Title page:

A TRANSATLANTIC PHENOMENOLOGICAL STUDY OF WHY STUDENT PSYCHIATRIC/MENTAL HEALTH NURSES CHOSE THEIR PROFESSION

By

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Appendices 1-7 available in separate document

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INFORMATION FOR ABSTRACTING AND INDEXING SERVICES

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Abstract (not to exceed 200 words - any continuation sheets must contain the author's full name and full title of the thesis):

Aim: - Ascertain why student nurses choose Psychiatric/Mental Health nursing.

Background: - There is a global shortage of nurses. There are problems with recruitment and retention. Research about students' reasons for choosing this field remains limited. The literature review discusses the reasons students choose the field and qualified nurses' reasons for staying or leaving.

Design: An Interpretative Phenomenological Analysis study, using semi-structured interview of 15 participants from three United Kingdom and one American University.

Findings: Reasons for choice included personal or family mental health experiences; learning about and fixing themselves; improving services; expectations of transformation and healing, and developing therapeutic relationships. Participants stayed on their course because of relationships with patients and the health care team. Like qualified nurses, participants' experiences with patients provided evidence of trauma; use of coping strategies and developing resilience. Participants indicated they considered leaving due to being inadequately prepared for working particularly in the face of violence/aggression; trauma; poor welcome and loss of supportive relationships.

Conclusions: - Key motivator is personal experience of mental health issues. In practice, qualified nurses need to be enabled to be supportive of students including providing clinical supervision. Students need enhanced education on trauma, de-escalation, safety, loss and resiliency.

Title:

A TRANSATLANTIC PHENOMENOLOGICAL STUDY OF WHY STUDENT PSYCHIATRIC/MENTAL HEALTH NURSES CHOSE THEIR PROFESSION.

Full Structured Abstract: -

This work is an interpretive phenomenological analysis of 15 student psychiatric/ mental health nurses' (PMHN) reasons for choosing their profession.

Aims and objectives: -

To find out why student P/MH nurses chose P/MH nursing. To explore reasons for choosing P/MH nursing; what experiences keep them going in the profession and might influence them to leave P/MH nursing.

Background:-

There is little published literature on why student nurses choose P/MH nursing (Edward et al. 2015, Ong et al. 2017). There are mixed messages as to what the role and function of a P/MH nurse is (Smoyak 2008, Lakeman and Molloy 2017). A

flawed history and potential gaps in the preparation of P/MH nursing students. There are issues over the suitability of some recruits (Kirkbakk-Fjaer, Andofossen and Hedelin 2015), attrition and retention (Stevens, Browne and Graham 2013, Cleary, Horsfall and Happell 2012, Jansen and Venter 2015), along with an emerging global crisis over nursing (Goodare 2017), national and international shortages of P/MH nurses (APNA 2016, HEE 2017, Johnson et al. 2018)

Design: -

This qualitative investigation is a study of complex, subjective experiences which uses phenomenology (Moran and Mooney 2002), and specifically IPA (Smith and Osborn 2009), as research method. A semi-structured interview gathered data which is then analysed (Heidegger 1923) through a range of psychosocial and phenomenological concepts.

Discussions:

Three themes emerged these were learning about themselves, fixing themselves and improving services. They stayed on their course because of the therapeutic relationships and being part of the team. Their most significant experiences were working intensely with service users, and working with severely distressed service users linked to trauma.

Findings:-

Reasons for choosing the profession mirrors other research (Edward et al. 2015, Ong et al. 2017), wanting to learn more about MH issues in response to personal experiences. 9 out of 15 participants declared personal experience of MH problems; the remaining 6 participants indicated immediate family experience of mental illness. The participants expected transformation, healing and recovery like qualified P/MH nurses in their work (Hubbard, Beeber and Eves 2017). The participants focused on therapeutic relationships with service users to remain in P/MH nursing. In common with qualified P/MH nurses (Jacobowitz et al. 2015), several of the participants' experiences provided evidence of psychological trauma during clinical practice. Participants showed a propensity toward positive coping strategies and some resilience (Pryjmachuk and Richards 2007).

Conclusions:-

The key motivator for student nurses to choose P/MH nursing is personal experience of MH issues. The key reasons to stay in P/MH nursing are therapeutic work with service users; positive P/MH nursing role models and effective team working. Reasons that student P/MH nurses might inevitably leave the profession include inadequate preparation for the realities of the work; particularly on working effectively with people who may become violent and aggressive; psychological trauma from

becoming overwhelmed by service users trauma, bullying, violent and aggressive incidents, lack of welcome particularly in clinical practice and loss of successful and/or supportive relationships (Bradbury-Jones, Sambrook and Irvine 2007).

Relevance to clinical practice and nurse education:-

Practice: P/MH nurses need to be enabled to be supportive of students.

Education: Student P/MH nurses need clinical supervision; enhanced education on trauma; dealing with violence, aggression, loss and resilience building.

Introduction

This thesis is an investigation into why psychiatric/mental health nursing (P/MHN) students choose their field of nursing. The title of the study includes the word "transatlantic" to reflect that the work was carried out in both the UK and America. In considering both UK and US nursing students this investigation was able, at least to some extent, to compare and contrast the diverging educational contexts which potentially influence career choice and satisfaction. It was carried out over four university sites, two in Birmingham, one in Ulster and one in Boston. The aim of this study is to find out why student P/MH nurses chose P/MH nursing. In order to meet this aim the objectives of this study are to explore student P/MH nurses reasons for choosing P/MH nursing; to find out what experiences keep them going in their chosen profession and what experiences are likely to influence them to leave P/MH nursing. This investigation is a study of complex, subjective experiences which indicate a need to use the philosophical basis of phenomenology (Moran and Mooney 2002) and specifically Interpretative Phenomenological Analysis (IPA) (Smith and Osborn 2009) (See chapter 2).

This introduction aims to set out the broad context and background of P/MHN practice and education. The objectives of this section are to consider the following questions in order to meet this aim;

- I:1 What is P/MH nursing?
- I:2 Why do we need to talk about P/MH nursing?

- I:3 Where is P/MH nursing situated historically?
- I:4 The demographics of nursing and identifying who are P/MH nurses?
- I:5 Who are the people P/MH nurses work with?
- I:6 How are P/MH nurses prepared for their work?

I:1 What is P/MH nursing?

So what is P/MHN and how is it defined? Attempts to define P/MHN as a professional group immediately focus on what P/MH nurses do as there is no general agreement on a specific definition. The poorly defined nature of P/MHN may well be related to the traditional roles of nurses, to do what the responsible physician tells them. On both sides of the Atlantic P/MH nurses are based in clinical practice, and in the UK nurses are still required to carry out care prescribed by a doctor (Mental Health Act (MHA) 1983 revised 2007). Whilst nurses appear to have greater autonomy in the US they are still directed by insurance company protocols agreed by medical staff (American Psychiatric Nursing Association APNA 2014a).

Hanson and Taylor (2000:423) state, 'The answer is that they [P/MH nurses] exist at the crucial point of human living, at the junction between action and experience.' Clarke's (2006) work on what a P/MH nurse is suggests that it emphasises a 'person's unique, subjective experiences, is person centred, focuses on a person's potential and what they consider important'.

It had been argued that P/MHN is ill defined, nebulous and P/MH nurses themselves lack clarity over what their responsibilities are (Clarke 2006, Smoyak 2008). In the UK there are blurring's of role boundaries across MH professional groups including psychiatrists, psychologists, occupational therapists and social workers amongst others (Department of Health DH 2007b). Moller and Haber (1996:1) indicate similar, if differing reasons, for the role blurring in the US:

> 'It may also be explained by the fact that many psychiatric CNSs (Clinical Nurse Specialists) have identified themselves as psychoanalysts, psychotherapists, family therapists or with other such labels that obscure their professional nursing identity. Whether this phenomenon occurs because CNSs are trying to "pass" as members of a more elite MH discipline or just lack marketing savvy, …the value of the MH services they provide are lost'.

P/MH nurses provide three necessary aspects of care to people with MH problems: custodial, procedural and therapeutic based on interpersonal work (Clarke and Walsh 2009). Custodial aspects refer to the implementation of MH specific law such as the MH Act (1983/2007) in the UK. P/MH nurses' have the right, through this law, to restrict MH service users' rights to go where they wish and are required by law to 'keep' MH service users in a safe place, this can be against the person's wishes if necessary. In the US whilst laws differ the custodial aspects of P/MHN care are also still evident. Procedural work requires P/MH nurses to carry out nursing care and treatment and implement aspects of medically prescribed treatment such as physical observations taking blood pressure, pulse, and body temperature and administering medication and assisting with the giving of Electro-Convulsive Therapy. These aspects of P/MHNs work are largely influenced and driven by policies in the UK.

(DH 1999a, DH 199b, DH 1999c, DH 2000, DH 2001a, DH 2001b, DH 2002a, DH 2002b, DH 2004a, DH 2007a, DH 2007b, DH 2008c, National Institute for Clinical Excellence (NICE) 2001, NICE 2004, NICE 2005a, NICE 2005b, NICE 2011a, NICE 2011b, NICE 2011c, NICE 2011d, NICE 2011e, NICE 2011f, NICE 2011g, NICE 2011h, NICE 2012a, NICE 2012b, NICE 2012c, NICE 2012d, See also Table 1:2 Appendix 2). The picture is different in the US. Whilst State and Federal laws relating to MH care do impact on P/MH nurses, there is certainly not the plethora of policy evident in the UK.

In contrast to procedural work the emphasis of therapeutic and interpersonal work in P/MHN has largely been around using the relationship with the patient to explore their issues and facilitate change which enhances the person's mental health (MH) (Peplau 1952, Barker 2009, APNA 2014).

From this perspective contemporary P/MHN in the UK has been influenced by two distinct philosophies. The first of these is the interpersonal tradition advocated by Peplau (1952, 1988) influencing P/MHN strongly in the 1970s and 1980s and still today, and championed in Phil Barker's (2009) Tidal Model with its emphasis on the nurse-patient relationship and 'human caring service'. Peplau's (1952, 1988) work was ground breaking in the US and led to the development of Masters level speciality P/MHN where she is still considered to be the 'mother' of modern P/MH nursing (Haber 2000). Whereas she influenced specific P/MH nurses in the UK initially those in educational positions and undertaking educational pre-registration nursing courses. This was reflected in the 1982 UK Syllabus for P/MH nurse

education (English and Welsh National Boards for Nursing Midwifery and Health Visiting 1982 ENB) but also in the work of people such as Phil Barker (1998). Her publication of a full nursing theory, a detailed explanation of what P/MH nurses need to know and do in 1952, which she briefly revisited in 1988, influenced UK P/MH nurses undertaking further study and continues to do so as well as changed practice. This is evidenced in work such as the Tidal Model (Barker 2012). A model of P/MHN practice, written specifically for the UK, which is still used in MH trusts as an exemplar for P/MHN practice. Of course she was not the only influence on the development of P/MHN and should be viewed alongside evolving theories in psychology (Beck 1967, Ellis and Grieger 1971, Padesky and Greenburger 1995); psychoanalysis (Freud 1979, Bowlby 1969); sociology (Goffmann 1961); counselling (Rogers 1951, Berne 1964, Heron 2001); psychiatry and recovery (Royal College of Psychiatrists 2016, Repper and Perkins 2001).

P/MH nursing has also been influenced by the second of these, evidence based MH care which emerged from medicine in the early 1990s. As Sackett (1997) explains evidence based approaches emerged from medicine, the ideas date back to the 1850s but the intention is that both clinicians' expertise and systematic research inform patients' treatment choices. Evidence based MH care emphasises best scientific evidence, clinical knowledge and service users' values within a multi-professional team context.

More recently these approaches are being integrated in P/MHN alongside an emphasis on the MH service user recovery model and social inclusion (Barker 2009,

Norman and Ryrie 2009, Pryjmachuk 2011, Nolan 2012). In the last twenty years evidence based MH care has led increasingly to an integration of both the interpersonal and evidence based traditions in P/MHN in the UK (Norman and Ryrie 2009). Similarly in the US there is now evidence of this dual approach to practice. The curriculum for P/MH nurses in the US incorporates greater educational input on both medication and evidence based cognitive behavioural treatment approaches alongside the more traditional interpersonal therapeutic approach advocated by Peplau (1952, 1988) (APNA 2014).

In evidence based mental health care the primary focus may shift from, or is not on, the nurse's relationship with service users; rather it moves to expanding the nurse's role to take on multi-disciplinary team work (Hemingway 2005). For example, non-medical prescribing, traditionally a Medic's role (Hemingway 2005); the Approved MH Professional, previously the Social Worker's role (MHA 1983/2007); Psychological Well Being Practitioners and High Intensity Psychological Intervention workers, traditionally psychologists' work (DH 2007a). Through these developments P/MH nurses support the delivery of evidence based MH care. Whilst Barker (2009) argued that this approach denies the uniqueness of P/MH nursing, many suggest that in focusing on evidence based mental health care it is important not to forget that, 'Effective P/MHN involves caring with people rather than for them, …priority is given to the exploration and development of the person's lived experience' (Norman and Ryrie 2009:75).

P/MH nursing in the UK has incorporated the recommendations from the Chief

Nursing Officer's Report of 2006 (DH 2006), a blend of interpersonal and evidence based traditions, which some acknowledge is likely to be an 'eclectic' approach in P/MH nursing (Pryjmachuk 2011), to embrace the Mental Health Core Skills Education and Training Framework (2016) commissioned by the DH and developed in collaboration with Skills for Health, Skills for Care and Health Education England Skills for Health framework which outlines national occupational standards in mental health. Both the APNA (2014) and Nursing and Midwifery Council (NMC) (2018) set out the expected standards and proficiencies of P/MHNs. These provide a clear baseline of what P/MHNs are required to be able to do and recognise the human relationships work and therapeutic efforts necessary within this role (APNA 2014, NMC 2018). Alongside these developments and in response to the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013) on compassion (Cummings and Bennett 2012, Ghisoni 2016) mental health services within the UK are acknowledging the need for a more compassionate approach to care which reflects Gilbert's work (2009) on compassion focused therapy and the adaption and inclusion of work from the US on trauma informed care (Sweeney et al. 2016). In 2018 P/MHNs are actively recruited to participate in National Institute of Clinical Excellence (NICE) Guidance reviews; there is a national body, Mental Health Nurse Academic's UK, alongside multiple forums within existing organisations, such as the Royal College of Nursing (RCN), representing and advocating for P/MHNs at both government and national level. However, there are still issues of concern around the future of P/MH nursing as Lakeman and Molloy (2017) highlight.

