses?
- Which particular practices (if any) do they perceive as being effective in fostering a caring philosophy?

Four central conceptual areas stand behind this research:

- The concept and theories of caring in society and healthcare
- Theories of caring for Nursing and Mental Health Nursing
- Caring in nurse education and educational fields more broadly
- Philosophical concepts relevant to nurse education

1.5 The Nature of the Study

This study is framed within an Interpretative Phenomenological Approach, and as such inquiry is concerned with human experience as it is lived and what it *means* to the person living it (Todres & Wheeler, 2001). The participant engages with the researcher in dialogue about the self and their lived experience of being-in-the-world. It uses qualitative methods, in particular, narrative, to investigate an under-researched area (Paterson & Crawford, 1994). This research design was adopted to unearth the 'storied' nature of nurse identity formation, especially during nurse preparation, where existing values and 'warrants' become crystallised and either converge with the dominant learning culture or begin to diverge, exposing differences in students' accounts of their identities and purposes especially in comparison with those espoused by the nurse educators and the nursing curriculum. In such situations of uncertainty, sense-making becomes a crucial process in the attempt to create order from disorder. Using cues to notice and bracket events, people, place the unfamiliar into known categories, pigeonholing or

labelling, to generate provisional, plausible, negotiated narratives (Weick, 1995). This research design reflects such uncertainty and unfamiliarity of purpose, and thus adopts a narrative methodological structure that allows participants' stories to emerge through narrative devices, namely semi-structured interviews. Nine student nurses from the Mental Health (MH) field were recruited, and although the number of participants is relatively small, it is coherent with the methodological literature concerning qualitative narrative research and utilising Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith et al., 1999).

Furthermore, by emphasising the narrative unfolding of value development and student perceptions of their nurse educators, the research design is longitudinal, contextual and involves being engrossed in the “*flowing soup*” (Weick, 1995, p. 128) of organisational events in an inductive effort to construct thick description (Geertz, 1973). Data was collected using in-course narrative interviews. The process of obtaining student narratives during their programme ensured that any chronological connections and the temporal sequencing of events as they occurred in their nurse education were preserved (DeFina & Georgakopoulou, 2008). It also allowed insights into possible changes in the nurses' inter-subjective experiences, an aspect that researchers in other contexts indicate would be difficult to gain through other methods (Syrjälä et al., 2009).

1.6 The Contribution of this Study

The proposed study will make several substantial and original contributions to knowledge:

- It will add substantive theory in an area where limited theory presently exists
- This study will provide a unique insight into how student mental health nurses and nurse educators navigate the development of caring values throughout nurse education

- The theory will lead to an understanding and explanation of the way that values may be fostered and developed in university-based nurse education programmes
- The theory will be relevant to the development of caring values in nursing at a time of significant political shifts in healthcare delivery

The potential range of contribution of this study is wide, if made accessible to the total community of nurses, student nurses and nurse educators in addition to the healthcare services and professionals involved in nurse education. It may enable a unique insight into the transformational processes involved in 'becoming' a caring professional. It portrays a transformational process, unique to each individual gained through self-growth and actualisation towards an ideal identity of who they are to become as a nurse, this could be termed as being 'nurse-centric', as "the importance of knowing self as caring cannot be emphasised as one can only understand in another what is understood in oneself" (Boykin, 1998, p. 44).

This research aims to answer conceptual gaps in the field by taking a novel approach that is original in both its emphasis and context. It will ask student (MH) nurses to narrate their journey of nurse education with a specific focus on whether, and how, a programme that explicitly espouses caring philosophy, actually does this through the values and aims of the curriculum and the pedagogic practices of its teachers. The literature will employ a conceptual framework spanning theories of caring, nursing, and nurse education. The research will utilise a narrative method in a variety of forms, based on the established conceptual anchors from the literature. It will then utilise a hermeneutic phenomenological analytical framework, to expose subtle interpretive layers. Ultimately, the research will expose its meanings in relation to the narratives from established literature and philosophical stances. Three superordinate themes are identified from the interpretive analysis and are presented in three separate sections, according to three related 'lifeworlds' (van Manen, 1991). Together these themes capture the height of the interpretive process, by making sense of the participants' rich

and deep descriptions of how their lived experiences influence the construction of their self as caring, and the transformation of their caring capacity in the context of their academic and professional lifeworlds.

The resultant discussion weaves the exposition of participant perceptions into the literature on the themes, with additional reference made to the complex articulation and interleaving of teaching theory and key philosophical stances. To conclude I will argue that it is vital to preserve and strengthen the ontological dimension of 'becoming' in nurse education despite the current instrumental, epistemological, technical and digitally enhanced culture of Higher Education.

1.7 Definition of Key Terms

For the purposes of this study the definition of 'student nurse' is any person enrolled on the three-year pre-registration programme for nursing, in any field (adult, child, learning disability and/or mental health). This thesis will, however, also refer to student nurses studying to be Mental Health Nurses and they will be identified as a student (MH) nurse. The term 'nurse education' refers to the programme on which pre-registration nurses are registered. The term 'practice placement' will also be used to mean the nursing practice placements in mental health services that intersperse the academic periods of study during university. Nurse-centricity is a term used to describe the participants' desire and aspirations to become a nurse that are embedded in the construction of their self-identity.

1.8 Overview of Chapters

The study is organised into six chapters each contributing to the overall exposition of the research questions:

Chapter One - has introduced the global and historical background and context of the research together with an outline of the purpose and potential contribution of the work, including the research questions.

Chapter Two - aims to identify and scrutinise the contemporary and relevant literature to the study and thereby, add conceptual density and increased conceptual specificity (Strauss & Corbin, 1990). Understanding and reflecting upon the research positives and limitations is crucial when searching for evidence in support of the proposed study (Parahoo, 2006).

Chapter Three - covers four main areas of methodological structure, comprising of: methodological framework and design; use of semi structured interviews; participation in the study; and the management of data and analysis.

Chapter Four - applies the interpretive stance to the rich data gained from the interviews. It is broken down to allow a journey through the interpretive process as it was experienced in order to reflect the methodology. Overall, the themes all correlate with the broader conceptual framework of ontology (a theory of being) and the participants' construction of 'one's self' as becoming a 'caring' professional.

Chapter Five - the research findings shall be explored in relation to ontological theory and the implications for nurse education. The framework for this study was drawn from a diverse range of empirical and research evidence from nursing and educational practice. It is the first phenomenological study in the UK to examine the socialisation of student (MH) nurses and their journey of becoming caring professionals in the 21st Century.

Chapter Six - the potential impact and implications for a new era in nursing, as nurse education is dominated by political power, technological advances and a corporate approach to productivity. This has a major impact on the profession and the delivery of nursing care and nursing education. How nursing and nurse education responds will be critical to the future of 'caring' as a fundamental professional value and the role of pedagogical practices in enhancing and enriching caring ethics.

Chapter Two: Grounding

2.1 Overview

This chapter examines the contemporary and relevant literature, thereby adding conceptual density and increasing conceptual specificity (Strauss & Corbin, 1990) to the study. The literature review is divided into four sections and presents the key conceptual and empirical framework relevant to the study. The four strands of literature that are examined comprise ways of knowing in nursing; 'concept and theories on caring', 'caring within nursing', 'caring within nurse education', and 'philosophical concepts'. Throughout the literature review, the focus moves from general principles to specific nurse education ones. The literature review includes a description of the areas neglected in previous studies regarding caring and nurse education, noting the dearth of research both on the diversity of pedagogic practices perceived as enhancing 'caring' and on how 'caring' values can be exposed by nurse educators, particularly considering student (MH) nurses.

2.2 Literature Search

For this study, a continuous and extensive search was conducted for literature as a concurrent process and an interactive response to the relevant clues and triggers considering a phenomenological approach. In this chapter, exploring the literature is intended to portray and inform the depth of this study. Therefore, a more illustrative and expressive account of the literature is presented to provide a breadth and depth of relevant theory and research to present phenomenological richness rather than a more scientific analysis.

It is also important to understand and reflect upon the research positives and limitations when searching for evidence in support of the proposed study (Parahoo, 2006). Hence, relevant literature was searched using CiNAHL, a well-recognised database for medical and healthcare journals, and Google Scholar, with the search being guided by concepts of sensitivity and specificity. Sensitivity guided the first stage of the search and was the process used to find as much information as possible related to the research

questions (Tappen, 2011). Google Scholar aids in undertaking searches that are multi-conceptual and inter-disciplinary as it can access databases of the largest and most well-known publishers and is thus more comprehensive than databases such as CiNAHL (Jasco, 2005). These searches led to significant amounts of literature that must be explored and assessed in relation to their relevance and significance to the research questions.

Specificity was used during the second stage of the literature search in which the number of research papers was narrowed down to those that were specifically related to the research questions (Tappen, 2011). The Population, Intervention, Outcome (PIO) framework was used to focus the literature search within the databases (Craig & Smyth, 2007) so that the Population stage of the framework was 'student nurses', the Intervention stage was 'teaching/education', and the Outcome stage was 'caring'. Then, the two searches for 'student nurse' and 'caring' were combined using the Boolean Operator 'OR'. Boolean Operators link search terms together to combine several components needed for a question using the terms 'AND' or 'OR'. The term 'OR' enables the selection of any one of numerous specific words and phrases in a list so that if a specified word appears in an article, it will be found in the search (Ibid). The final part of the structured search was the specify stage which was carried out using the Boolean Operator 'AND' that was applied to the first two searches and the final part of the framework which was the outcome. Boolean Operator 'AND' was used as a tool to limit the number of the search results and combine words together so that both of these are found in one article within the same search (Ibid). The search for literature was ongoing throughout the study as a response to the relevant clues and triggers for further inquiry.

The literature review that follows is divided into four sections and presents the major conceptual and theoretical framework relevant to the study. The four strands of research that are examined comprise the aforementioned strands. Throughout the literature review, the focus moves from general principles to specific higher educational ones. The literature review describes the areas neglected in previous studies concerning caring and nurse

education and notes the lack of research both on the diversity of pedagogic practices that are perceived as ones that enhance 'caring' and the ways in which 'caring values' can be exposed by nurse educators, particularly concerning student (MH) nurses. The literature review concludes with an outline of the philosophical concepts underpinning the discussion chapter of this thesis.

2.3 Concept and Theories of Caring

The language of caring is central to understanding its meaning and application within society, while its historical origin is relevant to any exploration of caring. Examining the origin of the word 'care' illustrates its dynamic and disputed use in current times (Fine, 2007). The term 'care' has evolved from primarily Greek and Latin origins. According to Fine (2007), in Greek terminology, the word 'charis' was used to signify grace or favour, and 'charitas' signified someone or something that was of grace or kindness. Similarly, 'caritas' in Latin is a derivation of the Greek word 'charitas' and is commonly translated as love or charity. Several contradictions evidenced in contemporary debates regarding care and its meanings in society, education, and specific occupational groups stem from the dichotomous presentation of 'cura' in Latin terminology (Ibid). For example, 'cura' is an adjective that denotes the weight of a mission or activity; it is also a noun that describes both a responsibility weighing heavily on people and a liberating force empowering people to their fullest possibility (Ibid).

Nonetheless, Fine (2007) challenges this theory of etymology for care and caring in the UK and instead prioritises The Oxford English Dictionary (OED, 2009). The OED traces care's origins to Old English words; the noun 'caru' meaning 'a worry or a care', and verb 'carian' meaning to trouble oneself. Therefore, 'to care' meant 'to worry over or about' which relates directly to the emotional caring referred to today. These meanings, however, have been expanded upon and have encompassed other applications. As with almost all linguistic conventions, the term 'care' changed to reflect society's concerns, practices, and norms. Consequently, the trajectory of meaning assigned to 'care' changed in the Victorian times when the term was

introduced to refer to the constant monitoring of the sick to prevent the spread of disease to the general population. Hence, the personal meaning of caring as being 'troubled by' was expanded to refer to an overall attitude of consideration and concern for others. This universal solicitousness, or ethic of care, can be considered as particular to several occupational groups.

Caring is a fundamental aspect of many occupational groups including doctors, teachers, and specifically, nursing. Though care and compassion is central to the current nursing policy, practice, and educational debates, there is a perceived lack of caring by nurses and an organisational culture of uncaring within healthcare (Lown & Manning, 2010; DH, 2012a; Francis, 2013). A re-examination of the term 'care' is necessary today considering the much-publicised Francis Inquiry (Francis, 2013) that highlighted the catastrophic failings of care at the Mid Staffordshire Trust and uncovered unnecessary deaths and suffering as well as presented an institutional culture of defence and deceit where mistakes and bad practice were concealed and suppressed (Francis, 2013).

The word 'care' is an emotive and value-laden term that has been exploited by many in the marketing industry because of its high recognition factor and positive image that helps highlight and sell products (Fine, 2007). The challenge for the 21st century concerning 'caring', is whether it can fit in this new society, and if not, how new ideals of caring that do fit can be achieved. The contested character of 'caring' will be central to any debate regarding its utility within contemporary society. However, before this, there needs to be a historical understanding of the notion of 'caring' considering its use in language and its conceptual clarity. The questions surrounding 'care' are not unique to nursing or academia as they pervade individual identities and private and public lives on a daily basis.

When examining the literature, it was evident that 'caring' is a complex concept, and depending on the context in which it is used or defined, it can have different meanings. An important emphasis by recent theorists is between 'caring' as a disposition and an action noting that the term can refer

to 'a mental disposition of concern' (Hugman, 1991; Tronto, 1993, McSherry et al., 2012). This is a cognitive and emotional state that involves an attentiveness and concern for another, which may be described as affective/expressive care. It can also indicate the physical work of providing assistance or practical action of care or the actual practices that are engaged in because of these concerns (Hugman, 1991; Tronto, 1993; McSherry et al., 2012), which are also termed 'instrumental care'.

A similar concept of 'care' is the distinction between 'caring about' and 'caring for' another person, and it is a concept to which most subsequent research has referred (Graham, 1983; Fine, 2007). Caring about someone signals concern for another, involving a sense of duty, moral commitment, or a sense of personal affinity such as love. Caring for, on the other hand, refers to the work involved in nurturing, sustaining, and tending another. This includes bodily work, which has become associated with low grade women's work as it popularly confers an objectification of the body. Several critics have argued against this stance, however, stating that bodily work involves a moral responsibility rather than an objectified role. However, this distinction is not supported in the majority of the Western economies where care is outsourced and thus devalued. It is often assumed that both aspects occur together because when someone is cared for it can be supposed that they are also cared about. This usually is the case, but in cases where this does not happen, the care can be experienced as detached or uncaring. The opposing stance notes that it is possible to care about someone or something but not care for them (as there is no need, or the person lacks the knowledge and skills).

Caring for another requires effort and skills, and the physical work of 'care' is often recognised through the activity and exertion involved. The emotional work, although invisible, has been acknowledged in the term 'emotional labour' (Hochschild, 1983), as it typically involves being attentive to the needs of another and undertaking any duties or activities to meet their needs in a caring manner. This emotional labour can be considered relevant to both formal (job role) and informal (family and friends) care although Hochschild

(1983) specified occupations in which personal sincerity was important. Research has also highlighted the short and long term emotional cost and stress involved in providing formal or informal care (James, 1992; Sass, 2000). The two elements involved in caring and the effort required are termed as 'labour of love', which also confirms that both action and disposition are linked (Finch & Groves, 1983). This explains the unique character of 'care' as a vocation and as an identity often pursued by women (Fine, 2007). This perspective also prompted the feminist critique of 'care' which is examined in subsequent sections.

Care is not a single entity but a series of interconnected phases that are part of a process of caring (Figure 2:1) (Tronto, 1993). Phase one is *caring about* which involves the mental disposition of caring that recognises the need for care in another. This is followed by a conscious recognition or a sense of responsibility towards meeting the care needs, and this phase is often associated with the masculine sense of responsibility of *taking care of* as opposed to the feminine characteristics associated with the next phase of *care giving*. *Care giving* equates to caring for (Graham, 1983) and involves physical action and work required to meet the care needs that are identified for another. This usually requires direct contact between 'care-givers' and the 'objects of care' (Tronto, 1993). *Care receiving* is the final phase which usually involves a response from the recipient of care that can result in further identifying care needs, bringing the process full circle. As this model combines several perspectives on caring, it can be considered a useful framework for both conceptual and analytical inquiry.



Figure 2:1
(Tronto, 1993)

An enhanced understanding of 'care' into this sequential approach aims to show that 'care' can function as a social value, an orientation to the world that goes beyond giving care to another person to a broader level of care demonstrating that care provides a general ethic for being in the world (Fine, 2007).

Caring can be regarded as an essential feature and expression of being human and is a process that individuals experience throughout their lives with their growing capacity to express caring (Boykin & Schoenhofer, 2001). This view of caring implies that as individuals consciously realise and acknowledge their capacity for caring relations, there is an enhanced probability that they will engage in more caring behaviours. It is significant to note here that language, conceptual, and dispositional elements of caring entwine and that impediments to completely expanding their capacity to care are linked with their ability to experience it. Recent research into the neural basis of emotions and language suggests that this reciprocity is an important precursor to consistent caring behaviour (Lenzi, *et al*, 2015). Thus, the model of 'nursing as caring' necessitates certain basic assumptions regarding

caring, as follows:

- *Persons are caring by virtue of their humanness*
- *Persons are whole or complete in the moment*
- *Persons live caring, moment to moment*
- *Personhood is a process of living grounded in caring*
- *Personhood is enhanced through participating in nurturing relationships with caring others*

(Boykin & Schoenhofer, 2001, p. 11).

Although people are considered to be innately caring (Ibid), actualisation of their potential to express caring varies depending on the situation and develops with time. Research examining the neural basis of caring and the explanations for the differences in individuals suggests a combination of biological, psychological, and social factors (Eisler & Levine, 2002). Caring is recognised as an aspect of evolutionary function that is essential for the survival of offspring in the majority of species. Though this capacity for caring, particularly for humans, is an evolutionary given, such theories cannot explain the difference in parental caring and in caring for strangers. Charles Darwin, in *The Descent of Man* (Darwin, 1871), nevertheless doubted whether 'survival of the fittest' could explain such caring parenting or altruism. In humans, the complex feedback system of the cerebral cortex and the subcortical affect regulation system is a probable mediator for the cultural expression, or suppression, of caring capacity (Eisler & Levine, 2002). The interaction between these biological systems and the person's physical and social environment provides a better understanding of caring, and uncaring behaviours and that "People do not spring up from the soil like mushrooms. People, produce people" (Kittay et al., 2005, p. 1). There is a genetically based capacity for caring, and there is ample evidence that lived experiences influence the development of the brain circuits (Barnes & Thargard, 1997; Eslinger, 1998; Eisler & Levine, 2002).

Care and relationships are inextricably linked (Bowden, 2001) which is

demonstrated in different contexts and relationships such as mothering, friendships, and nursing practice. In each context, care can be considered as having distinct features, and Bowden (2001) warns against the conceptualisation of care as a unified entity and states that any analysis of care or caring recognises the importance of its meanings within different contexts. Therefore, any analysis of care must provide a balance between the uniqueness of the specific case, which in this study is caring within nurse education, and the concern for the value of a general analysis that can identify common meanings from student nurses' experiences.

Despite its importance, the social phenomenon of care has only recently begun to receive serious attention from social researchers with the majority of previous research being conducted by specific professions holding a unique claim to the concept, such as in nursing (Fine, 2007). Before focussing on the concept of care within nursing and nurse education, this study examines the contribution of the feminist perspectives on care (Gilligan, 1977; Noddings, 1984); both focussed on care as a disposition and as an important part of the moral development of children linked to general education. Gilligan (1977) and Noddings (1984, 2003) have had significant influence in terms of the impact of dispositional themes when analysing caring and teaching. This broader phenomenon of care was previously neglected because of the general assumption that care was the responsibilities of families, in particular of the female members for whom it was considered natural, even instinctive, behaviour (Barrett & McIntosh, 1982). Hence, this informal care was often invisible and was taken for granted as part of private family life while ignoring its fundamental importance to social life (Graham, 1983). The feminist movement in the 1960s and 1970s when feminists claimed that the positive caring and ethical values that characterised women's work were predominately undervalued and essentially invisible compared to the value attributed to the mainly masculine workplace was significant.

An 'ethic of care' was espoused by Gilligan (1982) to counteract the situation so that the role, value, and alternative ethical position of women's daily

positioning of moral and nurturing responsibilities were raised (Ibid). These ideas stemmed from her (1977, 1982) research which determined that women's responses to moral dilemmas are qualitatively different to that of men's as women focus on protecting and maintaining relationships rather than following men's impersonal and abstract moral principles of justice. This supports the theory that caring for others is a form of moral reasoning and that regardless of gender it is a capacity to respond caringly and compassionately to complex moral scenarios and not just respond intellectually. There is "a responsibility to discern and alleviate the real and recognisable trouble in this world" (Ibid, 1982, p. 100). However, assuming that a person can provide a rational explanation or justification for their personal ethical code despite it being an embodiment of their moral development is not logical. In her work, Gilligan drew the following conclusion:

The logic of an ethic of care is a psychological logic of relationships, which contrasts with the formal logic of fairness that informs the justice approach...the ideal of care is thus an activity of relationships, of seeing and responding to need, taking care of the world by sustaining the web of connection so that no one is left alone (Gilligan, 1982, p. 73).

Thus, the essence of care is in its relational quality and no value judgment or claim of moral superiority implicitly defined care. Caring is not exclusively about emotion and feeling, or comfort and support, but is also about the challenges and occasional difficulties associated with growth and transformation (Gilligan, 1977, 1982).

Noddings (1984, 2003) has been equally influential, but with differing reasons, in her feminist critique regarding the development of care ethics. The quandary between the personifications of morality, in care versus justice, was not regarded as a problem by her. Alternatively, Noddings demanded recognition for what is essentially women's work as carers and care givers, leading to a re-positioning of care ethics.

An ethic based on caring is, I think, characteristically and essentially feminine – which is not to say of course, that it cannot be shared by men any more than we should care to say that traditional moral systems cannot be shared by women. But an ethic of care arises, I believe, out of our experience as women, just as the traditional logical approach to ethical problems arises more obviously out of masculine experience (Noddings, 1984, p. 8).

Both feminist critiques consider the concept of 'caring' as fundamental to the female persona and identity regarding all contexts of personal and public care giving regardless of the status inferred (Smedley & Pepperell, 2000). These essentially female attributes for caring have been claimed and transposed to such roles as a healthcare worker, nursing, teaching support, and several other roles identified with the broadly affective and experiential. Despite 'caring' being defined as a natural female disposition, numerous male workers are caring and value caring as a vital aspect of their work. However, it has been noted that they are more inclined to define 'caring' as a component of professional practice or high educational standards (Barber, 2002), rather than as an element of 'emotional labour' (Hochschild, 1983). There is a certain discomfort for men when adopting a quality typically associated with the female gender that can lead to detachment of the self from one's feelings and distancing oneself from caring attachments. Though this may sometimes be helpful, it can result in estrangement and loss of authenticity (Hargreaves, 1998).

Hence, care is not a concept unique to the nursing profession and is, in fact, relevant to the whole of human existence. Care manifests itself within the dynamic relationships between the world, state, market forces, communities, families, and individuals (Fine, 2007). While care is an ill-defined, complex, multi-layered concept, it can be applied to behaviour or activity (of providing physical and emotional care) as well as to individual attitudes and values about our responsibility to others. Care may also be understood as "an open and supportive orientation to strangers, to the community, to society (national

and global) and to the natural world” (Ibid, p. 4). Though care is usually considered a positive concept, it does have a darker side, such as over-involvement of the state in private affairs, enforced care which can create dependence and institutionalisation and be potentially harmful to the recipient. For decades, care has been considered as a double-edged sword that has been an issue for the state and policy makers, such that it has at times been considered too involved and too controlling in private matters and then being callous and indifferent to private concerns.

It has been noted that service users are in agreement with the British media in the belief that graduate nurses are not ‘caring’ nurses (Griffiths et al., 2011). Not only were the catastrophic failings of care at the Mid Staffordshire Trust resulting in unnecessary deaths and suffering highlighted, but an institutional culture of defence and deceit where mistakes and bad practice were concealed and suppressed also uncovered. While the Department of Health (2012) policy acknowledges the challenges of current systems of healthcare and new ways of working, it also reinforces the fundamental needs of people to be looked after with ‘care, dignity, respect and compassion’. Moreover, the concept of the 6Cs, care, compassion, competence, communication, commitment, and courage were also introduced (DH, 2012a) as a framework for all nurses, midwives, and care staff. All of this has culminated alongside wider changes to the workforce including an overall reduction in the number of qualified nurses, a concomitant increase in healthcare support workers, and task delegation from junior doctors. During this time, nurses’ work has also been subject to the new managerialism approach of increased standardisation, rationalisation, and external scrutiny (Allen, 2015). Thus, it does not surprise the nursing ideals of the past bear little resemblance to contemporary nursing practice. It is estimated that approximately 60% of patient contact/care is provided by healthcare support workers (Health Education England, 2015).

2.4 Caring within Nursing

It is not easy to define nursing, but when a person receives good nursing, they recognise it, and even more so when they don't receive it. "nursing requires a high level set of skills and understanding which taken separately may seem commonplace and undemanding but combined as a whole is far more complex and powerful" (DH, 2006, p. 4).

Nursing, as with any other profession or occupation that has human relationships at its core, is influenced by the place in which it is occurring, the person being nursed, and the resources available. In addition, the cultural context and interpretation of the definition will vary depending on the country. Nursing does not occur within a vacuum, and the social, economic, and political context shapes its performance and development. Definitions of nursing are like nursing itself, that is, they are dynamic as this profession is constantly evolving and being responsive to new knowledge and technologies. Nursing has evolved since its first inception as a vocational/practical based occupation into an increasingly professional, scientific endeavour. However, research and practice of nurse and patient narratives as well as public and professional expectations demonstrate that nursing will always be associated with its original meaning of 'caring'. Mayeroff's (1972) seminal work on caring presents a theory of caring which although adopted by nursing, it was more about the human caring that occurs between friends and family members. His model of caring was largely based on the affective element and not the instrumental. He considered caring to include knowing, patience, honesty, trust, humility, hope, and courage (Ibid).

There is extensive empirical evidence supporting the notion that the quality of relationship with another person is a crucial element in determining helping effectiveness (Truax & Carkuff, 1967; Watson, 2009). Watson (1979, 1988, 1990, 2008a) developed a theory of nursing based on caring as 'caritas', which is one of the theoretical underpinnings of this study. This is because Watson explored and explicated the fundamental role of caring at the heart of nursing practice (Watson, 2008a). Her writings on the

transpersonal nature of nursing are of particular importance in this study (Watson, 1988, 1990, 1996, 1999). Watson considered caring to be central to nursing and developed a 'science of caring' as a model for nursing practice (Watson, 1985). Her terminology 'caritas' was chosen to encompass a loving consciousness as the core of human caring that extended the meaning of professional nurse 'caring' to signify a deep ethical/moral, philosophical way of being/becoming more human/humane (Watson, 2009, 2012). The theory emphasises human caring and relationships as the foundation for healing work. Her work "places human to human caring as central to professional nursing responsibilities, the role and moral foundation for the profession. Preserving human dignity, relationships and integrity through human caring are ultimately the measures by which patient's evaluate their often 'cure' dominated experiences" (Watson, 2004, p. 51).

Watson (1988) was influenced by Rogers (1951) and Yalom (1980) as well as Peplau (1988) who emphasised the nurse–client relationship and the 'therapeutic use of self'. A central aspect of Watson's theory is the caring interaction between the nurse and the other person which creates a transpersonal field that facilitates transformation.

Human care can begin when the nurse enters into the life space or phenomenal field of another person, is able to detect the other person's condition of being (spirit and soul), feels this condition within him-or herself, and responds to that condition in such a way that the recipient has a subjective release of feelings or thoughts he or she had been longing to release. As such, there is an intersubjective flow between the nurse and patient. (Watson, 1985, p. 63)

This transpersonal field forms the basis for Watson's understanding of nursing and the transformational relationship between the nurse and another. Thus, her theory of holistic nursing is a part of the caring-healing paradigm (Watson, 1988). Therefore, healing relates to wholeness and means to 'make whole' and in the broadest sense relates to nursing practices considering the 'whole person' and not merely being blinkered to their

diagnosis or specific aspects of the person (Benner, 1984). 'Holistic' nursing was a phrase introduced in the 1970s to capture the application of wholeness to nursing epistemology and has remained a dominant discourse for professional nursing practice since then (Cowling, 2018). Watson (1990) further developed her theory to include a focus on transcendence and transformation which aligned with Roger's science of unitary human beings in nursing (Rogers, 1986).

The role of the mental health nurse is less understood compared to the other fields of nursing, adult, child, and learning disabilities. This, however, is not surprising as practitioners, leaders, and researchers working in mental health also often find it difficult to express what the concept comprises of in simple terms (Barker, 2009). Nevertheless, Peplau (1952, 1988) provided an enduring definition claimed by mental health nurses:

Nursing is a significant, therapeutic, interpersonal process. It functions co-operatively with other human processes that make health possible for individuals in the community. Nursing is an educative instrument a maturing force, that aims to promote forward movement of personality in the directions of creative, constructive, productive, personal and community living (Peplau, 1988, p. 16).

Even the most eloquent definition fails to adequately capture the profound purpose and the diverse methods, roles, and responsibilities involved in its practice. It requires an essentially human response to complex human experiences of distress. When someone is affected by mental illness, it is not the scientific, biological, or psychological theories that provide comfort and hope but the human qualities and human connection with another. All nursing interventions are expressions of the personhood of the nurse (Freshwater, 2002). This concept of therapeutic use of self is derived from psychotherapy and is now widely used in nursing (Peplau, 1952; Travelbee, 1971). Psychotherapy and counselling both strongly underpin mental health nursing practice. Mental health nursing is predominantly an interpersonal process that requires an emotional/psychological connection with another to

establish an effective therapeutic working relationship. When people come in contact with mental health nurses, they are often at their most vulnerable and need 'care' because of pain, fear, suffering, and loss of will to live. Therefore, taking care of others in society means that "the culture of nursing has a vital social-scientific role in advancing, sustaining and preserving caring as a way of fulfilling its mission to society and broader humanity" (Watson, 2008a, p. 18). Therefore, if it is agreed that caring is a moral imperative for nursing (Bevis & Watson, 2000), then "teaching caring becomes a moral imperative of nursing educators" (Ibid, p. 183).

2.5 Caring within Nurse Education

Caring is a central element in all educational sectors and is at the heart of teaching excellence, the importance of which is well documented in the literature and in almost all studies of outstanding teachers and teaching and academic work. The major body of evidence regarding caring within education concerns early years and primary school workforce. This line of work originated from the works of Gilligan (1977), Noddings (1984), and Goldstein (1999). Teachers who actively promote such caring already have a predisposition to caring in general and a devotion to social justice (Barber, 2002). Caring teaching reflects personal and deep-seated compassion to enhance the life chances of children who "don't get it anywhere else" (Ibid, p. 388).

Regarding general education, several studies (Wentzel, 1997; Monzo & Rueda, 2001) showed teachers expressing a positive longing to care for pupils and endorsing caring pedagogies. This was based on the fact that this approach to teaching benefits their pupils in various ways such as cognitively, socially, affectively, physically, and morally. Several studies have examined the notion of caring as part of moral education and of general education (Durkheim, 1961; Gilligan, 1977; Noddings, 2003). Durkheim (1961) stated that "morality begins accordingly, only in as far as we belong to a human group" (p. 80). Regarding education and the development of morality in children, he noted that schooling often rewards behaviours that are self-serving rather than attaching importance to qualities of morality

which are often seen as secondary to intellectual gain (Ibid). It was recently noted that “moral education is, then, a community-wide enterprise and not a task exclusively for home, church or school” (Noddings, 2003, p. 171).

Four major components of moral education were identified in relation to caring: modelling, practice, dialogue, and confirmation. Modelling is important as educationalists must demonstrate genuine care through their own behaviour (Noddings, 2003). Practice is demonstrated in the daily relationships between students and academics in and out of the classroom, including virtual learning, as part of a community of caring. Dialogue includes encouraging students to have authentic dialogue and voice their opinions and is a key role of educators, apart from merely imparting knowledge. This includes facilitating questions and discussions and exploring ideas and knowledge to enhance discovery and transformation. Finally, confirmation or affirmation indicates holding the student to the highest ethical ideal of self, their ideal self, in terms of what they are hoping to become. These four components represent the philosophical, ethical, and practical orientations to fulfil a caring science curriculum (Hills & Watson, 2011).

The power of caring and compassion in higher education and particularly vocational education is attested to (Avis & Bathmaker, 2004; Jephcote et al., 2008; Robson & Bailey, 2009). Adult learners need ‘different’ types of pedagogies that are more relational and responsive and less theorisable which are termed as ‘poorer pedagogies’ (Fenwick, 2006). Such approaches focus on the life histories of the learners. However, this relationship tends to diminish the value of such pedagogies compared to the more ‘scientific’ pedagogies. This is evident more in Higher Education (HE) where the meaning, value, and role of such caring pedagogies are confusing (Macfarlane, 2002). Increasingly, HE has felt the pressures of changes in funding and the quality of the relationship between students and educators at an individual level (Avis & Bathmaker, 2004). Ramsden (2008) believed that, generally, HE is changing and the role of academics is being reviewed to reflect this. The discourse on mass higher education with an increased number of students and increasing staff/student ratios and minimal funding

shows that, with more digitally enhanced supported education, in-person contact for students for their education experience required has reduced.

Caring, as a fundamental element of all nursing activity, means that it is often assumed to be part of the nursing curricula. Most pre-registration nursing programmes extol the importance of educating students so that they can become caring and compassionate nurses. There is little evidence, however, of the specific characteristics of the curriculum or any systematic approaches to foster such values (Graber et al., 2012). Pre-registration programmes are complex and multi-layered with diverse demands for effectively and efficiently developing the knowledge, skills, and attitudes of future professionals, with little agreement about how to achieve this. The recent location of nurse education within HE has led to enduring debate regarding its appropriateness for a practice-based profession. This is a fundamental debate regarding training versus education of nurses. The nature of the setting drives the philosophy and vision which, in turn, influences the educational curriculum. Though research on the impact of caring in HE is limited, it has been acknowledged that academics who are caring can influence and make a difference to a student's learning, and life, in a transformative way (Thayer-Bacon & Bacon, 1996; Weston & McAlpine, 1998). Caring can be viewed as simply a disposition and as a personal quality of the academic but not as a 'requirement', except in circumstances where an academic is considered a social or virtuous role model (as in nursing [AH]) (Fenwick, 2006).

The majority of the research regarding caring and nurse education originates and flourishes in America. In the 1990s, a curriculum revolution (Tanner, 2007) took place when the National League for Nursing stated that caring should be the core value in schools of nursing curricula. Following this, several qualitative studies were conducted regarding the concept of caring within the schools of nursing, some of which examined 'faculty to faculty' caring (Beck, 1994; Grigsby & Megal, 1995), 'student to student' caring (Beck, 1992; Hughes, 1993), 'student to patient' caring (Beck, 1992; Wilkes & Wallis 1993; Kosowski, 1995; Griffiths et al., 2012; Bramley & Matiti, 2014),

and 'faculty to student' caring (Appleton, 1990; Halldorsdottir, 1990; Miller et al., 1990; Beck, 1991; Hanson & Smith, 1996; Grams et al., 1997; Coyle & Conway, 2005; Adam & Taylor, 2014), all of whom identified the expression of caring and the positive effects caring can produce for student nurses. Whilst there have been several other studies over the decades, there remains a surprising lack of phenomenological studies into the development of caring values for particularly student (MH) nurses.

In student to teacher relationships, caring has been considered as essentially based on two assumptions. First, students must experience caring in these relationships and a caring environment to develop caring attributes and practices themselves (Watson, 1988; Diekelmann, 1990; Brown, 1991; Miller, 1991). Second, to empower students to develop critical thinking, a trusting and caring environment, often not provided in the clinical settings, is required (Watson, 1990; Diekelmann, 1992; Hsaing-Chu et al., 2013; Loke et al., 2015). Other research supporting the importance of caring relationships between faculty and students found that such a relationship can enable students to grow as caring professionals and can generate caring moments (Wade & Kasper, 2006; McGregor, 2007). A nurturing, caring environment is needed to empower student nurses, and student nurses should be valued as they are. Livsey (2009) noted that educators must make conscious choices about their interactions and the language and tone they use in communications, on the phone, in emails, and in feedback. Though there is no conclusive evidence that caring for students teaches them the elements of caring, several more recent studies, (Graber et al., 2012; Adam & Taylor, 2014; Labrague et al., 2015) have explored the influence of nurse educators on student nurses' caring practice.