I:2 Why do we need to talk about P/MH nursing?

The therapeutic nature of P/MHN work can be a contentious area with an expectation placed on P/MH nurses that they will seek to understand the person who is experiencing mental illness and help them towards recovery. P/MH nurses have agreed for some time (Peplau 1988, Barker 2009, APNA 2014) that an essential aspect of what they do involves 'the therapeutic use of self'. In order to do this the nurse is required to work towards empathic understanding of the person with MH problems and engage in an interpersonal relationship which promotes healing and recovery. However, other demands on nurses in the field such as implementing the MHA (1983/2007) may seriously damage or limit their ability to be therapeutic.

The potential for legal powers over others may be attractive to some people who desire control over others. Similarly, procedural work in P/MH nursing is often practical in nature, specific and clearly defined. Whilst nurses can quickly grasp its requirements there is little necessity to be therapeutic. Whilst P/MH nurses may be desirous of engaging with therapeutic aspects of their role, the existing tensions around this work, over resources and efficacy, that they are likely to encounter, could lead to a significant challenge to their hopes and expectations.

The shift in P/MHN to partnership working with MH service users is increasingly influenced by the recovery approach (DH CNO Report 2006). P/MH nurses have the most direct contact time with people with MH problems in all MH service settings yet that relationship can be fraught with difficulties (Bowers et al. 2009). Attempting to

work in partnership with service users and when necessary, to advocate on their behalf, can bring nurses into conflict with medical colleagues within the Multi-disciplinary team and within the legal framework within which P/MH nurses work. This leads to conflict around restraint over recovery.

Nurses are still considered, of all members of the Multi-disciplinary team, as most allied with the medical profession. Historically, nurses were seen as 'subservient' to doctors and most likely to comply with their requests (Turner 1995). Social workers, psychologists and other team members are more removed from both service users and Doctors, and under less immediate pressure to agree to their perspective. There are distinct power differentials amongst MH care professional groups.

As Nolan (2012:10) acknowledges, 'valuing the input of nurses appeared, however, not to be a priority of senior healthcare personnel, a situation that some would consider persists into the present day'. 'With current discourses that privilege shortened lengths of stay, standardised care and an emphasis on documentation' the ability of P/MH nurses to forge effective, meaningful therapeutic relationships with MH service users is potentially compromised; according to Evans (2007:194), 'the therapeutic relationship in [P/MH] nursing requires sustained attention, both in theory and practice, so as to maintain its position as foundational to practice.' It holds the potential to provide service users with the necessary psychical holding, from which they can talk to the nurse in ways they cannot talk to their friends and families. P/MH nurses are negotiating the needs of potentially vulnerable people in severe distress alongside meeting the legal requirements of the MH Act 1983/2007

and the implementation of policies such as Payment by Results (DH 2011), an increasing need to reduce costs, threats to employment, under resourcing and poor quality provision (Health and Social Care Bill 2012). Lakeman and Molloy (2017) in their published abstract state,

> Mental health nursing is a concept that has lost any real explanatory or conceptual power, yet nevertheless persists in public discourse and the collective imagination. In recent decades, powerful forces have contributed to the zombification of the mental health nursing workforce and the academy. An increase in medical hegemony, the ascendancy of allied health in mental health service provision, the need for uncritical and servile workers, protocol-driven work practices, and a failure of leadership to mobilize any substantial resistance to these trends have enabled the infection to spread. The recognition of zombification, active resistance against the forces that conspire to cause it, and the cultivation of genuine conscientious critical thought and debate offer the only hope of survival of mental health nursing as a thriving specialty.

In light of this can P/MH nursing successfully critically engage with and negotiate the issues around restraint versus recovery? Perhaps understanding the origins of P/MH nursing may provide some useful context to this discussion and help to place this work in its setting.

I:3 Where is P/MH nursing situated historically?

The origins of P/MHN in the UK is firmly situated in the old asylum system. It is difficult to date this exactly, but the Bethlem Royal Hospital in London admitted their

first mentally ill people in 1407. The Madhouse Act of 1774 established some licensing and inspection processes and in 1808 the County Asylum Act set up the process of funding and building of large asylums.

However, the largest impact was made by the Lunacy Act of 1845 when counties were obliged to build asylums for the mentally ill, which led to a significant increase in asylums nationwide (<http://thetimechamber.co.uk/beta/sites/asylums/asylum-history/the-history-of-the-asylum accessed 05/11/16>). It was this development in the latter half of the 19th century that also led to growing employment in the asylums. (Nolan's work of 1993 and Arton's work of 1998 provide useful and interesting history).

The occupational titles of asylum workers at this time were along the lines of "lunatic attendant" or "asylum attendant" (Nolan 1993). Attendants worked with a medical superintendent and ensured that people's basic needs were met in a restrictive, often punishing, environment (Symonds 1995, Arton 1998). Victorian morals and values were enforced and it was argued that 'lunatics' should be made to work for their keep, with many of the old asylums having working farms. They were also positioned on the edges of towns and cities to ensure that 'the healthy population were not infected with madness' (Symonds 1995:96). Whilst some 'enlightened' MH services did exist, these were predominantly for the 'wealthier'. For example, York Retreat opened in 1796 by William Tuke and the Quaker Society was the world leader in humane treatment of the insane, (History of York accessed 22/09/16) however, most of the UK asylums' philosophy and practice maintained elements of

this punitive, restrictive environment until well into the 1980s (some would suggest that it still exists today: Szasz 2009). This is not dissimilar to the development of US P/MHN which was also tied into the asylum system in the states.

During the 19th and 20th centuries, like the UK, in the US there were inequalities in the treatment of the wealthy in private settings and those in public hospitals. Abuses in the system abounded, as in the UK, typically treatment for promiscuity, sexually transmitted diseases and sexuality were all carried out in psychiatric settings up to and including the 1960s (Strumpf and Tomes 1992). As in the UK there was over medication of service users (Smith 2012), excessive use of Electro-Convulsive Therapy (Rothman 1985) particularly associated with disabling women (Ussher 1991), unnecessary surgical procedures such as lobotomies (Tartakovsky 2011), and multiple mis-diagnoses based on gender and ethnicity (Grandbois 2005).

However, there were other culturally specific issues of abuse in the history of US psychiatry directly arising from slavery, unlike the UK. An example of this is the psychiatric diagnosis of drapetomania, which was used for slaves who would persistently run away from slavery and was a classification of mental illness in the US (Littlewood and Lipsedge 1997). P/MHN in the US does not have a history of recruiting marginalised groups and does not have a diverse or large Black or Minority Ethnic (BME: in this case BME refers to all people from ethnic groups, regardless of birthplace or nationality) population in part due to early professionalization in the states and establishing a higher educational base before segregation was ended (National Black Nurses Association (NBNA) 2016).

Further changes in psychiatric care occurred when UK MH services came under the remit of the National Health Service (NHS) in 1948, the 1959 (Freeman 1998) and 1983 MH Acts also shifted emphasis away from restrictive environments to community based care and services and the 1990 NHS and Community Care Act embedded this into services, however, change was slow and often reflected social concerns rather than meeting the needs of people with MH problems (Szmukler and Holloway 2000). Unlike the UK, a vast private psychotherapy service existed in the US, and P/MH nurses were not part of that provision initially. The closure of asylums and large public mental hospitals happened much earlier and more rapidly in the US in comparison to the UK.

De-institutionalisation was pushed through in the 1963 Community MH Act during Kennedy's presidency by comparison this really only began happening in the 1990s in the UK. However, this shift was also influenced and shaped to some extent by the American health insurance system and through the development of certain psychopharmacology, psychiatric and P/MH nurse innovations. For example drugs such as Chlorpromazine became available in 1952 which appeared to ameliorate some of the worst symptoms of psychosis (Boyd and Nihart 1998). At this time the American Psychiatric Association (APA) released their first Diagnostic Statistical Manual which was a list of mental illnesses, signs and symptoms for Psychiatric use (APA 1952).

Again in 1952 a very significant figure in both the US and UK, Hildegard Peplau, published her first work on P/MH nursing. In the 1940s Peplau worked with Harry

Stack Sullivan a well-known psychologist who focused on interpersonal relationships and psychoanalysis. From her Masters research work at Colombia in 1947 Peplau produced the first P/MH nursing theory. This was presented in her 1952 published work, *Interpersonal Relations in Nursing*. Peplau's nursing theory was referred to as psychodynamic nursing in the US. *Interpersonal Relations in Nursing,* her seminal work, presented a nursing model and outlined how P/MH nurses take on a variety of roles in their work with service users and go through several stages in the helping relationship towards health. (See Appendix 1). Peplau also established and taught graduate nurses at Rutgers University between 1954 and 1974, when she became Emeritus Professor. Peplau went on to work with several well-known UK P/MHN academics including Phil Barker and her work continues to be a significant influence on P/MHN in both countries today

Although as stated in the UK P/MH nurses were initially labelled 'lunatic' or 'asylum attendants', they became 'mental nurses' from 1923 until 1994 when they became 'Mental Health nurses' following the Butterworth Report (DH 1994). In the US they were always called 'psychiatric nurses', even today the title has been extended to include MH but it remains P/MH nurse. Nomenclature can help to clarify role expectations initially because as "attendants" the role could be seen to be more in keeping with servitude, whereas with mental nurses or psychiatric nurses the emphasis was placed on an illness model. Subsequently the re-naming of the profession as 'mental health' nurses in 1994 has been argued to indicate a desire to work in a preventative, health promoting way in the UK and since 2010 in the US (Clarke 2008, Barker 2009, APNA 2014a). This work uses psychiatric/mental health nursing P/MHN throughout for consistency.

Rather than reflecting nursing as a position of servitude or of attending to a person's needs, the history of the asylum demonstrates clearly the abuses that 'inmates' were subjected to and shows that attendants were often more interested in lining their own pockets than caring for the 'inmates' (Arton 1998, Arnold 2008). Perhaps because of fears of 'madness' and rumours of brutality, attendants attracted early criticisms. For example, some attendants were paid in 'ale', (Nolan 1993). In Charlotte Bronte's *Jane Eyre*, Grace Poole, an asylum attendant now caretaking for Bertha Rochester, the archetypal madwoman in the attic, is blamed for the eventual death of Bertha and the permanent maiming of Rochester because of 'one fault, common to a deal of them nurses and matrons, she kept a private bottle of gin by her and now and then took a drop over much'. (Bronte 1847). This representation of the lunatic attendant as brutal, drunk and working class, contravened traditional images or expectations of 'nurses' within the United Kingdom who saw themselves as clean, morally correct Christian women (Brimblecombe 2006). Similarly in America as O'Brien-D'Antonio (1993:239) found when considering the requirements of nurse training during the 1860s, 'all nurses should be middle class…high toned...enlightened and refined'.

There was controversy as early as 1896 about including asylum attendants on the Royal British Nurses Association register. Asylum attendants were already expected to undergo three years of asylum training, including lectures, and to successfully pass two examinations alongside providing a certificate of good character which led to registration with the Council of the Medico-Psychological Association (Outterson Wood 1896). The response from the Matrons Council at the time indicates the strength of opposition to this proposal:

> we should most willingly welcome asylum attendants on to our register were they eligible to be registered under the standard of nursing education exacted from all trained nurses for such registration. Why should not these asylum attendants qualify for registration as the present members of the Royal British Nurses' Association have done? That is to say by passing through a proper course of training in a general hospital. Then the register would not be degraded and the public would not be misled into believing that un-trained lunatic attendants were properly trained nurses (Wingfield 1896:1804).

In the US Linda Richards established the first School of Nursing for P/MH nurses in the US at Boston City College in 1880, this development linked in to thirty additional asylums in the US. However, in the US the education of nurses shifted very quickly into colleges by 1913, and higher degrees in P/MH nursing were available from the 1940s (Nolan 1993, Boyd and Nihart 1998).

Before World War Two larger numbers of men, agricultural labourers and winter workers were attracted to this line of work in the UK. This resulted in a higher percentage of the working classes or the more marginal being employed in 'asylum care' (Brimblecombe 2006). Norman and Ryrie (2009:65) cited Bedford-Fenwick's distaste in relation to these social class considerations when she stated, 'considering the present class of persons known as male attendants, one can hardly believe that their admission (onto the nursing register) will tend to raise the status of the association'. The RCN continued to refuse registration to attendants: however, by 1923 the General Nursing Council offered an alternative nursing qualification and registration through this route as a 'mental nurse' (Norman and Ryrie 2009).

Marginal groups in the UK continued to have higher representation in P/MH nursing

post World War Two. More ethnically diverse groups unable to access more traditional branches of nursing such as adult or child came into P/MH nursing almost by default including Irish, Mauritian, and African-Caribbean nurses (Nolan 2012). In the twenty-first century we continue to see large numbers of African immigrant nurses entering P/MH nursing in the UK. Overall the figures would suggest that well over thirty percent of all BME nurses work in areas associated with mental illness (RCN 2007).

The RCN (2007) survey indicated that many of these BME nurses are specifically from countries with on-going civil unrest, war and torture such as Zimbabwe, Nigeria, South Africa, the rest of Africa and other Asian countries. Arguably, social issues such as gender, class and ethnicity were more obviously played out in P/MHN in the UK. In work or career terms these early prejudices may have reflected the stigma attached to mental illness and those associated with it (Strang 2007). So, more marginal groups in a nursing context such as men, working class people and people from different ethnic backgrounds, seeking work but being unable to access more mainstream health work 'ended' up in P/MH nursing. P/MH nursing can be viewed as a mechanism by which the mentally ill were removed from society, where the risk of ‘infecting’ society was managed, through a workforce of social control, of restraint, and arguably that concept lingers in practice today (Cutcliffe and Happell 2009). With this ‘historically’ flawed reputation established for P/MHN it is not difficult to question why people might choose this career now.

In this next section information about the broad context of nursing, numbers of P/MH nurses in the UK and USA is presented to provide some understanding of who P/MH

Nurses are.

I:4 The demographics of nursing and identifying who P/MH nurses are?

The section provides a factual overview and presents relevant data around the demographics of P/MH nursing in the UK and USA. Initially it is perhaps useful to provide an overview of the numbers of nurses in the United Kingdom and more specifically the number of P/MH nurses. The NMC (2017) stated that there are currently 690,773 nurses registered with them in the UK. There are a total of 317,980 nurses in England as at December 2017. 35,390 of these are P/MHNs (www.digitalnhs.uk accessed 21/02/2018) this has dropped from 40,630 in 2010, down overall by thirteen percent. As early as 2016 Griffin was reporting that the number of P/MHNs in England had fallen, the RCN (2016) warned that this left the remaining nursing workforce to 'bear the brunt' of increasing pressures. Murrells, Robinson and Griffiths (2008) established that P/MH nurses in the UK are on average five years older than their counterparts in child nursing and two and a half years older than adult nurses. Seventy percent of P/MH nurses are female and P/MH nurses are more likely to belong to an ethnic minority.

In the USA the nursing population remains mainly female with ninety-one percent of American nurses being women (National Centre for Health Workforce Analysis 2013) and eighty-nine point seven percent female in the UK (Marsh 2016). In the UK this is significantly less so in P/MHN with around thirty percent of the P/MH nurse

population being male (Murrells, Robinson and Griffiths 2008). The ethnicity of nurses in the US is made up of 83.2 percent white and 16.8 percent from black and minority ethnic groups, including African American, Asian, American Indian or Alaskan Native and non-white Hispanic (U.S. Department of Health and Human Services Health Resources and Services Administration 2010). In 2011 the World Health Organisation (WHO) reported that there were 2,927,000 nurses in the US (WHO 2011). Of these nurses, 150,000 nurses are registered with the NBNA (2016). The NBNA (2016) acknowledge that their organisation, founded in 1971, was necessary as 'black nurses in the late 60s and early 70s still, had very little presence and influence' in nursing.

There are some differences in the US, however, the evidence that P/MHN is unpopular is difficult to deny. In thirty-nine out of forty-three member states there are significant vacancies in P/MHN posts and recruitment to these posts is viewed to be in crisis (APNA 2016). In the UK there is acknowledgement that NHS nursing recruitment and retention in mental health is in crisis (Johnson et al. 2018). According to Health Education England (HEE 2017) there are 36,000 nursing vacancies in England, whilst Marangazov et al. (2017) on behalf of the RCN, gave a figure of 40,000. In terms of P/MH nursing, HEE (2017) provided the Health Select Committee (2018) indications that there is a 14.3% vacancy rate alongside a population rise of 5.7%. There is a global epidemic of MH problems (WHO 2016): an estimated 350,000,000 people are affected by depression; 60,000,000 people are affected by bi-polar disorder; 21,000,000 people are affected by schizophrenia and 47,500,000 people have dementia. As WHO (2016) acknowledge, 'depression and other MH conditions is on the rise globally'. One of the main care providers across

the globe are P/MH nurses, in 2014 the UK had 67.35 P/MH nurses per 100,000 population and the US had 4.25 P/MH nurses per 100,000 population (WHO 2014). The sad truth is that both here in the UK and in the USA P/MHN vacancies are rising (Quallington 2015, APNA 2016) and numbers of nurses being educated in the UK has been cut by ten percent over the last ten years (Quallington 2015), although there have been some recent moves to address this issue by HEE since 2015 with an increase in student nurse education commissioned numbers by up to six percent (Quallington 2015). There is also the looming demographic crisis in both the UK and US with over twenty-five percent of the nursing workforce in the US (U.S. Department of Health and Human Services Health Resources and Services Administration 2010) and around thirty-three percent of all P/MH nurses in the UK reaching retirement age in the next five years (Quallington 2015). Could this apparent difficulty in recruitment and retention be as a result of the people P/MH nurses work with?

I:5 Who are the people P/MH nurses work with?

The working environment of P/MH nurses has also shifted from working mainly with MH service users who may not have actively sought help and support, but were willing to accept treatment and help, to working with those who are seen as most in need, the serious and enduringly mentally ill and most reluctant. To illustrate this in the UK the number of detainees under the Mental Health Act (MHA 1983/2007) has risen from 29,593 in 1990/91 to 63,622 in 2015/16 (www.nhsdigital.uk NHS Digital KP90/ Mental Health Services Data set (MHSDS) cqc.org.uk – accessed

22/02/2018).

In the UK the response to perceived violent potential from people with MH problems and notions of preventing risk have influenced society, government policy and legislation. The response to alleviate public concern has potentially been to the detriment of the rights of people with MH problems (Paterson and Stark 2001). Specific examples include the removal of the treatability clause from the MHA (1983/2007). From the implementation of the Act in October 2008 detention was seen as an acceptable form of treatment even if the mental illness is not 'treatable'. The Community Treatment Order (CTO 2008) enables treatment in the least restrictive environment including the person's own home. There are concerns that P/MH Nurses in the UK may be required to enter people's homes against their wishes to administer medication, also against their wishes. In the UK the policy context may be positioning P/MH nurses as a 'social police force', and arguably their role is increasingly one of making sure that an 'unacceptable' level of mental illness is not visible in the streets, sanitising mental illness so that it develops an acceptable public persona (Cutcliffe and Happell 2009), reinforcing the role as one of restraint rather than recovery. As Holloway, Pinfold and Bindman (2001:268) state:

> We are increasingly, as professionals, expected to act as agents of social control on the mythical basis that in some way community care and de-institutionalisation has put the public at increased risk. And there is actually quite good data to show that this is simply not true.

MIND (Dawson 2007:3) echo these findings in their legal briefing paper:

> Many people consulted by MIND feel their relationships with professionals would be harmed by the increased threat of compulsion with those professionals being turned into 'MH Act Police Officers'. The reality in 2012 is that the use of Community Treatment Orders in the UK has risen by ten-percent in the last twelve months (Nursing in Practice on-line posting 25.10.12).

Whilst cuts have been implemented across MH services in the UK service users cared for under the provisions of the MHA (1983/2007) are significantly more disadvantaged and have more complex needs (Gilburt 2015). In the US there is a similar picture, with an increase in involuntary admissions, whereas if a person can ask for treatment they are viewed as being 'too well' for admission. Psychiatric inpatient beds in the US have been halved since 1955 from 34:100,000 to 17:100,000 the demand for MH care has increased. P/MH nurses in the US are working in similar conditions to their UK counterparts (Jaffe 2014).

Therefore it is not inconceivable to suggest that the complexity of need in the MH service user population is increasing. As acknowledgement of this heightened complexity of need in P/MHN in both the UK and USA are increasingly working with mental health service users and offering trauma based care in recognition of the causal relationship trauma has to mental distress and illness (Sweeney et al. 2016). P/MH nurses in the 21st century are working with the serious and enduringly mentally ill and some of the most vulnerable and disturbed people in our society so how are they being prepared for this work?

I:6 How are P/MH nurses prepared for their work?

In the UK nursing courses were required to demonstrate that students had achieved the NMC proficiency statements up to safe, effective and proficient levels in practice, as well as pass all academic requirements by the end of their course. UK courses are also required to demonstrate that they met the skills and knowledge standards set out in emerging policy documents (DH 2004, DH 2006, DH 2016). However, it is vital to point out that the current model of nurse education in the UK has yet again been through the process of consultation and review and changes are on-going (NMC 2018). The NMC published further consultations on pre-registration nurse education (NMC 2016) and the latest review requires a new model of nurse education to be available from October 2018 onwards. The NMC have retained field specific undergraduate nursing education with broad generic new standards for all registered nurses. This is alongside additional advanced proficiencies and greater depth of knowledge being required in all field specific aspects of nursing courses in their new draft standards for registered nurses due for approval in Spring 2018 (www.nmc.org.uk. Draft Standards of Proficiency for Registered Nurses 2018 accessed 25/02/2018). This is different to the model of nurse education employed in the USA. There they offer a generic undergraduate programme with P/MH nursing qualifications at masters' level. The Scope and Standards for P/MHN in the US are set out by the APNA (2014).

The UK model of nurse education also requires the student nurse to spend fifty percent of their education in the clinical practice environment. UK nurse educators

have long been concerned about the apparent theory practice gap. Traditionally the UK model of nurse education has required qualified nurse mentors working in clinical practice to role model, demonstrate and teach appropriate interventions and care (Hunt et al. 2012). This is alongside their existing work load. There are some commonalities with the US model but there is far more simulation in universities in the US and far more faculty presence in practice settings to reduce some of this potential burden on clinical nurses. However, the US have the same concerns as the UK that clinical nurses can feel overwhelmed by student numbers, and there is some consternation around student nurses' preparedness for the role of a qualified nurse in both countries (Boyer 2012, Hunt et al. 2012).

Table I:2 below outlines a typical UK P/MH student nursing undergraduate course content/outline (pre 2018 NMC standards). As the content is nationally determined and the process agreed via the NMC it is reasonably standard unlike the USA which has greater variety in structure and content although also determined by the APNA.

Table I: 2 Example of a UK student P/MH undergraduate nursing course.
Year 1 Professional values, legal ethical framework of nursing, introduction to evidence based health care, record keeping, team working, person centred care, diversity, code of conduct. Generic nursing skills – hand-washing, blood pressure, communication, medicines, systems, anatomy and physiology. Health- sociology, psychology, policy, public health, health education and promotion, linked to the four fields of nursing mental health, learning disability, child and adult. Nursing - maybe field specific relationship skills, nursing theories, models, process, assessment, planning, implementation and evaluation.

Values. Theory twenty-three weeks Practice twenty-two weeks Annual leave seven weeks.
Year 2 Field specific - acute care, crisis intervention, early intervention services, low intensity psychological interventions, evidence based MH care and interventions, cognitive behavioural approaches (CBA) and brief interventions, person centred recovery focused care. Evidence based health care - research process. Safeguarding - duty of care, vulnerability, legal framework. Theory twenty-three weeks Practice twenty-two weeks Annual leave seven weeks.
Year 3 Complex needs - dual diagnosis, evidence based interventions, trauma, family based work, holistic approaches. Research dissertation. Management - preparation for staff nurse. Theory twenty-three weeks Practice twenty-two weeks Annual leave seven weeks. (Based on the existing P/MHN programme at Birmingham City University 2016 as approved by the Nursing and Midwifery Council UK).

There are several nursing qualifications available in the US in order to become a P/MH nurse. Students must firstly undertake a generic four year bachelor in nursing degree (American Nursing Association ANA 2014). There are a variety of requirements and regulations (National Nursing League NNL 2016) which are based on federal and state laws. Universities have far greater autonomy over the course provision, and like most graduate courses, students can choose their major and minor subjects. As in the UK, American student nurses are required to experience clinical placements. At a basic level the ANA (2014) suggest that this must be across the life span, however, unlike their UK counterpart, where clinical practice hours are set out by the NMC, the clinical experience is determined by the individual

university and then approved by the NNL (2016), and state and federal requirements also have to be met. There is no over-arching curriculum content but standards for P/MHN are set out nationally by the APNA (2014). Drew (2014) concluded that, educational emphasis on the core (Advanced Practice Registered Nurse) APRN – P/MH curriculum including pharmacology, physical assessment and pathophysiology along with the speciality focus on psychotherapy across the life span provided a skilled practitioner for a range of health services. The APNA (2016) describes the educational content of the P/MH nurse advanced practitioner registered nurse role in slightly broader terms as including human development, physical and MH assessment, the diagnosis of MH conditions, integration and implementation of care, psychopharmacology, psychotherapy, practice, evaluation, consultation and liaison.

In the US there is an emphasis on student choice and satisfaction and that may be explained through the course fees process. Until recently UK student nurses were in receipt of a bursary and their course fees were paid, since September 2017 this is no longer the case. This financial change may lead to a shift to a more American model in the near future, however, initial reaction has left the UK dealing with a significant reduction in nursing course applicants (Ford 2017, Merrifield 2017).

Whilst the expected outcomes for P/MH nurse education are clearly and easily identifiable having been prescribed by the NMC (2010a) and the APNA (2014), the process experienced by student P/MH nurses is far less easily captured. In the UK there was a brief window of time in the 1980s and early 1990s when the process that student P/MH nurses experienced during their course was seen as a key part of their

education (English National Board (ENB) of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1982), and examining and reflecting upon this was seen as integral to understanding how they 'related' to fellow humans. In the UK there has been a real shift away from this process approach in P/MH nurse education.

P/MH nursing has recognised that clinical supervision can help them process the complexity of their work and promote positive outcomes in therapeutic work with service users (UKCC 1996, McLeod 1997, Butterworth, Carson and Jeacock 1999, Teasdale, Brocklehurst and Thom 2001, Edwards et al. 2006; Dickinson & Wright 2008, White and Whitstanley 2010, Carthy, Noak and Wadley 2012, Care Quality Commission CQC 2013). This should not be conflated with the supervision provided for student P/MH nurses in clinical practice in the UK, which is supervision based on the achievement of competencies and summative assessment, there is no denying that an opportunity for 'clinical supervision' does exist within this provision, however, it is not a formal expectation or requirement for the Nurse Assessor to provide clinical supervision with a focus on intra and interpersonal relationships (UKCC 1996, McLeod 1997, Butterworth, Carson and Jeacock 1999, Teasdale, Brocklehurst and Thom 2001, Edwards et al. 2006; Dickinson & Wright 2008, White and Whitstanley 2010 Carthy, Noak and Wadley 2012, CQC 2013). The provision of clinical supervision for student P/MH nurses in the UK appears patchy at best (Felton, Sheppard and Stacey 2012, Maplethorpe, Dixon and Rush 2014). However, student P/MH nurses in the US do experience this type of clinical supervision from both their clinical practice supervisor and their faculty supervisor (APNA 2014).