There is a positive correlation between instructors' caring behaviours and student nurses' caring behaviours (Labrague et al., 2015). Labrague et al. (2015) conducted a large descriptive study with 586 students from Greece, Philippines, India, and Nigeria that included interviews using two standardised questionnaires: the Nursing Perception of Instructor Caring (NSPIC) (Wade & Kasper, 2006) and the Caring Behaviour Inventory (CBI)

(Wolf, 1986). They concluded that through positive role modelling, student nurses could be professionally trained to develop competence in caring (Labrague et al., 2015). Witnessing and experiencing positive, caring relationships enables student nurses to become more aware of the importance of being caring and develop into caring practitioners (Noddings, 1984; Carlson et al., 2003). When the nurse educator/student nurse relationship is egalitarian and mutual, a connection can lead to transformational learning (Gillespie, 2005). Nurse educators empowered student nurses by recognising them as worthwhile and unique individuals (Miller et al., 1990); however, there is little evidence to indicate that the students were then able to translate this into practice (Labrague et al., 2015).

Research into nurse educators' perceptions of their caring in the work environment (Grigsby & Megal, 1992; Coyle & Conway, 2005) found that identified caring experiences suggested a connectedness with students and others. Coyle and Conway (2005) identified previous studies that had focussed on student nurses' perceptions of caring educator interactions (Beck, 1991; Dillon & Stines, 1996; Hanson & Smith, 1996) and emphasised the importance of nurse educators' understanding of the students' perspective regarding what constituted caring behaviour (Beck, 1991; Dillon & Stines, 1996). Dillon and Stines (1996) determined that nurse educators' caring consists of sharing and giving of self, respecting student nurses as individuals, and role-modelling caring behaviours (Ibid). Students also wanted nurse educators to take extra time to help them on an individual basis, address any issues, touch the student, express sensitivity, perceptiveness, and understanding, and express emotions, laughter, and tears (Ibid). Caring by nurse educators was found "to reduce student's anxieties and led to an improvement in basic skill and professional values acquisition" (Pullen, 2001, p. 287). Other studies on the teacher/student relationship (Morgan & Knox, 1987; Nelms et al., 1993) indicated that nurse educators placed a lower value on teacher caring compared to teacher competence.

When considering how caring values and practices should be taught to student nurses, reflection, journaling, and dialogue are seen as key teaching strategies (Smith, 1992). Role modelling is another area that has been examined as a method of socialising student nurses to adopt caring values (Forrest, 1989; Nelms et al., 1993). More recent studies have reinforced the notion that nurse educators in both university and in a practice setting play a vital role in teaching caring by modelling their values (Dillon & Stines, 1996; Haigh & Johnson, 2007; Newton, 2010). Modelling of caring attributes should be central to the educational process (Newton, 2010).

Research on the professional socialisation of student nurses has confirmed that they enter their educational programme as neophytes with an idealised view of caring nursing which most of them then lose (Mackintosh, 2006; Maben, 2008; Murphy et al., 2009; Curtis et al., 2012; Traynor & Buus, 2016). Melia (1987) noted that the dissonance between the theoretical understanding of caring practice and the reality of practical nursing creates stress and anxiety for student nurses. Other studies have also identified the difference between professional idealism and practice realism (Mackintosh, 2006; Curtis et al., 2012). Curtis et al., (2012) investigated how much value 19 student nurses placed on compassionate care and their own ability to deliver this once qualified. The students identified time and high patient throughput as frustrating and hindering to their desire to be involved in more 'compassionate' activities. This created a sense of vulnerability for the students when faced with constraints on their caring over which they had no control and an ethical dilemma between 'fitting in' or maintaining their idealism. Maben (2008) interviewed student nurses on three occasions: final year of training, just after qualifying, and then three years later. They reported that, in the beginning, all participants expressed a strong set of espoused ideals concerning delivering high quality, patient-centred, holistic and evidence-based care, whom they termed as 'idealists' (Ibid). However, at the end of the study, the participants fell into three main categories termed, 'sustained idealists', 'compromised idealists', and 'crushed idealists', because of the socialisation process that occurred during clinical practice.

The study of 16 pre-registration nursing students by Mackintosh (2006) focussed on the socialisation process during their training. Participants underwent two in-depth interviews: one at 6–9 months into the programme and another 6–9 months prior to completing the programme. The study reported that “socialisation results in a loss of idealism about caring in nursing as well as the identification of negative aspects of care” (Ibid, p. 953). The study identified an invisible dichotomy that exists between the caring ethos of nursing and the organisational nature of care giving that militate against the nurse’s ability to care (Ibid, 2006). Recently, Traynor & Buus (2016) conducted focus groups with four cohorts of student nurses (including all fields) totalling 49 participants and concluded that “the idealism of newcomers often gives way to disillusion while some nurses learn to temper their idealism with practical concerns” (Ibid, 2016, p. 194).

Overall, values developed by students during their training and early in their careers were determined to be affected at varying degrees by the nurse educators to whom the student is exposed (Haigh & Johnson, 2007), and there is “widespread recognition that nurse educators have an important and fundamental role to play in the transmission and inculcation of nursing values, even though such transmission occurs on an ad-hoc basis” (Ibid, p. 3). It is also advised that the transmission of such values should be communicated in a more structured way to gain maximum benefit.

Acknowledging the gaps in the literature, faculty/student caring interactions have been explored in several phenomenological studies (Appleton, 1990; Halldorsdottir, 1990; Miller et al., 1990; Beck, 1991; Dillon & Stines, 1996; Hanson & Smith, 1996; Grams et al., 1997; Haigh & Johnson, 2007; Newton, 2010) that identified how caring is expressed and the positive effects caring can produce for student nurses. However, to the researcher’s knowledge, and through extensive literature search and review, the researcher has been unable to locate any studies that focus specifically on how student (MH) nurses narrate and construct caring-meaning from their preparation programme and how they perceive nurse educators to influence the

developing values, beliefs, attitudes, and practice of the student (MH) nurses with whom they have contact.

2.6 Philosophical concepts

In chapter 5, I examine the process of socialisation of student mental health nurses as part of their education and identify relevant philosophical concepts regarding the dominant discourse in nurse education. Key philosophical concepts derived from Foucault (1977; 1980) and Deleuze & Guattari (1984; 1988) are integrated in the critical analysis of structural and personal power as a major source of social discipline and conformity and they are considered below. In examining the psychological/cultural meaning of the inherent 'invisible power' and 'hegemony' within nurse education, philosophy serves as an alternative lens through which to view and propose strategic action at the level of challenging or shaping discourse.

Michael Foucault 1926-1984 a French post-modernist philosopher has been greatly influential in shaping perspectives of power as a pervasive influence. His work in *Discipline and Punish: The Birth of the Prison* (1977) draws comparisons on the historical forms of punishment in the form of violent physical assaults on the body to the more civilised softer approach of 'discipline' such as incarceration. He identified that the 'softer' form of punishment also has a darker side, in its penchant for total control, and the demand for an inner transformation "The soul is the prison of the body" (Foucault, 1977, p.30). Foucault then goes further to state that this form of disciplinary approach to criminals has become a model for other institutions such as schools and hospitals, with the birth of the prison marks the birth of the "disciplinary society" (Ibid, p. 216). "The power to punish is not essentially different to that of curing or educating" (Ibid, p.303). He continually reinforces the links between discipline and individualisation, claiming "the disciplines function increasingly as techniques for making useful individuals" (Ibid, p211).

Foucault provides military training as an example of a modern approach to discipline, with the aim to produce 'docile bodies': "bodies that not only do what we want but do it precisely in the way that we want" (Ibid, p.138). In this

sense disciplinary power creates individuality out of controlling the body and soul it increases their power whilst also rendering them docile.

Foucault challenged the view of power as a discreet act of domination or coercion by people or groups to control others, he proposed instead that power is everywhere, it is 'capillary' like in that it is embedded and diffused in knowledge; it is neither exclusively agency or structure, power comes from everywhere (Ibid). His theory of power is distinct in three ways: that power is productive rather than repressive, that it is exercised as opposed to possessed and that it emanates from the bottom up (Ibid). Power according to Foucault is a relationship between people as the actions of one will affect another (Ibid). Power exists within all human relationships and permeates through society and individuals "are always in the position of simultaneously undergoing and exercising this power" (Foucault, 1980, p.98).

Disciplinary power is essentially productive and has extended through the production of knowledge particularly in the positivist and hermeneutic sciences and through the disciplinary techniques of surveillance, examination and discipline. Observation is a key mechanism through which disciplinary power forces a person to act in a certain way. "Disciplinary power is exercised through its invisibility, at the same time it imposes on those whom it subjects, a principle of compulsory visibility. In discipline it is the subjects who have to be seen" (Foucault, 1978, p.187). In this sense discipline is applied through a process of surveillance, or by the power of the imaginary gaze (Foucault, 1977) as whether observed or not individuals begin to control their thoughts and behavior to that what is expected and become "docile bodies" (Ibid, p.136). Hence individual bodies are observed, controlled, disciplined, transformed and improved (Ibid).

Gilles Deleuze 1925-1995 a philosopher and Felix Guattari 1930-1992 a psychoanalyst and political activist also examined power but conceived it as an individual endeavor and believed people have the "power to be" (Deleuze & Guattari, 1988). However they preferred the use of the term "desire" instead of power, as the person is an embodiment of their power and what they can achieve (Ibid). Deleuze and Guattari's (1988) theory of desire

consists of three elements: desiring production, assemblages or desiring machines and the Body without Organs (BWO). Desiring –production is productive in that it creates differences or something new, this is neither good nor bad but is creative. According to Deleuze and Guattari desire only exists as a desiring-machine in *Anti-Oedipus* (1984) and as an assemblage in *A Thousand Plateaus* (1988). “Assemblages are passionate, they are compositions of desire. “Desire has nothing to do with a natural or spontaneous determination; there is no desire but assembling, assembled desire” (Deleuze & Guattari, 1988, p. 399). The BWO is the space in which the assemblages realise its desire and where production occurs unconstrained (Deleuze & Guattari, 1988).

Their theory (Deleuze & Guattari) includes the examination of lines that make up the assemblages or desiring machines. Molar lines are rigid and segmentary and prohibit creativity and productivity, often dictated by the organisational structure. Molecular lines are less rigid and segmentary but still follow a distinct path within the organisation. Lines of flight represent an escape from the two other restrictive lines and lead to liberation and creativity outwith of the organisation (Deleuze & Guattari, 1988). Lines of flight exist when the molar and molecular lines breakdown or where something new develops. The process of the BWO is “directed towards a course of continual becoming” (Message, 2005, p.33). The process of “becoming” is a creative productive transformation towards a new way of “being” according to Deleuze and Guattari (1988). Nomadism as defined by Deleuze and Guattari (1984; 1988) and describes the multiplicity of lines of flight that resist the creation of a “docile body” (Foucault, 1977) and promote ultimate survival. This is the “pure movement evident in changes between [AH] particular events” (Deleuze & Guattari, 1988, p. 21). The nomad is a way of being that is between two points, characterised by change and development that is unrestricted by the organisation and enjoys an autonomy and direction of its own (Deleuze & Guattari, 1988).

2.7 Summary

This research aims to address the conceptual gaps in this field by taking a novel approach that is original in both its emphasis and context. It asks student (MH) nurses to narrate their journey of nurse education and specifically focuses their reflections on whether and how a programme that explicitly espouses caring philosophy actually does this through the values and aims of the curriculum and the pedagogic practices of its teachers. When student nurses' perspectives are exposed, nurse educators may be further aware of what student nurses really need and how they can be aided in learning about being caring in practice. The literature employs a conceptual framework spanning theories of nursing, education/nurse education, and philosophical theory. The research will utilise narrative practice methods in various forms based on the established conceptual anchors from literature and utilises an interpretive phenomenological analytical framework to expose subtle interpretive layers. Finally, the research presents its meanings in relation to the narratives from established philosophical concepts.

This qualitative study intended to explore the student (MH) nurses' perspectives on learning about caring from the students' points of view and gain insight into the possible ways to improve and sustain student (MH) nurses' caring abilities within contemporary healthcare services.

Chapter Three: Methodology

3.1 Overview

Nursing is rich in holistic explanations of human phenomena; this strongly connects to a strong conceptualisation of 'caring' and personal transformation (Watson, 1988, 1990, 1996; Newman, 1994; Freshwater, 2002). There is a need to use non-traditional methods of enquiry to study this kind of transpersonal caring (Watson, 1985). This chapter details the processes and procedures used in this phenomenological study. This investigation aims to reveal the lived experiences of becoming an (MH) nurse, including the participants' personal development, growth, and transformation, all of which are not readily available utilising a quantitative approach, based upon the precepts and practices of empirical science (Watson, 1985). Therefore, in the tradition of nursing scholarship and following the recommendation from Watson (1985), the utilisation of a phenomenological approach to study the concept of caring was selected.

All research questions are located within a paradigm in which they exist (Kuhn, 1970; van Manen, 1990). Some studies have utilised a quantitative approach towards measuring the caring behaviours of nurses and nursing students (Watson, 2008b). However, the aim of this study was to more specifically access the student nurses' perceptions and narratives of their lived experiences, which would be problematic to accurately measure. Therefore, the most suitable approach for this study was to ask the participants to share their lived experiences. As there was no intention to separate the participants from the topic, an epistemology that treasures such personal reflections was required. Hence the phenomenological approach to lived experiences, as explicated by van Manen (1990, 2014), forms the philosophical/methodological basis for this study.

This study covers seven main areas of methodological structure: Methodological Framework and Design, Interpretive Phenomenology, Selection Procedures, Data Collection, Quality and Ethical Procedures, and the Management of Data and Analysis. In the first stages of the study, initial

interviews with the nine student (MH) nurses were conducted between March 2014 and December 2015. After this, the interviews were transcribed and analysed, leading to the interpretation of the data, reporting of the findings, and discussion of the findings in relation to the theoretical and philosophical stances.

3.2 Methodological Framework and Design

This is an inherently qualitative study aimed at exploring the complex and taken-for-granted phenomena that are 'caring'. This research design enables the capturing of thick description (Geertz, 1973) of the meaning that participants bring to the phenomenon of caring. Phenomenology has no intention or aim to develop a theory or to solve a practical problem, it is "more a method of questioning rather than answering" (van Manen, 2014, p. 27). This makes this method ideally suited to the aim of the study: *to explore and examine student nurses' lived experiences of caring within the context of their graduate nurse education programme within an HEI in the UK.*

There has been a significant increase in phenomenological studies in the field of healthcare in recent years (Beck, 1994) because this method is ideally suited to understanding people's experiences of their health or illness and of their nursing care (Nelms et al., 1993; Sandala & Adorno, 2002). Van Manen himself has conducted phenomenological research in relation to nursing (1999). Within nurse education, there have also been several phenomenological studies on caring from the perspective of student nurses (Watson, 1999, 2001; Lundberg & Boonprasabhai, 2001; Kapborg & Bertero, 2003), all of which serve to reinforce phenomenology as an appropriate methodological approach.

3.3 Interpretive (Hermeneutic) Phenomenology

The term 'phenomenology' derives from the Greek word *phainomenon*, which means appearance (Holloway & Wheeler, 2002). Phenomenology is essentially an approach to philosophical study and as such has often been misunderstood as a method of inquiry. Caelli (2001) argues that "because phenomenology is first and foremost philosophy, the approach employed to

pursue a particular study should emerge from the philosophical implications inherent in the question” (p. 273). In order to address this, the three key questions of this study were examined in relation to the philosophical underpinnings and orientation. To achieve this, the researcher must first have an awareness of the origins of phenomenology and the different schools that have emerged within this field.

Phenomenological philosophy seeks to answer two key questions: the epistemological ‘how do we know’, referring to the nature of knowledge and what can be known, and the ontological ‘what is being’, relating to the nature of reality and our knowledge about it (Holloway & Wheeler, 2002). This means asking the question, ‘what does it mean to be a person?’ (Koch 1994) hence ontology is central to the interpretive process (Taylor, 1994). When considering how researchers can make use of interpretive phenomenology, particularly within pedagogically orientated contexts:

When we raise questions, gather data, describe a phenomenon, and construct textual interpretations, we do so as researchers who stand in the world in a pedagogic way ... pedagogy requires a phenomenological sensitivity to lived experience [that contributes] to one’s pedagogical thoughtfulness and tact (van Manen, 1990, p. 1–2).

Phenomenological methodology, therefore, involves a person's lived experience and the way in which they construct meaning from this within the context of functioning and communication (Cole & Knowles, 2001; Rossman & Rallis, 2003), specifically in regards to a specific phenomenon (in the case of this thesis, caring). Such lived experiences, or ‘lifeworlds’, are insights into people’s conscious lives and they reveal complex themes, surrounded by shifting values and dissonance with the participant’s inner lives. These are influenced by the pedagogical context in which they are located.

In organisational terms, within this research, the underpinning aim was to provide a voice for the participants to narrate their stories of caring within a nursing programme (as the phenomenon under study), but to do so by anchoring it in the overarching structure of their lifeworlds. The idea of the ‘lifeworld’ (*Lebenswelt*) is an important element of phenomenology

developed by students and colleagues of Husserl, which acknowledges that ordinary and commonplace experiences are not usually noticed. As such, phenomenology can help reveal and examine those lived experiences that are usually hidden or taken for granted (Cohen et al., 2000). According to van Manen (1990, p.10), “phenomenology asks for the very nature of a phenomenon, for that which makes a some “thing” what it is – and without which it could not be what it is” (Merleau-Ponty, 1968; Husserl, 1970). A key characteristic of phenomenological study is its location within the lifeworld. This is the world of everyday life, which Husserl identified as original, pre-reflective, and pre-theoretical. The concept of lifeworld is “the world as we immediately experience it pre-reflectively rather than as we conceptualise, categorise or reflect upon it” (van Manen, 1990, p. 9). Phenomenological reflection is always retrospective and not introspective; it consists of reflecting on a lived experience already passed (Ibid).

Another important concept relevant to phenomenology, and to this study, is that of inter-subjectivity, which was also developed by students and colleagues of Husserl (Cohen et al., 2000). Each participant involved in this study shared a common world, that of being in a student (MH) nursing community, and that world becomes accessible through the empathy they share with others in that community. The act of making sense of experiences is essentially inter-subjective (Schwandt, 2001). We understand and make sense of the world through the stories we tell; we are continually producing narratives to order and structure our experiences in life (Polkinghorne, 1988). People without narratives do not exist, everyone has, a story to tell. Hence, the focus of interpretive phenomenology is on ‘making sense’ and giving voice within context (Larkin & Thompson, 2012).

It is useful to appreciate the development and theoretical underpinnings of the methodology, including its philosophical origins. In philosophical terms, Husserl was the founding figure in the development of modern phenomenology, from which three main schools have emerged: Husserlian (1859-1938) Transcendental Phenomenology, Heideggerian (1889-1976) Hermeneutic Phenomenology, and the Existentialist Phenomenology of

Merleau-Ponty (1908-1961) and Sartre (1905-1980). Each school seeks to describe the lived experience of a phenomenon but from a differing perspective. Husserlian phenomenology considers that objective knowledge of the world comes from subjects knowing objects, so it involves *describing* a phenomenon (Dreyfus, 1991). The Heideggerian approach is more focused on *interpretation* and understands that “an understanding of the person cannot occur in isolation from the person's world” (Walters, 1995, p. 792). Lastly, existentialist phenomenology is concerned with analysing the notion of *being*; the ideas of *existence* and *essence* are from Sartre, who believed that “a person’s actual consciousness and behaviour (existence) precedes character (essence)” (Cohen, 1987, p. 31). Taking these different approaches within phenomenology are many influential figures, including Husserl, Heidegger, Sartre, Merleau-Ponty, Ricoeur, Marcel, and Gadamer. Heidegger’s interpretive approach was selected for this study as the most compatible in terms of understanding the meaning of the phenomenon for each person’s lived experiences in relation to their nursing and educational milieu. The central concern of interpretive phenomenology stems from Heidegger’s work on ‘Dasein’, which translates to ‘being-in-the-world’, or in everyday use ‘existence’. Within Heidegger’s philosophy, the key phenomenological concern is focused on how, as part of ‘being-in-the-world’, we engage with other objects or people that necessitate some concern or care. This is central to this study, as the main purpose is to expose what matters to the student nurses as part of their educational journey, in relation to being caring. Therefore, their ‘being’ and what is stated to exist is subject to their meaning making and how it is made sense of, in their worlds, within context.

Watson and Smith (2002) defined caring science or transpersonal caring as “an evolving philosophical-ethical-epistemic field of study that is grounded in the discipline of nursing and informed by related fields” while “located in a worldview that is non-dualistic, relational, and unified” (p. 456). The power of caring theory is significant in its ability to help nurses reconnect with themselves, their patients, and their peers. Caring theory offers “reminders of what we already know at some deep human, experiential level, but

continually pass over in our day-to-day living” (Watson, 2001, p. 197). This conceptual view of caring within nursing resonates with the hermeneutic phenomenological perspectives on consciousness, inter-subjectivity, and the meaning that arises from everyday lived experiences (van Manen, 1990). This hermeneutic element of interpretation was introduced by focusing attention on how we make sense and meaning of our worlds.

Many existing studies expose nursing as a complex practice and nurses themselves as having multiple identities and voices. Nurses narrate to themselves stories of caring and concern, salvation and solicitude, healing and helping. We speak of the multiple and different lifeworlds to which we belong, and each of us encounter different lifeworlds at different times of the day, such as the lived world of home, the lived world of work, and the lived world of education (Schutz & Luckmann, 1973). If education is to cherish and nurture caring nurses, it needs to seek the appropriate critical pedagogy to achieve this. Interpretive phenomenology is ideally suited to explore each of the student’s lifeworlds and how they intersect or intertwine. To date, the majority of research studies on the subject of student nurses’ development of caring has focused on objective measurement of their caring values (Watson, 2008b), neglecting the inherently subjective process of transformation. Hence, interpretive phenomenology not only offers utility as a new approach to understanding what is meaningful and what impacts on the participant’s development of caring as a nursing student, but also as an evaluative tool. One example of this may be highlighting the strategies found to be useful or advocated as successful in promoting a caring approach.

As discussed above, there are many positions from which one can engage with phenomenology as both a philosophy and a research methodology. These range from the purely philosophical to the thoroughly interpretive, including Grounded Theory and Ethnography (Lowenberg, 1993). Phenomenology “is not a single, unified philosophical standpoint” (Schwandt, 2001, p. 191), however, “basic to all these approaches is the recognition of the interpretive and constitutive cognitive processes inherent in all social life” (Lowenberg, 1993, p. 58). Referring back to the research questions identified

for this study, we can observe that in relation to each of the questions there is a sense of searching, not only for the describing of the 'object' of the experience, which would dictate a Husserlian approach to caring, but also for the meaning given to the 'object' within the lived experiences as part of their educational programme. This indicates a more Heideggerian approach. This study takes this approach in order to answer the question of experience and meaning. This philosophical stance both accepts and promotes that people are inseparable from their world (Taylor, 1989).

This study is characterised by an interpretive response and is contextualised within an explicitly 'applied' discipline, namely nursing academia within Higher Education. It is orientated towards a 'Phenomenology of Practice' (van Manen, 2002). It therefore stands as (ontologically speaking) a study in which consciousness is distinct from observed reality, but that can only be understood as being mediated through reality. Whilst it is acknowledged as a useful method for examining phenomena in practice settings, such as nursing, psychology, and education, it is also relatively new and can be seen as problematic (Lawler, 1998; Streubert & Carpenter, 1999). There can be tensions when trying to apply an essentially philosophical approach to a practice discipline (Lawler, 1998), however, three important areas that phenomenology can contribute to nursing research are grounding, reflexivity, and humanisation (Todres & Wheeler, 2001).

In this study, the methodological stance adopted to answer the question of experience and meaning is the Heideggerian (hermeneutic) phenomenological inquiry. Hermeneutic research will never arrive at a generalisable theory: its aim is to portray life and the world, to make them understandable rather than claim their universality (Faulconer & Williams, 1985). Any Heideggerian phenomenological inquiry is concerned with human experience as it is lived and what it means to the person living it (Todres & Wheeler, 2001). The participant engages in dialogue with the researcher about the lived experience of 'being-in-the-world'. The principle of incorrigibility (Paley, 1998) is one in which the participant's experience is "*inalienably*" (Ibid, p. 821) their own, but the description must be a faithful

reproduction of this. This faithful reproduction is implausible (Ibid) as there must be a shared interpretation, one in which both participant and researcher search for a common understanding. Two participants may share the same experience but assign to it differing or even opposing meanings. The *meaning* of the experience must be the aim of the interpretation. Nothing is revealed as anything until we encounter it and bring it into the context of human life (Polit & Hungler, 1999).

The being of the entity is found only in and can be explained, made understandable, only from the phenomenal exhibition and interpretation of the structure of encounter. Thus, any discoveries must necessarily be a function of the relationship that pertains between researcher and subject-matter (Heidegger, 1985, p. 217).

Traditional phenomenology demands that any pre-understandings by the researcher are recognised and put aside so that there is only minimal impact on the description of the participant's world. This is known as 'bracketing' (Husserl, 1970). Heidegger's hermeneutic phenomenology does not demand such bracketing, as the research process encompasses the existing world and its meanings for the researcher (Lowes & Prowse, 2001). Dreyfus (1991) considers Heidegger and implies that while *Dasein* is the subject knowing the object (the world), these two are so intertwined that one cannot be separated from the other. Many believe that as a researcher, it is not possible to ignore or bracket their own experience and pre-understandings as they are inextricably linked to interpretation. To expect researchers to do this is futile (Thompson, 1990; Annells, 1996; Gadamer, 1997).

Phenomenology was selected as a methodology to give student nurses a voice in describing what, for them, may well be a meaningful experience in terms of the concept of caring. This term is beset by paradox as it is predominantly described in subjective terms by students, and yet they encounter it in policy and statutory terms, frequently as the objectification of particular actions leading to desired targets or standards. Phenomenology thus permits a phenomenon that is frequently unidentified and maintains a concealed quality for the participants themselves to be clarified and to establish validity for personal experience. However, it can be argued that

once themes of "an experience have been identified, they can then become objects for reflection by the researcher and participant" (van Manen, 1990, p. 182).

This situation amounts to the problem of 'naming' caring. There is a problem with identifying its realisation and intent, despite actually admitting to it without it being misunderstood and misinterpreted. Phenomenology has particular strengths in this context, related to how it can alert one to existing understandings and sharpen one's reflective lens.

It is all to do with how phenomenologists 'name' the object of their reflections and/or research. Approaching an aspect of practice... and speaking about it in this way, using a language quite different from routine descriptions of it, can work to subtly sharpen a lens of objectivity unexpectedly available despite the apparently overwhelming degree of subjectivity embedded in the actual process of 'uncovering' (Thompson, 1990, p. 3).

In spite of the strengths of subjectivity and meaningful personal participation facilitated by interpretive phenomenology, its purpose in this study is not only to expose caring values and behaviours. This approach is also used to contribute to a more rounded and richer understanding of how experiences within nurse education are perceived by student nurses. The point of phenomenology "is to gain a better universal understanding of phenomenon. From the individual descriptions, general or universal meanings are derived, in other words, the essence of structures of the experience" (Moustakas, 1994, p. 13). An interpretive phenomenological approach requires "open research questions focused on the experiences, and/or understandings, of particular people in a particular context" (Larkin & Thompson, 2012, p. 103). Hence, this and the inductive nature of interpretive phenomenology led to a flexible research design that could be responsive to the emergent themes as the research process progressed and allow the optimum potential for discovery (Suter, 2012).

As individuals we are continually producing narratives to order and structure our experiences in life, as it helps us to understand and make sense of our world. (Ricoeur, 1981; Connelly & Clandinin, 1986; 1990). Thus, narrative

research studies are increasingly being used to study educational practices and experiences (Gudmundsdottir, 2001) as part of the qualitative or interpretive research tradition. While narrative research is a recognised method of inquiry (Carter, 1993; Gudmundsdottir, 1997, 2001), others view narratives as a producer or transmitter of reality (Heikkinen, 2002). It is the latter form in which narratives are considered within this study, as a representation of the student nurses 'lifeworlds'. Narrative research focuses on how individuals assign meaning to their life experiences through the stories they tell, so in this study, the researcher gained access to the individual's stories which have given meaning to their experiences of nurse education. However, people's knowledge and identities are dynamic, responding to new and conflicting experiences leading to a constantly forming and changing narrative. Hence, human knowledge can be regarded as a plurality of small narratives, local and personal in nature that is always under construction (Heikkinen, 2002).

The concept of dialogue is useful when considering the construction of narratives (Bakhtin, 1986), and there are three central concepts involved: utterance, addressee, and voice. Essentially, an utterance is a voice, which may be spoken or written, or which may be a thought, depending on who it is aimed at. An utterance always has an addressee; this can be ourselves on a psychological level or other people we meet or connect with. The addressee influences the voice, for example, a teacher will speak differently to children in the classroom from how they would talk to colleagues. Thus, an utterance will reflect at least two voices, the speaker and the addressee. In fact, Wertsch (1991) and Gudmundsdottir (2001) argue that the plural term 'voices' should be used. It is not only the voices of the speaker and the addressee that are reflected, but also other voices intertwined through a person's life culture and history:

One finds no singular voice because any claimed voice is a heteroglossia of culturally situated voices that ventriloquate through the singular voice that is claimed by the individual (Gudmundsdottir, 2001, p. 235).

Researchers have a unique role in this phenomenological research as they engage in theme-oriented dialogue where the outcome of the research “depends on the knowledge, sensitivity, and empathy of the interviewer” (Kvale, 1996, p. 105). However, they are also required to ‘bracket’, that is to review and suspend preconceptions and biases that they bring to the research (Polkinghorne, 1988; MacKnee, 2002). Interpretive phenomenology has an ‘epistemological openness’, and the lack of *prior* assumptions enables a connection with diverse bodies of knowledge. This stance compliments the extant research on caring; it does not seek to limit or categorise meanings but rather enables a process which is complex and fluid. As a result, the researcher’s own experiences and beliefs must be subject to critical reflexivity (Goodson & Sikes, 2001) and as such are explored in the following section.

3.3.1 Reflexivity

The phenomenological and ontological approaches of this study (into the lived experiences of the student (MH) nurses) both recognise the role of the researcher in the research and the inevitable connections made between the aims, methods, and interpretative layers exposed. The study has permeated all aspects of my being and over the years has ranged from being totally absorbing to absolutely nauseating at times. It has caused me many nights depriving me of sleep and sanity. Nevertheless, despite its peaks and troughs, my motivation has remained sufficient to enable me to reach this point of reflecting, looking forward to transforming as a person and as a nurse educator. As a practicing nursing academic, I recognise that I hold my own narratives of education and nursing. Reflexivity is the process of reflecting critically on the self as a researcher, the “human as instrument” (Guba & Lincoln, 2013, p. 198). We bring three distinct categories of self: brought/personal self, situational self, and research-based self (Reinharz, 1997). It is necessary to interrogate each of these selves in relation to the decisions we make regarding the research process, but also our interactions with the participants’ multiple selves, which gives rise to a “more complex and dynamic challenge in representing the study” (Denzin & Lincoln, 2013, p. 255).

3.3.2 Brought self/Personal self

Rather than provide a life history, I will examine the personal views and insights that became relevant during the course of my research study. The birth of the study stemmed from my personal convictions and belief in myself as a caring person, whatever challenges life presents. In a personal counselling session, I became aware that this can lead me to take on too much responsibility for others, by trying to do things or solve problems for them that may ultimately dis-empower or even infantilise individuals. So, my naïve belief that being caring and altruistic is always a positive virtue has been slightly amended; caring too much, or taking responsibility for others, can have a negative impact both on myself and on those connected with me. Nevertheless, I was aware that when interacting with the participants, I wanted to demonstrate my appreciation for them agreeing to take part in the study and I wanted to continue the 'caring' empathic approach that I hope I demonstrate during my interactions on a day to day basis.

My teaching has been essentially humanistic and holds a belief in the potential of every person. I have a strong preference for more experiential methods of learning, however, due to the changes in contemporary nurse education and an outcome-based curriculum, it has become increasingly difficult to protect this philosophy, and I am becoming more aware of my own cognitive dissonance in delivering teaching within a restrictive outcome-measured framework. It has led to me continually challenging my abilities and credibility as a nurse educator. I think I have managed to survive by maintaining a connection with the students as people in need of help and support, and this provides me with the satisfaction needed to continue.

3.3.3 Situational self

It was not until I actually started the interviews with the participants that I became really excited and convinced that the study was becoming real. However, alongside this came the nervousness and the self-doubt. Going into the interviews, I felt fairly confident that I would be able to 'interview well', having a background in counselling and a person-centred approach. I

felt that I would not lead or direct the responses of the participants, which was vital as the interview is “the hallmark of qualitative research” (Rossmann & Rallis, 2003, p. 180). Through effective interviewing, an understanding of the participant’s world is gained through experiencing the participant’s speech and responses. This provides a means of ‘seeing’ and ‘experiencing’ the participant’s experiences and is designed “to provide a framework in which respondents can express their own understanding in their own terms” (Patton, 1990, p. 205). Within this study, this notion of expressing understanding in one’s own terms is critical to entering the participant’s lifeworlds. I was very aware of being empathic in my approach, trying to see the person and their lived experiences of the nursing programme without projecting my own views. I was conscious of aiming to reach the other’s experience while realising that we are “bound by our shared participation in a matrix of participation” (Wertz et al., 2011, p. 317). This premise of empathy between self and others offers an opportunity for a deeper and more articulated understanding, but this also meant I was very conscious of not leading the participants.

During each interview, my aim was to establish the participant’s perceptions of their lived experiences of caring whilst on the nursing programme. In addition, for myself, I aimed to find out how I, as a nurse educator, can help them in their development of caring values and behaviours. I had some expectations in relation to how caring is exposed within the programme, from both my own experiences and the literature. However, during the interviews, it became apparent that some of the influences I thought may be relevant were not being perceived as such by the student (MH) nurses. For instance, the concept of nurse educators being role models as a key method for ‘learning caring’ (Watson, 1988; Diekelmann, 1990; Brown, 1991; Miller, 1991; Nelms et al., 1993) was not highlighted by any of the participants. Being open and transparent about my own being and becoming in this process is important, and as the motivation for the study, is bound up, in ‘who I am’ and ‘what I value in others’ (my self-identity). As I explored with the participants their values and motivation for entering nursing, I was aware of my own, and while I considered myself as being caring, nursing was not

something I had initially thought of as a career. Considering my background, I was not expecting the high level of motivation and commitment expressed by all the participants and their personal insights into caring about or caring for others.

3.3.4 Research self

My view of myself as a novice researcher meant that I had no definite views on how I would proceed. As such, this was not decided rigidly or formally from the beginning as this may have restricted the fluid nature of the research process. There was plentiful opportunity for new insights and even changes of direction along the way. Intrinsic to this study has been the eventual aim of ensuring a meaningful, well-planned, and ethical outcome for all those involved in this study. I struggled for several months in deciding the focus of my research, changing several times, but the concept of caring was always involved. Whether I should study how nurse academics are caring, or how they expose caring values to student nurses, being immersed in the field of nurse education obviously influenced my ultimate decision. Extended immersion in the field would ensure that I, as a researcher, would acquire a more global view of the phenomenon being studied (Rossman & Rallis, 2003). I finally decided that it was the study of the student nurses' perceptions that could offer more insight and meaning to the nature of the nursing programme, how and where 'caring' occurs, and how that can impact on their subsequent development of caring values.