Whilst the knowledge and skills being delivered both in the UK and USA P/MH nurse educational programmes make perfect sense, the process of learning and developing human relational skills, self-awareness, the ability to manage oneself, to be emotionally intelligent and resilient while working with highly traumatised people with very complex needs (Sweeney et al. 2016), is not transparent. In the new 2018 NMC Standards for registered nurse education they clearly state that specific communication and therapeutic skills much be evidenced at the end of the P/MH nursing programme to achieve registration. The emphasis on developing these therapeutic/relational skills seemed to have been situated in the clinical environment so these new standards may lead to a greater emphasis on educational process and academics providing more on this.

In the UK 50% of nurse education is delivered or spent in clinical practice settings. Orchard (1992) emphasised how the assessor's personal experiences, expectations and values may negatively influence student outcomes, and she recommended objective assessment strategies. Charleston and Happell's (2005) study focused on student nurses' perceptions of their experiences of support in the clinical environment, they found that students were consistent in identifying fear of the unknown as affecting their clinical experiences, specifically in relation to their mentors. In Henderson, Happell and Martin's (2007) work on the impact of theoretical preparation and clinical placement on student nurses' attitudes towards P/MHN they found a positive correlation to greater theoretical input about mental illness. Student nurses then had more self-reported confidence in dealing with a range of issues typical in MH and health care settings, for example, communicating with people who were highly anxious. However, they also found that clinical

placement had the greatest impact on the students in the study (these were student nurses undertaking an initial generic degree in nursing) but that the emphasis was on measuring increased skills and knowledge rather than exploring the students' experience in practice. Over quite a long period of time both of these studies demonstrated the importance placed on practice by student nurses. This is also true of student P/MH nurses in the US (Happell, Robbins and Gough 2008).

However, as Tummey and Tummey (2008) acknowledge MH services can be incredibly abusive environments, the disregard for people with MH problems in society can be reflected in MH services and staff can also experience that reduced status or value (Strang 2007). It is worth recognising that staff potentially working in abusive ways with service users may be likely to be equally abusive to relatively powerless student nurses. Bradbury-Jones, Sambrook and Irvine's (2007) work on empowering student nurses, demonstrated a lack of respect for student nurses from many nursing staff in clinical environments. They even used a metaphor for this phenomenon that 'nurses eat their young', to indicate the power differentials and abusive aspects of nursing (ibid. 346). Podmore (2012:42) indicates that it is 'fear of reprisals…, having to continue to work in the same environment…the novice level of skill and knowledge' and limited assertiveness that can lead student nurses to accept and become complicit in poor practice.

Positioning nurse educators more clearly in clinical practice, as Hurley et al. (2014:43) suggest, are useful mechanisms to enhance student P/MH nurse education and promote recruitment, whilst improving academic staff in 'currency and

relevancy to their teaching' and provide opportunities for collaborative research. However, ensuring that student P/MH nurses are appropriately and adequately prepared in not guaranteed.

This consideration of P/MH Nurse Education demonstrates that the NMC/APNA clearly influence content, but there are still concerns around nurse education, in the US these appear to be ameliorated to some extent, through nurse educators' strong links to work in the clinical practice setting. Clinical placements are recognised as highly impactful, assessor reliability in the UK is a major concern and the potentially abusive nature of P/MHNs towards student nurses in these environments remain concerning issues. The assessment process for future student nurses is under review by the NMC and details are not yet forthcoming. However, clinical supervision to support the development of values, therapeutic skills and reflective practice is being firmly re-positioned in nurse education within the new NMC standards for pre-registration nurse education in the UK (2018).

I:7 Summary and conclusion.

This introduction to the thesis has indicated the increasing complexity of P/MH Nursing and P/MH student nurse education, the need to be flexible and adaptable to an ever changing working environment, and an increasingly under resourced service. It also highlights some of the potential weaknesses in current UK P/MH nurse education, specifically around clinical supervision during the undergraduate

education period, the process of education and how student P/MH nurses learn to have therapeutic relationships with MH service users, although new NMC standards may well ameliorate some of these issues as they clearly respond directly to these concerns. There are issues around P/MH nurses ability to negotiate their role in relation to recovery versus restraint and with the increasing complexity of MH service user needs begs the question what motivates someone to become a student P/MH nurse, with not only these concerns, but also the context of constant change and uncertainty?

This introduction has set out to provide the background and context of this thesis by considering what P/MH nursing is; what the critical issues in P/MH nursing are; the history and development of P/MH Nursing; who P/MHNs are; who do P/MH nurses work with and how P/MH nurses are prepared for that work. The first formal chapter of this work will set out the rationale of this study, outline the aims and objectives of this work and clearly define the research questions. This thesis is focused on trying to find out why student P/MH Nurses choose P/MH nursing, what motivates student P/MH nurses to stay in their field of nursing and how their experiences might influence them to stay or leave. Chapter one will provide a review of existing work in this area.

Chapter 1 Literature Review.

1:1 Introduction.

This chapter will set out the rationale for this study, identify the aims, objectives and clearly state the research questions for this work. This chapter will outline the literature search strategy used and present a review of existing published materials relevant to the understanding and exploration of why student P/MH Nurses chose their field of nursing.

1:2 Rationale for undertaking the study.

The rationale behind this research was an attempt to understand what bought student nurses to P/MH nursing; had the participants considered their reasons, were they able to articulate these and what kept them continuing in their choice as future P/MHNs? There is limited empirical research in this area and therefore limited literature, part of the rationale is to add to existing knowledge and understanding of student P/MHNs reasons for choosing their field of nursing; contribute to improving their experiences; meeting educational and personal needs with greater effectiveness. Part of this desire to try to do something positive for student P/MHNs, incudes acknowledging their hard work, personal commitment, distress, difficulties

and joy whilst undertaking P/MH nursing studies and to listen, hear and tell their stories. Further justification for this research on a personal level, included academic curiosity, a desire to understand people's motivation and how this may emerge from human experience.

1:3 Aims of this chapter:

The Aims of this chapter are:

To clearly set out the objectives of this work.

To identify the research questions.

To demonstrate the literature search strategy.

To provide a review of existing literature on the thesis question area.

1:4 Objectives of this chapter:

The Objectives of this chapter are:

To clearly state the overarching research question.

To clearly state the supplementary research questions and explain their relevance.

To provide a descriptive route through the literature search strategy.

To present a review of published literature and research evidence around the identified research question and supplementary questions.

1:5 The aims and objectives of the study.

The aim of this study is to answer why student P/MH nurses chose P/MH nursing. In order to answer this question the objectives of the study are to consider what reasons do student P/MH nurses have for choosing P/MH nursing; once they have commenced their educational course what experiences keep them going and what experiences might influence them to leave.

1:6 Research questions.

The main research question of this thesis is – **Why do student P/MH nurses chose P/MH nursing**?

From a phenomenological perspective part of this work also considers how student P/MHNs perceptions of their experiences might influence that choice. In carrying out this work the data presentation and analysis chapters' focus on what the participants indicated in their semi-structured interview responses and in light of the

methodology, IPA (Smith and Osborn 2008) how this might be influenced by the experience of becoming a P/MH Nurse. Is this choice based on a desire to understand oneself and one's motives more effectively? How might this be influenced by the experience of becoming/being a P/MH nurse? Might it be a desire to learn how to help others and therefore oneself? However, these issues are explored in data analysis there is limited existing published work purely considering why student nurses choose P/MN Nursing. Therefore in order to understand why student P/MH Nurses chose their profession it is necessary and helpful to consider the following supplementary questions. Why do student P/MH nurses continue on their course? Why might student P/MH nurses leave?

Further questions are then asked in an attempt to explore why existing qualified P/MH nurses might undertake this work and why they might stay in nursing as a mechanism to explore strategies to retain student P/MH nurses; and on the other hand what might lead existing qualified P/MHNs to leave the profession; exploring existing literature on these further questions may also help to understand students' choice.

Therefore the literature review will address the initial main student P/MH nurse focused research questions, and consider the following supplementary questions to garner a greater understanding of student P/MH nursing choice. In order to find out - why might P/MH nurses do their work and stay in P/MH nursing? - This section will seek to determine what we already know about P/MH nurses' job satisfaction and retention - in other words why might P/MHN do their work? What do we already

know about P/MH nurses work engagement and intention to stay in P/MHN, what are the areas where P/MH nurses achieve greatest job satisfaction and engagement with work - in other words why might they stay in P/MH nursing? And finally where are P/MHNs lacking - in other words what do we already know about problems within P/MH nursing; what do we already know about P/MH nurses regarding the adverse effects of their work and why might P/MHNs leave their profession?

The next section of the chapter will set out the literature search strategy and review literature relevant in considering what might influence student P/MH nurses in choosing and discuss the questions identified above.

It is evident that there is some information on P/MH nursing reasons for choosing nursing; job satisfaction, retention, work engagement, intention to stay and reasons for leaving P/MHN but little on student P/MH nurses particularly in relation to career choice. Having carried out earlier work on this thesis and in order to reflect the recommendations from Examiners and in order to find answers for the research questions a further literature search has been carried out specifically to consider more recent literature.

1:7 Literature Search strategy:

Two electronic databases Cumulative Index to Nursing and Allied Health Literature

(CINAHL), and EBSCO host were searched for potential sources using keywords and a combination of search terms were used. These included psychiatric and mental health nursing, why choose nursing, reasons for; job satisfaction and retention; attrition; work engagement and intention to stay; burn out, compassion fatigue, vicarious trauma. Studies within the last ten years (2007 - 2017) were considered most pertinent, and older articles were excluded during the review. Following a review of the literature gathered it was possible to divide the evidence in to the following key sections, why do P/MHNs do P/MH nursing; or why do P/MH nurses stay in P/MH nursing; why are P/MH nurses likely to leave and why do student P/MH nurses choose P/MH nursing.

The initial search of five started with the following key words P/MH nursing; why choose nursing; reasons for. This produced 19,640 results; this search was then limited to English language only, academic journals, published between 2007 and 2017. This resulted in 4,445 articles. This search was then further edited using a major heading option of nursing students which provided 169 results. Of these 169 articles CPD (Continuing Professional Development), Opinion pieces and Editorials were further excluded. 29 articles were found to be potentially relevant to this study in terms of abstract and title.

The second search focused again on P/MH nursing; job satisfaction; and retention. This yielded 114, 092 results. The source type was limited to academic journals; dated from 2007 to 2017 in English language only and this reduced the list to 37,661. Due to the size of the results list this was subjected to a further advanced search

with the same key words but narrowing the search parameters to APNA with a further focus on manpower/statistics, CINAHL with parameters set at P/MH nursing and manpower again English language only and dated from 2007 onwards this resulted in 153 articles. These were further edited by excluding CPD articles, opinion pieces and editorials which resulted in 50 articles deemed to be potentially relevant to this study in terms of abstract and title.

Search three again focused on P/MH nursing and used the following key words, work engagement and intention to stay. Due to the very large results list a further advanced search was carried out using the same key words but focusing on manpower, statistics and trends and focusing the search on CINAHL and the APNA. This returned 550 articles. This list was then further edited again by limiting the results to English language, academic journals and dates of publication from 2007 to 2017 this led to 120 results this was further edited by excluding CPD, opinion pieces and editorials. This resulted in 31 articles deemed to be potentially relevant to this study in terms of abstract and title.

The fourth search again focused on P/MH nursing using the following key words burn out; compassion fatigue and vicarious trauma. A further advanced search was carried out which focused on statistics and trends, nurses as patients and nurses as a profession, this yielded 18,718 results narrowing the search parameters to between 2007 and 2017 limited this to 5,882 further limiting by excluding non-academic journals; opinion pieces, CPD and editorials non-English language reduced the returns to 2,656. This was then further edited by using psychiatric

nursing and job satisfaction as major headings. This yielded 92 articles.

The fifth search again focused on P/MH nursing using the following key words attrition and reasons for. This yielded 14,827 results narrowing the search parameters to between 2007 and 2017 limited this to 4,728 further limiting by excluding non-academic journals; opinion pieces, CPD and editorials non-English language reduced the returns to 3,444. This was then further edited by using student nursing as a major heading. This yielded no new articles.

From all five searches 192 articles were considered to have potential. The initial edit of these articles further excluded non P/MH student nurse studies and mental health service development and policy articles this further reduced the results list to 135 articles. This section considers what existing literature says about student nurses reasons for choosing P/MH nursing?

1:8 Question 1. Why do student P/MH health nurses chose P/MH nursing?

To date, there is some limited literature on motivation in student nursing; Moir and Abraham's (1996) work on why students wanted to become P/MH nurses indicated that they favourably compared it with the other options in nursing, particularly general nursing. Students who chose P/MH nursing indicated a strong preference for developing relationships with people over the 'task oriented' work required of general nurses; and they suggested that P/MH nursing had greater professional autonomy and focused on the experience of others (service users). In conclusion Moir and

Abraham (1996:298) found that P/MHN was seen as ‘involving therapeutic acumen and personal concern for patients.’

In Happell’s (1999) study of Australian student nurses preference for branches, where P/MH nursing was an undergraduate option, it emerged as a poorly regarded career choice. Of the 793 research participants involved only the geriatric and general surgical options were less popular than P/MH nursing. Happell (1999:482) identified the following reasons for the students’ lower preference: ‘lack of knowledge, experience or personal attributes; interest in another area of nursing; negative attitudes towards both the working environment and mentally ill people; sad, depressing or stressful nature of the work.’

Edward et al.’s (2015) survey on student P/MH nurses’ motivation to pursue their careers, surveyed over fifteen hundred student nurses in the United Kingdom and Australia and achieved a thirty-three percent response rate; over four hundred surveys were completed. Similarly to America, Australia offers a generic undergraduate nursing qualification with post registration specialisation in mental health. The United Kingdom offers field specific undergraduate courses, as mentioned earlier. Therefore, the student nurses surveyed in the UK were P/MH field specific students. Edward et al. (2015:4) found ‘personal experience of MH (such as a relative with an illness, or working with people who experience mental illness) enhanced student motivation for opting for a career in [P]MH nursing’. However, it is worth noting that this survey’s focus was on improving recruitment and retention to the P/MHN programme, so whilst the UK student nurses rated P/MH highly as their chosen field (not surprisingly as they had already chosen to work in this field) the

Australian student nurses undertaking the generic course indicated they would not chose P/MH nursing or were unsure: only thirty-two percent of these student nurses indicated that P/MHN would be an option for them. Edward et al. (2015) work indicates that student P/MH nurses opt for P/MHN because of personal experience, but that, in comparison to other fields, mental health remains an unpopular choice. The literature suggests that opting to become a P/MH nurse takes a certain drive to work in a particular way, however, the literature also hints that student P/MH nurses may have increased levels of exposure to MH problems, in family, friends or personally (Clarke 2008). The existing literature around student nurses' choice of field so far suggests that P/MHN is less popular than other fields of nursing.

In relation to student nurses, Jinks et al. (2014) found that 'significant numbers of (student nurse) entrants left due to domestic and ill-health problems' in the UK. Mackintosh's (2006) work stated that student nurses were idealistic in their beliefs about the caring nature of nursing. However, once they were exposed to nursing in the practice setting during their clinical placements, where many students witnessed poor examples of care, cynicism and emotional hardness they found this discordant with their previous beliefs. Some students were able to develop appropriate coping strategies, such as problem solving whilst others dealt with this by internalising the norms of the profession, such as emotional hardening or 'switching off'; Orton (2011) suggested that it was likely those students unable to do this, who continued to perceive a discrepancy between their expectations and experiences, who would withdraw from their course. Rhead (1995) had previously noted that clinical placements were a likely source of significant stress for student nurses. Kleehammer, Hart and Keck (1990) confirmed this, also reporting that the initial

clinical placement was the most stressful, and that a fear of making mistakes and carrying out clinical procedures were the most anxiety-provoking concerns for student nurses. Evans and Kelly (2004) noted that conflict between reality and the students' ideal practice on the ward, unwelcoming atmospheres and being reprimanded in front of staff and service users were the three predominant stressors for students while on placement. Alongside these studies, Last and Fulbrook (2003) found that if the student felt they were being given too much responsibility and were expected to contribute to the workforce, due to a lack of supernumerary status, the student would become extremely stressed. Deary, Watson and Hogston (2003) suggested that the coping mechanisms employed by students change throughout their course as their stress levels increase; they found, the use of less functional coping mechanisms increased as the students' course progressed.

In the USA as student nurses undertake a generic undergraduate programme before specialising at Masters level as P/MH nurses retention issues appear to arise from different causes. Williams (2010) acknowledges that students may react negatively to significant periods of time spent within university and only limited clinical practice time, as there is no requirement in the states for student nurses to undertake fifty-percent of their course in practice, unlike in the UK (NMC 2010a). Apparently, nursing programmes in the United States have seen a decline in students who are completing their nursing degrees from approximately seventy percent to about fifty percent during the last decade (Sayles and Shelton 2003, Wells 2007). There are differing reasons for attrition in the US to the UK; McCallum's work (2012) acknowledged the impact of financial pressures and increasing time spent in employment that is much more evident in the US. However, as in the UK,

McLaughlin (2010) found a dissonance between student nurses' expectations or aspirations for nursing and the reality. There is much less reference to personal health issues in the US in relation to undergraduate nursing students (Griswold 2014). However, when considering specialist P/MHN course attrition there is no available data for the student programmes but subsequently once in employment retention rates are relatively poor in part due to associated stigma, poor recompense and stress (Hyde 2013).

In their study of students' perceptions of the role of the P/MH nurse, Rungapadiachy, Madill and Gough (2004:714) found that students identified six key ways of working in clinical practice. There was an emphasis on administrative and physical hands on caring, an expectation to carry out more psychologically orientated and therapeutic work than was achievable, and a recognition of 'poor role models' in the practice setting. In the same study the authors identified four aspects of poor practice that student P/MH nurses raised in their study which are worth mentioning here.

These were, 'alleged malpractice, non-involvement, lack of skill and a negative approach to care' (ibid. 719). The students identified physical threat and physical abuse; staff who did as little as possible; staff who spent long periods of time in the office that service users were not allowed access; staff chatting over coffee; staff demonstrating a negative approach to care indicating that there 'wasn't anything more that you could do' (ibid. 719). Several of the P/MHN students involved in the study indicated that qualified nurses appeared to lack the necessary skills to cope with the client group, with one saying: 'I think for some people it's too difficult to have

to deal with other people's problems' (ibid. 719). Qualified nurses typically sought to ensure some space and time away from service users as a coping strategy. A negative approach to care was demonstrated in the dismissive response students received when seeking to offer therapeutic interventions, qualified staff insisting that the patient would just forget their work the following day. Staff wouldn't make an effort at all in some situations, students often observed staff reading newspapers and despite service users requesting a walk outside they would be denied. Administrative work in the unit office was often seen as being of greater importance than time spent with service users. One student in the study indicated that for many qualified staff P/MHN had just become 'work to pay the bills kind of thing' (ibid. 719).

The more recent literature associated with considering why student P/MHNs chose their profession falls into three categories initial student P/MHN choice, retaining student P/MHNs once they have commenced their course/encouraging student nurses to choose P/MHN from other fields and stress.

1:8i Initial student P/MHN choice.

Gunusen et al's (2017) qualitative study looked at thirteen students who had chosen a P/MH nursing internship firstly, from several nursing options, and indicated that this was directly due to the students perception of the care they could deliver, their experiences of working with P/MH nurses and personal reasons. Of the eleven students who indicated that P/MH nursing would be their last choice their reasons

appeared to be largely based on stigma associated with working with the mentally ill and a lack of knowledge and awareness of mental health issues.

Porredi et al's (2015) study of 116 undergraduate nursing students who had undertaken clinical placements and a course of study in mental health found that almost a third of the students were not interested in pursuing a career in P/MH nursing. Porredi et al (2015) did indicate that the positive return rate, over 60% of students in the study indicating that they would consider P/MHN as a career option, may have been due to positive experiences in clinical practice. However, they (Porredi et al 2015) expressed some concerns around the negative stereotypical beliefs many nursing students held towards people with mental health problems that they, 'are unpredictable, cannot handle too much responsibility and [are] more likely to be violent' (p152).

In Ong et al's (2017) study of five hundred nursing students from Singapore on their nursing choice, they found this was affected by pre-nursing school factors such as ethnicity, current education, parental wishes, having personal/familial experience of mental illness, prior work experience in mental health, interest in P/MH nursing and having undertaken a psychology module, much more than teaching methods and clinical exposure during nursing studies. They also found that students from both Indian and Malay ethnicities chose P/MH nursing more readily with Indian student nurses showing a higher uptake. They also found that positive perceptions of job prospects, positive attitudes towards psychiatry and extraversion were indicators of P/MH nursing choice.

The purpose of Jansen and Venter's (2015) study was to identify the factors preventing undergraduate nursing students in South Africa (SA) from choosing P/MH nursing as a career. 27 final year nursing students situated in Bloemfontein (SA), voluntarily participated in the research. The following categories emerged from the content analysis of the data: personal factors, working environment, unprofessional behaviour, learning environment and the unclassified category. Jansen and Venter (2015) concluded that P/MH nursing as a career choice is in a predicament and nursing schools need to implement practical strategies to recruit future nurses for this field.

Stevens, Browne and Graham (2013) study investigated the career preferences of undergraduate nursing students by comparing preferences at the start, middle, and end of a Bachelor of Nursing programme. Overall the preferences in a cohort of 150 students who began their Bachelor of Nursing studies in 2007 and completed in 2009, showed that P/MH nursing is one of the least desirable career choices for most nurses at the start of their course and remains so as they approach graduation.

The literature review so far suggests that perceptions of quality patient care (Gunusen et al. 2017); positive clinical placements (Porredi et al. 2015); pre-nursing school factors, for example experience of mental health issues (Ong et al. 2017) are significant factors in student P/MH nurses choosing their profession. The next section of the literature review looks specifically at published work on retaining student P/MHNs once they have commenced their course/encouraging student nurses to choose P/MHN from other fields.

1:8ii Why might student P/MH nurses stay on their course? Retaining student P/MHNs once they have commenced their course/encouraging student nurses to choose P/MHN from other fields.

In Charleston and Happell's (2005:304, 305, 308 and 309) study of student experiences of education they identified the positive benefits to students from support in clinical practice as, 'opportunity to access a competent role model; enhanced learning and problem solving because of this relationship; supported transition into practice and increased confidence level'. However, they also acknowledged that limited work had considered the P/MHN student perspective. Their study was carried out with twenty students based in a clinical area with a 'reputation for providing a supportive learning environment. Students identified their main concerns as, 'coping with uncertainty,' or their ability to work in P/MH nursing. These linked into the students, 'fear of the unknown,' as well as knowing what to do in a different clinical environment; alongside being adequately supported by assessors in practice. Students found how welcome they felt, 'the professionalism of staff and the degree of support during the practice,' had a significant outcome on their overall experience.

> Students expressed being more relaxed and able to learn when the attitudes, behaviour and support of the [assessor] were welcoming, nurturing and inclusive of the student…where students were left to fend for themselves without support or direction they expressed feeling distressed and overwhelmed. The students clearly identified fear and misapprehension as

complicating factors in learning and developing clinical competence (Charleston and Happell 2005:309).

Williams et al. (2009) study used a process of reflective journaling alongside discussion and support through clinical supervision, to study 28 graduate student P/MH nurses during their educational course, to determine what might keep them in P/MH nursing. The participants had reflected on their personal feelings, prejudices and difficulties in being present with people with mental health problems. They analysed twenty-eight nursing students reflective journals and overall they found that over time their students, 'gained a self-awareness that enabled them to become more genuine in their interactions with patients' (p42). Williams et al. (2009:36) stated that, 'positive correlations were found between manager caring and peer caring and their relationships with RN's (Registered Nurses) job satisfaction and intent to stay both in a position and in the profession'. However, the evidence to support that claim was limited to participants comments such as, 'I now feel comfortable in this setting' (p39), and the participants obtained, ' a clearer meaning of their role as practitioners in a psychiatric setting' (p41).

Happell's (2008) study sought to explore how impactful clinical experience on undergraduate student nurses could be. She gathered 783 pre-test and 688 post-test questionnaires from nursing students across Victoria in Australia. She employed the Psychiatric/Mental Health Clinical Placement Survey tool. The study (Happell 2008) showed a marked increase in intention to apply for a graduate programme in P/MH nursing following a clinical placement in P/MH nursing. Happell's (2008) work also indicated that post placement testing showed participants felt prepared to work

in P/MH nursing; and they were encouraged by qualified P/MH nursing staff to consider P/MH nursing as a career. The implication of Happell's (2008) work is that undergraduate generic nursing students need more exposure to working specifically with people with mental health problems and P/MHNs in order to consider P/MHN as a career.

Granados-Gamez et al's (2017) study of one hundred and ninety-four undergraduate nursing students also emphasized a need for nursing students to have direct interaction with people with mental health problems. Granados-Gamez et al. (2017) carried out three questionnaires, the Attribution Questionnaire - 27, the Questionnaire of Beliefs and a socio-demographic questionnaire. Overall they found that those student nurses who had direct experience of mental illness held far more positive attitudes and beliefs towards people with mental health problems.

The purpose of Thongpriwan et al's (2015) study was to describe undergraduate nursing students' attitudes toward P/MH nursing and how these attitudes influenced their professional career choices in P/MH nursing. A descriptive, online survey was used to examine students' perceptions of P/MH nursing. A total of 229 junior and senior nursing students were recruited from eight nursing colleges in Midwestern United States to participate in the survey. Although the students were of different ages, genders, ethnicities, and nursing programmes Thongpriwan et al. (2015) did not report significantly different perceptions of, around the students' knowledge of mental illness; negative stereotypes; interest in P/MH nursing as a future career; and beliefs that P/MH nurses provide a valuable contribution to consumers and the

community. However, they did find that negative stereotypical beliefs held and interest in a future career in P/MH nursing were significantly different between students who had P/MH nursing preparation either in class or in clinical practice and students who had not. They concluded that the more exposure students have to P/MH nursing through clinical experiences, theory classes, and previous work in the field, the more prepared they feel about caring for persons with mental health issues.

In 2015 Walsh carried out a study within a P/MH nurse training institution and with staff from a Mental Health Trust in England. The study collected both survey and interview data through focus group work. A thematic analysis led to the development of three main study themes. Walsh's (2015) work found the following processes were difficult for P/MHNs, the transition to qualified registered nurse; learning from experience, managing violence and aggression; working effectively with victims of sexual abuse or those who have a diagnosis of personality disorder. Whilst the study found some evidence to suggest the development of positive values in student P/MHNs there was a perception that newly qualified P/MH nurses lacked confidence, study participants also expressed doubt about whether it was possible to prepare someone for practice completely, Walsh (2015) also found that the relationship between student and the mentor is critical to the quality of practice learning. His work confirms the evidence that clinical practice and having a positive experience when working with P/MHNs is an influential factor in retaining student P/MHNs.

However, overall what the literature indicates so far is that P/MHN is not a popular career path; this raises questions about what attitudes and beliefs may divert or

attract students to this specialisation. Happell, McAllister and Gaskin (2014) carried out research which involved a survey of undergraduate nursing students at a regional university in Australia to clarify the nature of relationships between attitudes (for example, the value of mental health nursing, stereotypes of people with mental illness) and how they may be antecedents to considering P/MHN as a career path. Happell, McAllister and Gaskin (2014) ascertained that anxiety surrounding mental illness leads to less interest in P/MHN as a future career and suggests that anxiety is partly due to negative stereotypes, and countered by preparedness for the P/MHN role. Beliefs on how P/MHN can make a valuable contribution to people's well-being did not affect interest in pursuing P/MHN. Happell, McAllister and Gaskin (2014) concluded that their findings reconfirmed the need to reduce anxiety about mental illness through educational approaches that effectively prepare students for P/MHN, alongside challenging negative stereotypes of mental illness.