Within this research, I was fundamentally an 'insider' (Merton, 1972), a professional carrying out a study in my own work setting and as such engaged in practitioner research (Robson, 2002). I was an insider in two ways: as an individual nurse educator with a desire to care about all students, and as an insider who processes '*a priori*' intimate knowledge of the community because I had an in-depth knowledge of the University, its curriculum, and the participants. This situation brings both positive and negative results. The positives of being an insider included that I did not have to deal with any culture shock, I was able to enjoy enhanced rapport with the participants, and I could be seen by the respondents as empathetic (Kvale,

1996). However, it is not surprising that insider (practitioner) research has been the cause of much debate and scrutiny. Positivists may argue that, because of their involvement, the researcher is no longer 'objective' and their results may be distorted. Thus, the validity of insider research is threatened (Ibid, 1995). Supporters of anti-positivism and anti-positivist qualitative research claim that the arguments against insider research, in fact, apply to all types of research; one can never guarantee the honesty and openness of subjects, and research is always coloured by subjectivities. Complete objectivity is therefore impossible, but the task is to minimise the impact of any biases on the research process. To carry out research is to be conscious of, and to make the researcher's position and the research process transparent (Hammersley, 2000). By making the research process transparent and honest, readers are able to construct their own perspectives which "are equally as valid as our own" (Cohen et al., 2000, p. 106). However, many researchers will agree that it is important to recognise our own limitations and potentials as researchers (Hammersley, 2000).

Although caring is considered a universal concept and an essential aspect of nursing, there are several meanings applied to the term when used in different contexts. This creates a methodological problem when studying 'caring' as "researchers seldom discriminate between 'perceptions' of caring, the 'concept' of caring, the 'experience' of caring and caring itself" (Paley, 2001, p. 190). While many agree that caring is an essential part of nursing, "it is difficult to imagine any other health related discipline arguing for lack of conceptual clarity about the key concepts that underpin and inform their practice" (Cutcliffe, 2003, p. 342). This lack of agreement in relation to what constitutes caring is on-going, while its relationship with nursing is more definitive. Caring emerges as a concept which, while not fully developed, is central to the theory of nursing (Mayeroff, 1972; Crowden, 1994; Watson, 1999, 2008b; Roach, 2002).

Within this study, caring was not defined for the participants and was deliberately left open because it was important not to restrict their perceptions of caring. However, following analysis of the participants'

narratives it became clear that in fact, they may have been referring to different notions of caring. It was therefore felt that a short reflective piece from each participant describing their understanding of 'caring' would enable a more meaningful insight into their narratives and lifeworlds. Therefore, each participant was requested to complete a 500-word piece relating to the following prompt: 'Caring is...' (Appendix A). When examining their responses, it emerged that the effective element featured most strongly, with only two participants considering the instrumental element of caring in their reflection. So, from this it could be derived that when the participants talk about caring, the majority of time they will be referring to the emotional aspect of caring.

3.4 Selection Procedures

The aim of this study was to gather representative, rich, and truthful information about people, settings, social processes, and discourses based upon the research questions, in order to perform an in-depth analysis (Cole & Knowles, 2001). When describing the selection of the setting, context, and participants, I hope to establish the scope, purpose, and limitations of the research as well as the boundaries to enable the value or utility of the study to be judged (Rossman & Rallis, 2003).

The purpose of this study was two-fold: to gain an in-depth understanding of the place of care in nurse education and teaching, especially within Higher Education, and to examine how students' perspectives on caring are experienced on the educational programme. As such, I purposefully chose their own University; as mentioned earlier regarding practitioner research, this offered several advantages as opposed to following the futile quest for objectivity by selecting another University. In the next section, I outline the University context in which the pre-registration programme occurs and on which the participants in this research study. It is identified as HEI to avoid naming the specific institution. The naming of the institution was discussed during supervision, and it was agreed that the institution or its specific nature was surplus in the lived experiences of the participants.

3.4.1 The setting

The HEI in the study is situated within the UK. Originally a Mechanics Institute, it became a Polytechnic in 1969, complementing and reflecting the industrial heritage and activity of the region. Perhaps the greatest change for the HEI came in 1992, when it became a University or a 'New University', as ex-polytechnics are frequently termed in the media. The Schools within the University cover broadly conceived subject areas and the one chosen for this study, Health & Social Care, is arguably the most diverse in disciplinary and scholarly terms. Since 2000, the School has grown from 3,000 students to over 11,000 at present. This has been achieved by diversifying into many new areas associated with Health and Social Care. There are 225 academic members of this school engaged in a range of pedagogic activity, from Foundation Degrees through to Doctoral work, and from completely online tuition through to solely face-to-face teaching. The School is commissioned by NHS Health Education England (HEE) to deliver full-time programmes in nursing, midwifery, physiotherapy, occupational therapy, diagnostic radiography, medical ultrasound, operating department practice, foundation degrees (various), improving access to psychological therapies, dental nursing, dental hygiene therapy, and clinical psychology. The School also delivers social work and paramedic courses. The School's research institute has an ever-growing international reputation in the areas of public health, rehabilitation, service evaluation, and end of life care. It works collaboratively with the other Universities in the UK and collectively has enabled significant funds to be channelled into public health in the broadest sense. The School also has partnerships with other universities both nationally and internationally and has had research nationally and internationally acclaimed. The University has developed a range of international partners across Europe and Asia, with proposed developments in Africa and the Middle East. These programmes support global health workforce development and help to build human capacity so that developments become sustainable. The Quality Assurance Agency (QAA) for Higher Education has thus far identified units of teaching 'excellence' in Art & Design, computer science, history, social work, sport and exercise, electrical and electronic engineering, nursing, and a number of subjects allied to medicine.

3.4.2 The participants

The potential participants in this study included six different cohort groups of nursing students, each comprising approximately 260 students each September cohort, and 180 each January cohort, equalling approximately 1,320 student nurses. From this sample population, it was decided that any group in Year One would not have sufficient insight into the programme to give an opinion and Year 3 students would be focusing on their dissertation and final practice placements. Therefore, a sample group cohort (n=260) nearing the end of their 2nd year were invited to take part.

The nine participants who agreed to take part in the study provided brief biographical information as shown in Appendix H. Each participant had their own individual narrative of the insights and experiences that led to them a career in mental health nursing. While the findings are presented thematically in the next chapter, Appendix H provides a more unique and personal insight into each participant's biography and also acts as a reference/identifier point for the narrative extracts used in the chapter. The gender of each participant is identified, however, this information is not analysed or discussed in relation to the gendered nature of caring as argued by Gilligan (1977) and Noddings (1984).

Qualitative and interpretive research usually works well with purposive non-probability samples as it seeks to gain insights into particular practices or situations. Purposive sampling seeks to identify information-rich cases which can be studied in depth (Patton, 1990). The sample size for a Heideggerian study is difficult to determine. The sampling method used for this study was a purposive sample of student nurses who were willing to be involved in the study as "all sampling in qualitative research is purposive sampling" (Patton, 1990, p. 169). The aim in participant selection was to choose those who have the lived experience of caring as encountered within the pre-registration nursing programme and who are willing to talk about that experience (Polkinghorne, 1988; van Manen, 1997).

Once all the permissions and processes were in place, I was able to approach the student nursing population. I approached all four fields of nursing (Adult, Child, Mental Health, and Learning Disability) as this would offer a broader range of experiences and student narratives among nursing students within a particular year group. Approximately 260 students were sent an e-mail by an administrator on my behalf, requesting that they express an interest in participating by responding to myself. After two weeks, I had received only two responses, and these were both from mental health students. I then sent out a further reminder e-mail via the Administrator to the same group. As 'insurance' it also included another year group of approximately 180 (having gained permission to approach this additional group of students from the Director of Pre-registration Nursing). This produced no further volunteers from the original cohort, however, seven volunteers contacted me from the 'insurance' cohort; they were all mental health students. I reflected on the possible reasons for the poor number of responses from the students. These may have included not accessing their e-mails, being out on practice, and the workloads of the students. However, I still found it difficult to understand, given the significant number of students approached (440), that only nine had shown an interest in being involved in the study. I desperately wanted to follow up the reasons for this and ask the students why they hadn't volunteered, but of course, this was not possible and could have been considered coercive in some way. So, with this in the back of my mind, I realised I had to focus on beginning to collect data from the participants who had volunteered.

3.4.3 Informed consent and permissions

In essence, ethical practice and ethical codes rest on the principles of assuring the free and willing consent of participants to take part, ensuring the confidentiality of the material and protecting participants from any potential harm from their participation (Sieber, 1992; Kvale, 1996; Smythe & Murray, 2000). To ensure ethical research practices, the procedures for obtaining informed consent and permissions were adhered to (Rossman & Rallis, 2003). In addition, the University's Internal Ethics Committee Procedures

were followed. There are four main principles that were applied when gaining informed consent:

- *Transparency of the purpose of the research, to the audience and the research community;*
- *Full understanding of the participant's agreement to participate;*
- *Willing consent;*
- *Right to withdraw without penalty or consequence.*

(Ibid)

All of the participant information forms and questions developed within the study were written with these principles in mind, and the project and the forms were reviewed and approved by the researcher's Durham University Ethics Committee in the academic year 2013/14. The Ethical Approval Form is attached in Appendix B.

3.4.4 Informed consent and confidentiality

Informed consent and permissions serve to protect the participants of any research study in two ways: by assuring privacy and by concealing identity (Rossman & Rallis, 2003). Hence, the provision of information regarding how this would be ensured throughout the study is important and was addressed on the Participant Information Sheet (Appendix C). It was also revisited verbally prior to and following completion of the interviews. Informed Consent was gained following an explanation of the study and the processes and procedures involved; participants were asked to complete the Informed Consent Form (Appendix D). They were also informed of their right to withdraw at any time from the study without consequences, and this was reinforced on the consent form. Two other aspects relating to confidentiality were addressed: the protection of the data collected and the protection of the reputation of the participants. Every attempt was made to protect the confidentiality of the data collected. All information (recorded or written) and interview data were kept in a secure location at the researcher's place of work. To protect the identity of participants, pseudonyms (with three letter

names gained from a naming website) were used throughout the research for each of the participants. The confidentiality of the participants was paramount, and every effort was made to ensure this, by means of the use of pseudonyms and not directly naming the institution in which they were studying.

Due to the nature of interpretive phenomenology, participants were asked to share personal and professional details of their 'lived experiences' (MacKnee, 2002; Daniluk & Hertig-Mitchell, 2003). This was considered in the research design; during the interview, this may create a sense of vulnerability for the participants as they draw on sensitive or traumatic life experiences, especially when they are linked to how the past has, or perhaps will, shape the future (Daniluk & Hertig-Mitchell, 2003). In addition, the particular words that the participants use in interviews may enhance that vulnerability, through the possible sense of exposure. However, such dialogue between the researcher and participants played a major part in ensuring both the rigour and the representational quality of the study, and participants were given the opportunity to critically assess their portrayals within the thesis.

3.4.5 Gaining access and entry

The professional background of this researcher as a nurse educator within the School of Health & Social Care was helpful when arranging access to the HEI, the location for this study. All of the formal gatekeepers in the University were both supportive of and interested by, the research project. Thorough preparation prior to engaging in the research process is necessary to facilitate access to the participants, and part of this process includes establishing a rapport with the gatekeepers, establishing reciprocity, and establishing and maintaining professional credibility and reputation. A significant gatekeeper for this study was the Director of Pre-registration Nursing and their concern at the visibility of participants involved and any repercussions in terms of perceived teaching quality was relevant. A meeting with the Director took place in order to clarify several aspects of the study,

and as a result of these meetings, the Director was both fully informed and assured of the validity and integrity of the research process.

3.5 Data Collection Methods

The method selected to illuminate the concept of 'caring' was semi-structured interviews, following consideration of all the possible methods available. There were several ways in which data could have been collected, including focus groups, participant observation, and face-to-face interviews. These methods appear to have varying validity in terms of an interpretive phenomenological framework. Focus groups were considered incompatible with the Heideggerian approach because a large number of participants could 'contaminate' the description of experiences of the individual (Webb & Kevern, 2001). Conversely, it was felt that "a richer understanding of the phenomenon" (Bradbury-Jones, 2009, p. 668) could be achieved using individual interviews. Individuals need to have the "time and space, with minimal interruptions, to express their story" (Ibid, p. 669). Interaction is the essential feature of focus groups, enabling participants to question each other and to re-evaluate their own understandings of their experiences (Kitzinger, 1994). Focus groups have not been chosen for this study owing to both sample size and the need to preserve anonymity.

Face-to-face interviews were chosen as the method of data collection because these acknowledge "the complexity, uniqueness and indeterminateness of each one-to-one human interaction" (Scheurich, 1995, p. 241). There is a danger that the interviewee may want to "please the interviewer with a socially desirable response" (Bradburn, 1983, p. 291), but interviews will involve "higher order coordination of observation, emphatic sensitivity, and intellectual judgement" (Gorden, 1992, p. 7). Thus, the danger of the 'pleasing interviewee' can be countered by the interviewer being sensitive not only to what is said but also to how it is said, as well as noticing the interviewee's demeanour and body language while they are saying it.

Interviews with participants took place in a private room within the research area. At the beginning of each interview, the study information sheet was discussed, and any questions were elicited and answered. The right to withdraw at any time was reinforced. The participant signed the consent form, and a copy of this was given to them along with the letter showing ethical release by the local research ethics committee. The interviews were recorded using a digital voice recorder. I kept contemporaneous notes of my observations of body language during the interview to complement the audio recording, helping to look not only for what is verbalised, but also for what is expressed between the lines (Kvale, 1996). The data collection process began at the beginning of March 2014 and continued until December 2015. In the next section, the data collection procedure is described, along with an explanation regarding the justification of its use within this research study.

I was aware that within this study, the research questions would encompass past beliefs and experiences, and present identities and practices for the participants. As such, the interviews were critically aligned with the phenomenological nature of the experience of 'being caring' and based on phenomenological sensitivity (Ibid). I commenced the interviews with a broad, open-ended question to enable them to explore their background and motivations towards becoming an MH nurse. During the interviews, I was aware of demonstrating the capacity to understand and the ability to differentiate between what is important and what is not. This involves being sensitive to the situations where there may be influences or biases affecting the responses of the participants (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

The aim during the interviews was to facilitate a conversational style communication with the use of a few governing questions, but then following the direction of the participants' narratives with further prompts, paraphrasing, and non-verbal cues. This enabled the participant to describe their lived experiences in a fluent and unselfconscious manner, locating these descriptions in physical actions and behaviours (Thompson, 1990). Such a goal in phenomenology works from the premise that, normally, what

one expresses in speech is what one thinks.

So, the goal in phenomenological interviews is to capture the experience of the phenomenon through that which is spontaneously and unwittingly given, rather than through a thoughtful, intellectualised response (Merleau-Ponty, 1968, p. 126).

Although I was armed with a set of pre-determined questions for the interviews, the questions as set out in Appendix E, there was no attempt to adhere to the structure or to sequence the questions rigidly. Rather, it was an aide-memoire to facilitate the exploration of the phenomena of caring. In recognising the influential lens through which I view the world and my own beliefs, values, and ideals as they are embedded within this research, I was mindful of how to gain the lived experiences of participants in spoken and unspoken ways, whilst reducing the impact of my subjective influence.

So, although there were five key questions, the overarching aim of keeping the interview on track had to be balanced with the direction and side meanderings of the participants. The outcome of the interview relies on the “knowledge, sensitivity, and empathy of the interviewer” (Kvale, 1996, p. 105). This required a suspension of my own ideas, opinions, and theories so that I did not inadvertently influence the participants. Nevertheless, this can never be fully hidden or ‘bracketed’, meaning that reflexivity is required. The processes of phenomenological interviewing have been described clearly (Ibid; van Manen, 2006) as a suspension of certainty.

A second interview with each participant enabled me to explore issues that arose in the first interview in greater depth. The technique of memo writing (in which the researcher documents analytic ideas and insights) was also utilised. Memos provide documentary evidence of the analytic process as well as demonstrating reflexivity, thus adding to the rigour of the study. These memos were checked with the relevant participants to obtain verification, with the participants being offered the opportunity to memo write with the expectation that these were then incorporated into the final analysis.

3.5.1 Researcher's reflexive diary

Reflexive notes were taken throughout the research process for several reasons. Initially, notes were taken as a reflection on the research questions, activities, processes, and inner thoughts as a way of monitoring any observations, conversations, advice, and incidents (Rossman & Rallis, 2003). In addition, the notes were a way of monitoring and formulating various aspects of the research process, for example identifying the original purpose of the study and then identifying key steps throughout.

During the data analysis, notes were taken as a reflexive tool, by noting key observations and themes emerging from the participants' lived experiences. It enabled me to question my interviewing ability and the possible limitations and subjectivities inherent within the process. This last element was particularly critical during the phenomenological caring interview, where my attempts at 'bracketing' (Thompson, 1990) were critical to understanding the way in which the concept of 'caring' was allowed to emerge. Additionally, during the analysis phase, the notes were referred to in order to ensure consistency with the interview data. However, they did not form part of the reported analysis because they were based on my own perceptions and not those of the participants.

3.6 Data Quality Procedures

Efforts to ensure the quality of the research were taken throughout the process in several ways, whilst recognising the difficulties associated with the evaluation of qualitative research (Yardley, 2000). The quality of a study can be improved by the transparent and systematic collection of the data, by adhering to the approved ethical principles and procedures, and by being open to the examination of the process and findings by others (Rossman & Rallis, 2003). There is agreement that qualitative research is, at least, equally troubled by the idea of unsafe or unfounded findings as quantitative inquiry. Therefore, validity needs to be judged in relation to the purposes and circumstances of the research (Maxwell, 1990). As the interpretive findings of any qualitative studies in their findings make a claim at authority, it therefore stands that to "deny it has any validity" (Yardley, 2000, p. 219) seems

implausible. So, there is general agreement that it is imperative that qualitative study is subject to some evaluative criteria (Ibid; Whitemore et al., 2001). Yardley (2000) recommends that qualitative research demonstrates sensitivity to context, commitment and rigour, transparency and coherence, and that it makes an impact. Whitemore et al. (2001) provide a synthesis of criteria proposed to guide qualitative researchers in their endeavours. They identify primary criteria by which all interpretive studies can be judged: credibility, authenticity, integrity, and criticality. Each of these shall be considered in the following sections in relation to this study.

3.6.1 Credibility and Authenticity

Credibility refers to the "accurate interpretation of the data that the researcher's interpretation is trustworthy and reflects the experiences of the participants" (Whitemore et al., 2001, p. 530). Authenticity is closely related to credibility in that the meanings and experiences of the participant should be clearly communicated; participants should be able to recognise and relate to the findings. Together, these criteria attempt to address the "validity threats of distortion, bias and inadequate portrayal of the participants' views or phenomena" (Ibid), through various techniques. Credibility and authenticity involve ensuring the accurate interpretation of the meaning of the data (Carboni, 1995) so that there is confidence in the 'true' representation of the participants' lived experiences. To enable this, an invitation to attend a second interview was sent to the nine participants with the aim to gain participant feedback. Member checks or participant feedback is one of the single most important aspects of ensuring credibility in research (Miles & Huberman, 1994; Rossman & Rallis, 2003). Such checks enabled the participants to hear how their viewpoint had been interpreted and they were also provided with an opportunity to expand further on their thoughts, to clarify any issues, and correct any inconsistencies. However, the member checks carried out served to agree and reinforce the interpretations for five of the nine participants. The other four participants failed to engage with arranging or attending the second interview, thereby creating some concern that my interpretation may not be as accurately perceived. The second interview was designed to be a "reflection on meaning" (Seidman, 1998, p.

12), for it is important that interpretations are transparent, showing clearly how the interpretation relates to the data (Green, 2005). Participant feedback occurred for each participant during the research.

Authenticity involves an attempt by the researcher to stay true to the phenomena (Hammersley, 2000) being studied, and to recognise the subtle differences in a participant's voices. Participants were identified as they were in an ideal position to provide a wealth of information regarding the research questions (Miles & Huberman, 1994). This use of purposive sampling enhances the trustworthiness, integrity, and credibility of the study (Patton, 1990). I also recognised myself as an 'insider' and acknowledged my possible influence on the participants to speak authentically. However, I tried to minimise any influence by isolating the research process from the educational context and by reducing the power imbalance via interactions. Also, by ensuring the ethical principles regarding confidentiality and the right to withdraw without consequence were reinforced with the participants, enabling them to speak freely.

3.6.2 Integrity and Criticality

To ensure the integrity of the research, the data management and research processes need to be consistent and true to the methodology employed (Kvale, 1996). As such, the transparency of the research processes, the accurate interpretation of the data, and maintaining sufficient records and documentation to allow audit trails was necessary. Criticality is reflected in the interpretive process and the reflexivity of the researcher to demonstrate their influence on the study. It also refers to how well a researcher presents their findings and provides adequate detail in order that other subsequent researchers may determine the utility of the findings for their own research (Houston, 1990).

The integrity of the data was established through the process of member checking and discussion around the emerging themes with colleagues, which was carried out over the ongoing period of data analysis and interpretation. Transparency has been achieved by describing in detail each stage of the

research process, describing the collection of data, the interpretive analysis, and how the findings emerged from the data (Miles & Huberman, 1994). The analysis phase was lengthy and complex as I struggled with the amount of data collected and the various potential interpretations available. Discussion with my supervisors and peers (whilst ensuring participant confidentiality) helped to clarify and refine my often-embryonic interpretations, being able to verbalise and discuss with peers embedded in the context of the study was particularly productive. Every effort was made to present findings using thick descriptive frameworks to adequately reflect the depth and complexity of the phenomena of caring. Attention was paid to representing the participants' voice with the use of extracts as part of presenting the findings.

The use of my reflective notes helped the monitoring and tracking of the research process and my interactions with participants and others. While these notes are not incorporated in the findings, some of these are included in the reflexivity section of this chapter (3.3.1-3.3.4). Records of all the interview data, reflective notes, supervision sessions, and ethical information have been maintained throughout the study to enable an audit trail for transparency and to establish dependability (Rossman & Rallis, 2003).

In an endeavour to ensure high standards of credibility, trustworthiness, and rigour of the study I have continually reflected on my decisions, interpretations, writings, and actions.

3.7 Data Management: Collection and Analysis

In any research project, data management and analysis are informed by the research questions of the study. The research questions for this study are:

- Which particular values and philosophies do student mental health nurses feel stand behind them and their choice of educational programme?
- To what extent do student mental health nurses feel that their programme prepares them to be caring nurses?

- Which particular practices (if any) do they perceive as being effective in fostering a caring philosophy?

Interpretive phenomenology involves a focus on the significance of the participants' orientation and the meanings within the lifeworld context. It is not an attempt to make claims for *all* contexts. It is also challenging as "it can be argued that its method of inquiry constantly has to be reinvented anew and cannot be reduced to a general set of strategies or research techniques" (van Manen, 2014, p. 41). The analysis of the data began immediately after the interviews, with the noting of my initial thoughts and impressions. The audio recordings were replayed several times whilst waiting for the interviews to be transcribed, to orientate me to the individual accounts and to the overall concerns emerging from the participants. Once the transcriptions were completed, I read and re-read them to immerse myself into the accounts and delve further into the analysis. The data was indexed according to the source of information since this is important within the later analysis process (Miles & Huberman, 1994). All the data was indexed to identify the participant and the page and line number of the page (Appendix F) (Lincoln & Guba, 1985). This transparent and rigorous collection is a critical aspect of the whole research process (Miles & Huberman, 1994).

Two copies were made of all the data collected. The first was kept as a hard copy and was managed chronologically over the course of the study. During the on-going data collection in the academic years 2014/15 and 2015/16, two copies of this data were used for data categorising, one according to the participant (Appendix F), and one according to themes across all participants (Appendix H).

3.7.1 Data collection and analysis

Following the first formal interview (March 2014), and on receiving the transcribed interviews, I carried out a phenomenological reading in which the swirling meanings of the text become its strength. This first step of open reading was achieved by merely listening to the expressions of the participant without any agenda, aim, or real attention to the research

phenomenon. This holistic reading is similar to what Freud (1912) called 'evenly hovering attention'; I was aiming not to add judgement or selectivity to any particular spoken experiences, but simply to treat all of the details with openness to provide a background for the next step. In this step, I was able to gain an overall feeling of the participants' orientation in relation to nurse education, and I was overwhelmed by their enthusiasm, commitment, and honesty.

Although there are many variations of the way in which phenomenological data analysis can be undertaken (Fisher & Tronto, 1990), data analysis followed the four-step process described by Giorgi (1985, 1985). Giorgi made the procedures of phenomenological, psychological analysis more explicit, systematic, and accountable. This was in contrast to the informal way phenomenological research had previously been conducted. The four essential steps of protocol analysis are:

- *reading for a sense of the whole,*
 - *differentiating the description into meaning units,*
 - *reflecting on the psychological significance of each meaning unit,*
and
 - *clarifying the psychological structure(s) of the phenomenon*
- (Giorgi, 1985).

This iterative and incremental data analysis process allows for clarification and honing of categories during the analysis process. Interrogation of the categories revealed patterns and relationships across categories that can be integrated to gain a greater understanding of the phenomenon of interest. For this study, there was one primary source of data: transcriptions of interviews. Grounded in the related literature and the research questions, the data was interrogated and structured according to the identified concerns of the participants. Inductive coding involves the use of provisional codes during initial data collection (Miles & Huberman, 1994). Initial codes emerged (Appendix F) from the data that provided a structure for further analysis and interpretations. These initial codes consisted of 70 unique phrases (Ibid),

which were then expanded, refined, modified, and/or discarded later on in the analysis (Appendix F).

Each interview transcript was read, and statements relevant to this study were highlighted and extracted. These statements were then interpreted into a coding a word or phrase in terms of stating a precise meaning or significance. These codes were then checked with the participant because it is important for interpretations to be transparent, showing clearly how accurately the data has been interpreted (Green, 2005). The value of such checks has been questioned (Sandelowski, 2002) as participants may say what the researcher wants to hear and not disagree with the interpretations. However, the participants may be interested to hear how the researcher has interpreted their narratives (Doyle, 2007) and such member checking allows the participants an opportunity to correct the interpretation if needs be.

In the second step, I attempted to differentiate segments or units of the participants' description that were relevant to the research questions. These were selected passages of any size or description, selected with psychological sensitivity to their meaning that is relevant to the research and intuitive to my own worldview and sensibilities. This process formed a pattern analysis (Anfara et al., 2002) as the initial codes were then grouped into themes (Appendix F & G) (Miles & Huberman, 1994). There is no correct formula for this step in the research literature or the next step of the reflection, as it became necessary to further differentiate or combine some of the themes.

The third step was much more difficult. In this stage, I needed to attend to what the expressions in each unit reveal about the phenomena under investigation. The research involves multiple questions, all of which need to be systematically posed to each meaning unit in turn, and the research answers those questions in light of the meaning unit. It is in this stage that I needed to explicate what each meaning unit reveals about each individual example of the phenomena, with the help of imaginative and intuitive variation and it is here that a generalised knowledge emerged. The literature

was revisited at various stages of the analysis to clarify interpretation and meanings from the data. This level of analysis involved the connections and cementing of the themes with the relevant theoretical and philosophical stances (Anfara et al., 2002). It was at this point that the connection between the data and the literature flourished, developing a coherent framework synthesising data, constructs, and concepts. In particular, themes arising out of saturation of the data were ordered to reflect the significant themes that were considered to authentically and truthfully characterise the participants' lifeworlds (Fig. 4:1).

According to Giorgi (1985), the researcher collects the naive descriptions from the participants who have lived through the situation that is relevant to the topic under investigation. The researcher then reflects on the person's experiences of their situation, explicating lived meanings, including each person's embodied selfhood, emotionality, agency, social relations, language, and temporality as visible in examples of the subject matter under investigation. When conducted methodically, this approach is characterised by meticulous and thorough description that achieves fidelity to psychological life by clarifying its processes meanings and general (eidetic) structures.

The final step of structural understanding and description involved the integration and statement of insights gained from all of the various reflections on the meaning units. This final step entailed being able to articulate the meaningful organisation of the investigated phenomena as a structural whole, so all the pieces in terms of the meaning units are drawn together to provide a full/partial picture of the phenomena in question (Diagram 4:1). This involved the development of a narrative account based on the super-ordinate themes, which is presented in the next chapter (Fig.4:1).

3.8 Summary

From the analysis and reduction of the data, super-ordinate themes were identified:

'Being Caring' captures the importance of the 'personal lifeworld' in the

development of caring as a core construct for the participant and how this acts as a motivating factor to be caring towards others.

'Becoming Caring' encompasses one aspect of the participant's journey of 'becoming' caring, both theoretically and inherently intra-personally whilst in University, and the key pedagogical approaches that the students feel are important in developing their understanding and actions around becoming a caring nurse.

'Caring in Nursing' theme captures the socialisation of the participants in the professional lifeworld and their experiences of caring for others whilst on their practice placements.

Chapter Four: Findings

4.1 Overview

In this chapter, the student (MH) nurses' narratives are analysed in relation to the emergent themes derived from them. According to van Manen (1990), themes are the vehicle by which we make sense of a phenomenon and open us up to a 'deepened and more reflective' grasp of the phenomenon.

As I arrive at certain thematic insights it may seem that insight is a product of all of these: invention (my interpretive product), discovery (the interpretive product of my dialogue with the text of life), disclosure of meaning (the interpretive product given to me by the text of life itself) (van Manen, 1990, p. 88).

Within the phenomenological process, thematic invention and discovery are not governed by rules or procedures, but it is rather a free act of 'seeing' meaning (Ibid., 2014). The interpretive analysis of the participant's lived experiences involved the reading and re-reading of the transcribed interviews while acknowledging the researcher's role in posing the questions regarding care. Much of the analysis was undertaken using the participant's words. Hence, the following sections predominantly include quotes from the participants, as it would seem disrespectful to replace them with the author's own words. While interpretation is unable to lay claim to any 'ultimate' truth, the researcher's aim is to present a genuine and meaningful analysis of their stories.

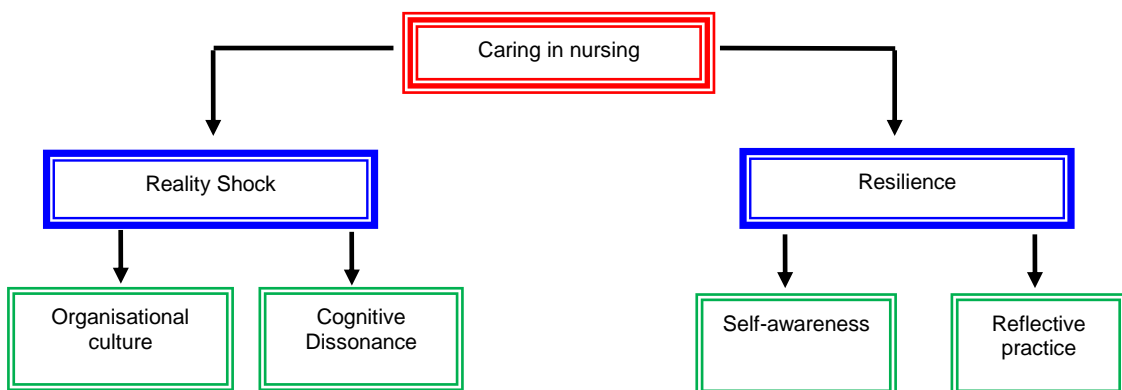
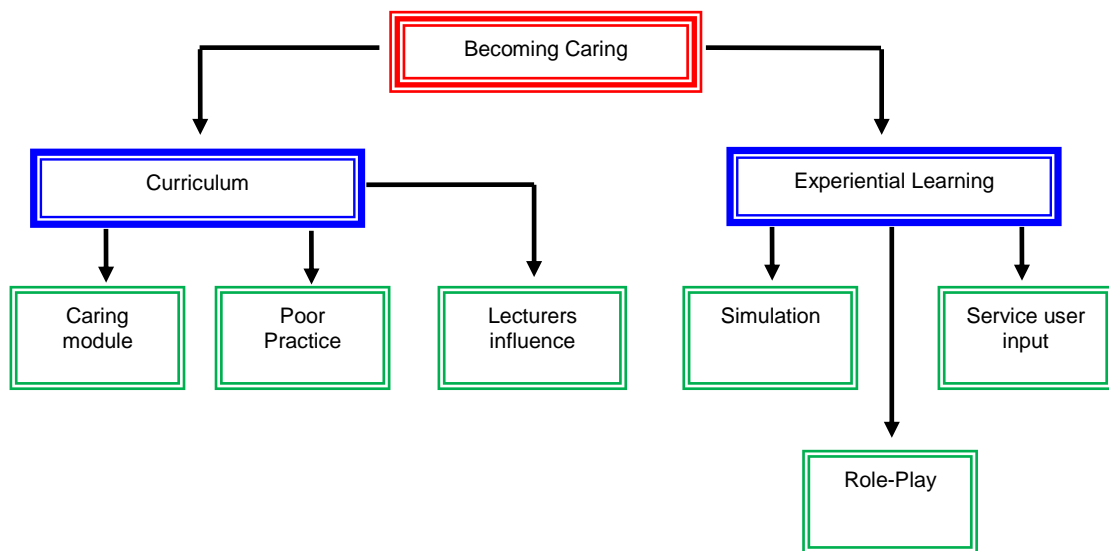
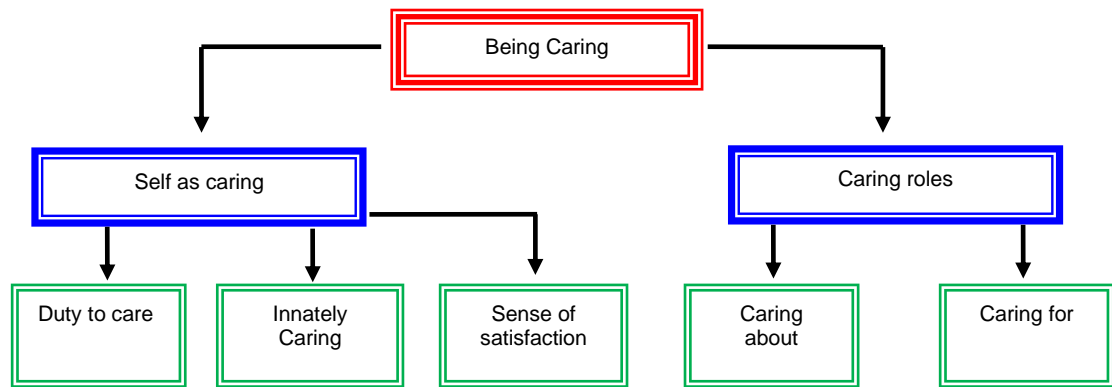
This chapter focuses on presenting the findings of the data analysis, as described in the previous chapter. This chapter refers to lifeworlds (van Manen, 1990) as they are crucial elements of the IPA process to make sense of the participant's personal, academic and, professional worlds. Each of these themes captures the peak of the interpretive process, by making sense of the participant's rich and deep descriptions of how their lived experiences influence the construction of their self as caring. From the initial analysis, many themes were identified relating to the student nurses' narratives.

Following several levels of analysis, these were then grouped into three superordinate themes, with the major themes and sub themes highlighted (Figure 4:1).

This chapter reflects on the interpretive stance that was applied to the rich data gained from the interviews. It is divided to describe a journey through the interpretive process as it was experienced. Overall, all the themes correlate with the broader conceptual framework of ontology (theory of being) and the participants' construction of 'oneself' becoming 'caring' professionals.

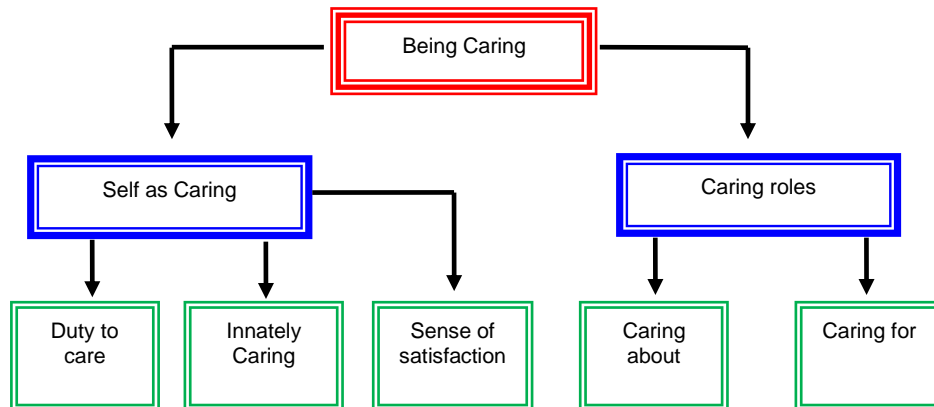
Whilst presented as separate fragments, for the purpose of reporting the findings, the themes (Figure 4:1) are inextricably linked and are considered fluid and dynamic in the nursing programme's process of developing caring values and behaviours among the participants. They influence and are influenced by each other. Each theme will now be examined in turn, with analytical comments added to provide a 'walk through' of the interpretive process.