Trenoweth's study (2013) sought to explore the psychological and personal changes of student P/MH nurses over the first two years of their pre-registration P/MH nursing programme. Students from two P/MH nursing cohorts at a London university were invited to participate. A semi-structured interview was used and the participants were asked to talk openly about their experiences. A total of seventy-two interviews were conducted. Trenoweth's (2013) results indicated that participants moved from feeling uncertain, to increasing awareness and understanding of self and others, and, ultimately, feeling more accomplished in relation to their occupational world. Trenoweth (2013) concluded that P/MHN educators need to support students in developing their confidence and perceptions of self-efficacy and recognise individual differences in student's responses to uncertainty.

Cleary, Horsfall and Happell (2012) study focused on the difficulty in attracting graduates of nursing programmes into P/MH nursing and concluded that remains an ongoing challenge. They claim that undergraduate nursing students do not always regard P/MHN favourably for future employment. In Australia, where this work was undertaken, undergraduate nurses are employed as assistants in nursing (AIN) in mental health settings. Cleary, Horsfall and Happell's (2012) work indicated that there was no published research exploring their role, the career trajectory into P/MHN, or its effectiveness as a recruitment strategy. Cleary, Horsfall and Happell (2012) carried out a literature review to delineate factors that might contribute to the desire of AIN to work in P/MHN. Nine factors were identified: acceptance by nurses, fitting in with the culture, managing the workload, developing a realistic appraisal of the effectiveness and limits of psychiatry, constructive learning from direct interpersonal interactions with clients, practicing communication skills, being supported in a structured way, working with positive role models, and the overall quality of the employment setting. Cleary, Horsfall and Happell (2012) concluded that a comprehensive understanding of these factors can enhance the experience of undergraduate nursing students working as AIN, and potentially increase recruitment into P/MHN.

In Happell and Gough's (2009) work they found that negative attitudes toward people experiencing mental illness and P/MH nursing as a career option had previously been recognized as a major barrier to sustaining an adequate P/MH nursing workforce. Their observational study explored the relationship between 688 undergraduate nursing students' attitudes relevant to the mental health field, preparedness, and career preferences after they had completed a mental health

placement. A comparison was also made between the self-reported attitudes, beliefs, and preferences of two groups of students, one with and one without relevant clinical experience, and a clinical evaluation survey, were explored. Happell and Gough (2009) argued that the findings have direct implications for P/MH education. Their work showed a strong association between educational preparation, placement experiences, and students' attitudes toward P/MH nursing and consumers of mental health services. Their findings indicated that students with clinical experience felt significantly more prepared for employment in the mental health field and significantly less anxiety surrounding mental illness than did students without clinical experience.

Happell (2009) also carried out a state-wide study with undergraduate nursing students in Victoria, Australia. This study measured students' attitudes toward people with a mental illness and toward P/MH nursing and their sense of preparedness for mental health practice. A questionnaire was administered at two time points; the first time point was following completion of the P/MH nursing theoretical component, and the second was following the completion of clinical experience. An additional scale was added at the second time point to evaluate students' opinions about their clinical placement. The findings indicated significantly different attitudes and opinions depending on the university students attended. The amount of theory undertaken in the course accounted for some of this variance. However, Happell (2009) contended that the students taking courses with a larger theoretical component tended to demonstrate higher scores (suggestive of more favourable attitudes) on all of the subscales, and that these differences were sustained following the completion of the clinical placement. These findings suggest

that the amount of theory students receive in P/MH nursing may be more influential than existing literature suggests.

Happell (2008) also carried out earlier survey work on 703 undergraduate nursing students designed to measure their satisfaction with P/MH nursing clinical practice and identify factors influencing this, for example length and type of placement, time spent with a preceptor. A questionnaire was administered to undergraduate nursing students in Victoria, Australia, at the conclusion of their clinical experience in mental health. Happell's (2008) findings demonstrated a high level of satisfaction, particularly in feeling welcomed, oriented and supported, and having appropriate opportunities for patient care. Happell (2008) found that students' views were influenced by the duration and type of placement and time spent with a preceptor. She suggests that the findings from this survey provide useful intelligence around the structuring of positive P/MHN clinical experiences in nursing education.

Again earlier work carried out in Australia by Henderson, Happell and Martin (2007) examined the level of, and factors contributing to, undergraduate nursing students' satisfaction with clinical experience. Henderson, Happell and Martin (2007) administered a survey to undergraduate nursing students. Their findings suggested that the provision of support and the ability to become actively involved in patient care are the two most important factors affecting the students' perceived quality of clinical placements. However, there was a marked difference between community and in-patient clinical experiences. The survey results indicated that students preferred in-patient clinical placements because they were more actively involved in

patient care and better able to meet their learning objectives.

Kirkbakk-Fjaer, Andfossen and Hedelin (2015) carried out a qualitative study in order to describe fifteen preceptors' expectations of nursing students' preparedness before they entered the psychiatric field. Their findings show that preceptors were concerned about the nursing students' will and ability to reflect on and exercise knowledge for, managing the student role and themselves; for adapting their perspective on humanity; for their understanding of illness and how they interact with people with mental illness. They concluded that the preceptors expect nurse educators to ensure students have sufficient theoretical knowledge as well as assessing the students' personal maturity prior to ‘allowing’ the student entry to working in P/MH nursing.

This section of the literature review indicates clearly that clinical placements and education on mental health issues directly impact on student nurse choice, developing confidence and efficacy as well as reflective journaling and clinical supervision are positive student P/MHN retentive factors. On generic undergraduate nursing courses this exposure to P/MH nursing can and does have a positive effect on student nurses considering P/MHN as a career, but there is little data whether this translates into actual career choice. Kirkbakk-Fjaer, Andfossen and Hedelin (2015) work on preceptors’ expectations also indicates that P/MHN educators need to ensure that student nurses who have clinical placements in mental health care settings are suitably prepared. A consistent factor in the literature that appears to negatively impact on student P/MH nurses is the effects of experiences of stress.

The next section of the literature review considers stress in student P/MHNs and the impact on career choice and retention.

1:8iii Why might student P/MH nurses leave?

The literature and context considered in relation to P/MH nurse education, earlier, suggest that there is a dilemma in terms of what the actual educational provision is for student P/MH nurses and whether it is suitable to meet students' expectations and enable them to become compassionate and caring nurses. Rhodes and Bouic (2007) found 'attrition from P/MH nursing programmes occur when students establish the reality of the job (stressful, shift and weekend working, travel) and it doesn't match their preconceived ideas and beliefs about the job' (p35). They contend that providing a summer school for candidates prior to commencing nursing studies in the UK led to a reduced attrition rate. Like the work of Rhodes and Bouic (2007) Happell, McAllister and Gaskin (2014) and Thongpriwan et al. (2015), also argue for enhanced education on mental health issues for student nurses.

In 2004 Tully examined causes of stress and how student P/MH nurses coped with these and she found that students had significantly higher than anticipated levels of stress. According to Tully (2004) several of the students were at risk of developing a physical or psychiatric illness. Pryjmachuk and Richard's (2007) study also investigated stress among pre-registration nursing students. Their study explored student nursing field differences in terms of where their stress originated, what the

levels of stress they experienced were, and what mechanisms the student nurses used to cope. They carried out a survey of all nursing students in a university in Northern England, using a range of measures including the Student Nurse Stress Index, General Health Questionnaire and the Coping Inventory for Stressful Situations. They found that student P/MH nurses were different from the child, learning disability and adult student nurses in relation to the quantity and characteristics of the sources of stress they faced, the levels of stress they experienced, and the ways in which they coped. Pryjmachuk and Richards (2007) suggested that these differences were helpful to the P/MHN students' well-being and presented the idea that 'the concept of 'hardiness'- especially its focus on a sense of being in control' – helped explain their findings.

Nolan and Ryan (2008) carried out a multi-method study on twenty-eight P/MH nursing students. They initially administered the General Health Questionnaire (GHQ 28). Their findings indicated that sixteen out of twenty-three respondents experienced mild to severe stress. Overall the study suggested that potentially forty-eight percent of student P/MH nurses have stress levels above those likely to remit without intervention. Nolan and Ryan (2008) also found that relationships in the clinical environment worked both ways; when poor or unsupportive becoming a source of stress; conversely when positive and supportive relieving stress. Participants in the study also referred to matching their competence with levels of responsibility as a source of stress, the participants who indicated this aspect of further stress were fourth and final year students specifically. Workload issues also emerged as a potential stressor, again reasonable demands and some level of perceived control over personal workload were viewed favourably, whilst lack of

control and a heavy workload were identified as stressors along with academic and clinical schedule conflicts.

Freeburn and Sinclair's 2009 paper reported research outcomes of a study into personal stress experienced by P/MH student nurses undertaking a diploma programme in Ireland. They used a phenomenological research approach. Freeburn and Sinclair's (2009) work found that both the students' internal and external worlds, were impacted by their stress experience and they argued that that this potentially lessened the students functioning, inhibited their growth and development. Freeburn and Sinclair (2009) suggest that this knowledge had implications for lecturers, personal tutors, nurse educationalists and nursing curricula. They argued for more proactive approaches to the provision of guidance and professional support for both students and staff.

Galvin et al. (2015) interviewed twelve P/MH nursing students as part of their qualitative study on the stress student P/MH nurses experienced during their course. According to Galvin et al. (2015) the participants found academic demands unbearable at times particularly during clinical placements. This work also found that some of the participants experienced negative attitudes towards them from staff in the clinical environment. Galvin et al. (2015) also noted that younger student nurses were more likely to report feeling overwhelmed on their initial placements, and were especially challenged when trying to raise concerns about the quality of nursing care and services specifically in in-patient areas.

Alzayyat and Al-Gamal's (2016) work considered sixty-five undergraduate nursing students from five universities in Jordan. Pre and post psychiatric clinical placement tests were carried out. These tests included the Perceived Stress Scale and the Coping Behaviour Inventory alongside demographic data gathering. The findings showed that those student nurses who employed avoidance or transference coping strategies were likely to experience higher stress levels. Student nurses from lower socio-economic classes were also likely to experience higher stress levels, specifically in relation to financial concerns. Interesting like Nolan and Ryan's (2008) work this study also found that final year undergraduate nursing students experienced higher stress levels both in terms of patient care and professional knowledge and skills. Alzayyat and Al-Gamal (2016) suggest that this is due to greater professional demands, students own higher expectations and greater empathy and insight into being a service user.

The literature acknowledges student P/MHN career choice associated stress. Rhodes and Bouic's (2007) work acknowledges that the stress in relation to the realities of nursing can lead to student attrition. Other studies (Nolan and Ryan 2008) recognise health issues for student P/MHNs associated with high stress levels. Pryjmachuk and Richards (2007) also recognise potential 'caseness' but contend that student P/MHNs have a developed hardiness that can maintain them. Final year students are particularly at risk as are younger students and greater support may be necessary.

Most of the existing associated literature helps to consider what may keep student P/MHNs going on their educational programmes or leads to reduced retention rates, this is relevant to this investigation as it does provide some initial insights and helps to consider possible motivation for student P/MH nurses, however, literature on that specific aspect 'why they chose P/MHN' remains limited. In summary the literature on why student P/MHNs choose P/MH Nursing indicates that significant factors are personal experience of mental health issues (Edwards et al. 2015) and Ong et al. (2017) found that pre-nursing course factors such as ethnicity, interest and prior experience of working with and learning around people with mental health issues were positive indicators of P/MHN choice. The relevant associated literature suggests what appears to keep students engaged with their nursing courses includes the therapeutic relationship with mental health service users; positive clinical placements which include good role models and mentor – student relationships; enhanced theoretical understanding; improving confidence and efficacy over time (Trenoweth 2013); professional guidance and support (Freeburn and Sinclair 2009); reduced anxiety regarding mental illness; Pryjmachuk and Richards (2007) also suggest that student P/MHNs have a hardiness that keeps them going which is different to other fields of nursing despite similar levels of stress. This next section of the literature considers why qualified P/MHNs might stay in nursing and explores whether this could help provide some understanding of student P/MHNs initial choice.

1:9 Question 2. Why might P/MH nurses choose P/MH nursing and stay in P/MH Nursing?

Johnston et al's (2016) work on stress in health care professionals may provide a useful start point to consider why all nurses, not just P/MHNs remain, in what can be a difficult and demanding profession. They examined physiological and psychological effects of stressors and of work stressors in nurses. Over two nursing shifts, 100 nurses rated their experienced stress, affect, fatigue, stress and nursing tasks on electronic diaries every 90 min, heart rate and activity were measured continuously. The results showed that heart rate was associated with both demand and effort. Johnston et al. (2016) concluded that in predicting psychological and physiological stress nurses' real time appraisals were the most important factor. Their work also indicated that when effort was high, perceived reward reduced stress, and that notion of perceived reward may be a relevant factor in why P/MHNs remain in nursing.

Dickens, Sugarman and Rogers (2005) work on P/MH nurses' perceptions of their work environment found evidence of some good supervisor support, but limited autonomy, alongside an inability to innovate or therapeutic risk take due to increasing levels of bureaucracy. However, their work failed to address the implications of this other than to suggest that further work was recommended.

Carthy, Noak and Wadley (2012) acknowledge the risks of occupational stress and burnout, as do White and Whitstanley (2010), Dickinson & Wright (2008) and earlier work in this area by Edwards et al. (2006), Teasdale, Brocklehurst and Thom. (2001), Butterworth, Carson and Jeacock (1999) and McLeod (1997). These investigations present evidence to support clinical supervision as a strategy to

manage this and promote good P/MHN practice. These studies have clearly established risks to P/MH nurses and situate these within a stress and burnout framework.

Duffin (2009:21) reported on a small survey on qualified P/MH nurses as to why they remained in P/MH nursing a sample stated,

> ‘There is a deep humanity underpinning the relationships we have with patients.’
>
> ‘Only in mental health do you meet such amazing and complex individuals.’
>
> ‘A good nurse can make a tremendous difference to entire families.’
>
> ‘No shift is ever the same – I never get bored.’

Alexander, Diefenbeck and Brown (2015) carried out a detailed phenomenological research study with eight seasoned P/MH nurses to explore their career choice and longevity in P/MH nursing. In terms of the nurses reasons for choosing P/MH nursing their study indicates that the interest developed prior to or while in nursing education, this is not dissimilar to student P/MH nurses reasons according to Ong et al. (2017). Alexander, Diefenbeck and Brown (2015) also indicated that choice was related to personal relevance, again matching results found for student P/MH nurses by both Edward et al. (2015) and Ong et al. (2017). They also found ‘validation of potential’ a determining factor. The qualified nurses’ longevity of career was linked to ‘over-coming stereotypes to develop career pride, positive team dynamics and remaining hopeful’. For student nurses the literature indicates that an inability to overcome

stereotypical issues around people with mental illness were an influencing factor in not choosing P/MH nursing (Happell and Gough 2009, Happell, McAllister and Gaskin 2014, Porredi et al. 2015, Thongpriwan et al 2015, Granados-Gamez et al. 2017, Gunusen et al. 2017). Positive team dynamics and hopefulness were also indicated in literature around student P/MH nursing choice and retention (Cleary, Horsfall and Happell 2012, Walsh 2015, Gunusen et al. 2017).

Beckett et al. (2013) carried out action research in a newly developed mental health setting, they facilitated a series of 'away days,' initially with the nursing team and then other members of the multidisciplinary staff team to encourage person centred practice. Transformational leadership principles were adopted in the facilitation of team activities underpinned by strengths and solution-focused practices, staff were positive and participated well in practice development activities. The project resulted in the creation of a development plan for the ward, which prioritised five key themes: person-centred care, personal recovery, strengths-based principles, and evidence-based and values-based care. Beckett et al's (2013) work highlighted the importance of leadership which 'parallels the ideals promoted for clinical practice' in P/MHN to promote job satisfaction.

Nakakis and Ouzouni (2008) earlier work reviewed existing literature and confirmed that a variety of factors influence stress and job satisfaction of P/MH nurses. Among these, clinical leadership and quality inter-professional collaboration between nurses and doctors and amongst nurses are particularly important. Nurses' job satisfaction was found to be influenced primarily by psychological stress and the quality of

clinical leadership.

Hautala-Jylha, Kikkonen and Jylha (2007) sought to analyse and describe the conceptions of patients and personnel concerning the patient-nurse relationship in psychiatric post-ward out-patient services. They particularly noted in P/MH nursing, that the significance of the patient-nurse relationship needs to be emphasized. In a successful and collaborative patient-nurse relationship, the patient learns to care for him/herself and to restore interest in taking care of him/herself and surviving in everyday life, concomitantly this can be a positive factor in P/MHN job satisfaction.

Van Bogaert et al. (2013) suggest that burnout and work engagement are two sides of one coin. Health care staff who have a great deal of energy, are enthusiastic about their jobs and are absorbed by their work are described as being work engaged. Van Bogaert et al. (2013) investigated the relationship of nurse practice environment aspects and work engagement (vigour, dedication and absorption) to job outcomes and nurse-reported quality of care variables within teams using a multilevel design in psychiatric inpatient settings. Positive nurse practice environment aspects (good team relationships, involvement in work related decision making, appropriate resources and support) were associated with work engagement, and in turn work engagement was associated with job satisfaction, intention to stay in the profession and favourable nurse-reported quality of care.

Van Sant and Patterson (2013) carried out interesting work on the risks to P/MHNs

of interpersonal connection with patients' emotional pain and psychological distress. In their study they found connectedness to be a process and personal decision that, with self-awareness and individualized self-protective/self-separating strategies, can enhance patient healing as well as nurse satisfaction and growth. The ability to make an interpersonal connection may be a significant factor in why P/MHNs stay in their profession.

McAllister, Happell and Bradshaw (2013) work on the strengths of P/MH nursing carried out a thematic analysis on P/MHN leaders in Australia, experiences of meaningful work. The participants articulated that they found 'intrinsic rewards' in their work; making genuine connections with patients and working therapeutically were valued highly and clearly meaningful. However, in Mehrnoosh et al's (2015:551) work whilst they acknowledged that, 'the therapeutic relationship is widely accepted as the basic core and essence of psychiatric nurse's role and is thus essential for providing quality mental health care'; their study of 15 P/MH nurses found that,

> despite the widely claimed importance of the nurse-patient relationship in psychiatric settings, this relationship is powerfully influenced by individual and organisational factors that have not been considered adequately in previous research', and that this crucial relationship is mostly unseen and 'in the shadow.

Much of the work on why P/MHNs leave the profession includes discussion of organisational factors such as stress, however this study by Hubbard, Beeber and Eves (2017) provides an alternative perspective. Hubbard, Beeber and Eves (2017)

work revealed that whilst exposure and vulnerability to secondary traumatisation was evident in a group of P/MH advanced practice nurses, this preceded empathic engagement, reaction, and alteration/transformation. They suggested that conditions leading to secondary traumatisation could have a positive outcome in P/MHN. They concluded that in order to provide good quality patient care P/MHNs need to recognise secondary traumatisation symptoms and receive reflective clinical supervision. In light of this work the suggestion is that along with empathic engagement; providing quality patient care and reflective clinical supervision may keep P/MHNs at work.

The literature indicates that P/MHNs are more likely to stay in the profession if there is good clinical leadership, good team working, an involvement in decision making, effective support, supervision and appropriate resources however the evidence indicates that the nurse – patient relationship is also a, if not the most, highly significant factor. These may also be aspects of work that student P/MHNs are looking for in choosing P/MH nursing, there are clear correlations with the literature on student P/MHNs around quality patient care and career choice.

1:10 Question 3. Why might P/MHNs leave the profession?

In this section of the literature review it may initially be useful to consider the state of nursing globally. An example of the research being carried out into nursing demonstrates that nursing appears to be heading into a period of crisis. Goodare's (2017) work sought to decrypt what determining factors contributed to all nurses

leaving the clinical facet of the profession. Goodare's (2017) primary argument is that nurses encompass the largest professional constituent of the health care workforce in most countries, resulting in the impact of a shortage of these professionals, as immense. A global shortage of nurses is here, and the margin in the reduction of these health professionals is thought to be worse than any of the preceding cyclical reductions. More than half of the nursing profession feel they are underpaid and overworked, resulting in the likelihood of patient's needs not being met significantly increasing. Lengthy hours, quality of working environments, lack of leadership and the ageing population and workforce, can all be seen as influential factors. Goodare (2017) suggests this is likely to leave the nursing profession in a situation of calamity. Goodare (2017) concludes that in light of the predicted global demand for nurses over the next decade, the departure and retirement of the existing nursing workforce will potentially result in the loss of significant and treasured experience and organisational knowledge, weakening the capacity and capability of the nursing profession.

In Europe nurse job satisfaction, stress and burnout have also been found to have significant correlation with intention to leave. The UK has one of the highest rates of nurses reporting burnout across Europe (Heinen et al. 2013). There are a number of risk factors associated with job dissatisfaction and stress which are outlined in Health Education England's 2015 report. Stress and burnout are particularly high in young, newly qualified nurses, where turnover rates tend to be high in the first year of qualification and remain high, or even rise, during the second year of service before declining' (HEE 2015). In a European nursing survey, 42% of UK nurses reported burnout (the highest of all ten European countries surveyed), compared to the

European average of 28% (Heinen et al. 2013). High levels of burnout have been documented in the healthcare professions, especially nursing in the US too (Continuing Education for Health Care Professionals 2014).

This earlier work by Decola and Riggins (2010) indicated the problems that are currently emerging in nursing. They carried out a survey of 2203 nurses in 11 countries. Their results showed that 92% of the nurses surveyed said they face time constraints and 96% said that spending more time with individual patients would have a significant impact on patient health. Forty-six per cent of nurses said their workload was worse today than it was 5 years ago. While only 53% of nurses said it is very likely they will be practicing nursing in 5 years, national differences did exist. Decola and Riggins (2010) concluded that these conditions contributed to nurses' lack of firm commitment to their profession.

When the psychological well-being of nurses was analysed as early as 2006 by the RCN, their study found that nurses' levels of psychological well-being had worsened since a previous study carried out in 2002 (RCN 2002). Nurses' psychological well-being appeared worse than that of the general population. Fourteen percent of nurses were psychologically healthy but experiencing some difficulties; twelve percent were experiencing a broad range of difficulties; or more intense problems in particular areas. Fourteen percent were experiencing raised levels of distress, where some action may be required in terms of seeking medical help. Johnson et al. (2018) considered mental health care staff's well-being and burn out in the UK, they found rising levels of burnout alongside worsening well-being and linked these two

concerns to poorer quality and safety of patient care, higher absenteeism and higher turnover rates.

This section reviews existing literature which discusses factors which lead to P/MHNs dissatisfaction with their profession and why they might leave nursing is considered. Ascertaining why qualified P/MHNs might leave the profession might provide some insight into why student P/MHNs initially choose the profession – for example if P/MHNs are dissatisfied with their ability to offer patients a therapeutic relationship, the therapeutic relationship could potentially have been the determining choice factor.

Part of this discussion is an acknowledgement of how society and culture influence P/MHN. MH work has an existing reputation in western society. By many people it is perceived only in relation to an illness perspective as something unknown, irrational and to be feared (MIND 2013). Whilst more common MH problems have increasingly become familiar within western society, serious and enduring MH problems such as schizophrenia remain demonised. This was demonstrated in the work commissioned by the Royal College of Psychiatrists from 1998-2003 in their anti-stigma campaign in relation to schizophrenia. At the end of the campaign they found that nationally attitudes towards people with schizophrenia had actually worsened (Crisp et al. 2005).

Negative attitudes and beliefs around mental illness and workers in this field are

nothing new. Examples of this can be seen in the historical associations around mental illness and poverty, which are evidenced in the 1845 Lunacy Act (Coppock and Hopton 2000). During the 19th century, moral degeneracy was also closely linked to mental illness, for example a diagnosis of general paralysis of the insane was directly linked with syphilis and subsequent incarceration was perceived to be in response to promiscuity (Wallis 2012). Brutality in treatments such as electro-convulsive therapy and media representations as demonstrated in films such as *One Flew Over the Cuckoo's Nest* (Kesey 1962) have potentially led to further stigmatising, or a 'spoiled identity' (Goffman 1990) for both people with mental illness and those associated with working with them. It has been suggested (Strang 2007) that this stigma carries across generations and has implications for student P/MH nurses who have to negotiate this potentially stigmatised relationship in their choice of profession.

Is the desire to choose P/MHN influenced by the impact of nursing on the individual? What then are the likely effects of choosing nursing? The United Kingdom nursing employment rate fell to eighty-two percent for nurses at three years post qualification, which indicates that this is a critical juncture for nurses and a point when they are likely to leave the profession.

According to Murrells, Robinson and Griffiths (2008) P/MH nurses experience a decline in job satisfaction over time, which suggests that they have a bigger challenge in achieving this. Satisfaction with client care and resources, they argue, both start at a low level for P/MH nurses and remain stubbornly low. Given Murrells,

Robinson and Griffiths' (2008) work it would not be unreasonable to propose that there was a causal relationship between the issues of poor client care and services and job satisfaction decline.

Considering Prosser et al's (1999) earlier work, which looked at mental health, burnout and job satisfaction in a longitudinal study of MH staff, including over 100 nurses, indicated that while nurses had relatively high emotional exhaustion and poor psychological well-being, they remained 'satisfied' with their job. This suggests that P/MH nurses' satisfaction with their work has diminished over recent years. Richards et al. (2006) argue that P/MH nurses experience a level of trauma in and through their work that requires further exploration and an organisational response.

Richards et al. (2006:34) acknowledge the specific concerns about the 'prevalence of low staff morale, stress, burn-out, job satisfaction and psychological well-being amongst staff working in in-patient psychiatric wards'. They also confirm that reports have been made of P/MH nurses working, 'with greater numbers of highly disturbed service users alongside increased levels of violence, sexual assault and substance misuse'. This element of the literature review suggests explanations for reducing job satisfaction rates and indicates some of the bio-psycho-social sequelae of the working reality for P/MH nurses today.

Key indicators of job satisfaction for P/MH nurses are sickness/absence rates, stress and health issues. Since the late 1990s there has been recognition of increased

rates of sickness and absenteeism from work, in comparison to the general working population of the United Kingdom, of all health care workers, due to higher levels of both physical and mental illness (Wall et al. 1997, Williams, Michie and Pattani 1998.) 'Emergency services and healthcare, both known for their stressful working conditions and high rates of overtime, also have the highest rates of absenteeism over ten percent in the US' (Circadian 2005). Stuart et al. (2000) found higher levels of absenteeism in P/MH nurses in primary health care settings in the US. Gibb et al. (2010) confirmed high rates of stress-related sickness, particularly in P/MH nurses in comparison to allied health professionals. Mark and Smith (2011), in a consideration of all nursing groups, indicated that twenty-seven percent of all hospital staff were classifiable as suffering from stress and mental ill health and that the suicide rates for nurses were significantly higher than the national average.

Diener and Chan's (2010) work acknowledges that low morale, stress and reduced well-being contribute to illness and reduced longevity. Fischer (2014:1) stated that, 'there are 2.7 million nurses in America, and a (new) survey of more than 3,300 of them found that nurses are stressed, overworked, underappreciated, and underutilised'.

Fagin et al. (1996) found that three out of every ten P/MH ward based nurses in the UK experienced psychological distress, and there was evidence that some ward based P/MH nurses experienced higher depersonalisation scores, a recognised symptom of anxiety according to the WHO (2010), which is indicative of mental distress and potential mental illness. Levert, Lucas and Ortlepp (2000) found high

levels of burnout in ward based P/MH nurses. Tummers, Lambert and Beatie's (2002) comparative study of work characteristics and reactions between general and P/MH nurses found P/MH nurses exhibited significantly more emotional exhaustion in comparison to general nurses. Richards et al's (2006:39) systematic review of studies of P/MH nurses' stress, job satisfaction and burn out found that study results ranged as high as fifty-five percent of all P/MH nursing staff were 'in the top one third for the negative aspects of burnout (specifically) emotional exhaustion and depersonalisation'. In the US there are similar trends. The national hospital data indicate there are growing problems with overcrowding of inpatient psychiatric units (Virtanen et al. 2008), rapid patient turnover (National Association of Psychiatric Health Systems [NAPHS] 2006), more incidences of aggression, seclusion, and restraint (Serper et al. 2005, Steinert et al. 2007), and an increasing number of adverse events such as staff injuries as well as patient medication errors (Grasso et al. 2003; Grasso et al. 2005; Hanrahan and Aiken 2008). A shortage of MH professionals exacerbates these problems (The Annapolis Coalition on the Behavioural Health Workforce, 2006). Additionally, there is a serious shortage of P/MH nurses (Hanrahan, 2009).