Figure 4:1 - Key Findings



4.2 Being Caring (Personal Lifeworld)

“to live is to be touched” (van Manen, 1991, p.125).



The first superordinate theme of ‘Being Caring’ captures the importance of the ‘personal lifeworld’ in the development of caring as a core construct for the participant, and also describes how this functions as a motivating factor for the participants to be caring towards others. When considering the participant’s motivations, it became clear that psychological theories that emphasise a central role of ‘self’ in a person’s motivations, personality and development are crucial, as they all deal in their own way with how individuals forge their identities. Major theories on the concept of self, have remained largely unchanged since the formulations of James (1890) and Mead (1934). For example, the self is a reflexive phenomenon that develops in social interaction and is based on the social character of human language. How humans develop representations or ideas about themselves can have immense motivational power (Dweck, 2000). Here, the ‘self’ is considered to be a collection of abilities, temperament, goals, values and preferences, which distinguish one person from another (Tesser, 2002). A social-cognitive approach examines how social information is processed and how peoples’ beliefs, values and goals set up a system in which they define themselves and operate within (Cantor & Zirkel, 1990; Mischel & Shoda, 1995). These are processes which can aid understanding of the participant’s development of ‘self’ and the meaning within their narratives. There are five aspects to a persons’ self-identity; somatic, proprioceptive, and kinaesthetic dispositions

which are a person's given aspects (tall, short, eye colour and hair colour), and psychological traits (impulsive, introverted, caring or melancholic) (Rorty & Wong, 1993). The given aspects or dispositions relate to the theme of 'self as caring'. Meanwhile, the theme of 'caring roles' is related to the effect of social influences on role identity and group identity. Role identity is comprised of the various roles that people have in life (mother, son, friend, nurse, teacher or doctor) and how that role is performed (being the helper or listener). Group identity constitutes the variety of groups that a person belongs to, such as innate (race and gender) or acquired (education, class or occupational). The final and most relevant aspect of self to this study is the 'ideal' identity (Rorty & Wong, 1993). Individuals aspire to become their ideal self, with the participants aspiring to become a nurse. These aspirations create an image of the person that they could become in the future, rather than who they are currently, and this leads them to become nurse-centric.

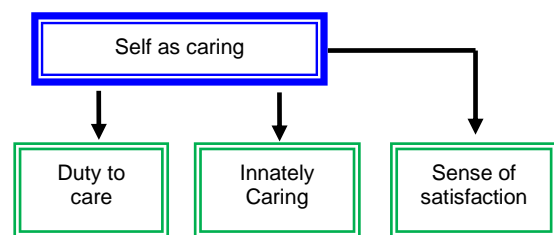
There is a relationship between the different aspects of self, as the personal characteristics valued by an individual's other identities motivate and inspire them to construct and become their ideal self. There can also be conflict between an individual's various identities. For instance, someone may be caring, but the image related to their occupational role may be concerned about productivity and efficiency. Aspirations therefore require evaluation of the four identities to enable a change of characteristic for the individual to achieve their ideal identity. Thus the ideal identity can offer stimulation and motivation to change and transform a person's identity to achieve their goal (ideal identity).

The first major theme in this section, 'Self as caring', represents fundamental aspects of personality that are central to the person's self-identity. Three sub-themes emerged; 'duty to care', 'innate caring', and 'sense of satisfaction'. These all appear to be intrinsic to the individual's personality and propagate their interest in nursing. The second major theme of 'Caring roles' represents the lived experiences of some of the participants. The two sub-themes of 'caring for' and 'caring about' have further cultivated their intrinsic caring, commitment, and motivation to help others. This is

demonstrated through their narratives, with all the participants possessing a motivation to care, although some did not have the personal insight gained through previous key caring roles. This does not mean that their motivation to care is any less, though opportunities to care for others can increase awareness of the ‘emotional labour’ involved, and can further provide individuals with an understanding of their capacity to care for others.

4.2.1 Self as Caring

Caring is considered here as an innate feature, an expression of being human, and as a process that each person experiences throughout their lives as their capacity to be caring grows. Although people are innately caring, actualisation of the potential to express caring varies in the moment and develops over time (Boykin & Schoenhofer, 2001).



Three sub themes were identified as ‘duty to care’, ‘innately caring’, and ‘a sense of satisfaction’.

4.2.1.1 Duty to care

This theme is grounded in the notion of responsibility when there is a conscious recognition, or a sense of responsibility towards meeting care needs (Fisher & Tronto, 1990). Responsibility involves a conscious decision to accept concern for the need and then requires a flexible negotiation of the actions required to meet the need (Barnes, 2012). When considering responsibility within an ethics of care framework, it is embedded in the implicit cultural practices, rather than in a set of formal rules or promises (Tronto, 1993). Helping and being useful to others was seen as something intrinsic to the participant’s and their view of themselves in the world:

I've always been the person that someone turned to... I was always the problem-solver for everybody... If anyone had issues, they would come to me... I don't know... I think life has its own counsellors and I always played that role (Dax).

This informal role of being the ‘helper’ for family and friends indicates that some people understand this as a natural way of being. The terminology used, the notion of being a good person, and being able to help others distinguishes this from the formality or duty of caring in a healthcare context:

All the other jobs that I'd done... it doesn't seem to matter if I don't... I can't explain it but every other job... it wouldn't really matter if the work didn't get done ... but nursing, it's someone's life in your hands and it matters... it matters to me (Kat).

You need to have some sort of interest in it... have to like being around people... want to look after people... you've got to have that instilled in you... be like a good person... I don't think you need the care experience (Nea).

The importance of wanting to help and nurture others is identified as a natural disposition, which is also identified as a prerequisite to be a nurse (Murphy et al., 2009):

Sounds really corny, but it is because I want to help people... I feel like I can in some way... enjoy meeting people and finding out what their story is... just being around people... I think there has to be something inside you that really wants to do it... to motivate you (Sky).

The desire to help, care, and connect with others that is seen can be described as an activity of relationships, of seeing, responding to needs, and taking care “of the world by sustaining the web of connection so that no one is left alone” (Gilligan, 1982, p. 73). Responsibility to and for others can be seen not simply as a duty or obligation to others to help, but rather a personal choice to help others in a general and personal ethics of care (Fine, 2007):

I don't know... I think you're either a naturally caring person or you're not... but I can switch it on and off... seems strange but I can if I want to care about something, I will... if I don't, I can completely detach myself (Lil).

This element of personal choice can be a conscious decision whether or not to accept responsibility to help others.

4.2.1.2 Innately caring

Although closely linked to the previous theme, innately caring is distinguishable and presented as a single entity. Innately caring refers to the emotional aspect of the individual and how this influences them. This is often a personal quality of caring people, and can come to define them, having arisen from their cultural values and beliefs that are often developed in childhood. It supports the notion that caring is a “basic way of being in the world and that caring creates both self and world” (Benner & Wrubel, 1989, p. 398). It is evident that caring is a natural part of being, which is a key motivator to becoming a nurse:

Through my life... I've always been a caring kind of person (Dax).

I definitely see it as a natural quality (Mya).

For some people, such individual values and previous experience of caring dictates how they interact with others in their care (Mlinar, 2010; Schwind et al., 2014):

It's either something that's instilled in you... but my nana said to me, 'It's a calling... to be a nurse is a calling and it's something that you either have inside of you or you don't'... I agree with my nana... you're either a caring person or you're not, and if you're not then you shouldn't be in this profession (Kat).

The strong belief that caring is an innate quality means that there is a very real question of whether caring can be taught or learnt:

But, I've always been caring. I don't think that will change... can being caring develop? I don't know... I either think you are or you aren't... there are skills you use to be caring, they will develop, but being caring is just there (Asa).

You can't be taught to care... I don't think you can be taught to care... It's not something you learn... it's something that's inbred in you or it isn't... in a nursing sense (Lil).

There is an acceptance that caring is expressed through the behaviours used in being a nurse, which can be developed as part of the learning process. Nonetheless, there is a compelling belief that caring (the personal ability to care) cannot be taught because it is either present or it is not:

I don't think caring can be taught... it can be taught how to appropriately show somebody that you care and... show somebody how to appropriately care for somebody... absolutely... you can care too much... you can care too much in everyday life (Lil).

I don't think you can teach caring... like caring in itself... you can be taught better how to approach things... but I don't think you can put something in that's not there (Mya).

4.2.1.3 Sense of satisfaction

All nurses 'care for' people through the delivery of practical and tangible nursing care, but not everyone will 'care about' people. This difference is frequently encountered in practical settings, where choices about how to treat patients and the decisions made become highly visible and the consequences are acutely felt and experienced. An additional key motivation found to care for others besides possessing a caring disposition, was also a belief in and a desire to do something worthwhile for others. This motivation is supported by the sense of satisfaction drawn from making a difference to others. A sense of achievement is reflective of the nurse's ability to either contribute to the patient's recovery or improve the services provided. Much of a nurse's caring behaviour is based on a "desire for pleasure, stress reduction and positive self-expression that arises from warm relationships with others" (Eisler & Levine, 2002, p. 11):

Can make such a huge difference to someone's life... I know care, compassion and communication... the 6Cs... it is the fundamental basis of nursing... I think if you see a miserable nurse and a polite, friendly nurse... the two concepts that that patient will come away with... from those two experiences... will be vast... it really will (Dax).

Here there is a demonstrable difference between a 'caring' or 'uncaring' nurse. The 'caring' nurse is able to be responsive to the person as "a unique individual, perceives the others feelings and sets apart one person from another" (Watson, 1999, p. 34). Meanwhile, the 'uncaring' nurse may provide the physical and technical care, yet are "insensitive, non-perceptive and do[es] not distinguish one person from another in any significant way" (Ibid.):

I think just to make a difference to people's lives... is the main thing... just to help people (Asa).

It's just such a privilege... It's just such a nice thing to do... to do something for people that maybe haven't had the fortune of having as good a life as what I've had (Mya).

This reflects a common notion felt by the participants that providing care is a privilege. Furthermore, they demonstrate an appreciation for being in their position to help people and there is a shared desire to provide a better service for people:

To try and help... be part of administering a better service to patients and... I care about people and to make sure that they get the best quality care... in a healthcare environment... I think it can make a massive difference to people... it really can (Dax).

The rewards gained from showing care and compassion to others and helping to improve their health and well-being is a strong motivating factor which far outweighs any financial gain that may be accompanied from alternative employment:

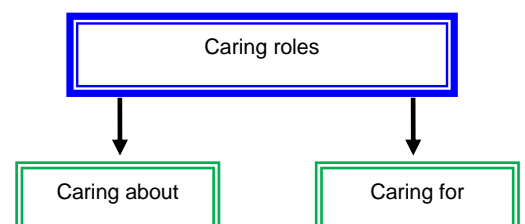
Other jobs... it didn't come across like... the full potential to show care or compassion... with people, and have that communication going... doing stuff for people and getting that reward as a job... so yes (Tai).

Money might motivate you or being promoted... but actually I think job satisfaction and going to work... wanting to be there... wanting to do this is what motivates me... I'd much rather go to work and enjoy what I'm doing than get paid a lot of money for it (Sky).

This sense of responsibility, desire to help others in distress, as well as the need to make a difference and improve services is a strong motivator for the participants. Yet, this is countered by feelings of ambivalence towards any monetary or promotional reward, although this belief may change once the participants encounter the harsh realities of nurses' lives (McHugh et al., 2011).

4.2.2 Caring Roles

Personal insight into caring was gained through the different roles experienced by the participants, either through caring about or for



other people in their lives. This relates to the development of a person's role identity according to their responsibilities and capacity to care. Whilst their personal experiences may be different, relevant awareness and knowledge about caring is acquired and can stimulate an interest in nursing.

4.2.2.1 Caring about

Caring about someone signals a concern for another and involves a sense of duty, moral commitment, or a sense of personal affinity such as love. The term refers to a mental disposition of concern. This cognitive and emotional state involves an attentiveness and concern for another, which may be described as effective or expressive care (Hugman, 1991; Tronto, 1993; McSherry et al., 2012). A family member's illness is understood as an influential factor in both their recognition of being caring and in their capacity to actively care for others:

It's quite personal really... My mum's like me really... outgoing and bubbly and chatty and full of life and when the children... came along I just watched her crumble with depression and it was a really hard time... I saw her get some help and she had a bit of counselling and antidepressants and I saw her get through it really... and it just inspired me to want to do that (Kat).

In this instance, her mother's illness, the impact it had on the family, and the help she received inspired Kat to help others in the same way. Early inspiration towards a nursing career is clear from her reflection on the experiences of a loved one's mental illness, and the impact that has on her as a child. That said, this interest was not pursued immediately after completing school. It appears to be common for there to be a period of trying different occupations before starting (mental health) nurse training:

And trying different kinds of work, travel agents, business administration and the finally care work and... I thought do your nursing... that's what you really want to do (Kat).

Other rationales offered for delaying nurse training was to wait until they felt more confident in themselves to tackle the rigours of the training, or that they were caring for their own family despite a childhood desire to become a nurse:

I never had the confidence to... until own children were grown up... and... 'a dead-end job'... I always knew that I would absolutely love to do it... I just never thought that I could (Mya).

This lack of self-belief to actively pursue the career until later in life was a common theme shared by many:

My... brother spent loads of time in hospital... very poorly when he was young... like total admiration towards the staff... and it was one of the things I thought; 'I'll never be able to do this' (Jay).

Coming into nursing at an older age is not always due to a lack of self-confidence upon leaving full time education. Leaving it 'till the time was right' for some of the participants also played a part in their decisions:

Wanting to do this when... 19, but not feeling quite ready for it... getting a well-paid job... wasn't until... made redundant at 29 that... considered nursing again and with encouragement... applied for the programme aged 31 (Jay).

Another perspective giving inspiration to begin a career in nursing, whether sooner or later, was nursing as the 'family trade'. While none of the participants described pressure from other nurses in the family, nursing was deemed to be inbuilt, innate, and 'in the genes'. Students with family connections in nursing have an insight into and interest in nursing from a young age via contact and experiences with family members (Barriball & While, 1996; Dockery & Barns, 2005). Through such family insights and interactions, they appear to have gained an awareness and insight into nursing, potentially even developing an interest without realising it. While absorbing information from family members throughout their childhood, there is a sense of inevitability, with some feeling that it was a given fact that they would pursue a nursing career, with the notion of nursing being 'inbred':

My mam was a nurse... my grandma was a nurse and my granddad was a nurse... everybody's a nurse... and it's just... obviously been brought up around nurses... like following in their footsteps... kind of inbred... in all of us... my cousin's doing an access to nursing at the minute... and it's inbred (Lil).

This 'gravitation' towards nursing was not always the case among the participants, as an element of choice is always present, while people are able to make deliberate decisions about their future and make deliberate and rational choices to enter nursing:

A lot of experience with my family... lot of community psychiatric nurses and stuff... I was quite interested in what they did and I'd like to be part of that (Nea).

It appears that the experiences and stories of practicing nurses allowed for an understanding of the knowledge, attitudes and skills involved in nursing. Nevertheless, while 'positive' aspects of this are evident, such experiences were also found to act as a dissuading factor when contemplating a career in nursing:

My dad worked there... It's in the family... mental health... but I said I'd never go down the same road as everyone else (Asa).

4.2.2.2 Caring for

For some participants, it became clear that a strong motivation to care for others came from their lived experiences of actually taking care of others in different contexts. Caring in this context refers to the work involved in nurturing, sustaining and tending to another person. It can also indicate the physical work of providing assistance, the practical action of care, and the actual practices we engage in as a result of these concerns, otherwise known as Instrumental Care (Hugman, 1991; Tronto, 1993; McSherry et al., 2012). This transforms and progresses the notion of caring, from the emotional element to the physical actions associated with caring. The participants had experience of caring for others in different contexts and thus their responses are individual, however their emotional response is shared in this context, in that it developed and stimulated an interest in nursing.

Their experiences afforded them informal insights and interests in nursing as a caring profession (Larsen et al., 2003; Prater & McEwen, 2006) without the formality associated with nurse training:

I always loved nursing... I've looked after my grandmother from when I

was young... I was about three... she got blind, and I can remember it and everything... as she got older she became dependent on us (Tai).

As 'caring for' started at a young age, they did not understand it as caring for per se, rather it was just what you did for a family member who needed help and assistance:

Although you were caring for her it didn't come as caring (Tai).

This fits with the invisible nature attached to informal care. Nonetheless, it is not necessary to be a primary carer for a family member to experience such 'hands on' caring.

Choosing to work in the care sector in a formal caring role is a common feature of 'caring for', and starting as a Healthcare Assistant is often considered as a natural starting point for a career in nursing. This experience can provide valuable insights into the nature of the 'nursing profession'. Some participants experienced 'caring for' in the informal role, while others experienced it as an employee:

I was 26 by the time I decided to go and work in a care home... and thought... do your nursing... that's what you really want to do (Kat).

Formal care experience can be a crucial factor in understanding caring for others, and can help to develop insight and knowledge in considering a nursing career:

I never really thought I'd choose it as a career path... I got a job as a healthcare assistant and then just loved it instantly really... that's the only reason though... through working in the area (Asa).

The potential value of a person joining a nursing programme with some background or experience in healthcare is a subject for debate (RCN, 2012), although they tend to fare better than those coming straight from college. Besides the life skills they have acquired, actual caring experience may be invaluable:

To get some grounding and it was only a care job, but it was spot on because... with a lot of the younger people on the course and the ones

who drop out... they've had no experience of care until they came on the programme... went to placement and hated it (Jay).

Similar to working in a care environment, unpaid volunteer work with others is another avenue to gain insight, experience, understanding, and an interest in pursuing a role in nursing:

There was life experiences that I had... and I went to do some voluntary work... for a mental health charity, and worked... as a support worker and a one-to-one mentor... I fell in love with what I was doing... I went back to college... redid all my qualifications... just so I could follow this pathway... sometimes you've got to step out of your comfort zone and sometimes adversity brings you to do that (Dax).

For this participant, it took a personal hardship to instigate them rethinking their life and make a positive decision and change to help others by pursuing a career in nursing.

Overall, the motivations towards entering a nursing career identified by the study participants in part align with the understanding and explanations derived from previous studies; the desire to 'care for others' and to 'make a difference'. There are many complex and dynamic explanations for why people choose a career in nursing, yet the desire to help and care for others is a dominant factor when applying for a pre-registration nursing programme (Boughn, 2001; Parker & Merrylees, 2002; Zyberg & Berry, 2005; Cowin & Johnson, 2011). In common with this study is the influence of life events, especially family trauma, which are important primary motivators for choosing a career in nursing. Furthermore, the personal virtue of caring continues to be a driving motivator in considering a nursing career and being able to fulfil this intrinsic capacity to care is vital for maintaining their engagement with their nursing career. Other primary motivators include prior employment in care, volunteer experiences (Rompf & Timberlake, 1994), and being influenced by people they respect. These intrinsic factors are all consistent with the participants in this study. Such personal-based motivations appear to have a significant influence on nurses, since those who decide to become a nurse in childhood are less likely to leave within five

years compared with those who decided to do so later in life (Barriball & While, 1996).

The importance of selecting and recruiting the 'right' people into the profession cannot be emphasised enough, to both ensure that those recruited have the correct values and make the most efficient use of NHS education funding. Nevertheless, the withdrawal of the NHS bursary for nurse pre-registration education may be having an impact, as nursing applications have on average dropped by 20%, while certain specific fields have seen a 50% drop in applications, further compounding the NHS nursing workforce crisis (Jones-Berry, 2017). Nurse recruitment and retention issues are recognised as a worldwide concern (Lai et al., 2006; Preston, 2006). In recent years in the UK, nursing workforce cuts have led to FTE vacancy rates of 7% in the NHS and 9% in adult social care. These percentages account for around 24,000 FTE vacancies, and cuts to commissioning for nursing training from 22,000 in 2008/9 versus 17,000 in 2012/13. Such shortfalls have resulted in a 55% increase in the use of more costly agency nurses to cover 40% of the shortages, leaving 15,000 FTE permanently unfilled. The potential solution for this would be recruiting and training more student nurses, but this has not been implemented. This is despite the numbers of applicants increasing by 33% between 2009 and 2014 (RCN, 2015), which could now be viewed as a lost opportunity and an indication of government short sightedness. Despite the existing nurse shortages, 30,000 nursing applicants were turned away in 2014 due to a lack of funding, equating to 60% of the applicants (Ibid.). Furthermore, the gap remains even after Health Education England called for a 4.5% increase to commissions in 2015 (Ibid.).

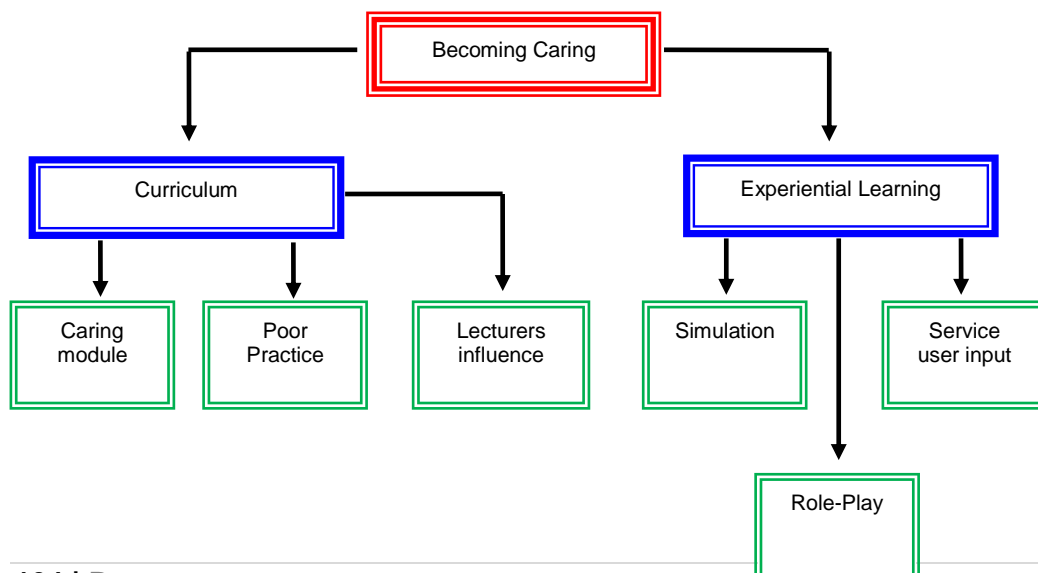
Personal insight is developed from these intrinsic motivations of 'self as caring' and their lived experiences of 'caring roles', with the two being able to be either mutually exclusive or interconnected, dependant on the individual's life experiences. Some may be deeply motivated to care for others, but they have not yet encountered a particular need to practically fulfil that motivation. This does not mean that the motivation to care is any less than those who

have experienced caring for others in their lives. Nonetheless, the opportunity to care for others in a physical sense can increase awareness and understanding of the ‘emotional labour’ involved and their own capacity to care for others. Perceptions of caring consist of the cognitive and emotive elements of an individuals’ concept of caring; the beliefs and values of what it is to be caring as a nurse. This is often based on a lay view of nursing, particularly if the individual has no prior nursing experience of any form, contributing to the nurse-centric focus.

It is therefore vital for the nursing profession to continually update its knowledge and insights regarding what factors are influential in considering a career, and what the personal qualities are that potential applicants believe are required to become a nurse. Once accepted onto a nursing programme, professional socialisation begins in two different lifeworlds; academic and professional. The participant perceptions of how caring is experienced are presented in the following two superordinate themes of ‘Becoming Caring’ and ‘Caring in Nursing’.

4.3 Becoming Caring (Academic Lifeworld)

“pedagogy is the fascination with the growth of the other” (van Manen, 1991, p. 13).

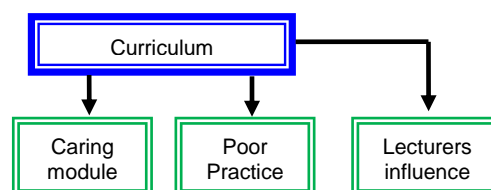


Caring is recognised as a central, though complex dimension of being a nurse (Leininger, 1988; Watson, 1988; Barker & Buchanan-Barker, 2004). Nursing student socialisation is identified as the transition from a lay perspective, to a more professional view of nursing (Davis, 1975; Day et al., 2005). This theme encompasses one aspect the participants' journey of 'becoming' caring, both theoretically and inherently intra-personally, whilst at university and the key pedagogical approaches that the students consider important to developing their understanding and the actions around becoming a caring nurse. It embraces the importance of listening to narratives from service users, lecturers and other students, through to involvement in role-play and simulated activities. Their lay perception of caring consists of how the cognitive and emotive elements of an individual's concept of caring influence and construct their beliefs and values surrounding what it is to be caring as a nurse. Their idealistic views are shown through the values and beliefs they consider part of being caring, which will have developed over time and are dependent on life experiences.

This theme therefore explores the participant's personal perceptions of caring and how these begin to intersect with the lifeworld of the academic pre-registration nursing programme, which either reinforces or challenges their values and beliefs about caregiving and nursing.

4.3.1 Curriculum

The programme aims to provide a professional education that meets the requirements for entry onto the Nurses' part of the NMC Professional Register (Mental Health) and the Award of BSc



(Mental Health) and the Award of BSc (Hons) Nursing Studies (Mental Health) by the respective Higher Education Institution (HEI). During the curriculum planning consultation process, a primary concern of service users, carers, and practice mentors was the development of students' communication and interpersonal skills. Within a first-year module, drama, simulations, role-play and written communication exercises are employed to develop student's skill set, and to instil an

empathic approach to service user care. Both self, and peer assessment were also used to facilitate student learning and development. The use of drama within this module sees academic staff acting out situations by portraying interactions with others. Students are then asked to critique these and explore how the simulations made them feel, along with providing appropriate approaches and professional caring behaviour. Caring within the nursing programme is explicit in many of the module aims and outcomes, particularly the modules related to the development of practice. The core elements of caring practice run throughout the programme as an integral theme for students of all fields:

It runs throughout... that caring focus... I don't know if you're taught to be caring... I think... there's just something within you... can they teach you?... there's a lot of emphasis on it (Sky).

Care and compassion and all the other things... I think those two are the first two that I think of... obviously communication as well (Mya).

The core essence of caring is perceived as being visible or 'felt' within the programme in relation to caring about, or being attentive and compassionate:

Care... using your caring nature... compassion... the 6Cs really... and how you get that across to people to empower them as patients... how you use it to empower yourself as well as a student nurse within practice... It's dealing with people and getting across to them... to empower themselves to deal with situations that they're in or I'm in (Tai).

The transition from fresh enthusiasm for caring at the beginning of the programme, to the more professionalised form of caring at the end of the programme needs to be adapted or tempered in some encounters with service users (Murphy et al., 2009):

We all have an enthusiasm because we're brand new to it... and... want to save the world... come in as a bit of rescue... thinking that you can save everybody... when you get to know that the patient has to be ready... they might not be ready to be saved and changed... the interventions might not be there straightaway (Kat).

The next statement demonstrates a potential transformation in the understanding of caring as a concept since it is a more measured and considered expression of caring:

Rather than just going in like a big cuddly caring bear that's just after everyone... maybe touching a little bit more on what's appropriate and when, at different levels (Kat).

A common theme that the participants raised was how to demonstrate caring in an appropriate way, with the participants offering differing perspectives. The participants acknowledged that the programme does teach students to care more appropriately:

Yes, I think... that's probably another thing that you're taught as well really... how to go about being caring... although you might want to go over and hug them... they probably don't want a hug... [laughter]... it's about reading... probably... reading the situations... and acting appropriately to what's going on around you... I think you learn that out in practice... yes (Sky).

Some of the participants were frustrated by other student's open displays of a naive caring disposition, as strong emotions were expressed about what expressions of caring were considered inappropriate, even extending this to a criticism of clinical staff:

Because I think some people have inappropriate caring... sometimes I'll see the people in class and they're like, 'My heart bled for them' and 'I just wanted to take them home'... No, you're there to nurse them... not to baby them... that creates dependency... especially in personality disorder as well... one of the nurses in the Community Team I was in... it was ridiculous... patients were ringing up every day because... had a friendship with them... it was ridiculous (Lil).

Here we can see that the correct balance in the therapeutic relationship is essential; balancing caring enough to connect and respond competently, without becoming over-involved and paternalistic towards the service users. This can be a real challenge for student nurses and is part of the troublesome knowledge that must to be negotiated for them to become competent at caring.

4.3.1.1 Caring module

As previously stated, one of the modules in year one is specifically focused on developing care, compassion and communication. The aim of this is to enable the student to gain knowledge and understanding of the concepts which are fundamental to developing effective communication skills, as well as a caring and compassionate approach to nursing practice throughout the patient journey. The module explores the foundations of therapeutic nursing by identifying appropriate interpersonal and communication skills and the development of nurse-patient relationship, including the therapeutic use of 'self'. The need for self-awareness and personal effectiveness within the caring role is explored, and strategies for effectively managing challenging situations are introduced. This module is underpinned by the NMC (NMC, 2010), *Essential Skills Clusters*, and the *Care, Compassion and Communication in Practice* policy (DH, 2012a). Whilst acknowledging the challenges of the current healthcare systems and new ways of working, it reinforced the fundamental needs of people to be looked after with care, dignity, respect and compassion, and also introduced the 6Cs of Care; Compassion; Competence; Communication; Commitment; Courage (Ibid.) as a framework for all nurses, midwives, and healthcare staff. They acknowledge that the values and behaviours covered by the 6Cs are not a new concept in themselves, but rather they are part of a strategy to reinforce enduring values and beliefs that underpin care wherever it takes place (Ibid.).

The awareness and knowledge of the participants regarding the 6Cs was demonstrated:

The 6Cs... always follow the 6Cs... your non-verbal communication... it was really important... I used the SOLER thing on placement... tried to use that... it really did work (Asa).

SOLER, 'Sit squarely; Open posture; Lean forward; Eye contact; Relax' (Egan, 1998) is an acronym that describes a framework that can enhance self-awareness, and is used to encourage appropriate and effective non-verbal behaviour when communicating with people. This framework was

found to be useful for several of the participants, who then transferred this into their practice:

I've always been all right... I'm good at talking with people... but things that you don't think of... like the body language... the SOLER thing that we've learnt... tools like that when you're working with people can make such a difference... I've never even looked into body language at all before but things like that (Mya).

This module made an impact on the participants as it reinforces the notion that there is more to 'caring' than is first thought:

The module... Care, Compassion and Communication... it gives you the theory behind things... like therapeutic relationships... you wouldn't really know until you do the module at uni... but my personal opinion is that you're either a caring person or you're not (Kat).

The benefits of theoretical knowledge are acknowledged in relation to developing and enhancing communication skills and developing a meaningful therapeutic relationship. Nonetheless, the opinion that a natural disposition to care must already be present in a person remains a dominant discourse for the participants. Conversely, Fang et al. (2014) indicates that caring should and could be taught and learnt, which can be explained either by cultural differences or by how caring is defined, however:

Getting people to expand and open up and tell us... life story ... that's a skill that's got to be learnt... face to face with a patient... we do it in the group... I did find really good (Dax).

Then again, some of the participants also felt that having been accepted onto the nursing programme, a person is inherently adept in caring, compassion and communicating, making the need for a module devoted to these elements redundant. They reject adding to their current thoughts about caring, and lack the openness to engage with and examining the core values:

About care, compassion and communication... it's the most ridiculous thing I've ever heard... why are you doing nursing if you're not caring, compassionate and you don't have good communication?... it's just ridiculous... that we have to do a full module on it... we wouldn't be here if we didn't have all of the three... I think it's ridiculous...

everybody thinks that's ridiculous... that they have compassion and communication (Lil).

This view was strongly expressed by a number of participants, demonstrating that there was a division between those on the nursing programme. This division could be inferred to be related to whether caring is a case of either nature or nurture, and further reflects the significant challenges regarding the need to address issues of care compassion and communication through a specific module:

I think it's very sad that you have to have a module on care, compassion and communication... I think it's totally shocking (Nea).

Furthermore, it was felt that this module could be a covert way of 'weeding out' those without the capacity or capability to care, reiterating the nature versus nurture issue:

I understand why we have it, but I think there should be a way of wringing people out that aren't already like that without having to do a module on it... I think it's a waste of time (Nea).

The above perspective could be explained by the participants' strong sense of themselves as being caring, combined with the view that caring is innate, leading to the conclusion that there is no need to learn about caring. Nonetheless, this is an attitude that presents a challenge to any further learning or development in relation to caring.

4.3.1.2 Poor practice

Nursing is widely recognised and depicts itself as a caregiving occupation. Indeed, nursing is defined by this relational connection with patients, so when society questions whether patients are being cared for, it is nurses who are held to account (Allen, 2015). This perspective can be drawn from several critical documentaries (BBC, 2005; Channel 4, 2005) and the Francis Inquiry (Francis, 2013). The implications are clear; nurses no longer care. It has subsequently been claimed that the principal reason for such poor clinical care was the decreased quality of (university based) nursing education, particularly after the switch to degree level education (Lown & Manning, 2010; DH, 2012a; Francis, 2013).

The student nurses were made aware of such poor practice, and appeared to challenge core beliefs about nursing:

Feeling upset and confused... because you can't understand why people would go into a caring position and treat anyone like that... it got my back up a lot... I thought 'how dare you' when you've been taught to care for people and you've disrespected people's trust and gone on like that... it shouldn't even... never mind someone who's in a caring position (Sky).

It seems obvious that we must make certain that caring work is competently performed as this is a moral imperative of care (Tronto, 1993), because intending to provide good care, even “accepting responsibility for it, but then failing to provide good care, means that in the end the need for care is not met” (Ibid, p. 133). This moral obligation to provide good quality care in a competent manner strongly aligns with a nurse’s legal ‘duty of care’ and The NMC Code of Practice (NMC, 2015). Failures to care competently usually occur in large bureaucracies (Tronto, 1993) where problems may be taken ‘care of’ at some level, but there are no mechanisms to ensure that care is actually provided at an acceptable standard. Such institutionalised failure to provide competent care within nursing have been clearly highlighted by Francis (2013), which relayed the catastrophic failings of care at the Mid Staffordshire Trust that led to unnecessary deaths and suffering. The same report also uncovered an institutional culture of defence and deceit, where mistakes and bad practises were concealed and suppressed. Unfortunately this is not new to nursing, and over the centuries inquiries and criticism of nursing care or institutions have been well established in all fields of nursing (Martin, 1984).

Student nurses are made aware of such poor practice, with one participant reacting strongly to this, as it appeared to challenge their core beliefs about nursing:

The stories that aren't very nice... get your blood boiling... when you're safeguarding and when we've been shown things like Winterbourne.. things like that... I suppose you don't really know how much things like that get to you until you're shown them... shown on the TV... I

purposely didn't watch it... because I knew it would upset me... what they showed us about the bad nursing and the bad practices... opened my eyes (Sky).

It has been shown that caring (and uncaring) can be learnt by observing both caring and uncaring behaviours (Fang et al., 2014). Such negative portrayals of nursing can however cause frustration leading to the value of such an input into the programme was questioned:

I understand why we went through all of that and why it was important to show us... I'd never act like that, it's not within me, and it shouldn't be within anyone really... I just remember thinking I'm sick of hearing about bad nursing... there's Winterbourne and the Francis report... and for a long time it was about that (Sky).

4.3.1.3 Lecturers influence

The participants identified both positive and negative experiences with the nurse lecturers. There is a significant body of evidence which suggests that the values developed by students during training and early in their careers can be affected by the nurse educators that students are exposed to. There is widespread recognition that nurse educators have an “important and fundamental role to play in the transmission and inculcation of nursing values, even though such transmission occurs on an ad-hoc basis” (Haigh & Johnson, 2007, p. 3). Student nurses need to experience a therapeutic relationship in which they are valued and where teachers come alongside them as people or professional friends (Costello & Haggart, 2008). Teaching staff acting as role models and them being caring in their relationships with the students enable them to grow and develop (Sorrell & Redmond, 1997). Positive influences occur particularly when lecturers share personal experiences of caring for others (or being cared for), which may legitimise the knowledge and remind students that lecturers are also nurses:

When lecturers talk about their own experiences... using their own experiences when giving lectures... I'm lacking that experience... it helps me as well... and you draw from those... so I think that's good (Tai).

There is a perceived and definite influence in facilitating the interaction in the classroom and how this can be managed to ensure contribution and value for all the students, not simply the few more vocal individuals:

If there's interaction in the class... and people think 'well if I don't say something, I'm going to get chosen anyway' ... it will encourage people because if someone's having a heart attack on the floor... you can't just sit back (Dax).

If the teacher's attempts to encourage and manage the classroom interaction, is felt as criticism by the participants, or that their opinion is wrong, this may have a negative influence on the student's confidence, increase the likelihood of them not wanting to contribute in future sessions, and ultimately limit the pedagogical relationship with that lecturer:

I think it's just the teachers not knocking you down when you have an opinion about something... or when you might disagree with them or what they're saying (Nea).

Another area highlighted with the potential to have a negative impact on the participants was a perceived lack of interest or time given by lecturers to interact with students as part of their personal tutor role:

I know that a lot of people... they couldn't see their tutor last year... 'Oh, you don't need to see me this year'... 'Well, you don't need to see me'... I know we're all busy, aren't we?... maybe personal tutors doing a little bit more for people... it is hard and university is solid... so it's a really, really difficult undertaking... doing a degree?... with this workload... maybe you do just want to... like, 'How are you doing?; How are you getting on?' (Jay).

This study does not support the notion offered by a number of authors that nurse lecturers are powerful role models in developing caring behaviours (Fahrenwald et al., 2005; Wade & Kasper, 2006). There is a distinct lack of reference to this relationship between the student nurses and lecturers, the reasons for which have been reflected upon. It may be that the participants did not consider it relevant because it was not specifically enquired about, or that they felt unable to disclose their views on this relationship to a fellow nurse lecturer. There is also a possibility that the participants felt that the capacity to create such a therapeutic relationship is a casualty of the current

educational process that involves large groups and modular learning with many different lecturers (Costello & Haggart, 2008). Yet, previous studies suggest that students engaged with pastoral care from faculty staff can gain feelings of belongingness and value, helping instil a belief in themselves as practitioners (Sorrell and Redmond, 1997).

4.3.2 Experiential Learning

Experiential learning is a proven and valued method of learning based on the notion that people learn best from engaging with the experiences they are learning about (Kolb, 2014). It is seen as fundamentally different from more passive teaching methods such as lectures and seminars. Theories of experiential learning cover a vast range of learning experiences, but in relation to this work, experiential learning refers to the teaching activities within the classroom that aim to replicate 'real life clinical experiences' that could be encountered in the practice placement. An experience itself does not constitute effective learning, rather it must be transformed into a learning experience by a process that challenges preconceptions and tempers emotive responses with critical reflection and extracts the correct knowledge from the consequent action (Ibid, 2014). Three main methods were identified by which the participants felt the development of their caring ability and knowledge were enhanced in the classroom, from simulating care experiences, through role-playing, to listening to service user narratives.

4.3.2.1 Simulation

The use of simulation in nurse education has become increasingly popular and widespread in the last decade, although it is not a new concept. Originally located within the experiential theoretical perspective (Kolb, 1984; Cioffi, 2001), simulation is considered a suitable pedagogy for teaching clinical skills in nurse education. While there are a variety of delivery methods, including role-play, case studies, and the use of technological equipment or software, they all aim to identify common experiences, generate analysis, and address issues important to practice experiences. As students move through the programme they are expected to engage in role-play and simulations, involving complex scenario work focusing upon, for

example, safeguarding, challenging poor practices, and in the mental health field, hearing voices.

Participants identified some of their simulation experiences in the programme as beneficial by it enabling them to develop their skills and caring approach:

Simulation sessions and stuff... which I think is really good... actually this is how it's going to be when you get out there... was when you started to actually realise... oh God yes... I know what you're talking about now (Kat).

One of the key requirements is that the area being simulated must reflect reality for it to be effective, as properly constructed simulations facilitate authentic learning. A participant provided an example a simulation session (in relation to feeding others) where they gained enhanced understanding of what it must feel like to be fed by another person, and they realised that they could empathise with others in this position, thus making them more likely to be caring and compassionate in this situation:

It makes you think how much the patient feels as well... it's not just you... about being the nurse all the time... it made you understand that's how they're going to feel... having yoghurt slapped on my chin and all that!... that's exactly what they're going to feel isn't it? (Kat).

Simulation allows the participants to feel safe in making mistakes, helps them recognise their strengths and weaknesses while carrying out certain activities, and also provides the opportunity for immediate feedback, thereby aiding self-awareness and the development of their caring behaviours (Hinchcliff, 2004; Hand, 2006):

You don't want to hurt anybody... as a nurse... try and be as gentle and as sensitive as possible... but if it's going to take you two hours to clean someone's backside ...you're not really doing something right... to do it on a mannequin... and to give that personal care... it's checking that you're doing everything right (Dax).

4.3.2.2 Role-play

Role-play is another form of simulation which aims to imitate a real-life scenario in the safety of the classroom (Davis, 1975), whereby students act out roles within a problematic or challenging situation (DeYoung, 1990).

Immediate feedback and discussion can help students appreciate problems or experience a situation through another person's eyes, which can in turn increase their awareness and understanding of human relationships:

In a role-play and the lecturers... obviously one was a patient... one was a nurse... a very inconsiderate not caring nurse... and one was a nice nurse... I must say that role-play... with the lecturers doing it... just stuck in my head (Mya).

The impact of witnessing the difference between a caring and an uncaring nurse resonated with the participants, and the effect was retained more than when they were actively involved in a role themselves. Most role-plays within the programme are designed so that one student takes the role of the 'nurse', a 'service user', or an 'observer'. It has been found that actively participating in role-playing increases student confidence in their ability to perform skills related to cognitive, psychomotor and affective domains (Fitzgerald, 1997; Rowles & Brigham, 1998). Simulations can also however pose challenges, not least of all the need to create an authentic situation that enables the student to suspend their disbelief and engage in the learning process:

Role-play isn't the same as doing it in real life because you think differently... it's not the same doing it with somebody in a classroom because it's set up, but if you're doing it on a ward... it's completely different... it's real and you've got to deal with it and you can't back out of it and you can't hesitate... you've just got to get on with it... I think you've either got it or you don't (Nea).

It is recognised that for some students (and lecturers), role-play can provoke anxiety or can be intimidating (Lasater, 2007; Lundberg, 2008), which may lead to avoidance and criticism of this method of learning. Overall though, there is increasing evidence of the positive outcomes of this teaching method, particularly in response to the decline of clinical placement availability (Bland et al., 2010), and reduced clinical tutoring in the placement area that uses real people in real situations:

I think... maybe... more role-play... would benefit people... it would get them away from the fear of being frightened... at the end of the day you're going to ask someone the wrong question... it's going to happen... you're going to make a mistake... we're human beings... but,

if you learn to be able to say... okay that was maybe the wrong question and learn the skills around finding an alternative to that... I think that would benefit students a lot (Dax).

4.3.2.3 Service user input

Positive benefits were gained from sharing service user input ('experts through experience') who narrated their experiences of mental illness, of being cared for or not, and to identify their perspective of what is important when being cared for. The involvement of service users in nurse education recruitment, curriculum design, and teaching, has grown in the last two decades (DH, 1994). It is now anathema to contemporary Higher Education to think that this would not happen as the benefits of this include an enhanced understanding of individual experiences, an appreciation for individual differences, and a greater understanding of the social context of people's problems (Rudman, 1996). Service user involvement is central to the learning and teaching strategies used within the programme, for example, a workshop delivered by external agencies exploring the health needs of vulnerable groups (such as asylum seekers) and classroom activities which enable students to pose questions to a group of service user to determine what a positive outcome means to them, as well as attending a service user support group and presenting their experiences and learning to their peer group.

Service users coming in to see how things have been done for them... and what they expect... these are things that would help me rather than just being theoretical about stuff... service users... they can share their views... as we all learn they're the best when it comes to their own illness... we are learning from them and knowing this is what they expect and this is what we are supposed to do... if we're not learning from them... how can we do better? (Tai).

The value of service user input, known as 'experts through experience', as opposed to a lecturer trying to deliver similar (but inherently theoretical) content is far superior in terms of the reality and authenticity of the information provided (Atkinson & Williams, 2011):

When the service users come in to speak to us... they're saying how it really is and you're not listening to a teacher saying how it is... or should be... it's an actual life story and you can't say, 'Well, yes, you're right or

you're wrong,' because that's what they've experienced... it brings you back to reality and makes you look at an actual person instead of just a case study (Nea).

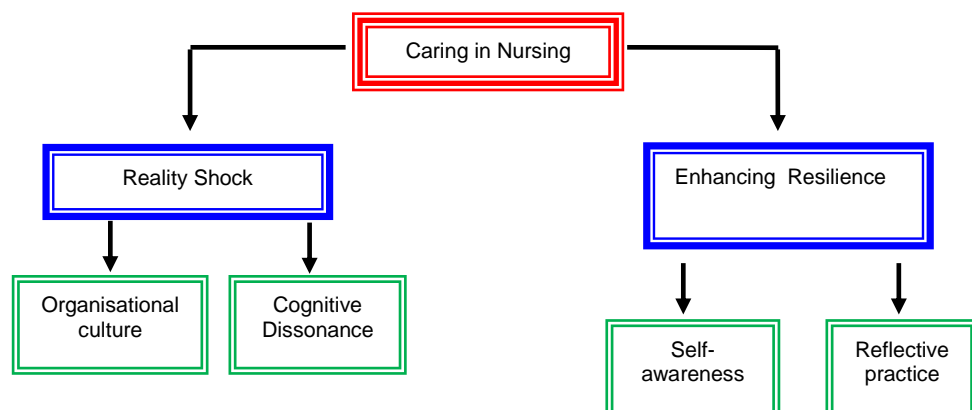
Engaging with service user perspectives also enhances empathy and instils the need to ensure the further development of individualised care (Simpson, 2006). Some of the service users' narratives engendered an emotional and reflective response for some participants:

We had one person that self-harmed a lot and she was quite close to my age... I remember she talked like me and... had quite a similar upbringing... it was just weird how her life turned out and how she ended up and how the services didn't really help her... it was heartbreaking... quite emotional to see how the services had let her down in a way... it makes you more passionate to want to make things better when you're qualified (Nea).

This demonstrates the immense impact that can be achieved through the involvement of service users in student nurse education. Its importance in emotional development (Rush, 2008; Terry, 2013) has been acknowledged in the continued movement for meaningful involvement of service users in nurse education (DH, 2009; NMC, 2010).

4.4 Caring in Nursing (Professional Lifeworld)

"personal growth is deep learning" (van Manen, 1991, p. 170).



The 'Caring in Nursing' theme captures the participants' socialisation in the professional lifeworld and their experiences of caring for others whilst on their practice placements. Practically half of the total programme hours are spent in practice placements working within a range of statutory and non-statutory placements. Learning in practice encourages students to make links between theory and the 'real world' applications of nursing care. Perceptions of what caring is consists of the evolved view of caring ideals - implicit values and beliefs - and can be understood as the result of the synergy between the innate quality of caring and the impact of lived experiences on the individual. It is changeable, particularly in student nurses, and it is assumed that new entrants hold high ideals (Watson, 1999). Yet, it has been found that these can change during the nursing programme because the professionalisation of caring can diminish their innate caring qualities (Murphy et al., 2009). This was illustrated through a caring trajectory, in which at the commencement of training, students begin idealistically eager to care for others, only to begin the third year disillusioned, cynical, and preoccupied with getting through their work (Smith, 1992). There is a stream of research indicating this has continued, with a loss of student nurse idealism having been reported during the process of professional socialisation (Watson & Lea, 1997; Watson, 2000; Mackintosh, 2006; Maben, 2008; Murphy et al., 2009; Curtis et al., 2012; Traynor & Buus, 2016).

The crucial position of the clinical environment is in the provision of a realistic context for students to develop their knowledge, skills, and attitudes (Levett-Jones, 2011). It can also face students with the 'reality' of contemporary nursing practice, creating emotional and ethical dilemmas that may compromise or transform their concept of caring. The success of nurse educational programmes can depend on the effectiveness of clinical placements (Henderson et al., 2012), and there is strong research on the positive influence of the role of practice nurse mentors in the development of nursing students (Davies et al., 1999):

Obviously... practice is reality... so it's the best way to learn... you learn better from people who are in nursing (Asa).

Whilst recognising the positive impact of 'real world' practice on their learning and development, participants also expressed a concern about some of the challenges that they and other nurses faced to be caring in practice. The first major theme, 'Reality Shock', identifies the cultural and personal challenges they encounter that impact on their ability to be caring within services. The participants described a dissonance between their professional ideals and nurse-centricity with the practice realism they were confronted with in practice. The second major theme, 'Enhancing Resilience', is an overarching term to encompass the need to adapt or change to survive by developing strategies that they recognised as enabling them to manage their personal and professional challenges to be caring and maintain their caring capacity.

4.4.1 Reality Shock

While care and compassion are central to the current nursing policy, practice and educational debates (Lown & Manning, 2010; DH, 2012a; Francis, 2013) are located within an increasingly complex landscape of healthcare provision, dominated by concerns over outcomes, efficiency, austerity, productivity, and competence (Gray & DaSilva, 2010; Health Service Ombudsman, 2011). Participants identified pressure on registered nurses to provide effective and timely care within clinical practice placements. Increasing clinical workloads can negatively impact the student experience, as stress during the practice placement can result in reduced interpersonal interactions (Hoel et al., 2007). There is then an obvious need to ensure that an organisational culture of caring is created within the healthcare system to enable environments which are conducive to caring behaviours. We need to create environments where we "model the right behaviours and demonstrate them to those who use our services" (DH, 2012a, p. 3). Whilst it is recognised that most practice placements offer a positive learning experience, several studies have identified that student nurse's experience stress and conflict in practice because the reality of the working environment differs or contradicts the professional ideals associated with what caring nursing entails (Thomas et al., 2012). This experience has been identified as

a 'reality (or culture) shock' (Fitzpatrick et al., 1996; Gray & Smith, 2000; Kevern & Webb, 2004; Brennan & McSherry, 2006).

4.4.1.1 Organisational culture

Participants identified work pressure on registered nurses to provide care whilst responding to organisational demands within the clinical practice placements. Increased workload demands in clinical areas have been shown to negatively impact the student nurse experience, as increased stress can lead to strained interpersonal relationships (Hoel et al., 2007). The impact on staff morale is evident when dealing with the challenges and pressures of contemporary (mental health) nursing practice. The supremacy of a 'production line' mentality within contemporary healthcare has led to increasing priorities placed on productivity, efficiency, and effectiveness in nursing placements. These priorities have been highlighted as impacting on the participants' ability to be caring and the degree to which they could observe others caring (Watson, 2001; Finfgeld-Connett, 2008). Reduced numbers of qualified nursing staff have necessitated the use of 'bank staff' or staff from other wards covering positions (usually on overtime) to fill staffing gaps. These staff may not be used to working in that particular ward, and these practices result in registered nurses having less time to carry out their role and responsibilities. Participants alluded to nurses feeling run down or downtrodden:

People blag their way through things... or I think that they're so run down and so... like downtrodden... with the amount of pressure that a nurse has put on them, and healthcare assistants as well, that I think the care goes out the window (Lil).

It may be that staff still want to be caring, but the way services are monitored and funded have changed priorities and limit the amount of time they can spend with service users. This supports Paley's (2014) analysis of the Mid Staffordshire case in that there is not a deficit of care and compassionate values in nurses, but instead other tasks dominate their time. Paley refers to social psychology and the role of inattentional or ethical blindness to explain why caring nurses may not demonstrate caring behaviours (Mack & Rock, 2000; Palazzo et al., 2012). As Tolman (1948) writes, when individuals are

hurried and preoccupied, they experience “a narrowing of the cognitive map” (p. 208):

They've cut the numbers of the staff working on the wards... you haven't got as much one-to-one time with people... it's the government really isn't it and privatisation of hospitals... I think everything's become a ticky box... it's all down to how much it's costing... nurses still want to be nice and provide a reassuring service... but I don't think they've really got the time to do it as much (Dax).

There is less time to be with service users and communicate and develop a therapeutic relationship with them due to the time pressures placed on registered nurses as a consequence of an outcome measures approach to nursing that has been prioritised over professional values (Bradshaw, 2009):

I really do think that that happens... like you don't have the time to sit down with your patient... it's all paperwork, paperwork, paperwork (Lil).

Pearcey and Draper (2008) interviewed twelve student nurses regarding their clinical experiences, who expressed their disillusionment with the reality of clinical nursing and felt their expectations were not realised. They reported that the dominant features of nursing were paperwork, completing tasks and meeting targets, at the expense of patient contact and communication (Ibid.). Surprisingly, ten of the twelve participants considered the paperwork to be of paramount importance due to the legal necessity of defending and justifying decisions. It may be that a caring and compassionate approach is actually discouraged in the ‘real world’ due to the influence of performance indicators or targets linked to services, something also identified by the participants:

I think they try and train it out... I think having Payment by Results... I've never seen it the other way... but I remember doing a Payment by Results course in my last placement and I asked the woman... 'So, it's basically about money', she was like, 'No, of course it's not about money' (Jay).

During their nursing placements, the participants highlighted the contemporary healthcare organisational culture that is concerned with productivity, efficiency, and effectiveness which promote a quick fix approach to caring, with the participants feeling that this impacted their ability to be

caring, as well as the degree to which they observed others being caring (Watson, 2001; Finfgeld-Connett, 2008).

4.4.1.2 Cognitive dissonance

Much has been written regarding the socialisation of student nurses in clinical areas and the influence of a positive learning environment (Melia, 1987; Castledine, 1995; Ousey & Johnson, 2007; Bradshaw, 2009). Nevertheless, student nurses may also experience cognitive dissonance as part of their professional socialisation as they discover that the reality of nursing practice is different to the caring ideals taught on the nursing programme (Curtis et al., 2012; Houghton, 2014). The participants in this study perceived that registered nurses spent much of their time completing documentation, and they questioned the need for this as it took them away from caring for the service user. This increased participant concerns about their future and their role as a registered nurse because they sought to become a nurse to care for others (aspirations linked to their ideal self-identity):

I think it's [paperwork AH] overemphasised... it could be made easier... I understand that you need to document things from a legal point of view... to cover yourself... as a student nurse or a nurse when I become one... I find it's more contact time with documentation with less contact time with the patient... it's a little bit disheartening (Tai).

Participants expressed views that while they were taught the theoretically based professional values required of a caring nurse (care, compassion, and communication), the reality of nursing in clinical practice nonetheless creates a dissonance that requires managing:

It gives us the background we need... education wise... but the problem is when you get into practice... [laughing]... what you've been taught is, a lot of times, different from what you practise... because of... the culture within the organisation... you'd want to be caring and compassionate and everything... but it's all about the document and it's how you transition that and spending the amount of time to write what you want to write (Tai).

This idea of transition suggests the participant needed to find a balance between challenging the constraints of professional ideals or adapting these ideals to meet the reality of the practice constraints:

As nurses, who are doing the job... what time do you find to do that and how long does it take to be caring and compassionate with people who have mental illness... people who need a huge amount of time to sit one-to-one... you feel a little bit disheartened when you leave uni and you go into practice, when balancing the two (Tai).

The reality of nursing practice poses a challenge for participants resulting in a sense of vulnerability and fear for the future. Conversely, some are able to deal with this cognitive dissonance by always doing their best within the practice constraints:

There are a lot of things that could dishearten you along the way, but if you can have it in mind that you just want to do the best you can with what you've got... then that doesn't change you, but I can see how it could... (Kat).

Some suggest that there is an important link between care staff feeling safe and cared for in an organisation and their ability to provide safe and high-quality care to patients and families (Finfgeld-Connett, 2008).

4.4.2 Resilience

Negative and challenging experiences are encountered on the journey towards 'becoming a nurse'. Students are required to develop resilience to manage these stressful situations. The participants' caring ideals can be thwarted by organisational threats, which create dissonance and stress, and they must prepare and develop strategies to increase their resilience to this. Resilience can be seen as the process that allows individuals to put unpleasant and painful incidents to one side, enabling them to get on with life (Luthar, 2000). Alternatively, resilience could be the ability to recover from or avoid the serious effects of negative circumstances (Dudley et al., 2011). Resilience is relevant to both personal and professional development and is considered an important attribute when recruiting student nurses to the programme (DH,



2013). Given that student nurses will experience considerable 'emotional labour' in their nursing practice, it is important for them to learn how to deal with it. Such emotional labour can involve the induction and or suppression of emotions, aimed at presenting an outer appearance that makes others feel safe and cared for (Hochschild, 1983). Emotional labour calls for the application of personal and intrapersonal skills or 'intelligences' (McQueen, 2004). Emotional Intelligence (EI) is now considered an important aspect of nursing practice (Freshwater and Stickley, 2004), with the ability to perceive, understand and use emotions appropriately in caring interactions helping nurses care more effectively (Salovey & Mayer, 1990). This engenders an awareness of their own and others' emotions, while making them better able to manage or respond appropriately (Petrides & Furnham, 2003). EI includes self-awareness, self-regulation, self-motivation, empathy and social skills. The benefits of EI have been discussed in relation to caring for patients and enhancing the nurse's ability to reflect on their practice (Freshwater & Stickley, 2004). It has also been considered a positive tool in helping nurses deal with the 'emotional labour' of caring for others and enhancing the caring relationship (Montes-Berges & Augusto, 2007).

4.4.2.1 Self-awareness

Self-awareness is both a component of EI and a personal competency that encompasses recognising one's emotions and their possible effects, knowing one's strengths and limitations, and having confidence in one's self worth and capabilities (Goleman, 2001). Self-awareness can help lead to effective and appropriate interpersonal interactions and personal and professional relationships. In demonstrating self-awareness, the participants identified specific personal issues which they felt may hinder their ability to express caring behaviours. Student nurses can feel uncertain and unsure of how they can emotionally connect with service users in the placement context (Curtis, 2014). This self-awareness helps them to connect to their values and beliefs, and to be aware of their emotions and how emotions can affect their engagement with service users in empathetic and therapeutic ways (Costello & Haggart, 2008).

Overall, the participants were grateful that they were in the role of (supernumerary) student, as this offered many benefits, such as limited responsibility, time to interact with patients, and none of the pressures placed on qualified staff:

As a student I think I'm lucky... I'm jumping with joy... because you have all the time to sit down and talk and listen as well... I find a lot of time you don't even get time to talk... it's just listening... it's like I think I'm privileged in being a student. I'm dreading becoming qualified (Tai).

Personal life issues and other demands can affect a person's ability to care for others, and an important factor is being able to care for oneself while enhancing their caring ability for the benefit of others:

If things are happening in my personal life that might make me less... I'm really good at putting that to one side and I don't let it affect me, like the way I interact with service users... I don't think I ever would... no matter what's going on in my life... I don't think I would ever change my behaviour, in my job (Asa).

It was identified that it was more difficult to feel caring towards some service users, either because of their behaviour or what they considered lifestyle choices:

It is hard... I've read a care plan and been like, 'How am I supposed to then go and care for this person when I know what they've done'... although you do try and detach yourself, it's your own moral values and things like that... it is hard (Lil).

The difficulties in caring for some service users was also freely disclosed:

I try to... but then if I compare how I've cared for somebody who's done something really bad in comparison to somebody who's had something really bad done to them... it's completely different... I don't purposely do that... you do it unconsciously... It's always going to be in the back of your mind (Lil).

There was also a struggle with caring for some service user's for individual reasons which were reflected on:

I think I'm more caring and compassionate to people that haven't brought it on themselves... I get frustrated with patients... I do still care about them, but I don't have as much sympathy for them when they've been discharged and then gone on a £2,500 drugs spree over the

course of nine days and then get re-admitted into hospital... no sympathy at all... I don't have any patience for them at all (Nea).

When expressing potentially judgemental views about a person's behaviour, it is recognised that despite a reluctance to care for that person on an emotional level, their duty as a nurse demands that they care for this person and deliver effective individualised care. Nevertheless, challenges to the student nurse's capacity to care, requires exploration and discussion to enable them to express and deal with any negative emotions impacting on their caring:

I still look after them and do what you're supposed to do... I wouldn't ever fail in my duties as a nurse but I just wouldn't have the same emotion about them... I wouldn't be really happy for them if they got discharged like I would with a different patient (Nea).

For others, it is not individual service users that create a conflict, but rather a group of service users within a specific setting (such as within forensic mental health) where personal safety and security is invariably an issue. This is explained as being a consequence of a lack of knowledge and understanding leading to such views:

The challenge for me is going to be the forensic... I think it's great that you get to do that... because you might just care for people that... through no fault of their own they've got a mental illness... the majority absolutely are not dangerous, so you can plod along for three years doing that and then you could come across somebody... everyone will be in there because of a different thing... but I think the similarity will be... I don't know... I'm assuming... but for me the similarity probably is going to be that they've had awful backgrounds and not really nice parents (Mya).

An effort to understand and empathise with how people may develop certain pathology is alluded to here, as they reflect on their feelings about the service user group.

4.4.2.2 Reflective practice

Reflective practice is regarded by many as an essential component of professional competence and is increasingly being utilised as evidence for continuing development and revalidation (NMC, 2015). Reflection and

reflective practice also play a central role within the learning and teaching and assessment strategies utilised during the programme. Students are introduced to the concept of reflection and reflective models and skills are introduced in the first practice module, which are then enhanced through activities designed to develop self-awareness and understanding of their personal beliefs and values, using reflection upon practice. They have viewed this as playing a major role in applying theory into nursing practice by enabling them to develop a greater sense of responsibility and accountability in their practice (Chong, 2009). Several strategies were used to enable the reflective process during the nursing programme, including reflective essays and group discussions. The role of reflection in nursing is taught along with the various models of reflection for the students to use (Johns, 2002; Schon, 1983). Reflection is enabled within the curriculum via teaching and assessment, with some assignments requiring a reflective element which is a reflection on action (Schon, 1983). On each placement, students are required to devise a Strengths, Weakness, Opportunities, Threats (SWOT) analysis which they can use to develop a learning contract that identifies their specific learning needs in relation to that placement. Reflection in action usually occurs when there is an incident or disruption of usual practices where routine responses cannot be applied (Schon, 1983).

Reflecting on what may help to change any negative feelings towards a service user, the participants demonstrated that there is a need to take responsibility and develop self-awareness in relation to overcoming obstacles to caring:

We do a lot of reflection... I don't know what could be done about feeling like that against certain patients... you've got to learn that yourself... or experience a change around with that sort of person... and see them get better and stuff like that... to actually change your perspective on it (Nea).

The ability to preserve personal and professional boundaries while maintaining empathic communication with service users is acknowledged as an important skill (Freshwater & Stickley, 2004):

I've always thought 'oh well it's nice if you give them this and give them that'... but not if they don't want to... that could cause a barrier because now I think they'd be thinking 'this isn't good enough... my life's not good enough'... so that could make them feel a bit... like you're above them... that was a big lesson learnt (Mya).

Together with reflection, feedback was considered helpful in developing caring behaviours. A tool used to assess the student nurses' communication on this particular programme is the 360° tool. This tool invites the service users, the student, and their mentor to assess the student's communication to develop their self-awareness and reflective skills:

Feedback... I think you learn a lot from it... I've just done my first assessment by myself... I learn much better, practically, than I do academically (Dax).

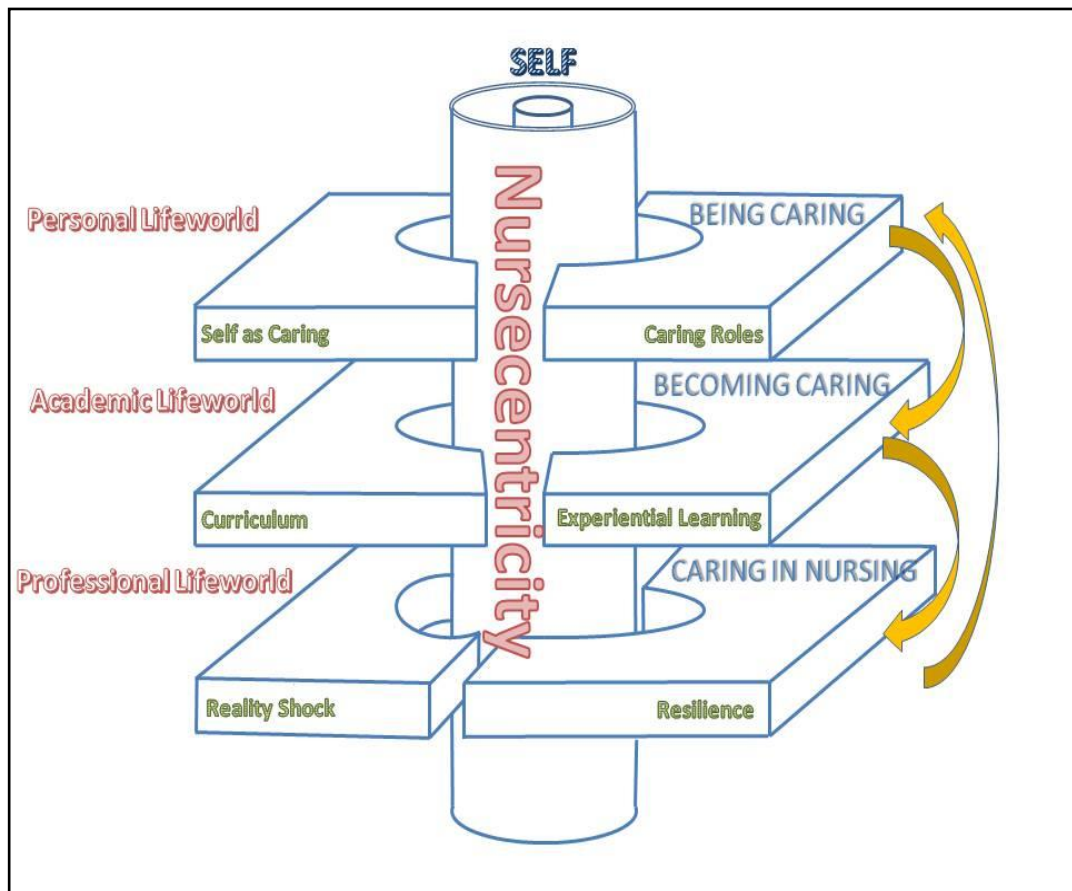
I think the 360° tool is really good because that gives... that helps us to develop... our mentor and service users tell us what we're doing right and what we can improve on... that's really good, in terms of developing further (Asa).

While there are clear benefits of the clinical experience for learning, 'real nursing' is fundamental. Both are equally challenging environments for students who experience a cognitive dissonance between the theory of professional values of caring and the actual reality of caring in contemporary practice. Helping students to be able to deal with the above challenges, will be essential for their professional development, whilst also training nursing mentors to support them. Through the "unfolding experience of reflection the nurse is looking backwards to the future, she is becoming whilst being, recognising his or her self as a dynamic and worthy being whose presence makes a difference" (Freshwater, 2002, p. 16).

The following (Diagram 4:1) is a diagrammatical representation of the three superordinate themes and the interrelationship between them.

(Diagram 4.1)

‘Diagrammatic Representation of sub-themes relationship’



4.5 Summary

The preceding sections have presented the key findings gained from the participants' narratives. It has emerged that the participants were exposed to these aspects of their being and encounter influences from three different arenas; personal, academic (university) and professional (nursing). As the diagram shows, there is a core self from which their ideal self is represented as 'nurse-centricity'. Each participant began their nursing programme with their own personal interests, desires, attributes, experiences, and aspirations. They are then socialised in both the academic and clinical environment in a cyclical nature by progressing through each stage of the nursing programme to become a caring nurse. Each lifeworld impacts and influences how the person thinks, feels and interacts in the different lifeworlds and when combined as a whole. It is hoped that the overall aim of the nursing programme - to create a competent caring and compassionate nurse, possessing not only the intellectual knowledge and psychomotor

skills, but also the effective capabilities in the form of caring human values - has been achieved.

Nurse Education in the UK is shaped not only by nurse lecturers and practice mentors, but also by the environments and cultures in which nursing and education take place (O'Driscoll et al., 2010). Nurse lecturers facilitate the learning of caring compassionate practice through their personal and pedagogical approaches to provide the underpinning theory and values, while working in partnership with practice mentors in the practice settings to set learning outcomes and support their achievement. In practice placements, practice mentors help provide the learning opportunities and the support to help students deal with the challenges they may face. Meanwhile, it must also be acknowledged that student nurses are not always a blank canvas when they arrive at the beginning of the programme, instead having their own narratives of 'being caring' from their individual lived experiences. These narratives may encompass a diverse range of cultural, psychological, social, spiritual, and physical life experiences that are not necessarily age dependent. As educators, we must accept that adults' learning interests are "embedded in their personal histories, in their visions of who they are in the world and in what they can do and want to do" (Cross, et al., 1978, p. 19), which the following chapter explores further.

Chapter Five: On Being and Becoming

5.1 Overview

In this chapter, the research findings will be explored in relation to ontological theory and the connotations for nursing education. The framework for this study was drawn from a diverse range of empirical and research evidence from nursing and educational practice. It may be one of the first phenomenological studies in the UK to examine the socialisation of student (MH) nurses and their journey towards becoming caring professionals in the 21st Century. This work sets out to explore the perceptions of student mental health nurses regarding their specific values and motivation towards becoming a nurse, and the educational practices they feel are preparing them to become caring nurses. The following discussion weaves the exposition of the participants' perceptions of their student journey into the literature on these specific areas, with additional reference being made to the complex interweaving of teaching theory and other relevant philosophical stances. In the current technical, digitally enhanced culture within Higher Education there is a need to ensure a 'holistic' approach to learning, incorporating both the epistemological and ontological dimensions of nursing education.

In this chapter I will discuss the rationale for a dualistic approach to nursing education, with a refocus on Ontology and Transformational learning, to achieve two aims: to enrich rather than erode (emotional) caring values; to prepare students for the 'reality shock' of practice experiences.

5.2 Deconstructing 21st Century Nursing Education

The continuing criticisms of nursing standards being ubiquitously expressed, by service users (Patients Association, 2012; Griffiths et al., 2011), the media (Patterson, 2012), politicians and policymakers (DH, 2012a; RCN, 2012; Francis, 2013) and the nursing profession alike (Chaffer, 2012), has led to an increased focus on and examination of nursing education. The crucial nature of the response to this by nursing education will be resonant for the nursing profession and healthcare services for the future; therefore, there is an

opportunity for nursing to re-examine its priorities and ensure that they are assigned the necessary prominence within nursing. Central to this endeavour is a requirement to analyse the concept of caring within nursing and healthcare education and to question its relevance to contemporary practice. Is it desirable or achievable?

The participants offered evidence to suggest that present healthcare systems and organisational cultures are incompatible with the well-established professional ideals of caring within nursing:

It gives us the background we need... education wise... but the problem is when you get into practice... [laughing] ... what you've been taught is, a lot of times, different from what you practise... because of... the culture within the organisation... you'd want to be caring and compassionate and everything... but it's all about the document and it's how you transition that and spending the amount of time to write what you want to write (Tai).

Several researchers (Chalice, 2007; Brown, 2011; Burnham, 2013) have found evidence to suggest that caring is no longer a viable characteristic of contemporary healthcare environments, and compassionate and caring services are diminishing. If this 'reality' in nursing practice remains ignored then student- and qualified nurses will continue to become disillusioned, dissatisfied and cynical, choosing either to remain in nursing as 'burnt-out and uncaring' or to leave the profession (Benson & McGraith, 2005). It is reported that one in 10 nurses are leaving and currently there are more nurses leaving than joining the profession (Quaile, 2018). This is in addition to the acknowledged shortage of nurses previously highlighted. Combined with the current crisis and shortages of nurses this could be disastrous for the healthcare system and could bring NHS services to a standstill (RCN, 2017).

The lack of individual caring qualities has been identified as the reason for nurses being 'uncaring' themselves, leading to the atrocious situation that occurred at Mid Staffordshire NHS Trust. Paley (2014) has challenged the assumption that the nurses were actually uncaring people. It has been observed that 'fundamentally caring people' in certain contexts can behave in

an uncaring manner (Darley & Batson, 1973). Paley (2014) argues that if we divide caring into a motivational (caring about) element and a behavioural (caring for) element, then it is possible to accept that the nurses in this situation did still care about their patients but were unable (due to circumstances) to care for them. The neural analysis of caring capacity also offers a neuropsychological explanation for a lack of ability to be caring, ongoing stress being one factor identified (Eisler & Levine, 2002). He goes on to state that it was not the individual nurses' values and qualities that were uncaring, but rather, "it was the interlocking set of contextual factors, affecting social cognition, which cannot be corrected by teaching caring to student nurses" (Paley, 2014, p. 278). The findings in this study would indicate that all those entering the nursing programme consider themselves to be caring individuals and this caring was embodied within their self-identity and their nurse-centric motivation:

You can't be taught to care... I don't think you can be taught to care... It's not something you learn... it's something that's inbred in you or it isn't... in a nursing sense (Lil).

Nevertheless, a central aim of education is the transformation of self, "real education laying hold of the soul itself and transform[ing] it in its entirety" (Heidegger, 1998, p. 167). Transformation of the self towards becoming a professional is not a totally individual or isolated endeavour. Learning to be a professional involves not only knowledge (epistemology) and skills but also a sense of who we are becoming (ontology). As student nurses seek to enter the profession, they 'transform themselves' into a professional by embodying the routines and traditions of nursing. This process of socialisation, in two distinct life-worlds, so to speak, is difficult and complex with many challenges to be overcome, some of which have been identified by the participants in this study. The purpose of the pre-registration nursing programme is to prepare student nurses for the challenges of practising within their field of nursing. Mindful of this and of my role as a facilitator of transformation and growth, it is imperative to locate the findings conceptually and theoretically so that they can contribute to nursing life as an evolving entity (Rawnsley, 1999).

5.3 Self Power and Knowledge

A large element of the function of both the life-worlds (the environments in which the participants' learning occurs), in the University (academic) and within local Mental Health Services (professional), aids in nurturing the student through a period, and self-determined process, of developing their ideal (nurse-centric) identity. A professional identity that will (upon completion of the training programme) become such that they can function, in a range of arenas and modalities, as a caring, competent, qualified nurse. The process of socialisation starts on day one of their training and continues until the day they retire or leave the profession. As the majority of the student's journey occurs within large institutions, some of Foucault's (1980) theory provides a useful critique of how dominant institutional standards and discourses can influence the student (MH) nurse's development of caring. Here, it is exposed and disclosed how language and discourse can control and oppress rather than liberating learning and transformation. Foucault (1980), Deleuze & Guattari (1984; 1988) philosophical concepts are considered in relation to the process of being and becoming a caring mental health nurse.

Foucault considers that a relationship between people is the essence of power (Foucault, 1977) and knowledge, and that one individual affects another's actions: this can be considered within the context of how the educational and clinical environments influence and nurture the development of the student's (ideal) identity as a qualified nurse. The presence of power is seen in all human relationships, and it permeates society. Foucault (Ibid) states that power is conceptualised as a relation between forces, "the moving substrate of force relations which, by virtue of their inequality, constantly engender states of power ... [that] are always local and unstable" (p. 93). These forces operate in both life-worlds to which the participants are exposed as their professional socialisation occurs. The continually evolving face of the NHS, for example: its operational directives, and managerial and workplace models and changes (improvements) in care delivery systems, coupled with regular changes to Higher Education organisational and Nurse

Education Curricula, reflect the fact that power relations are deeply unstable and changeable as encountered by the participants. Foucault (1980) stated that power, “is employed and exercised through a net-like organisation” (p. 98), and individuals, “are always in the position of simultaneously undergoing and exercising this power” (Ibid). They are, “not only its inert or consenting target, they are always also the element of its articulation” (Ibid). He was making the point that the power to influence and develop personal change towards an identity like that of a qualified nurse is present in the everyday articulations undertaken by the student (MH) nurse (in both the University and the practice setting) - and the influence of the ‘knowledge power’ vis-à-vis both of these stakeholders is part of their mutually agreed relationship, which he terms ‘conditioning’. The educational and practice demands have the power to seek and demand the conformity, compliance, and good behaviour required of the student (MH) nurse, to prepare them for life as a qualified nurse through the control of the regimes. Student nurses have the power to conform and utilise the resources offered to them to develop their own (ideal) self-identity of what it means to be a qualified nurse, and by doing so, they are actioning the behaviours and beliefs necessary to survive the pressures placed upon them by two powerful agencies (Higher Education and the NHS). This identifies power as ‘capillary’, in that power is everywhere, and most people are seen as agents, not just passive victims, of the powerful few (Foucault, 1980). So, by utilising the wide-ranging resources available to them, students not only become part of the capillary network, but they are also preparing themselves to become agents of the powerful (NHS and/or University) when they qualify.

5.4 Emancipatory and Caring Pedagogy

Whilst recognising the importance of gaining the necessary knowledge and skills to become a competent nurse, this study has highlighted the importance of an ontological (theory of being) dimension. The professional programme can then be conceptualised in terms of developing ways of being and becoming a caring nurse. Nevertheless, how this transformation occurs is rarely theorised or conceptualised formally within the educational programmes. The concept of caring in a professional context could be

considered as complex and elusive (Paley, 2001). The implicit nature of care within all nursing activity, however, means that it is often assumed to be part of the nursing curricula. As we have already suggested, the participants in this study identified their own meaningful perspectives of caring when entering the programme (Appendix A): these are then subjected to other experiences, challenges, perspectives or views of caring during their learning. This is well summarised below:

The qualities of the personal self within the profession are the key to excellence' and that 'professional development is radically centred in development of self' on 'personal being and becoming' and the 'understanding of individual human agency in the realm of practical actions (Butler, 1995, p. 153).

The process undertaken by students when developing their 'nurse-centric' identity requires them initially to be mere recipients of information (educational, organisational and clinical). So, in the initial stages of their training, as neophytes student nurses may engender a degree of academic and professional docility (Mackintosh, 2006; Maben, 2008; Murphy et al., 2009; Traynor & Buus, 2016). Disciplinary power is demonstrated and enforced through the requirement to successfully complete both academic and practice placement assessments: students are focused upon these and absorb all the information they can to be successful in this endeavour and to become the ideal professional. Successful completion of these assessments allows the student to progress further into the Nursing Programme and thus start to transform their own personal values, opinions and ways of working (Cross, et al., 1978), though while still conforming to the enforced professional standards. Thus, individuality is created out of the collective student body (Foucault, 1977). The operations of disciplinary power include observation at their centre.

Observation of the student (MH) nurse occurs in the practice setting and also at University (and to an extent in their private lives) to ensure that they are behaving and performing as professional, competent practitioners and that no action (within or without the organisation) will damage or bring said organisations into disrepute. The student body is the subject of attention and

while it is obviously not subject to physical force, it does have to conform to forces of discipline and control (University and NHS regulations on professional behaviour). This resonates with Foucault's sovereign power theory whereby any person who violates the law of the state (NHS and Higher Education) must receive punishment (adjudicated through University and NHS Trust disciplinary processes, and removed from their training, or worse). This is to "create fear, and discourage further crimes by the citizens" (Ibid, p. 9): the "citizens" here being the participants of the nursing educational programmes. Whilst Foucault's terminology is harsh and severe, the essence of the discourse is pertinent. Foucault (Ibid) reminds us that individual bodies are created from the group, through observation, and comparisons are continually made to a norm of average behaviour. This is enacted through the use of assessment and feedback at regular stages throughout the educational programme. By demonstrating conformity to the normative standards of behaviour (successfully passing the required assessments and demonstrating the appropriate knowledge, competence and professional behaviour) the individual is controlled, yet transformed and improved. Thus, the concept of docile bodies resonates to some degree with Locke's (1690) notion of a *tabula rasa* in that the human mind at birth (or the student at the commencement of their training) is a complete but receptive blank slate upon which experiences and knowledge about the world around us are engraved, to aid the development of knowledge. Nonetheless, from the participants' narratives, it is clear that they do not arrive as such and therefore nursing education needs not to treat them as 'blank slates' or 'empty vessels' to be filled with knowledge. As beings we are 'always already' - shaped by our past that we can never 'get behind' and so we are never 'blank slates' or 'empty vessels' (Heidegger, 1962).

Students begin their nursing programme with a personal epistemology of caring, based on their lived experiences, these being influenced by age, gender, social and cultural factors as evident from the interview data and Appendix H. As already stated, these lived experiences often provide the motivation to want to care for others:

It was personal experience that gave me the drive to do it ... my mam suffered abuse as a child ... and that led to a breakdown when we were all young children ... and getting good help totally can give you a different outcome ... it could have gone a different way for her ... so I thought I really would love to be that person that really does something for someone like that (Mya).

However, these fundamental values and beliefs can be challenged by their experiences on the nursing programme, leading to uncertainty or doubt regarding their previous view of caring as 'troublesome knowledge' (Meyer & Land, 2003). Student nurses inevitably experience ethical dilemmas: "conflict about what to value, who to be, and what to do" (Beckett, et al., 2007, p. 643). Contradictory messages from academia and practice lead to the identified experience of 'dissonance' for student (MH) nurses:

What you've been taught is, a lot of times, different from what you practise, because of ... the culture within the organisation ... for example, you'd want to be caring and compassionate and everything, but it's all about the document, and it's how you transition that and spending the amount of time to write what you want to write (Tai)

Professional values can vary between individuals as a result of diversity of education, culture, personal values, marital status, life experiences and work (Iacobucci et al., 2012). All would acknowledge that, for whatever reason, there was a lack of compassion demonstrated by professionals at Mid Staffordshire NHS Trust (Peate, 2012; Darbyshire & McKenna, 2013) and the resultant call for nurse education to place a greater emphasis on enhancing compassionate care is widespread (Cummings & Bennett, 2012; Griffiths et al., 2011; RCN, 2012). The essence of compassionate care is seen as being central to good nursing practice; however, there is an underlying feeling (or fear) that this has been lost along the way, as both practice and education in nursing have developed to meet current needs (Corbin, 2008; Griffiths, 2008). While education may concentrate on lived experiences and the meaning of caring, and the desires and values the students bring with them to their educational programme (Parker & Merrylees, 2002) these can be seen to be challenged during the programme, through various processes (Smith, 1992; Watson & Lea, 1997; Murphy et al., 2009).

The expectation for nurses is clear: they are expected to be caring and compassionate in the care they deliver no matter what, yet in reality they are striving to deliver safe, dignified, high-quality care in a complex, changing and often challenging health service (Buchanan, 2013). Participants narrated a view that they were being taught the theoretically based, professional values required of a caring nurse - care, compassion, and communication; however, the reality of nursing in clinical practice creates a dissonance that requires management:

There are a lot of things that could dishearten you along the way but if you can have it in mind that you just want to do the best you can with what you've got ... then that doesn't change you, but I can see how it could (Kat).

The reality of nursing practice poses a challenge for student nurses, which results in a sense of vulnerability and fear for the future; however, some are able to deal with this cognitive dissonance by always doing their best within the practice constraints. It is suggested that staff still want to be caring, but because of the way services are monitored and funded, priorities have changed and they have less time to spend with service users (Paley, 2014):

People blag their way through things ... or I think that they're so run down and so ... like downtrodden ... with the amount of pressure that a nurse has put on them, and healthcare assistants as well, that I think the care goes out the window (Lil).

Participants reported that a caring and compassionate approach is actually discouraged in the 'real world' due to the performance indicators or targets linked to services. Dissonance is experienced as part of professional socialisation as the reality of nursing practice was, and is, different to the caring ideals taught on the nursing programme (Curtis et al., 2012). Expectations of clinical practice are idealised and based on a vocational image of nursing as "helping and caring for sick people" (Holland, 1999, p. 57) leaving student nurses ill prepared for the realities of clinical practice:

It was a bit like kind of wanting to change the world at first and I think that took into placement. I think it got on a few people's nerves at first

but I think that's what it was, I think it was just generally just to help people less fortunate than yourself (Jay).

While there are definite benefits in using clinical practice to experience 'real nursing', these are equally challenging environments for students who experience ethical dilemmas and dissonance between the theory of professional values of caring and the actual reality in contemporary nursing. Preparing students to be able to deal with these challenges and preparing nursing mentors to help support them is essential (Bevis & Watson, 2000). All nurses, student or not, will face complex moral and ethical issues on a daily basis and will need to become expert ethicists, making decisions about complex moral issues for which there are no precise rules or guidance:

Only a mentor/preceptor/teacher modelling a humanistic caring ethic and having a dialogue with students that underscores constructed knowing and encourages them to be personally related to the ethical issues involved can facilitate and enhance students in their moral development for life and for nursing (Bevis & Watson, 2000, p. 184)

Power is a relationship between forces that are "always local and unstable" (Foucault, 1977, p. 93). This relationally determined power is recognised within this study but also on the more individual perspective of 'power to be' (Deleuze & Guattari, 1988). Removing the focus from the relationship between the student and the educational and clinical settings, and placing it firmly in the student's hands, allows the latter the opportunity to create their personal self-identity necessary to 'survive' the training programme and, by utilising their inherent 'power to be', students enter a state of 'becoming' (Deleuze & Guattari, 1988). This is the "pure movement evident in changes between [AH] particular events" (Deleuze & Guattari, 1988, p. 21). Therefore, 'becoming' functions, and becomes evident, at two levels. Firstly, there is the transition from macro to micro social contexts as the students move from being a member of the wider society and then engages with educational and clinical experiences. Becoming also occurs as they begin to reframe contextual power (knowledge) and utilise their action(s), their power to be, to enable them to adapt to, and survive, three years of socialisation through the transformation towards their nurse-centric identity:

It annoys me, because I think if you're going into nursing, you know that you're accountable, you know that you're responsible, you know that you've got to go by these - like the code of conduct. Things about care, compassion and communication, it's the most ridiculous thing I've ever heard in my life. Why are you doing nursing if you're not caring, compassionate and you don't have good communication? (Lil).

Foucault's reciprocal power relationship offers an analysis to understand power and knowledge within the nursing programme. Within this context it is understood that students, through their creation and development of self-identity, will develop a sophisticated understanding of the power of knowledge and equally will have knowledge of the role of contextual power. Yet it does not offer an effective, or sophisticated, understanding of the actual processes that occur when students reframe contextual knowledge and power through their behaviours during the training process. A more erudite understanding is provided through Deleuze & Guattari's (1984) 'desire' and the 'desire to become' or 'desire to other', for they are desiring to become a competent qualified nurse within the clinical setting and are preparing to become a different version of themselves to achieve this:

Yes, I think ... that's probably another thing that you're taught as well really ... how to go about being caring ... although you might want to go over and hug them ... they probably don't want a hug ... [laughter] ... it's about reading ... probably ... reading the situations ... and acting appropriately to what's going on around you ... I think you learn that out in practice ... yes (Sky).

Whilst Foucault (1980) and Friere (1972) focused on the socio-cultural location of power, Deleuze & Guattari considered knowledge and professional power as an individual affair (Deleuze & Guattari, 1988). They would say that the ability to develop a nurse-centric self-identity is an individual affair as no two students will develop in the same way or direction, and that students have the 'power to be' (Deleuze & Guattari, 1988; Colebrook, 2005). Critical of the word 'power', Deleuze & Guattari (1988) favoured their own word, 'desire', which they see as creating relations through which knowledge/power might operate (Deleuze & Guattari, 1988; Colebrook, 2005). In this sense it is viewed positively, for there are not people who *have* the power [AH], nor who suffer *from* power; it is not repressive nor something we suffer from (Ibid). Rather, a student is the

embodiment of their own power and they are characterised by what they, and that knowledge/power, can do and achieve. The aim of nurse education in this case being:

A philosophical belief in human freedom, a 'Wide Awakeness' that is paradigm shattering and emancipatory calls for encouragement, self-reflection... educators come in touch with their own humanity ... encourage release of the human spirit (Greene, 1978, p. 37).

When the students are enabled to utilise active knowledge/power, they maximise their potential, and in doing so they allow it (knowledge/power/knowledge), and themselves, to push themselves to the limits of the positive and professional - clinically and academically, behaviourally and in terms of endurance. Hence, this (re)affirms it's, and their existence in which they (knowledge/power, the student (MH) nurse and the burgeoning self-identity) are inextricably linked through acts of passive and active resistance against the hurdles they encounter during the training:

I think it's just the teachers not knocking you down when you have an opinion about something ... or when you might disagree with them or what they're saying (Nea).

Another aspect of developing and reframing contextual and individual knowledge/power is the outcome of the dynamic relationship between the student's individual abilities and psychosocial forces (Deleuze & Guattari, 1984, 1988). There is a clear relationship between a student's chosen actions of learning and self-development and how they choose to utilise them in learning environments. The ownership of this personal learning is firmly in the hands of the student (MH) nurse as they choose the methods to maintain ownership of it:

It's all very well and good doing all these presentations but instead of having a presentation, to have a discussion about the topic instead because otherwise people just stop listening and they don't learn anything. If you're having a discussion you're going back and forth to each other and you're listening, you're engaging but if you're just watching a presentation you're not learning anything (Nea).

It is in the interaction between, and incorporation of, all the factors of the development of a nurse-centric self-identity (Being Caring; Becoming Caring;

Caring in Nursing, and all their component behaviours and activities), and their substrata of influence and understanding, that nomadology (Deleuze & Guattari, 1988) enables an uninterrupted flow of movement between learning strategies and personal development. Personal meanings that, “we attribute to our experience are acquired and validated through human interaction and experience” (Mezirow, 1991, p. xiv). It is a theory that is partly a developmental process, but more as, “learning is understood as the process of using a prior interpretation to construe a new or revised interpretation of the meaning of one’s experience in order to guide future action” (Mezirow, 1996, p. 162).

A holistic approach recognises the role of feelings, other ways of knowing (intuition, somatic), and relationships with others in the process of transformative learning. It is “about inviting ‘the whole person’ into the classroom environment, we mean the person in fullness of being: as an effective, intuitive, thinking, physical, spiritual self” (Dirkx, 2006, p. 46). The participants identified aspects of this in the theme of ‘experiential learning’ when they narrated an engagement with critical reflection leading to a transformation towards their nurse-centric self. Learning to monitor beliefs and assumptions (truths) we hold about ourselves and others is valuable, as we are not always aware of how we ‘see the world’ through our own value lens and how this can influence our behaviour (caring or not):

I understand why we went through all of that and why it was important to show us ... I'd never act like that, it's not within me, and it shouldn't be within anyone really ... I just remember thinking I'm sick of hearing about bad nursing ... there's Winterbourne and the Francis report, and for a long time it was about that (Sky).

This educational approach will prevent simple acceptance of information (without the ability to critique and analyse and apply it to practice) and will help the individual ultimately to survive educational experiences and ultimately qualify as a registered nurse. This flow is situational, fluid, and contextual to the student, and is in response to the immediacy and the nature of the situation they are experiencing. As such, it utilises a ‘multiplicity of

narratives' (Fox, 2002) to achieve this, and is not seen in itself as an outcome, but as a process as well as part of the overall learning process:

We do a lot of reflection, don't we? So, I think that's already happening. I don't know what could be done about feeling like that against certain patients because I think you've got to learn that yourself or experience a change around with that sort of person and see them get better and stuff like that, to actually change your perspective on it (Nea).

Nomadism (Deleuze & Guattari, 1984, 1988) is seen as travelling along a multiplicity of lines of flight in order to move from one point to another. The students in this study are enacting (or travelling along) clearly considered, prescribed and chosen paths (molar and molecular lines), however some of their behaviours and actions may fall outside of the organisational norms (lines of flight). Such nomadic behaviour enables students to utilise their 'power to be' (Deleuze & Guattari, 1984, 1988) to survive their nursing education and achieve their desire of the nursing qualification that would allow them to take their newly developed nurse-centric identity forward as, "changes change in relation to other changes" (Goodchild, 1996, p. 173). This reflects the fluid and contextual activities of learning and the fact that nothing (be it a behaviour, an interaction, a response) is static for long, as everything changes in the struggle for survival.

For the students in this study, the reciprocal nature of the relationship depends on them having broken previously created employment and social rules and roles and then responding in a way that is both dictated to, and expected of, them by learning requirements and environments, thus resulting in the creation of a new nurse-centric identity. This relationship between the student, and their immediate learning requirements and environments, is based both on Goffman's (1961) notion that individuals find ways in which to adapt to such potentially oppressive, diverse and potentially threatening (to their self-identity) societies. To adapt is to survive: the basic maxim of students who need to adapt to different learning environments and methods and different clinical environments and regimes. It is this adaptation that provides the students with a breadth and depth of knowledge experiences, and in turn, influences their 'caring nurse' potentiality.

According to Goffman (1961), the first thing a person learns upon entering a hospital is how to become a patient. This observation is also applicable to becoming a student (MH) nurse in their multifaceted training programme, which incorporates both the educational and the clinical environments. Goffman (1961) offers a dual model consisting of the official self and the performing self. In order to survive in any kind of social order, he suggests, an individual has to engage in a continuous process of evaluating the demands and expectations made upon him (the necessity to demonstrate effective engagement with the learning process), and attempt to satisfy those by presenting an acceptable behaviour to the outside world (the need to demonstrate professional competence and confidence during this development of nurse-centricity). This continuous construction of the official self is stage-managed by the performing self that is motivated by the existential drive to survive, and as such individuals are in a perpetual state of bewilderment lest they be caught out of character and be denied their privileges and ultimately their lives (Ibid).

This is comparable with the students in this study utilising activities of learning and knowledge/power in order to develop their new self-individuality through the creation of nurse-centricity. This adoption of an ever-changing self-identity, and subsequent behaviours is a consequence of the student's chosen actions of gaining knowledge/power. The folding of past to present and then into future ensures continuity and change in our lives and opens up 'flight paths' and possibilities;

Life is a becoming beyond what it is because the past, not fixed in itself, never fixes or determines the present and future but underlies them, inheres in them, makes them rich in resources, and forces them to differ from themselves (Grosz, 2004, p. 255).

Even participants with no prior experience of 'nursing' bring with them the notion, even if somewhat idealised, of what the nursing profession entails, and this initially underpins their becoming. The process of change with continuity endures throughout our lives and careers; we are continually learning and changing as people and as professionals. Grosz (1994)

describes a process of doubling, a temporal ambiguity that allows the past, present and future to form this continuity:

The present not only acts, it consolidates, the past; it doubles itself as both present and past, actual and virtual. And it is only this doubling that enables it to resonate with the resources, the virtual, that the past endows to it and to the future (Grosz, 1994, p. 251).

The participants in this study frequently lived out this narrative as they drew on their resources to enable them to display behaviours that were either an extension of existing values, attitudes or traits - or were transformed, derived from the necessities of the context and situation they were in at that time. They all reported, however, that the learning environment brought about changes in them and their actions and behaviours, and their thought processes and attitudes were different as they progressed through their training programme as opposed to before joining the programme:

It was a bit like kind of wanting to change the world at first, and I think that took into placement. I think it got on a few people's nerves at first, but I think that's what it was, I think it was just generally just to help people less fortunate than yourself (Dax).

Temporality enables continuity of self, whilst opening up other ways of being that are “inherent of the past in the present, for the capacity to become other” (Grosz, 2004, p. 252).

Nonetheless, this can also create resistance, as was noted in the language of some of the participants and their lack of openness, to seeing new ways of being ‘caring’. Strong views were evident in the narratives that ‘caring’ could not be taught, and potentially could create tension and challenges to their capacity for caring:

Thing is about care, compassion and communication, it's the most ridiculous thing I've ever heard in my life. Why are you doing nursing if you're not caring, compassionate and you don't have good communication? It's just ridiculous, that we have to do a full module on it, and they're still banging on about it (Lil).

They may need to assimilate knowledge and values that are unfamiliar or challenge their established meaning-schemes, “made up of specific

knowledge, beliefs, value judgements, and feelings that constitute interpretations of experience” (Mezirow, 1991, p. 5). A broader meaning perspective is one that acts as a personal paradigm involving, “a collection of meaning schemes made up of higher-order schemata, theories, propositions, beliefs, prototypes, goal orientations and evaluations” (Mezirow, 1991, p. 2) and “they provide us [with] criteria for judging or evaluating right and wrong, bad and good, beautiful and ugly, true and false, appropriate and inappropriate” (Mezirow, 1991, p. 44). Heidegger (1962) points out that we learn from others, learning to think and act as ‘they do’, even if at times we ‘fall into line’ with how we are supposed to think, act and be:

So, I think you're asked to toe the line because things like competence can be held against you. I only needed these signed off, so I toe the line sort of thing, so it is difficult. I think you do get your wings clipped a little bit just to get through the placement and get signed off (Jay).

From this, it could be seen that individuals’ ‘performing’ self dominates while they are engaged in the learning process, as they superficially change aspects of themselves, to meet the demands of their academic and professional lifeworld, until this eventually becomes embodied and embedded in customary practice. In order to guarantee educational survival their performing self may differ, either slightly or markedly, from their authentic selves. The process of stripping the students of their (social) preconceived notions of care and caring is carried out in order to ‘shock’ their performing self into submission and accept the new demands made upon them (Goffman, 1961). The student is required to conform and become compliant to the dualistic authority of the University and the NHS in the desire for professionalism and high-quality care. This process also serves to reinforce in the student the power relationship, inherent in healthcare delivery, that they have become part of. These “house rules” (Ibid, p. 51) are explicit and lay out the main requirements and expectations of student nurse conduct, while serving as a formal reminder of the potential sanctions that the student could find themselves facing within both the educational and clinical environments. Foucault (1977) highlights how language is “organised around different systems of meanings” (Ibid, p. 10) which offer certain people positions of power, while disempowering others.

As with any other professional organisational, especially when it is a closed institution (Goffman, 1961), language is an overt demonstration of power. Language: the jargon and acronyms that are used to infuse a sense of professional magic. A large part of the student's development is the assimilation of this 'power language' into their self-identity, the understanding and competent, knowledgeable usage of it, for example: knowing and being able to discuss psychiatric diagnoses and symptomatology. Wittgenstein talks about the 'language game' (McGinn, 2008), by which he refers to *both* the activities used to teach people language *and* [AH] the activity of using language. In this sense, students are taught the language(s) of both the authority organisations (NHS and University) and these are reinforced on a daily basis through activities of academia and practice learning, to ensure understanding of and compliance with their usage. This language game commences on their first day of training and continues in ever increasing increment as the training progresses and the nurse-centric identity is developed.

Language mirrors the customs, as well as the regulations, of nursing and higher education. Some of these are prescriptive and proscriptive, detailed, written in formal legalese to reflect their inherent authority and power. In relation to the dominance of evidence-based practice, Castledine (1995) notes that, "the scientific components of medicine have also become the scientific aspects of modern nursing, and have led us into a more dominant medical model of nursing care than ever before" (Ibid, p. 937). Recognition exists for the need to transition/deconstruct the nursing curriculum from one with a major focus on content knowledge and skill development, to one that has humanitarianism at the heart (Clark, 2005). Deconstruction in this sense relates to breaking down the dichotomy in which one approach is favoured over its opposite by the dominant discourse. As has been revealed in this study, this dichotomy exists in both nursing and nurse education, with the empirical, epistemological knowledge in the form of evidence-based practice outweighing the ontological, aesthetic and personal ways of knowing. Nevertheless, the aim is not to reverse this dichotomy but rather to show it as

it is, so that such differences become valued. There exists a false dichotomy between the art and science of nursing (Smith, 1993), with science considered as quantifiable, “covering the nurse’s science of curing and treating illness (epistemological) whereas arts are considered expressive, covering the nurse’s art of healing (ontological)” (Ibid, p. 42).

Other forms of language are created, conveyed, implemented, and reinforced through the interactions of students and the unwritten, narrative culture of education and clinical practice while individuals continue to develop their ideal self-identity and are contextual, situational (and thus fluid). One form is language designed to apply power, while the other is intended to empower. This is a reflection of the numerous clinical settings and the range of learning encountered by the student. The student needs to learn how to assimilate and utilise this range of differing clinical and educational languages and terminologies in the performance of their daily practices. This involves learning aimed at understanding the meaning of what others, “communicate concerning values, ideals, feelings, moral decisions, and such concepts as freedom, justice, love, labour, autonomy, commitment and democracy” (Mezirow, 1991, p. 8). Friere’s (1972) emancipatory view of education is also relevant to understanding the potential for such a caring pedagogy:

The lecture based, passive curriculum is not simply poor pedagogical practice. It is the teaching model most compatible with promoting the dominant authority in society and with disempowering students (Ibid, p. 10).

Hence, power is of crucial significance in the classroom, for if, “teachers or students exercised the power to remake knowledge in the classroom, then they would be asserting their power to remake society” (Ibid), and “liberating education consists of acts of cognition, not transferrals of information” (Ibid, p. 53). In a similar vein, learning is a deeply personal experience, as it relates to the discovery of personal meaning. The emphasis of significant learning is focused on the personal relationship between the facilitator and learners in his/her student-centred learning (Rogers, 1951), thus mirroring his/her person-centred counselling approach. Bevis & Watson (1989)

explicated a transformative caring pedagogy for nurse education, calling for an approach that, “appeals to freeing the human potential, an approach that allows one to develop not only rational and moral capacities but emotional, expressive, intuitive, aesthetic, personal capacities and to bring about one’s full self to bear with one’s life work, in this instance, the work of human caring” (Ibid, p. 47).

The culmination of Watson’s worldwide influence has been captured in Lee et al., (2017). When referring to *Caritas Literacy* Watson relates to literacy in the widest sense of an expanded human consciousness, able to reflect, critique and interpret meaning into ‘being’. She notes that, “some collective mindsets could be considered illiterate” (Ibid, p. 19).

Without emancipation, education is an oppressive tool. It is an assembly line industry producing nurse-workers who on average follow the status quo. They may make waves, but they stay within the rules while living lives that are circumscribed by the inflexibility of large medical empire-bureaucracies and bear the inevitable stamp of banality and mediocrity. Emancipatory education encourages learners to ask the unaskable, confront injustices and oppression and be active agents in their lives and in their work (Bevis, 2000, p. 162).

Harsh, “unkind, controlling cultures within impersonal institutions, corporations, and social networks” have been identified as illiterate (Watson, 2011, p. 22). The NHS and Universities could be considered as such, as they increasingly focus on task-orientated practice, with specialist and controlling language, ‘scientising’ (Lee, et al., 2017) of human emotions and the reduction of humanness to an ‘object’. This view relates to Heidegger’s powerful and insightful critique of modern universities. He recognised the increasing trends of professionalisation, corporatisation, instrumentalisation and ultimately technicalisation (Heidegger, 1998). The spread of hegemonic power is insidious within the organisational culture and creates a barrier to a caring and emancipatory culture or pedagogy.

Yet here again we face a situation in which as a problem gets worse we become less likely to recognise it; the ‘impact’ of this ontological drift toward meaninglessness can barely be noticed by contemporary humanity because they are continually covered up with the latest information (Heidegger, 1988, p. 142).

How then can such an ontological revolution occur in relation to 21st century nurse education. Real education, “lays hold of the soul itself and transforms it in its entirety by first of all leading us to the place of our essential being and accustoming (eingewohnt) us to it” (Bonnett, 2002, p. 168). Such Heideggerian ideals of teaching and learning call into question the dominant instrumental discourse of education in a manner that has relevance now and for the future (Bonnett, 2002).

We have to get out of our head and into our heart for this next evolution of humanity” (WCSI, 2010).

5.5 Summary

This chapter has generated pertinent issues regarding the concept of caring within nursing practice and nurse education while questioning how caring can be embodied within the socialisation process whilst one is becoming a mental health nurse. The findings suggest a system by which to critique the issues of self, knowledge and power for student nurses’ experiences within the professional lifeworld of academia and nursing practice. The refocus and enhancement of an ontological dimension is proposed to assist nurse educators to encourage/facilitate an emancipatory, caring pedagogy that will enhance this transformative process.

In the final chapter, the thesis concludes by re-examining the original research questions, the hermeneutic phenomenological process, the limitations and the implications and unique contribution of the study.

Chapter Six: The Journey Ahead

"The farther back you can look, the farther forward you are likely to see."
Winston Churchill, (1874 - 1965).

6.1 Overview

This study emerged from my personal worldview as a 'caring' person and 'caring' nurse educator. In order to progress my own 'becoming' as a facilitator of 'becoming' for future nurses, I initiated this phenomenological investigation into the deeper transformative passage of student (MH) nurses' experiences. This was prompted prior, but with relevance to, the considerable debate, regarding the role of nurse education in developing and promoting the caring capacity of nurses. In this particular phenomenological study, the purpose was to gain the perspectives of student (MH) nurses on their thoughts, experiences and learning about caring, and to gain insight into possible ways to enrich and enhance student nurses' caring abilities, to help them become the caring nurse they aspire to be.

This final opportunity to reflect upon the thesis as a whole and the transformational opportunities for such a study on myself, student nurses and colleagues in academia and in nursing practice is addressed in this chapter. The future path of nursing education is not known, but nevertheless, the need to ensure caring remains not just as a fundamental concept within it but becomes encompassed within a caring and emancipatory pedagogy. This points to an original and significant contribution to the extant body of knowledge in this field. The limitations inherent in the study will also be indicated before we offer a final thought.

This thesis began by identifying the objectives of the research in chapter one, and three research questions have guided this study. In this concluding chapter I shall reflect on the research journey and the key themes in relation to these questions:

- Which particular values and philosophies do student mental health nurses feel stand behind them and their choice of educational programme?
- To what extent do student mental health nurses feel that their programme prepares them to be caring nurses?
- Which particular practices (if any) do they perceive as being effective in fostering a caring philosophy?

These questions were generated from and grounded within the extant scholarship and my personal knowledge of the ontological issues regarding caring and nurse education. The hermeneutic intention was, then, to enhance ‘understanding’ as a feature of being and as such is grounded in prior knowledge and research as identified in Chapter 2 (Grounding). This study is underpinned by the comprehensive work of Watson (1979, 1988, 1990, 2008a) and others in relation to ‘Caritas’, who have guided and transformed the idea of caring within Nursing and the educational pedagogies in America. Nonetheless, their teachings have not had the same major impact or the same developmental influence here in the UK. Watson (1999) states that “human caring involves values, a will and a commitment to care, knowledge, caring actions and consequences” (p. 29). As part of their professional socialisation student nurses develop reflexive and habitual patterns of caring behaviour that guide their interactions, derived from the self. This thesis has focused on the portrayal of the student (MH) nurses’ lived experience and how meaning is constructed within the context in which they function and communicate (Cole & Knowles, 2001; Rossman & Rallis, 2003) - but above all, with regard to their caring values. It has given student (MH) nurses a voice through which to recount their stories of developing caring within a nursing programme. These stories were then anchored within the overarching structure of the three lifeworlds as represented in Chapter 4 (Findings).

The conclusions drawn from the findings are considered in relation to each of the research questions.

6.2 Returning to the Research Aim and Questions

This study has been preoccupied with experience and meaning, contributing to a more rounded and richer understanding of how experiences regarding caring are perceived by student (MH) nurses. As indicated in Chapter 3 (Methodology), the research results in hermeneutic phenomenology make no claim to theoretical generalisability (van Manen, 1990). Therefore, the following insights and conclusions are made in relation to this study specifically, in relation to the original research questions.

Question 1: Which particular values and philosophies do student mental health nurses feel stand behind them and their choice of educational programme?

The theme 'Being Caring' clearly captures the importance of the 'personal lifeworld' in the development of caring as a core construct for the participants. It was strongly asserted by the participants, that caring is a personal quality that cannot be taught, hence supporting the belief that "caring is a basic way of being in the world and that caring creates both self and world" (Benner & Wrubel, 1989, p. 398). Nevertheless, caring in nursing is not necessarily innate to nurses (Olshansky, 2007) and before being able to extend the self in caring relationships, one should first intentionally know the self as caring (Pross *et al.*, 2010). The implications for curricula include the need to ensure that strategies are in place to support the student's awareness of the self as a caring being whilst synthesising and internalising incrementally what caring in nursing is about. Part of the nurse educator's role lies in identifying the student's individual capacity for growth in caring and their engagement with critical reflective opportunities.

The importance of wanting to help and nurture others was identified as a natural disposition, which is also seen to be a prerequisite for becoming a nurse (Murphy *et al.*, 2009). Whilst there is an acceptance that caring, as expressed in the behaviours of a nurse, could be developed as part of the learning process, there was a compelling belief that caring (the personal ability to be) cannot be taught because it is either present or not. This

personal virtue of caring in the participants proves to be a key motivator in the decision to engage in a career in nursing; and being able to fulfil this intrinsic capacity to care is vital in maintaining their engagement within nursing. The impetus or trigger to apply to become a student (MH) nurse was embedded in personal life events, especially trauma within the family as a prime motivator, and other factors such as prior employment in care, volunteering experiences and being influenced by people they respected. These intrinsic factors are all consistent with other studies (Rompf & Timberlake, 1994).

The most visible aspect of self in this study was expressed as the 'ideal' identity, which I have termed nurse-centricity. As much as a person aspires to become their ideal self, the participants identified their aspirations towards becoming a nurse. These aspirations create an image of the person they strive to become in the future but are not yet, and as such they become nurse-centric. Thus, their ideal self-identity can offer stimulation and motivation to change and transform their identity in order to achieve their goal (ideal identity). As the art of caregiving is an interpersonal process, the subject of self can be considered key:

Human caring can be most effectively demonstrated and practiced interpersonally. The intersubjective human process keeps alive a common sense of humanity; it teaches us how to be human by identifying ourselves with others, whereby the humanity of one is reflected in the other (Watson, 2012, p. 43).

The participants confirmed the embodied nature of their caring as central to their self-identity and as an enduring concept in their process of becoming a mental health nurse.

Question 2: To what extent do student mental health nurses feel that their programme prepares them to be caring nurses?

Overall the participants were positive regarding the role of the professional programme in championing caring as the essence of nursing. They found

that this is portrayed in several pedagogical practices enacted within the programme that are consistent with an experiential, epistemological approach. Caring was also made visible in the nursing programme as explicit in many of the module aims and outcomes, particularly the modules relating to the development of professional practice. The core elements of caring practice were seen to run throughout the programme as an integral theme for students. Whilst the benefits of theoretical knowledge are acknowledged in relation to developing and enhancing communication skills and developing meaningful therapeutic relationships by the participants, the opinion that a natural disposition to be caring needs to be present, remains a dominant discourse for all participants. Part of the learning in relation to being caring is footage of poor and abusive care, but such negative portrayals of nursing appeared to cause frustration for some participants, as this challenged their fundamental beliefs regarding nursing and their nurse-centric identity.

Several effective pedagogies were identified by the participants, all coming under the category of experiential learning, which is a proven and valued method of learning and is based on the notion that people learn best from engaging with the experience they are learning about (Kolb, 2014). In relation to being caring, participants experienced increased awareness of what it may be like to receive care from the service user's perspective, gained during simulation activities (for example, when being fed). It has been found that students who actively participate in role play increase their confidence in their ability to perform skills related to cognitive, psychomotor and affective domains (Fitzgerald, 1997; Rowles & Brigham, 1998). Moreover, a more authentic account of experiencing mental illness is afforded when provided by service-user input. These 'experts through experience', as opposed to a lecturer, provide a more real, vivid and effective narrative (Atkinson & Williams, 2011). Engaging with service-user perspectives also enhances the participant's empathy and highlights the need to ensure the further development of individualised care (Simpson, 2006).

A significant body of evidence agrees that values developed by students during training and early in their careers can be affected by the nurse educators to whom the student is exposed (Haigh & Johnson, 2007). Due to this empirical evidence, there was an expectation that the participants would highlight their relationship with their lecturers as being influential, possibly viewing them as role models for being caring. Yet despite this notion of nurse educators being powerful role models in developing caring behaviours (Fahrenwald et al., 2005; Wade & Kasper, 2006) there is a distinct lack of reference to the relationship between student nurse and nurse educator in this study. Admittedly, one participant highlighted an issue with the lack of availability of their personal tutors for one-to-one contact. Possible explanations may be workload and a lack of time; however, this would require further research with nurse educators, as there is limited research in this area. Nonetheless, the relationship between nurse educator and student nurse is at least considered by others to be a critical element of the educational process (McGregor, 2007; Labrague et al., 2015).

Question 3: Which particular practices (if any) do they perceive as being effective in fostering a caring philosophy?

The 'Caring in Nursing' theme captures the socialisation of the participants' in the professional lifeworld and their experiences of caring for others whilst on their practice placements. Whilst recognising the positive impact of 'real world' practise on their learning and development, participants also expressed a concern regarding some of the challenges to be caring that they and other nurses face in practice. Participants expressed a view that they were being taught the theoretically based professional values required of a caring nurse - care, compassion, and communication - but experienced a 'reality shock' with the actual caring they encountered within the practice areas. They identified the cultural and personal elements they considered as impacting on the ability to be caring within services. The contemporary organisational culture within healthcare, of productivity, efficiency and effectiveness promoting a quick fix approach to caring, as experienced by the participants, led to student nurses' experiencing stress and conflict in

practice (Thomas et al., 2012) as they struggle with the reality of clinical practice.

Participants identified the particular strategies that they perceived as enabling them to manage the personal and professional challenges both to being caring and to enhancing and enriching their capacity for caring. Reflective practice is viewed as playing a major role in applying theory to nursing practice, as it enables individuals to develop a greater sense of responsibility and accountability in their practice (Chong, 2009). The ability to preserve personal and professional boundaries while still maintaining empathic communication with service users was acknowledged as an important skill (Freshwater & Stickley, 2004). Emotional Intelligence (EI) was referred to and considered an important aspect of their nursing practice (Freshwater & Stickley, 2004), as was their ability to perceive, understand and use their emotions appropriately, in caring interactions that can facilitate care more effectively (Salovey & Mayer, 1990). Through the “unfolding experience of reflection the nurse is looking backwards to the future, she is becoming whilst being, recognising his or her self as a dynamic and worthy being whose presence makes a difference” (Freshwater, 2002, p. 16).

The responsibility for the education and socialisation of future nurses falls to the NHS and HE in providing a remedy for the ‘crisis in care’. Nevertheless, current attempts by each at blaming the other are not productive. If these two powerful organisations cannot co-operate, then it surely spells doom for the future of ‘caring’ as we have come to know it. The impact of new ‘managerialism’ pervading nursing is summarised:

Our collective memory of nursing is being overwritten by a new managerialism. Nursing is subtly and insidiously being reformatted, re-engineered, processed to become something which may be efficient and effective in a managerial, commercial and business sense but which is something unrecognisable as something nurses or patients wish to engage with (Carter, 2007, p. 270).

It could be contended that the above is also becoming true of nurse education, and ‘teaching excellence’ has become an empty concept with the

real focus on becoming an 'excellent bureaucratic corporation'. HE has become preoccupied with its own maximised self-perpetuation, governed by league tables and input/output ratios (Readings, 1996; Clark, 1998).

In Chapter 6 (Discussion), Foucault (1980) and Deleuze & Guattari, (1984; 1988) provide a relevant critique of the dominant institutional standards and discourses involved in the professional socialisation of student nurses, exposing and disclosing how language and discourse can control and oppress, rather than liberate. Whilst Foucault (1980) and Friere (1972) focused on the socio-cultural location of power, Deleuze & Guattari considered knowledge and professional power as an individual affair (Deleuze & Guattari, 1984; 1988). This involves learning aimed at understanding the meaning of what others, "communicate concerning values, ideals, feelings, moral decisions, and such concepts as freedom, justice, love, labour, autonomy, commitment and democracy" (Mezirow, 1991, p. 8). Friere's (1972) emancipatory view of education is also relevant to understanding the potential for a caring pedagogy. How, then, can such an ontological revolution occur in relation to 21st century nurse education? For real education, "lays hold of the soul itself and transforms it in its entirety by first of all leading us to the place of our essential being and accustoming (eingewohnt) us to it" (Heidegger, 1998, p. 168).

This research set out to discover what student (MH) nurses' perceptions are of the teaching and learning of 'caring' as experienced within their pre-registration education. On the basis of this research, it can be concluded that the process of socialisation towards becoming a caring professional is foremost in their narratives. The process of 'being' and 'becoming' in relation to their caring capacity is crucial in the descriptions of their experiences in the three separate, but intertwined lifeworlds. I have attempted to present the participants' stories with honesty and with integrity *vis-à-vis* their original meaning and have had the opportunity to confirm this (member checking). The overall credibility and quality of this study stems from prolonged engagement in the field over many years, ensuring that I have been immersed wholly in the contextual flow of the phenomenon under study

(Rossman & Rallis, 2003).

6.3 Original Contribution of the Research

The purpose of this research was always to gain knowledge regarding the deeper, transformative experiences of student (MH) nurses. Much of what was revealed by the narrative lies in the subtle nuances in their being and becoming 'caring' as a registered mental health nurse;

- The research is exclusively focused on student (MH) nurses and contributes an original insight into their perspectives and values in relation to their caring capacity. The importance of their self-identity is central to their motivation towards becoming a caring mental health nurse. The concept of nurse-centricity is presented as an important part of their being and becoming in their personal, academic and professional lifeworlds.
- It produced multiple narratives of the process of professional socialisation as a student mental health nurse, and of the range of issues, they encounter in their transformational journey. The importance of personal strengths and resilience was highlighted as central to the ability to deal with the dissonance created between professional idealism and practice realism.
- The findings as presented add to the substantive theory by providing unique insights into how student mental health nurses and nurse educators navigate the development of caring values during nurse education. Transformational learning has a central role to play in the process of becoming a mental health nurse, together with a caring and emancipatory curricular approach.
- The study reinforces and adds to an understanding and explanation of the ways in which values may be fostered and developed in university-based nurse education programmes.
- The study is of significance to the future of the development of caring values in nursing and nurse education at a time of significant political shifts in healthcare, HE and nursing-education delivery.

6.4 Implications/Recommendations

Traditionally, nursing education has placed greater focus on the development of cognitive and psychomotor skills, and whilst their importance is undeniable, the nursing student's values, attitudes and beliefs are equally important to caring, professional practice. Despite the many studies supporting the need for caring in nurse education, the literature continues to reflect an absence of information on how this can be embedded throughout the nursing curricula (Cook & Cullen, 2003; Haigh & Johnson, 2007; Benner, 2012). In nursing, caring can be seen as the extension of the self to another through intrapersonal and interpersonal experiences (Watson, 1999; Boykin & Schoenhofer, 2001). Caring in new student (MH) nurses is an innate human quality that requires awakening and validating rather than instilling. Nursing curricula need to embed teaching strategies grounded in the ethics of caring, which promote the advancement of caring values in student (MH) nurses. This may be via the non-traditional experiential methods - highlighted by this study as being effective in enhancing their caring capacity. Beliefs can be enhanced by experience, reflection and education (Underwood, 2002). Nurse educators will be required to defend and treasure such approaches in contemporary HE institutions with a key strategy for more technical, digitally enhanced methods of teaching and learning.

The challenge for nurse educators is to protect and enhance the ontological aspects of the curriculum, which are being perceived as unnecessary and non-cost effective. The focus is largely on content and objective clinical data, procedures and technological competencies and skills. A caring science curriculum (Lee et al., 2017) seeks to move beyond this traditional focus, so that future nurses will be educated, informed and inspired, as well as passionate about the nursing profession. Changes to the curriculum do not need to be major: this goal just requires a rethinking of the location of caring and its visibility and validation throughout the curriculum. It requires creating a space within the curriculum for new meaningful experiences, which encourage reflection and critical discussion regarding feelings and attitudes

about caring. Nurse educators in their interactions with student (MH) nurses also need to be cognisant of their language and power, to create and to role model caring actions and behaviours in their relationships with student nurses and others. After all, although the claim is not much supported in this study, both Felstead (2013) and Baldwin et al., (2014) do at least assert that academic and clinical role models are the most significant influence on the development of a student's own professional values.

Pedagogical approaches and curricula need to be congruent with the theories of caring in nursing and to include opportunities for creativity, reflection, inquiry and mindful presence (Schwind et al., 2015). Nursing curricula and educators should reflect the range and effectiveness of strategies both to prepare and support students in terms of the impact of their practice placements and the dissonance they may encounter. Introducing and embedding approaches that develop resilience, and increase emotional intelligence, are essential in protecting the nurse-centricity and caring ideals of the student nurses. Effective strategies are identified in this study and supported educational theory through reflective practice. If not addressed, the adjustment to professional identity can lead to negative consequences for the student nurse's ability to be caring (Mackintosh, 2006).

Previous research has identified the negative impact of professional socialisation on the student nurse's caring behaviours and it is accepted that new student nurses enter as neophytes with an idealised view of nursing, which most then lose (Mackintosh, 2006; Maben, 2008; Murphy et al., 2009; Traynor & Buus, 2016). The frustration and disillusionment faced by student nurses in this study supports this assertion, as the 'reality' of practice placements appears to challenge their professional idealism and nurse-centricity (Mackintosh, 2006; Curtis et al., 2012). The findings of previous studies that, during the course of their nursing programme, students are socialised to care less in order to cope more effectively, has major repercussions for nursing and nurse education. There is clearly a need for an agenda to address this aspect of socialisation in nursing practice as well as

in the curricula. How can the socialisation of student nurses be achieved in a way that values and facilitates sustained idealism?

Transformational learning is essential in enabling the student (MH) nurses to help transform the meaning of their attitudes, beliefs and emotional reactions by engaging in critical reflection (Meizerow, 1991). Critical reflection encourages a focus on and analysis of the impact of their assumptions on their experiences, resulting in a new perspective. This is similar to internalisation, as attitudes, values and beliefs become integrated into their worldview. Student (MH) nurses require guidance from both practice and nurse educators to enable them to reject the thinning of professional values and caring and to reinforce the ideals that motivated them to become a mental health nurse. An enhanced focus on and awareness of self would be beneficial when exploring individual caring capacity and behaviours, and also indeed in relation to developing personal resilience. Fostering strategies to build resilience would positively influence nurses' ability to be caring, and would challenge any barriers to caring practice within the organisation - for example, task orientation (Hofmeyer et al., 2017).

6.5 Limitations of the Study

It is acknowledged that the study took place within one HEI; hence, any conclusions may not be generalised. There were several factors that created limitations for this study. Whilst some did not impact on the findings, they constrained the recruitment of participants. For instance, not being able to access the students directly meant that I had to rely on administrative staff to make contact with the student group. Therefore, one limitation over which I had no control was the sample size. Nevertheless, the depth and richness of the data collected compensated for this.

The sample also consisted of one field of nursing students: mental health. Originally considered a weakness, however, this has now become a unique quality of the study. Nevertheless, a key feature of any phenomenological study is that, if repeated, it can present different or even contradictory findings:

As the complex life-world does not remain static, and so alternate descriptions may always exist. As a result, a full explanation of the world is not possible nor is it possible to obtain causal certainty and inference. Or the production of law-like statements (van der Zalm & Bergum, 2000, p. 212).

I must therefore acknowledge that if another researcher had followed the same research process, interviewing the same student (MH) nurses, they *could* have drawn very different interpretations and findings, and yet claim equal credibility. This reveals, no doubt, the boundless sources of knowledge as conjured phenomenologically in a hermeneutic inquiry.

6.6 Direction for Future Research

The incumbent role of nurse education is, then, clearly to produce competent professionals who can remain ‘caring human beings’, whilst responding effectively to social, economic and cultural transformations and contemporary nursing demands. Further research is required, however, into how this can be achieved and if it can be maintained within the context of HE. The two concepts of, “training and education continue to challenge the pedagogical practice of nurse educators as they struggle with the legitimacy of nursing as a discipline within HE with its essentially practice-based orientation” (O’Conner, 2008, p. 749).

The criticality of the relationship between nurse educator and student nurses needs further study to explore the exact nature and context of any positive and negative influences on caring values, as there is limited research in this area (van der Zalm & Bergum, 2000). Whilst there is a general agreement that nurse educators can have a positive influence on student nurses’ caring behaviours (Dillon & Stines, 1996; Haigh & Johnson, 2007; Newton, 2010;) there is no simple recipe to facilitate this influence.

6.7 Final Thoughts

Although caring remains a contested concept, it is an essential professional value for contemporary nursing practice. Caring, or as Watson (1988) terms it, *caritas* is the 'heart and soul' of nursing, and without it, nursing and nurse education would become an empty technical, robotic profession, without any capacity to connect human to human:

Any profession which loses its values becomes heartless;

Any professional who becomes heartless becomes soulless;

*Any profession that becomes heartless and soulless becomes
Worthless!*

(Egger, 2001, p. 14)

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Appendices

APPENDIX (A)

Responses to “Caring is

Tai: - “... *displaying kindness and concern for others*” (affective)

Kat: - “... *a part of who you are, skills can be acquired, but are not always in your nature*” (affective)

Sky: - “... *showing compassion and kindness to another*” (affective)

Lil: - “... *the actions, behaviours and attitudes by which the nurse responds attentively to the service users physical, intellectual, emotional and social needs with an aim of achieving service user specific self-fulfilment*” (total)

Mya: - “... *is to have an empathic nature with a non-judgemental approach while incorporating the 6Cs in a patient centred way*” (affective)

Jay: - “... *to be compassionate and hardworking towards achieving positive outcomes for each individual*” (affective & instrumental)

Dax: - “... *to have the patients’ best interests at heart. Having the skills and the compassion to promote and achieve the most positive outcome*”

Other Elements Identified;

| | | | |
|------------------------------|---------------------|------------------------------|-----------------------|
| Wanting the best for someone | Commitment | Competent, Communicate (6Cs) | Promote self – belief |
| Being Respectful | Intuitive | Helpful | Promote dignity |
| Interest | Empathic | Open | Warmth |
| Passionate | Ethically Moral | Approachable | Kindness |
| Compassionate | Supportive | Calm | Loving |
| Encouraging | Non Judgemental | Honest | Genuine |
| Acting in the Best | Listening to Others | Professional | |
| | Patient Centred | Interested | |

APPENDIX (B)

Ethical Approval Form

From: SMITH J.C.

Sent: 04 December 2013 15:15

To: HALL A.

Cc: WALKER-GLEAVES C.; ED-PGTSTUDENTS E.

Subject: Ethical approval: A. Hall

Dear Angela

I am pleased to inform you that your application for ethical approval in respect of "A narrative study of student nurses' lived experiences of caring values development within their graduate nurse education programme" has been approved by the School of Education Ethics Committee.

May we take this opportunity to wish you good luck with your research.

Sheena Smith
Research Office
School of Education
Durham University

Tel: (0191) 334 8403
www.dur.ac.uk/education

APPENDIX (C)

Informed Consent Form

Title of Project:

A narrative study of student nurses' lived experiences of caring values development within their graduate nurse education programme.

Have you read the Participant Information Sheet YES/ NO

Have you had an opportunity to ask questions and to discuss the study YES/ NO

Have you received satisfactory answers to all of your questions YES/ NO

Have you received sufficient information about the study YES/ NO

Who have you spoken to?

Are you aware that digital recordings will be made from the interviews and meetings and transcribed for the study and for the future dissemination of any findings.

YES/ NO

Do you consent to participate in the study YES/ NO

| Do you understand that you are free to withdraw from the study-:

- at anytime and
- without having to give a reason for withdrawing and
- without affecting your position or learning within the University ?

YES/ NO

NAME (IN BLOCK LETTERS)

.....

Signed

Date

Thank you for reading through this information.

If you wish for any reason to discuss further any aspect of the research study you can contact me as follows:

Angela Hall Work phone: 01642 384923

APPENDIX (D)

Participant Information Sheet for Student Nurses

Seeking Expression of Interest

From: Angela Hall - Doctoral Research Study

Title Of Study:

A narrative study of student nurses' lived experiences of caring values development within their graduate nurse education programme.

Dear Student Nurse

I work in the School of Health and Social Care and I am currently seeking to recruit a group of 2nd year student nurses from cohort 1209 (adult, child, mental health and learning disabilities) who might be willing and interested in participating in my Doctoral Study. The aim of my study is to explore and examine your narratives of your experiences of caring within the context of your nurse education programme. These narratives will be gained from a series of individual interviews.

My research is qualitative and interpretive, and will be organized around the narratives that you provide. Should you wish to take part in the research, all information collected as part of this study will be stored in accordance with the Data Protection Act (1998) unless any abusive or unprofessional behaviours or actions are disclosed and/or discovered then confidentiality will be breached and SOHSC procedures may need to be initiated and dealt with outside of the research study. You will be identified in my final thesis, using a pseudonym.

As a participant in this Doctoral Study, you would be required to:

1. Complete a profile sheet, giving demographic and contact details;
2. Participate in 3 approximately one-hour long recorded conversations, plus other informal meetings, spanning a period of one year March 2014- March 2015;
3. Comment on and verify conversation transcripts and interpretive material (optional).

This is not an action research project and there is therefore no expectation that you will engage in any action-reflection-evaluation cycle. I aim to record and interpret your self-perceptions and experiences of the challenges and changes that have occurred during your nurse education programme. You are welcome to participate in the interpretive process as far as your time and interest allow. Your involvement or non-involvement will not in any way impact upon your academic study nor compromise the quality of your eventual and ultimate care on patients. If you are interested in taking part in this research study, you should be available to participate in the study over the next 12 months. This study has full permission from my work institution (Teesside University) and Ethical Approval from my institution of candidature (Durham University).

My Doctoral Supervisor is Dr. Caroline Walker-Gleaves who can be contacted if you have any questions or queries - caroline.walker-gleaves@durham.ac.uk. If you are interested in participating in this study, please reply to my e-mail by **Monday 10th February 2014**.

With many thanks in anticipation,

Angela Hall

APPENDIX (E)

Doctorate Research Interview Questions

“What motivated you to apply for this educational programme?”

(Research Question 1)

“Why did you want to become a nurse?”

(Research Question 1)

“What one thing/message stands out in terms of the programme philosophy?”

(Research Question 1)

“Do you feel this programme is enabling you to become a caring nurse?”

(Research Question 2)

“Can you describe something that you have experienced in the classroom that has positively influenced your development of caring values?”

(Research Question 3)

“Was it expected, How did you feel, what did you think, what was the consequence of it?”

“What are the main methods in which caring values are exposed and expressed as part of the teaching/interaction with nurse educators?”

(Research Question 3)

APPENDIX (F)

Two examples of transcribed interviews with coding and thematic development

Transcribed Interview for participant 1

| Interview #1 (File DW B0058) – March 2014 | | Idiographic theme (Initial coding) | Emergent nomothetic theme | Nomothetic (Final) theme |
|---|---|------------------------------------|---------------------------|--------------------------|
| Line No | Participant (P) Researcher (R) | | | |
| 1 | R OK ... I just want to clarify that we've gone through the informed consent form and you're quite happy to go ahead | | | |
| 2 | P Yeah we have indeed | | | |
| 3 | R Okay ... great ... the first thing I want to ask you about really is ... what motivated you to apply for the programme and come on the programme | | | |
| 4 | P Erm ... a lot of personal experiences from ... like grandparents and things like that and looking after them and then I got really interested in the psychology when I was growing up and I did originally want to be a Pathologist but I realised I was a bit too ... like ... stupid ... for that | 1)Caring for family | A2. Caring for | 4.2.2.2Caring For |
| 5 | R <i>(laughs)</i> Right ... | | | |
| 6 | P Basically ... erm ... and then ... that's why I started getting into Psychology and then I did GCSE in Psychology and got an A in that and then I just wanted to go into ... like ... the caring profession ... and that sort of was a natural progression | 2)Studied psychology | | |
| 7 | R Okay ... so it was around caring | | | |
| 8 | P Yeah ... | | | |
| 9 | R It was that kind of ... so why a nurse specifically 'cos you said caring profession ... why did you want to become a nurse then | | | |
| 10 | P Erm ... because I had a lot of experience in the family ... there's a lot of ... like ...Community Psychiatric Nurses and stuff like that and I was quite interested in what they did and I'd like to be part of that ... I don't know how to explain it other than that | 3)Nursing in family | A1. Caring about | 4.2.2.1Caring about |
| 11 | R So was it from their stories ... | | | |
| 12 | P Yeah ... | | | |
| 13 | R or ...what they told you about it | | | |
| 14 | P Yeah ... | | | |

| | | | | | |
|----|---|---|--------------------|-------------------|-------------------------|
| 15 | R | What kind of things attracted you that they were saying | | | |
| 16 | P | It was just like ... the different ... cos I didn't really know much about things like schizophrenia and stuff like that ... quite intriguing ... that sort of interested me ... and then one of my uncles friend kept buying me loads of books about it and I got really into it ... so ... | 4)Reading | | |
| 17 | R | So it sounds like people were feeding you ... | | | |
| 18 | P | Yeah ... | | | |
| 19 | R | ... with that information and kind of getting you interested | | | |
| 20 | P | Yeah ... | | | |
| 21 | R | So ... if you were to think of one thing ... in terms of the programme ... what kind of key message do you think comes through ... in the programme so far is there a key theme ... is there a key ... kind of ... philosophy that you've picked up on ... if any | | | |
| 22 | P | Not particularly cos ... erm ... there's always that thing of you should be born to be a nurse but then certain tutors have said well you don't have to be born to be a nurse ... so you sort of got mixed messages of different teachers and it sort of influenced how you felt about it ... like I always thought you were ... like ... you were born to do this sort of job or you weren't ... you just couldn't grow into it ... you could either do it or you couldn't ... but ... other people beg to differ | 5)Nature | B2. Caring motive | 4.2.1.2 Innately caring |
| 23 | R | Right ... so what kind of things are they saying ... | | | |
| 24 | P | ... what do you mean ... | | | |
| 25 | R | what kind of things are people saying that ... | | | |
| 26 | P | ... erm ... that you can just fall into it and learn to like it ... but ... I don't think that's the case at all | | | |
| 27 | R | So what do you think and why | | | |
| 28 | P | Because some of the things that you come across you can either deal with it there ... especially like crisis situations when it's like life or death you can either get on with it and do what you are supposed to be doing or you can let it overwhelm you ... so ... I think ... I think you need to experience it before you know what you are doing | 6)Natural instinct | B1.Desire to help | 4.2.1.1 Duty to care |
| 29 | R | <i>(Brief pause)</i> So what you are talking about is ... are you saying that you need care experience before ... | | | |

| | | | | | |
|----|---|---|--|---|--|
| 30 | P | <p>... No ...I don't think you do ... I think you have to have some sort of interest and you have to like being around people and you want to look after people or you've got to have that sort of instilled in you and actually be like a good person ... erm ... but I don't think you need the care ... like I haven't had loads of care experience ... I've looked after relatives and stuff ... but I'm sure a lot of people have done bits and bobs like their grandparents and things like that ... and the only thing I had other than that was the work experience I wanted so I could ... like ...could apply to Uni and I thought that would help me get in basically ... and I did volunteering work and that led onto a job from that ... so it just sort ... that just sort of rolled out ...so ... I don't think you need it though</p> | <p>7)Good person</p> <p>8)Work experience</p> | <p>C1. Caring person</p> <p>B2. Caring motive</p> | <p>4.2.1.2 Innately caring</p> <p>4.2.2.2 Caring for</p> |
| 31 | R | So what did that give you then ... | | | |
| 32 | P | <p>It gave me just an insight into what it was all about ... just that ... cos this ... like ... that ... my first proper job as well ... so ... it's just ... sort of ... knowing what you do in your working life ... cos I was 17 when I got my first job ... so it's a bit ... a shock to the system but ...</p> | 9)Insight | B3. Sense of satisfaction | 4.2.2.2 Caring For |
| 33 | R | So do you feel this programme's enabling you to become a caring nurse ... | | | |
| 34 | P | <p>I think its very sad that you have to have a module on Care Compassion and Communication ... I think it's totally shocking ... I understand why we have it but I think ... you should ... there should be a way of weeding people out that aren't already like that ... without having to do a module on it ... I think it's a waste of time ... for the people who already have that instilled in them ... like I didn't feel I benefitted anything from that module cos ... I didn't already know it but I ... I didn't know like the theory behind it but I was already practising it and I think that's more important ... and the same goes ... like the academic side of it ... I don't think that's as important as the actual bit ... you can be a fantastic nurse without being really good at writing an essay ... and it frustrates me a bit ... like people focus so much on that instead of the practice ... I know why the theory's important but I still think it should be more practice based cos you learn more that way ... if after 1st year I didn't really understand ... like the theory ... I didn't understand any of the theory until I went out and did it ... so ... yeah</p> | <p>10)Teaching on caring not needed.</p> <p>11)Selection of caring people rather than teaching it.</p> | D1. Caring module | 4.3.1.1Caring module |
| 35 | R | You just said 'they' put more importance on the academic work ... who do you mean by 'they' ... | | | |
| 36 | P | It's you ... the ... teachers ... the University | | | |

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| | | ... basically ... | | | |
| 37 | R | In what way does that come through ... | | | |
| 38 | P | Because you get loads of help with ... the academic work and loads of support for that but you don't get as much input through your practical side of things ... like ... like this ... we had this conversation with one of our tutors last year about doing ... erm ... bloods and doing ECGs and learning how to do them and they said it isn't relevant in practice ... but it is because every time we go into practice ECGs and bloods are done all the time ... so I don't know why that isn't relevant to practice ... so that's quite annoying ... hands down when we go out into practice and people need to do it we have to get a random doctor that's covering 12 wards ... to come and do it on our ward ... when you could do it if you were trained ... but we don't get trained | 12)Less practical input 13)Practical skills needed | | |
| 39 | R | So do you think that interferes within care in practice then | | | |
| 40 | P | Yeah ... cos it ... especially in the mental health side cos we don't do as much of the physical stuff anyway ... you don't do any of the physical care ... not near as much as you do in General ... like ... I've been a Healthcare Assistant in the local hospitals as well and you sort of miss that really intimate side of looking after people you don't ... you just don't get to experience that in mental health ... which isn't always a bad thing ... some people aren't cut out for looking after ... for cleaning up poo and sick and stuff ... but ... you might have to one day ... so | 14)Less physical care | | |
| 41 | R | ... and it does occur in some areas doesn't it ... so ... | | | |
| 42 | P | Oh yeah | | | |
| 43 | R | ... so that's needed ... can you think of any examples then in the classroom where there was a positive influence on you and your kind of caring | | | |
| 44 | P | It was when the service users came in to speak to us ... cos obviously they say how it is and you're not listening to a teachers saying how it is ... it's an actual life story ... and its ... you can't say well yeah ... you're right or you're wrong cos that's their experience and it sort of brings you back into reality and makes you look at an actual person instead of just a case study | 15)Service users speaking and 16)Person not a 'case' | E4.Service User input | 4.3.2.3Service user input |
| 45 | R | So it's more real | | | |
| 46 | P | Yeah ... its more applicable | | | |

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| 47 | R | So what sense does that give you when you hear somebody else talking about their experiences | | | |
| 48 | P | It depends what the experience is about ... sometimes it can be quite happy sometimes it's quite distressing ... erm ... it just reminds you to do your job properly in a way ... I don't know how to explain that one ... it's quite a difficult question | 17)Emotional | E4.Service user input | 4.3.2.3Service user input |
| 49 | R | Maybe thinking back to a particular person and how you felt | | | |
| 50 | P | We had one person that ... erm ... self harmed a lot and she was quite close to my age ... and I remember she ... like ... she talked like me ... and stuff like that ... and she had quite a similar upbringing ... and it was just weird how her life sort of turned out and how she ended up ... and how the services didn't really help her ... and it was quite like ... heartbreaking's a strong word ... but it was quite ... it was quite emotional to see how services had let her down ... in a way and it makes you sort of more passionate to want to make things better when you're qualified | 18)Service user narrative instills passion | E4.Service user input | 4.3.2.3Service user input |
| 51 | R | So do you feel that ... in terms of care ... it's the emotional element | | | |
| 52 | P | Yeah ... it's like ... you're supposed to keep that professional boundary where you're not supposed to get too attached but I don't think you can do your job properly unless you have some sort of connection with them ... like ... you really have to care about someone to deal with some of the stuff and actually get then to open up to you about certain things ... erm ... especially when they won't tell anybody else ... like even their own family members ... there's a lot of trust you've got to build up ... like you're not supposed to tell them anything about you or anything but ... but there isn't any harm in saying ... oh well I've got a few sisters and stuff like that cos it helps them talk to you ... so I think you do have to have that sort of emotional connection to be able to do ... to be a nurse ... it shouldn't be any other way | 19)Personal connection 20)Emotional connection | A1.Caring about | 4.2.2.1Caring about |
| 53 | R | So how do you develop that ... are there anything's in the classroom that helps you do that ... other than ... as you've mentioned ... service users | | | |
| 54 | P | Not really in the classroom ... its more how you ... experience your placements and how your mentor helps you interact with people ... like you do the simulations in classes about talking to people ... I can't remember ... we did one in 1 st year ... and ... it was just rubbish ... it was when we were practising the 360° tool and you had to do it on each other ... and it's just not the | 21)Poor simulations | E1. Simulations | 4.3.2.1Simulation |

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| | | same ... role play isn't the same as doing it in the real life ... cos you just ... you just do things differently ... like ... it's just not the same ... erm ... what was the question again [laughs] | 22) Role play is false | E2.Role play | 4.3.2.2 Role play |
| 55 | R | [laughs] ... examples in the classroom that helped you develop that care ... other than service users ... any exercises or interactions | | | |
| 56 | P | No ... it's just ... you got to do it in practice ... you can't ... it's not the same doing it with somebody in a classroom cos its fixed and its set up ... but if you are doing it on a ward or you visit somebody in their own house its completely different ... it's ... it's real and you got to deal with it ... and you can't back out of it ... and you can't hesitate ... you just got to get on with it ... and ... I think you've either got it or you don't ... and I know it can take a little while to build up the confidence of people and you just can't like bombard yourself ... and you've got to get that rapport with them ... erm ... that reputation with them ... to be able to ... have that [??] conversation but it's just building it up gradually ... but you've still got to ... [??] do it ... | 23) Practice is real | E2.Role play | 4.3.2.2 Role play |
| 57 | R | It sounds like you feel it's some kind of transition that goes on ... | | | |
| 58 | P | ... yeah ... | | | |
| 59 | R | ... throughout the programme ... you got something to begin with but that develops over the years ... where do you think you are with that at the moment in terms of developing from when you started | | | |
| 60 | P | I've got a lot more confidence in speaking to people I don't know ... erm ... especially like ... we've just finished that last placement ... erm ... like even in the first like couple of weeks I talked a lot more than I did ... like my first ever placement ... and you just sort of like get on and ask them how their day was and ... like even like in the MDTs and the Ward Rounds and stuff like talking to the Doctors and giving your ideas and stuff like that ... that sort of has come more easily this year than it did last year ... cos you sort of know what you're talking about a bit more ... you don't feel like you're ... like a pain ... in the ... backside ... so to speak | 24) Confidence | | |
| 61 | R | So do you feel Nurse Educators ... us in the classrooms ... do you feel we have a role to play in terms of developing your caring values or do you see it happening totally in practice | | | |
| 62 | P | I think it's like [??] ... like I know some people that are on this course that I personally don't think they should ... I don't | 25) Uncaring and on programme | B2.Caring motive | 4.2.1.1 Duty to Care |

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| | | <p>think they have a caring bone in their bodies ... and I don't know how they got through ... and you see people that haven't got on the course and you think well why didn't they ... and it's ... it's really strange ... there are quite a few people I've been on placements with and stuff like that ... that are like Healthcare Assistants and stuff and they haven't got on the course ... and they're really really good at what they do ... and you just like ... I don't see why you haven't got in ... there's no reason for them ... and then there are some people that come here and aren't even doing it cos they want to be a nurse ... like I know people that ... there's a few people on this course that are only doing it because its an easy way to get into the RAF ... because you have to have a degree in sciences and this is the easiest one ... and it's just like ... well you shouldn't even be on the course ... that's quite frustrating ... but ... it's either inbuilt or it isn't ... you can't teach it ... not at all ... you can ... you can sort of teach ... what makes somebody caring ... and somebody can write about it all day long but it doesn't make them caring just because they know about it ... does that make sense...</p> | <p>26)Caring and not accepted on programme</p> <p>27)People studying nursing for other reasons</p> <p>28)Caring can't be taught</p> | | <p>4.2.1.2Innately caring</p> |
| 63 | R | Yeah ... it's the theory of how you should respond ... | | | |
| 64 | P | ... yeah ... | | | |
| 65 | R | ... but that doesn't mean that person will actually be like that ... | | | |
| 66 | P | ... yeah ... | | | |
| 67 | R | ... so ... do you think whether the tutor's caring or not has any influence | | | |
| 68 | P | Yeah ... cos if they're not you don't want to pay attention to their lectures ... you just don't care ... if they don't care why should you care ... it demotivates you if they have a bad attitude ... | 29)Lecturer Caring attitude | F.Lecturer influence | 4.3.1.3Lecturer influence |
| 69 | R | Tell me a bit more about that | | | |
| 70 | P | ... erm ... like for example ... that one who said that you don't have to be ... like ... born into nursing you can just fall into it ... and learn to like it ... she had a really bad attitude about it ... and it was just ... well ... why are you teaching us ... if you are not passionate about it then why should we be ... and ... it was quite ... I found it quite shocking really ... cos you get told when you come here that you've got to be passionate about it ... and you've got to be really be motivated to do it ... and it's a hard course ... and this and that ... so when you stuff like that it's like well ... if you're not bothered why should we be ... | 30)Lecturer's bad attitude | F.Lecturer influence | 4.3.1.3Lecturer influence |

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| 71 | R | So it has an impact on you and your thinking ... and the opposite of that ... what might be the opposite kind of experience ... | | | |
| 72 | P | Well then you get them teachers who can make the most ... like ... boring lectures ... about like research ... really interesting because they apply it to what you are doing that actually shows that actually showed that ... they care about what you are doing ... and like if they see a teacher doing something ... not doing something wrong ... but say ... like the Friday ... the research module ... that didn't really apply to mental health at all ... and the teacher we had got really frustrated by it and you could tell how annoyed he was ... so he was like doing his own thing on it ... and because he was making that much of an effort to make it better for us ... you could see how much he cared ... and that makes it better ... | 31)Lecturers caring | F.Lecturer influence | 4.3.1.3Lecturer influence |
| 73 | R | So I'm just wondering how those caring values ... or seeing somebody who's caring and trying to do their best ... how that kind of ... | | | |
| 74 | P | Just ... well ... it's inspiring ... it's a bit of a cliché word ... but it was ... it makes you ... it makes you more willing to ... not willing to want to do it ... but ... it like ... fires you up and gets you going ... about it ... you don't just like sit back and let it stress you out ... you just think well ... yeah this has got a good implication for us and stuff like that ... it makes more sense if they've got more passion when they're talking about some stuff ... otherwise you just don't really care ... which probably doesn't make much sense [laughs] ... | 32)Passion is infectious | F.Lecturer influence | 4.3.1.3Lecturer influence |
| 75 | R | ... [laughs] ...so from your point of view if you could give the answer as to how ... how to help people be more caring ... as a nurse educator ... what would it be that you would do ... or what would you change about the programme ... | | | |
| 76 | P | ... what would I change about the programme ... | | | |
| 77 | R | ... or the people ... | | | |
| 78 | P | ... or people ... erm ... I'd have it more field focused ... because sometimes you get the lectures that really don't apply very well ... or ... or ... they just don't go into it enough ... to apply to mental health ... like ... that ethics one that we weren't invited to cos it wouldn't apply to us ... even though mental health is one of the most ethically ... erm ...what do you call it ... it's a really confusing subject ... and all those complexities surrounding it ... erm ... and it's really annoying when you get told that you're not allowed to go to one of those type of lectures ... or you go to a lecture | | | |

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| | | <p>and it's like adult this and adult that ... and it [??] apply to us ... and then you don't really take notice cos it doesn't make sense ... so if it was more ... if it was more mental health structured it would be a lot better ... cos even the things like the Hierarchy of Needs ... it doesn't apply that much to mental health ... because ... even things like the intervention plans and stuff like that ... it's completely set out different to ... in the adult section ... the adult wards ... like even the admission packs and stuff like that ... that's completely different ... and what you do when somebody gets admitted onto the ward ... it's just completely different ... there's ... it's not the same ... theirs is much more physical and ours is much more emotional ... so ... I just think it needs to sprout off a bit more and be a bit more divided ... cos it gets really confusing ... in the lectures as well when we are doing all these different group presentations and we get some that are in our mixed groups and some are in our field specific groups ... and it's just too much cos you're trying to catch with everybody ... and then the adults are going off doing their own thing cos they have loads of booklets to do ... and then we don't really ... we just need to get on with whatever we need to get on with ... and then we try to organise between 5 different groups ... that's what it's been like this year ... like we've got that one in there ... and I haven't spoke to anybody in my group since January ...[??]</p> | | | |
| 79 | R | So that all theory stuff isn't it ... is that right | | | |
| 80 | P | <p>... yeah ... it's all like ... it's like juggling everything ... but even the ... erm ... when we were doing the triggers ... the mental health field had their own set of triggers ... but then when we went to do the presentations and stuff they went oh no we'll do the adults ... so even that bit was taken away from us ... so none of that applied to us ... so we're doing about like Warfarin ... and how many people do we come across with Warfarin ... we do come across it but we don't have to have as much knowledge as they do ... and we weren't covering anything on our side ... so we ... it just felt like a waste of time for us ... they were getting more out of it than we were ... so if it was spilt off it wouldn't be bad ...</p> | | | |
| 81 | R | <p>I'm just thinking about the caring ... you said there were people on this programme who were only doing this as a means to an end ... do you think there is any way we could ensure that they are caring at the end of it ... is there anything at all you can think of</p> | | | |
| 82 | P | <p>No ... because some of them do just have it ... it really is literally just a means to an end ... they're never going to put it into practice</p> | 33)Motivation for | | |

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| | | ... I know a couple who even aren't going to get their PIN ... they just getting it ... they're doing it for the degree ... literally that's it ... for people like that I don't think there's any hope for them at all ... they might be caring people but they don't want to do this as a career ... and I think that's wrong ... cos ... cos it's a waste of money for them ... if they want that they should pay for it themselves ... but ... | degree award | | |
| 83 | R | So thinking about you and where you are in terms of caring ... where would you say you are now ... cos obviously we are going to meet up again hopefully later on and we'll probably come back to some of these key questions | | | |
| 84 | P | I think I'm more caring and compassionate to people that haven't brought it on themselves ... erm ... I can get quite frustrated with patients ... I do still care about them ... but I don't have as much like sympathy for them ... when they've like ... been discharged and go on a £2,500 drug spree over the course of 9 days and then get readmitted into hospital ... no sympathy at all ... I don't have any patience for them at all ... but ... and then you see the people that really can't help what they're doing ... like people that have really horrible hallucinations that are making them go wild ... erm ... I ... I ... do really care about that ... and I put a lot of effort into what ... like ... what I'm doing for people ... I just don't have as much sympathy for certain categories of people ... | 34) Some people don't deserve care 35) Some people are worth caring about | I2.Client Group | 4.4.2.1 Self-awareness |
| 85 | R | So it seems to be the people who ... in your mind ... make a choice about what they're doing in their lives and the lifestyle and how that affects them ... | | | |
| 86 | P | It's more the ones who have no regrets about what they doing ... they like get readmitted and then kick off when they don't get any leave ... you think well you're not going to get any leave cos you've only been back a day and last time you went out on leave you went on a £2,500 drug spree ... so ... no you're not getting any leave ... and then they kick off at you ... so I've got no time for them ... I'll still be nice to them and civil ... but ... I don't think I'd put as much effort into looking after them as I would somebody else ... cos they don't ... they don't ... well no ... they don't deserve it ... there's people that need more help than they do and they just throw ... well ... what help you give them ... away ... | 36) Some people waste the care they are given | I2.Client group | 4.4.2.1 Self-awareness |
| 87 | R | So there's some people who deserve that care and compassionate attitude and others that don't | | | |
| 88 | P | Not that they don't like ... ever ... they just ... they get it and then they throw it away ... | | | |

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| | | so they shouldn't really get it a 2 nd or 3 rd or 4 th time around like some of them do ... | | | |
| 89 | R | ... cos it can be quite frustrating can't it ... | | | |
| 90 | P | ... yeah ... I would still like look after them and do what you're supposed to do ... I wouldn't ever like ... fail my duties as a nurse ... but ... I just wouldn't have the same emotion about them ... like I wouldn't be really happy for them if they got discharged like I would with a different patient ... and I wouldn't ... like I wouldn't be really disappointed or surprised or shocked if they came back in ... yeah ... so it's not like totally heartless ... it's just I wouldn't feel much about them ... | 37) Duty to care | B1.Desire to help | 4.2.1.1Duty to Care |
| 91 | R | It seems like that connection that you talked about earlier on ... | | | |
| 92 | P | ... yeah ... | | | |
| 93 | R | ... that wouldn't be there maybe ... | | | |
| 94 | P | ... yeah ... | | | |
| 95 | R | ... with some people ... so in terms of caring ... it's not being a caring person all the time ... | | | |
| 96 | P | I think you can get quite ... erm ... I'm trying to think of the word I'm looking for ... you know when people sort of go through the same rigmarole ... I can't think of the word for it ... it's like when you see death quite a lot you sort of get used to it ... it's sort of like that ... but it wouldn't be like with a whole group of people it just would be like with a certain person ... if the same person ... goes through services over and over again ... I think you get quite ... just ... used to it ... it would affect you the same way ... the more it happened ... | 38)Desensitisation to certain people | I2.Client group | 4.4.2.1Self-awareness |
| 97 | R | So it sounds like you're saying that with some people this caring in general the care you give ... | | | |
| 98 | P | ... yeah ... | | | |
| 99 | R | ... would stay the same ... | | | |
| 100 | P | ... yeah ... | | | |
| 101 | R | ... more or less and its bound by the duty and all of that stuff ...erm ... but then there's actually caring in being connected to a person | 39)Caring as duty and caring as human connection | A1.Caring about | 4.2.2.1Caring about |
| 102 | P | ... yeah ... | | | |
| 103 | R | ... which happens on a more individual basis ... | | | |
| 104 | P | ... yeah ... | | | |

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| 105 | R | ... and is that the only thing that would affect you in relation to that ... the person's degree of control over their behaviour ... | | | |
| 106 | P | Yeah pretty much ... erm ... yeah ... that's the only sort of person that ever annoys me ... cos ... I just think well I don't know how to help you anymore ... but there isn't really anybody else I can say that to ... like even people that like have serious like alcohol problems and stuff like that ... I'd still have a lot more sympathy for them and stuff ... I don't know why ... yeah ... I don't have many discriminations either ... like I'm not ... I don't mind ... not I don't mind gay people ... but I'm accepting of like gay ... and different races and stuff like that and that doesn't bother me in the least ... but that's probably my generation ... and [??] (?? older - AH) older generations are a lot more ... [??] (?? wicked - AH) ... and that sort of thing ... I'm not ... I don't have a religion myself or anything ... so I'm quite accepting of everything like that ... so ... in that sort sense there's nothing that would prevent me looking after somebody ... like even people like rapists and stuff like that ... erm ... not that it doesn't bother me what they've done and stuff like that ... but I think it's sort of ... it can be helped ... it's when I feel they can't be helped that it annoys me ... it sort of dwindles my caring ability ... | | | |
| 107 | R | So do you think anything could be done in class to look at those situations or analyse what's happening in terms of self awareness and those processes | | | |
| 108 | P | We do a lot of reflection don't we ... so I think that's sort of already happening ... I don't know what can be done about ... feeling about like that ... against certain ... patients ... cos I think you've got to learn that yourself ... erm ... or experience like a change around with that sort of person ... and see them get better and stuff like that ... to actually sort of change your perspective on them ... or be more open minded ... and probably be a bit more closed minded when it comes to that sort of thing ... it's just me ... | 40) Reflective practice | J. Reflection and Feedback | 4.4.2.2 Reflective practice |
| 109 | R | So do you think exploring that would help for you ... | | | |
| 110 | P | Explore how like in a classroom setting? ... it probably would yeah ... if you sort of looked at ways of like tackling it ... erm ... cos you don't really do that ... you do like the basics of patients that ... are going to get better ... but you never say well what if that doesn't work ... you never discuss that ... but a lot of the times the first course of action doesn't work ... erm ... so it would help to explore those ... explore the situations see the different outcomes of it ... rather than just well ... we'll do that and | 41) Explore not being effective | J. Reflection and Feedback | 4.4.2.2 Reflective practice |

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| | | that'll work ... but that isn't like real life ... it's like an ideal situation ... | | | |
| 111 | R | So generally do you think there should be more exploration within the classroom of developing attitudes, beliefs, opinions of student nurses | | | |
| 112 | P | Yeah ... I think there's too many too scared to say anything ... a lot of people just sit and don't like give an opinion ... but sometimes that's the teachers fault though ... cos some of the teachers make you feel like ... if you say something that you're wrong ... or they say ... you're not wrong but that answers not entirely right ... which is basically saying you're wrong even though it's an opinion ... so there is a few teachers that are like that ... and it just makes you not want to say anything ... so ... yeah ... it tends ... | 42) Fear of being wrong in class | F.Lecturer influence | 4.3.1.3Lecturer influence |
| 113 | R | ... yeah ... I'm just thinking ... I guess it's quite difficult in the classroom because there are so many to get that deep in terms of individual feelings and things that people may find that threatening | | | |
| 114 | P | Yeah ... erm ... very defensive ... especially when you have discussions about things ...like ... what was the one we had before ... about euthanasia ... some people are very passionate for both sides of it and it causes a bit of friction in the class and then the teacher gets involved ...and then if the teacher doesn't agree with whichever side of it ... the other side just stops talking ... even though their points are perfectly valid ...but they stop talking because the teacher said ... you know ... basically ... that happened once ... | 43)Lecturer influence | F.Lecturer influence | 4.3.1.3Lecturer influence |
| 115 | R | So do you think we have too much influence maybe in some situations ... | | | |
| 116 | P | Yeah ... especially in stuff where you are trying to explore the issues ...cos you don't really get chance to actually say what you mean ...it's all well and good doing all these presentations but instead of having a presentation have a discussion about the topic instead ...cos otherwise people just stop listening and they don't learn anything ...but if you're having a discussion you are going back and forth between each other and listening and you are engaging ...but if you just watching a presentation you're not learning anything ...like there's one guy in our class this year that did a 50 PowerPoint presentation ... on self harm ...even though he was an adult nurse ... he was getting all the information wrong ...so I was like ... I was trying to correct him a few times ... and he said no, no, no, that's what the book says ...I said like that's not true ...when's the book from ...the '40s ... No ... that was | | | |

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| | | quite annoying <i>[laughs]</i> ...yeah ... | | | |
| 117 | R | How do you think we could encourage more of that kind of discussion ... the type we've been talking about ... | | | |
| 118 | P | Instead ... well ... it's like ... the triggers were good but ... instead of ...because some teachers go now I want you to do presentations ...but our group decided they weren't going to cos we were sick of them ... to death ... so we just did like a discussion ... and a back and forth ... but then our teacher would tell us off for not doing a presentation ... but ... but nobody would listen to our presentation ... so we didn't bother ... but the triggers were good because it give you a scenario and then you could explore the issues around the scenario ... but then they say no, only do this criteria and then we get told off for exploring it properly because we didn't just stick to just the one criteria ... but it doesn't always work like that ... so ... we erm ... I think it's better to just let us like ...give us a scenario and let us find all the information around it and then discuss within a class ... rather than separate groups ... just do a big class discussion on what you've found ... and ... cos people have different ways of finding things ... and ... and have different experiences ... and they'll all be able to contribute ... but of you are just reading it off a wall there's no point ... | 44)Groupwork | C3.Scenarios | 4.3.2.1Simulation |
| 119 | R | So the group would have to be fairly small to get everyone involved cos as you know ... | | | |
| 120 | P | ... oh yeah ... but that's the thing with erm ... why it would be better to do it within the field groups as well cos they're split up ... and the adult nurses are only having like 10 or 12 in a group so that's like quite a nice size for a discussion but ... we were ending up with like 40 people from 4 different fields not really knowing what we were talking about ... cos it was all rushed and put together like in the last hour or whatever ... but if you had plenty of time to find all the information around it ... you would be able to have a proper discussion and you might actually take something away from it ... | | | |
| 121 | R | Can you think of any other sessions in the classroom that have been useful in terms of developing caring values ... discussions ...reflections ... | | | |
| 122 | P | ... erm... <i>[long pause while thinking]</i> ... it's been a long 2 years <i>[laughs]</i> erm ... when you talk about like the scandals and things like that ... and things like safeguarding that always bring up that little bit of passion and people sort of get going by it ...erm ... and you see like peoples sort of true colours then when you are talking about stuff like | 45) Poor practice | C2.Failings in care | 4.3.1.2Poor Practice |

| | | | | | |
|-----|---|--|---|-----------------------------|----------------------------------|
| | | <p>that ... erm ...I don't know really ...it just depends what you've been talking about ...and what people are interested in ... if people are more interested in a topic then they are more likely to talk about it and be sort of honest saying what they feel about it ...erm ...like some people are embarrassed talking about certain things ... like we had that lecture on drugs and substance misuse ... and people just like didn't want to talk about it like it was a taboo subject ... so nobody wanted to say anything so we didn't really get anywhere with that one ... no-one said anything it was just like there's your key lecture [??.....?? Boots ??]... nothing got said after that ...</p> | | | |
| 123 | R | <p>So I guess what I'm really interested in is what we give you or what we could give you in terms of developing that caring</p> | | | |
| 124 | P | <p>I think the only thing you can really do is just ... sort of ... keep the passion going rather than ... trying to teach being caring ...cos you can't ...you know ... like I said before you can't teach being caring ...you just are or you're not ...you can give people all the views in the world but it doesn't make them like a good person ... erm ... I think the service users things definitely help cos ... its a real person and you can't really hide from the fact that they're telling you how it was for them ... you can't get away from it ... erm ... I think its just the teachers not knocking you down when you have an opinion about something or ... when ... well ...when you might disagree with them or what they're saying you should not be knocked down ... I think that's about it ...</p> | <p>46)Create passion</p> <p>47)Lecturer power</p> | <p>F.Lecturer influence</p> | <p>4.3.1.3Lecturer influence</p> |
| 125 | R | <p>Okay ...thanks ... is there anything else you want to say before we finish</p> | | | |
| 126 | P | <p>No ...</p> | | | |
| 127 | R | <p>Thank you</p> | | | |
| | | <p><i>Fin</i></p> | | | |
| | | | | | |

Transcribed Interview Participant 7

| Interview # 7 (File DW B0062) – April 2014 | | Idiographic theme (Initial coding) | Emergent nomothetic theme | Nomothetic (Final) theme |
|--|--------------------------------|---|---------------------------|--|
| Line No | Participant (P) Researcher (R) | | | |
| 1 | R | Right can we just confirm that you have consented to be involved in the research and are happy to go ahead. | | |
| 2 | P | Yes that's fine | | |
| 3 | R | Do you remember what motivated you to apply for the programme? | | |
| 4 | P | Yes. It was through my job, the only thing really. I never really thought I'd choose it as a career path, to be honest. I got a job as a health care assistant and then just loved it instantly, really. But I tried; I was unsuccessful the first time. They said I was a bit young and to get a bit more experience so I came back a few years later and reapplied. That's the only reason though, through working in the area. | 8)Work experience | B2. Caring motive 4.2.2.2 Caring for |
| 5 | R | Were you wanting to work in that area or was it just..? | | |
| 6 | P | No. My dad's a mental health nurse. It's not got nothing to do with my dad being a nurse but he got me a job as a health care assistant, just for money and I went there and never really thinking I'd like it. | 3) Nursing in family | A1. Caring about 4.2.2.1 Caring about |
| 7 | R | I was going to say were you keen to start or were you a bit? | | |
| 8 | P | No, I didn't know what to expect but, as soon as I got there, I loved it and knew it was what I wanted to do, really, straightaway. | 8)Work experience | B2. Caring motive 4.2.2.2 Caring for |
| 9 | R | So it surprised you? | | |
| 10 | P | Yes, yes. | | |
| 11 | R | So why do you think you want to become a nurse then? | | |
| 12 | P | I think just to make a difference to people's lives, is the main thing. Yes. Just to help people. | 7)Good person | C1. Caring person 4.2.1.2 Innately caring |
| 13 | R | Is that what you got where you were working? | | |
| 14 | P | Yes, that's what I got through where I was | 8)Work | B2. Caring 4.2.2.2 Caring |

| | | | | | |
|----|---|--|-------------------------------|-------------------|-------------------------|
| | | working, yes. | experience | motive | for |
| 15 | R | Anything else kind of excite you about it? | | | |
| 16 | P | Trying to think; it's hard when you're put on the spot but I'd be able to come up with loads of things if I was to really think about it. Just to help people, I think. To make a person's life the best it can possibly be, under the circumstances. Help someone recover fully, if possible. That excites me. | 67)Motivation to help | B1.Desire to help | 4.2.1.1 Duty to care |
| 17 | R | Obviously you have been on the programme for over a year now, what are the key messages do you think? | | | |
| 18 | P | Key message. The six C's. Always follow the six C's. Like your non-verbal communication, I picked up from last year, it was really important. I used the SOLER thing on placement, actually, tried to use that and it really did work. Obviously, I never used to use it in my job but then it does make a difference. | 68) 6Cs | D1. Caring module | 4.3.1.1 Caring module |
| 19 | R | You were not aware of it before? | | | |
| 20 | P | Oh no; I wasn't aware of what I was doing, before the first year, really, with my non-verbals. That was a key message I picked up; to always be aware of your non-verbals. The six C's, key message. What else? There's a few things but they're the main ones, I think. | 68) 6Cs | D1. Caring module | 4.3.1.1 Caring module |
| 21 | R | So ... communication | | | |
| 22 | P | Yes, that's what the whole question is about, isn't it, like therapeutic relationships, communication. | 69) Therapeutic relationships | D1. Caring module | 4.3.1.1 Caring module |
| 23 | R | What has that given you? | | | |
| 24 | P | What's it giving me?...Like, it's fundamental, isn't it? You need it, to be a nurse.... It helped to form relationships with people on placements.I can't really explain; it's hard being put on the spot. | | | |
| 25 | R | We will move on then. Do you think the programme is enabling you to be a caring nurseand in what ways? | | | |
| 26 | P | Yes.....But, I don't think it's just the programme, I think that's my nature anyway.....Yes, but, the programme does. | 5)Nature | B2. Caring motive | 4.2.1.2 Innately caring |
| 27 | R | So what kind of activities are helping? | | | |
| 28 | P | On the programme....? Obviously, what we get taught at university. I think you learn a lot more on placements, to be honest..... Most of things I took away from last year was in practice. It's just the way I learn, I think. I learn from writing the assignments..... but just being in university and stuff, I find it hard to take | 23) Practice is real | E2.Role play | 4.3.2.2Role play |

| | | | | | |
|----|---|---|----------------------|-------------------|-----------------------|
| | | things away from the lectures and things. | | | |
| 29 | R | Is that because of how it's delivered or just....? | | | |
| 30 | P | I don't think I can learn like that. I do a lot of reading on my own, as well. Like, if we had a lecture, I don't really pay attention – well, I do, but I find it hard to take things away so I go away and read around it myself. Like, the other day, we had all day on schizophrenia and psychosis and I just read around it in my own time, when I got home. | | | |
| 31 | R | You said it mainly helps in practice, what kind of things are helpful? | | | |
| 32 | P | In practice? Obviously, practice is reality, isn't it, so it's the best way to learn..... You learn better from people who are in nursing, I think. | 23) Practice is real | E2.Role play | 4.3.2.2Role play |
| 33 | R | So what do you learn from them...? | | | |
| 34 | P | Everything, really, don't you? How to carry out your duties, really. Everything. You learn everything from your mentors, don't you? | | | |
| 35 | R | So can you think of any examples in the classroom that has had an impact on your caring? | | | |
| 36 | P | Well..., SOLER again..... I learnt that in care, compassion, communication module last year.... That hit me; that enabled me to come across as more caring. What else. That whole module..... Like, it taught you to overcome barriers, like communication barriers. Everything within that module really helped for me to be more caring in practice,I think. | 68) 6Cs | D1. Caring module | 4.3.1.1 Caring module |
| 37 | R | What kind of activities? | | | |
| 38 | P | Activities?....You know, I can't really remember much from last year, really..... I can, but not the activities. | | | |
| 39 | R | Was it practicing communication quite a lot? | | | |
| 40 | P | Quite a lot; a bit of role play and stuff. But we do that this year, on a Thursday. We do a lot of role play on a Thursday,which helps. | 62)Role play | E2.Role play | 4.3.2.2Role play |
| 41 | R | So were you expecting that to happen with SOLER | | | |
| 42 | P | For it to be effective?.... No. I'd learnt it and then never really, to be honest, thought I'd use it. I thought it was something that I'd do anyway, without even thinking about it. But, I actually try to do all the things it says, like sit squarely, open posture and | | | |

| | | | | | |
|----|---|--|-------------------------------|-------------------|-------------------------|
| | | everything, like we are now. Yes, it really did work but I never thought – I thought it would just be something that I did, anyway. At first, I wasn't doing it, in practice, then I tried using it a little bit and it paid off. | | | |
| 43 | R | So how did that feel? | | | |
| 45 | R | What did you notice that happened differently? | | | |
| 46 | P | The patient responded better; it did help to develop a therapeutic relationship with people. | 69) Therapeutic relationships | D1. Caring module | 4.3.1.1 Caring module |
| 47 | R | So in terms of developing caring values where do you feel you are?..... Do you feel that you can develop further? | | | |
| 48 | P | Yes. You can always develop further, really, can't you? Yes, but, I've always been caring. I don't think that will change. Can being caring develop? I don't know. I either think you are or you aren't. There are skills you use to be caring, they will develop, but being caring is just there, isn't it? | 28)Caring can't be taught | C1. Caring person | 4.2.1.2 Innately caring |
| 49 | R | So it is just part of your nature? | | | |
| 50 | P | Yes; it's part of my nature, yes. | | | |
| 51 | R | How do you show that in practice? | | | |
| 52 | P | How do I show being caring? Anything. Do you want me to give you an example? | | | |
| 53 | R | Yes if you would like... | | | |
| 54 | P | I'm trying to think of one. There was a service user that got put on a new medication – being caring could be anything – and I went on the internet and printed off loads of stuff for them and handed them it so they could read through it and make a decision. Anything like that; being caring, anything. Anything. That's just one example. | | | |
| 55 | R | Sometimes it's just that little bit extra? | | | |
| 56 | P | Oh yes..... I could easily have not done anything there but they were feeling a bit anxious about starting it so I went and printed off... | | | |
| 57 | R | You picked up on that? | | | |
| 58 | P | Oh yes, I could see that they were anxious about it and I said, would you feel better if I got you some information around it? They said, oh yes. I went and got it and brought it back and felt a lot better about the whole thing. That's me being caring, I think. | | | |
| 59 | R | So what do you think are the main ways in which we expose you to caring values and | | | |

| | | | | | |
|----|---|---|----------------------|---------------------------|----------------------------|
| | | develop your thinking around caring? | | | |
| 60 | P | Definitely more in the seminars, the workshops. The role play, I think, helps us to develop our – because we've done quite a lot of that this year, already. I think that helps us develop being caring a lot. Are we just talking about caring? | 62) Role play | E2.Role play | 4.3.2.2Role play |
| 61 | R | Mainly yes... | | | |
| 62 | P | Yes, whatever we do in the workshops really. | | | |
| 63 | R | So how does the role play help? | | | |
| 64 | P | Well, we did it in placements, so I'm trying to think how role play is different from actually in reality. I think you still learn more in practice, from the role play but it's better than just going through a power point about how to interact with a patient. It's still better than that but I still think you learn more out in practice. | 23) Practice is real | E2.Role play | 4.3.2.2Role play |
| 65 | R | What might the role play give you the chance to do in class that makes it different to practice? | | | |
| 66 | P | Well, you're an observer, aren't you? Like sometimes you're an observer so you get to see how your colleagues interact with the patient; other people on the programme and maybe pick things up from them. But, you observe real nurses, qualified nurses, in practice, so it's always going to be better, I think. | 23) Practice is real | E2.Role play | 4.3.2.2Role play |
| 67 | R | So are there any other ways that we can help people be more caring? | | | |
| 68 | P | I think it's already really well done, to be honest. Like the 360 degree tool and things like that. I think the university has got it right, in terms of us developing. I can't think of any other ways. | 70) Feedback | J.Reflection and Feedback | 4.4.2.2Reflective practice |
| 69 | R | What about interactions with your tutors? | | | |
| 70 | P | Like tutorials? | | | |
| 71 | R | Yes or your personal tutor? | | | |
| 72 | P | Would that help us to develop? Yes, I think it would. I think I only had two appointments last year with mine. But, yes, to go over strengths and weaknesses and things like that, yes, maybe. But, I don't think there's much more that the university can do. I think it's really well ... | 71)Personal tutor | F. Lecturer influence | 4.3.1.3 Lecturer influence |
| 73 | R | That is good then... | | | |
| 74 | P | I think the 360 degree tool is really good because that gives, that helps us to develop, doesn't it? Like our mentor, and service users tell us what we're doing right | | | |

| | | | | | |
|----|---|--|--------------|---------------------------|----------------------------|
| | | and what we can improve on. That's really good, in terms of development further. | | | |
| 75 | R | So do you think more feedback....? | | | |
| 76 | P | Yes. Feedback is really good. Well, how are we supposed to know what to improve on if we don't get feedback so I think the 360 degree tool is really good for that? But feedback in general, as well, because I didn't get a lot of feedback from my mentor in practice. I always used to say, am I doing things right. She use to say, if you were doing things wrong, I'd tell you, so assume you're doing things right. But I don't think it should be like that. I think we should be getting told, constantly, that we're doing things right. | 70) Feedback | J.Reflection and Feedback | 4.4.2.2Reflective practice |
| 77 | R | Because that is the reassurance you need.... | | | |
| 78 | P | Yes.... I think you still need reassurance..... Because I used to always think am I doing this right? She used to say, look, if you were doing it wrong, I'd tell you straightaway, so I think we need constant reassurance and feedback. That's why I was grateful for the 360 degree tool because I finally got to see what she thought, really, that I was doing good. But I don't know if other universities use the 360 degree tool, do they? | | | |
| 79 | R | I am not sure.... | | | |
| 80 | P | I thought it was just that used it? But I think it's really good. | | | |
| 81 | R | So it's interesting to get feedback from your mentor and service users....as people tend to underestimate their ability.... | | | |
| 82 | P | I did, yes. Because you didn't want yourself to be – I sort of, I think I mainly put good and I got like higher from my mentor and the service user. But feedback is the best thing to develop, I think, further. | 70) Feedback | J.Reflection and Feedback | 4.4.2.2Reflective practice |
| 83 | R | That's good, is there anything else that you want to say before we finish? | | | |
| 84 | P | No I don't think there is. | | | |
| | | <i>Fin.</i> | | | |

APPENDIX (G)

Overall participant responses according to the Themes of the study

The guidance from Smith (2011) advises the researcher to monitor the overall themes for each participant.

| Theme/Pseudonym of participants | <i>Nea</i> | <i>Sky</i> | <i>Tai</i> | <i>Mya</i> | <i>Lil</i> | <i>Dax</i> | <i>Asa</i> | <i>Kat</i> | <i>Jay</i> |
|--|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Super-ordinate Theme 1: Being Caring | x | x | x | x | x | x | x | x | x |
| Major Theme: Self as Caring | x | x | x | x | x | x | x | x | x |
| <i>Subtheme:</i> Caring Duty to Care | x | | x | | | x | x | x | x |
| <i>Subtheme:</i> Innately Caring | x | x | x | | x | x | x | x | x |
| <i>Subtheme:</i> Sense of Satisfaction | | x | x | | x | x | | x | x |
| Major Theme: Caring Roles | x | x | x | x | | x | x | x | x |
| <i>Subtheme:</i> Caring About | x | x | x | x | | x | x | x | x |
| <i>Subtheme:</i> Caring For | x | x | x | | | x | x | x | x |

| | <i>Nea</i> | <i>Sky</i> | <i>Tai</i> | <i>Mya</i> | <i>Lil</i> | <i>Dax</i> | <i>Asa</i> | <i>Kat</i> | <i>Jay</i> |
|---|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Super-ordinate Theme 2: Becoming Caring | x | x | x | x | x | x | x | x | x |
| Major Theme: Curriculum | x | | x | | | x | x | | x |
| <i>Subtheme:</i> Lecturer Influence | x | | x | x | | x | x | | x |
| <i>Subtheme:</i> Care Module | x | x | | | x | | x | x | x |
| <i>Subtheme:</i> Poor Practice | | x | x | | x | | | | x |
| Major Theme: Experiential Learning | x | | x | x | | x | x | x | |
| <i>Subtheme:</i> Simulation | x | | | x | | x | | x | x |
| <i>Subtheme:</i> Service User Input | x | | x | | x | | | | |
| <i>Subtheme:</i> Role-play | x | | | x | | x | x | x | |

| | <i>Nea</i> | <i>Sky</i> | <i>Tai</i> | <i>Mya</i> | <i>Lil</i> | <i>Dax</i> | <i>Asa</i> | <i>Kat</i> | <i>Jay</i> |
|--|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Super-ordinate Theme 3: Caring in Nursing (MH) | x | x | x | x | x | x | x | x | x |
| Major Theme: Reality Shock | | | x | x | x | x | x | x | x |
| <i>Subtheme:</i> Organisational Culture | | | x | | x | x | | x | x |
| <i>Subtheme:</i> Cognitive Dissonance | | x | x | | | x | | | |
| Major Theme: Resilience | x | x | x | x | x | x | x | x | x |
| <i>Subtheme:</i> Self-awareness | x | x | | x | x | | | | x |
| <i>Subtheme:</i> Reflective Practice | | x | x | | x | x | x | | |

Appendix H: Participant Biographies

Participant 1

Nea is a twenty year old female, who is local to the area in which the HEI is situated. She has attended the local comprehensive school and studied at GCSE level, then completing an Access course at a local college to gain the entry qualification to the programme. She had experienced caring for her grandparents and also there were several Community Psychiatric nurses in the family from whom she gained an insight and awareness of mental health nursing. She also volunteered in a caring role prior to working in care, which she did to enable her to apply for the nursing programme.

Participant 2

Sky is a twenty nine year old female, who was born and has lived locally to the area in which the HEI is situated. Sky completed her BSc Psychology with Criminology in 2007 and then looked into working in probation. She did some community development work, helping people find jobs and go on courses. She has also volunteered in schools and with elderly people. She initially applied to the social work programme but didn't complete the form correctly. It was at this time that her mother was ill and it was this that prompted her to look into nursing as a career. Sky also worked for a year as a support worker within community mental health services prior to commencing the nursing programme.

Participant 3

Tai is a thirty five year old female who was born in Jamaica, and moved to the UK several years ago. She had experienced caring for family members particularly her grandmother who was blind. Having always wanted to study nursing she joined the army hoping to become a nurse, however the opportunity was not available so she left. Tai's early memories of people with a mental illness, is within a culture that cared for people within the family and often hid them from the community.

Participant 4

Mya is a thirty seven year old female who lives approximately forty miles away from the HEI. She identified personal experience as the motivation to study mental health nursing. Her mother had suffered abuse as a child, and that led to a breakdown when Mya was a young child, she witnessed the help she received towards her recovery, which led to a personal interest in mental health. When she left school she began nursery nursing, however once her children were at school, her interest for mental health nursing returned and she applied to university.

Participant 5

Lil is a twenty two year old female, who was born and lives locally to the area in which the HEI is situated. She describes herself as belonging to a family of nurses and being raised by nurses (although none are mental health nurses). She described the stories they used to tell her about nursing. Lil had experience of mental health nursing in Romania as part of a charity trip she attended. She had also considered a career as a paramedic in the army but chose to study mental health nursing instead.

Participant 6

Dax is a forty year old male, who lives approximately thirty five miles away from the HEI. He initially began work in his father's building firm as a joiner and it wasn't until an injury later in life, resulted in him taking on some voluntary work for a mental health charity. He worked with people as a support worker and a one to one mentor. He describes himself as always being fascinated with mental health and so he went back to college and studied the required qualifications, so he could then apply to become a mental health nurse.

Participant 7

Asa is a twenty five year old male, who was born and lives locally to the area in which the HEI is situated. He had no thoughts of becoming a mental health nurse even though his father is one, but his father helped him get a job as a health care assistant. It was through working in mental health care that Asa loved the work and he soon realised it was what he wanted to do as a

career. He was unsuccessful on his first application so waited a few years and then was successful at interview to join the mental health nursing programme

Participant 8

Kat is a thirty year old female, who was born and lives locally to the area in which the HEI is situated. She had personal experience when following the birth of her siblings she saw her “crumble with depression” and how she was able to recover with help from services. This inspired her to want to help others. Nevertheless following school she began a business apprenticeship and it wasn't until she was twenty six that she decided to work in a care home and then study at college in order to become a mental health nurse.

Participant 9

Jay is a thirty one year old male, who lives approximately thirty miles away from the HEI. His personal experience of nursing was gained when his twin brother spent a lot of time in hospital when he was young. He developed an admiration towards the staff and this remained in later life. He was going to apply for nursing when he was nineteen, however felt he was too young and then gained employment in business. When he was twenty nine Jay was made redundant and it was then that he began to volunteer and then gained employment in care. This gave him the grounding to realise his earlier desire to become a mental health nurse.