Baum and Kagan (2015) considered job satisfaction and intent to leave among 52 P/MH nurses via a self-administered questionnaire. They found that nurses under 35 had a higher intention of leaving nursing, more senior nurses were content to stay, closed ward nurses were more likely to intend to leave than open ward nurses and full time nurses had higher job satisfaction than part time P/MH nurses. This corresponds to some of the literature around student P/MH nurses and stress, younger students seem less able to cope (Galvin et al. 2015, Alzayyat and Al-Gamal

2016).

Hanrahan et al. (2010) found several factors which could reduce stress and burn out in P/MH nurses and referred to better leadership and management, closer nurse physician relationships as two examples but confirmed that P/MH nurses working in acute general hospital wards are likely to be experiencing stress and burn out on a similar scale to their UK counterparts.

In Cushway, Tyler and Nolan's (1996:279) study of 111 P/MH nurses the major source of their stress, 'was found to be the difficulty of handling potentially violent or difficult service users in the context of scarce staff resources'. Within this context, studies concerned with overt aggression in MH units such as El-Baldri and Mellsop's (2006) work indicate that around 15 percent of service users will be aggressive against staff, with most cases directed against nursing staff. However, many studies consider causative factors for aggression rather than those on the receiving end of the aggression, examples of this include the work by Grassi et al. (2001) who consider when aggression is most likely to occur and the diagnosis of service users who are aggressive. Another example of this is Kho et al's (1998) work which focuses on the incidence of aggression in relation to the perpetrator's gender, ethnicity and diagnosis rather than any impact on those under attack.

However, in Zhong-Xiang, Kun and Xun-Cheng's (2008) study of stress and coping strategies in 188 P/MH nurses in China, their survey revealed that dealing with death and dying was viewed as the most stressful situation. They also noted that P/MH nurses most often used positive coping strategies and this is also reflected in work

on student P/MH nurses (Pryjmachuk and Richards 2007).

Whilst dealing with stress is likely to have an impact on P/MH nurses' health, Robson and Gray (2007) and White, Gray and Jones (2009) contend that many P/MH nurses also do not follow a healthy lifestyle. Robson and Gray's (2007) work showed that MH workers have a higher rate of smoking than the general population and they do little to protect their own mental health, in terms of implementing mentally healthy strategies, (for example walking in green space MIND Ryan 2015) picked up by the BBC (2011) who provide a useful summary. Ratschen, Britton and McNeill (2011:6) acknowledge the 'historic smoking culture (which) still prevails within MH settings'. Other studies (Trinkoff and Storr 1998, Bennett and O'Donovan 2001) appear to indicate that P/MH nurses may participate in more risky behaviours which actually may threaten their mental health.

Trinkoff and Storr (1998) considered the use of substances (cocaine, marijuana, prescription type drugs, cigarette smoking and binge drinking) by more than four thousand nurses over the previous year. They found that the prevalence of use of all substances was 32 percent and of the nurses studied, P/MH nurses were most likely to smoke. Trinkoff and Storr (1998) suggest that the acceptance of drugs in controlling psychiatric conditions makes P/MH nurses more willing to use substances themselves. As the study gathered anonymised data, nurses may have felt more comfortable reporting their personal habits. Bennett and O'Donovan (2001) also found, in their consideration of substance misuse by doctors, nurses and other healthcare workers, that certain specialities were at higher risk, and these

specialities included psychiatry and P/MH nurses.

In a qualitative study of twelve nurses who misused substances, Lillibridge, Cox and Cross (2002: 219) acknowledge that most work in this area has been limited to North America and 'that this is a poorly researched and understood problem'. They found links to 'the increasingly demanding and often traumatic nursing work environment', and recommended work on stress reduction to limit risks of substance misuse amongst nurses. Dunn (2005:573) recognised that substance abuse occurring in the general population is around ten percent which mirrors the percentages of those in the nursing population. She acknowledges that '[P/MH] nurses also experience high levels of substance use'. This research indicates that practicing P/MH nurses will use a range of strategies to cope with their perceived job stresses many of them potentially un-healthy and adding additional risks to personal mental health and well-being.

For P/MH nurses who do experience mental illness or addiction issues Glozier et al's (2006) study on nurses' attitudes to co-workers returning to work following 'illness' indicates that they are likely to be met with negative attitudes in comparison to physical illness, 'those with alcohol problems were held in particularly low esteem'. Glozier et al. (2006:534) contend that 'psychiatric illnesses are stigmatised…with the degree of behavioural blame important'.

Numerical data and literature presented so far indicates that P/MH nurses have worsening levels of job satisfaction, that they are working with increasingly complex

needs of MH service users, incidences of violence and aggression are increasing and particularly those working in acute in-patient MH care settings in both the UK and USA are subjected to a stressful and traumatising work environment. Quirk and Lelliott (2001) confirm that Admission rates have increased in both the UK as have bed occupancy rates and compulsory admission rates specifically in the UK, in relation to orders under the powers of the MH Act (1983 as amended 2007). They acknowledge the evidence of violence, sexual harassment and substance misuse in these settings, accompanied by rapid staff turnover, low staff morale and an increasing proportion of difficult to work with service users. They indicate that nurse-patient contact has decreased, despite being perceived to be an important aspect of care, and that service users are critical of conditions finding units both boring and un-safe. Quirk and Lelliott's (2001) work suggests that conditions are such that P/MH nurses are working under tremendous pressure. Steinert et al. (2007) noted similar conditions in the US. Gani and Meikle's (2015) article discusses concerns over the significant increase in compulsory detentions suggesting that people are not getting help for their mental health problems early enough. Gilburt's (2015) review of mental health services, for the King's Fund, 'Mental Health Under Pressure', found widespread evidence of poor quality care with inadequate support for those with severe problems. It notes that people with mental health problems are more isolated than they were before.

Clarke and Flanagan's (2003) work suggested that in practice, P/MH nurses retreat into procedural tasks when pressured by a perceived overwhelming demand for care and compassion from MH service users. Being appropriately graded, with job satisfaction and lower stress, raises psychological well-being, with inappropriate

grading, low job satisfaction, high stress (including experiences of bullying or harassment) being linked to poorer psychological well-being; this is closely linked into whether nurses will seek to change their job. There is clear evidence that nursing per se is currently a stressful and distressing profession, but how does P/MHN fit into this context?

The stigma and marginalisation experienced through undertaking P/MH nursing, as Strang (2007) suggests, may be passed across and through generations. As a profession P/MHN experiences not only distancing reactions from the public as already noted (Strang 2007) but also tends to internalise this sense of a spoiled identity (Goffman loc cit). This alongside the recognition of the associated stigma for groups entering the profession, needs to be acknowledged within a framework of pre-existing exposure to prejudice, discrimination, oppression and even torture for some student P/MH nurses (Clarke 2008).

Clarke and Flanagan's (2003) work on acute P/MHN care and students' perceptions of this offers useful evidence that P/MH nurses can be seen to be reacting to their service users' traumatic experiences in self-preserving ways, and by becoming avoidant of patient interaction. In their unique study of P/MHN they identified potential evidence of trauma and responses such as Post Traumatic Stress Disorder in P/MH nurses. Arguably P/MH Nurses have not acknowledged the levels of trauma that exist within the profession itself. There is evidence that all nurses find their work potentially traumatising (Buyssen 1996). There is also evidence that up to fifty-nine percent of people admitted to MH inpatient units experience post-traumatic stress

disorder directly due to being an in-patient. Up to fifty percent of women in MH services have been sexually assaulted (Seeman 2002) yet the bulk of MH provision, which is considered to be unsafe with rising incidences of violence and aggression, continues to be offered by the secondary sector services (Jones et al. 2010).

More recent work indicates that P/MHNs working environment have not necessarily improved. Ward's (2013) research study on 13 female P/MH nurses found fear as the underlying factor in violence and aggression both from the nurse and patient. Yet concluded that the nurses in the study saw this as 'part of the job'. Ward (2013:281) states, 'that physical, emotional and psychological violence is a central theme and an expected work hazard for registered nurses working in acute in patient mental health care facilities'. Burns (2014:14) acknowledges that P/MH nurses, 'are the most frequent victims of assault among health professionals'. Jacobowitz et al's (2015) work found assault of staff in psychiatric hospitals a frequent occurrence, and concluded that hospital staff are at risk of developing post-traumatic stress disorder (PTSD). They compared the rate of traumatic events, resilience, confidence, and compassion fatigue to PTSD symptoms. Their analyses identified two variables that were unique predictors of PTSD: (1) trauma-informed care meeting attendance and (2) burnout symptoms. Severe traumatic events, age, and compassion satisfaction also contributed to the model. Jacobowitz et al. (2015) contend that developing protective factors such as using a model of trauma informed nursing care with service users and compassion satisfaction may help reduce PTSD in psychiatric staff.

Ridenour et al. (2015) considered the incidence and risk factors associated with

workplace violence of P/MH nurses in eight locked psychiatric units in America. While there work was hampered by issues around nurse and patient confidentiality they concluded that P/MH nurses are at high risk for aggression from patients.

Mangoulia et al's (2015) study secondary traumatic stress/compassion fatigue, burnout and compassion satisfaction in P/MHNs in Greece, and their risk factors found the majority of 174 participants were in the high risk group for secondary traumatic stress/compassion fatigue (44.8%) and burnout (49.4%), while only 8.1 % of nurses showed a possibility for compassion satisfaction.

Zerach and Shalev's (2015) study examined posttraumatic stress disorder symptoms, secondary traumatization, and vicarious posttraumatic growth among Israeli P/MH nurses who were compared to community nurses (CP/MHN). They examined the contribution of P/MHN perceptions of the aetiology of their patients' mental illness to their nurses' PTSD, secondary traumatisation and vicarious posttraumatic growth. Zerach and Shalev's (2015) results showed higher levels of both PTSD and secondary traumatisation symptoms within the P/MHN group, but lower levels of vicarious posttraumatic growth, when compared to CP/MHN. While secondary traumatisation symptoms were positively related to vicarious posttraumatic growth among CP/MHNs, PTSD and secondary traumatisation symptoms were negatively associated among P/MHNs. Finally, exposure to patients' violence, PTSD or secondary traumatisation symptoms, and illness attribution dimensions of 'powerful others', predicted nurses' vicarious posttraumatic growth. They concluded that P/MHN are an at-risk population for work-related stress.

McTiernan and McDonald's (2015) work on 69 P/MHNs in Ireland suggests that nurses were operating in a moderately stressful environment. P/MHNs identified the main stress factors as lack of resources, workload and organizational structures/processes. They also compared hospital and community based P/MHN groups and reported average levels of emotional exhaustion, low levels of depersonalization and average levels of personal accomplishment, however, there were significant differences between the hospital and community-based nurses. Hospital based P/MH nurses reported higher depersonalization scores, and community nurses had a greater sense of personal accomplishment. The personal accomplishment scores of hospital nurses were below mental health professional norms. Avoidant coping strategies were favoured by both groups. Zerach and Shalev's (2015) and McTiernan and McDonald's (2015) work both indicate that community based P/MH nursing may offer better job satisfaction and retention whereas hospital based P/MH nursing is likely to have lower job satisfaction levels and therefore greater attrition rates. Yet as referred to earlier Henderson, Happell and Martin's (2007) study suggests that student P/MHNs prefer in-patient clinical placements in comparison to community. This phenomenon may be as a result of less resources and a need to engage student nurses more quickly and intensely in direct patient care in the in-patient setting because of staff shortages and resource issues.

Lee et al. (2015) explored and compared the psychological well-being of 196 hospital-based MHN (97 forensic and 99 mainstream registered P/MH nurses or

P/MH state enrolled nurses). They sought to examine exposure to inpatient aggression and work stress, and identify factors contributing to the development of post-traumatic stress reactions and general distress. They found that both mainstream and forensic nurses experienced similar psychological well-being. As a group, 14-17% of mainstream and forensic nurses met the diagnostic criteria for post-traumatic stress disorder, and 36% scored above the threshold for psychiatric caseness. Interestingly when compared to Pryjmachuk and Richards (2007) on stress in a student nurse group many student nurses also already demonstrated 'caseness'. However, the student P/MHNs, in comparison to other fields of nursing, responded differently to similar levels of stress, and student P/MHNs demonstrated a hardiness, which may be reducing over time in qualified P/MHNs? More specifically what the literature indicates is that those P/MH nurses working in acute in-patient mental health care settings are likely to experience higher levels of stress, poorer psychological well-being and be at greater risk of PTSD.

Yada et al. (2014) looked at gender differences in P/MH nursing. Yada et al. (2014) found that of the 159 female P/MH nurses they surveyed, these nurses tend to spend more time building rapport with patients and developing cooperative working relationships with colleagues; although they encountered more sexual harassment from patients. In contrast, the 85 male P/MH nurses surveyed responded to aggressive patients and tended to resist physical care aspects of the role particularly in relation to female patients. Male nurses were however, more likely to encounter physical and verbal assault from patients. These gender differences might result in differences in job-related stress, job satisfaction and intention to leave P/MH nursing, but there is limited analysis of these perspectives offered.

Baby, Glue and Carlyle's (2014) study acknowledged both the physical and psychological harm P/MH nurses experience as a result of patient assaults. Their study outlines the protective strategies for combating negative consequences of workplace violence include practice of self-defence, social support and a supportive and consultative workplace culture with access to counselling services and assistance in all aspects, including finances. However, the work does not acknowledge the impact of assault on job satisfaction and retention.

Bimenyimana et al's (2009) research also explores and describe the lived experience by P/MH nurses of aggression and violence from patients in a Gauteng psychiatric institution. Their findings indicated the violence and aggression to which P/MH nurses were exposed to was overwhelming. They conclude that as a result, P/MH nurses are emotionally, psychologically, and physically affected, and respond with fear, anger, frustration, despair, hopelessness and helplessness, substance abuse, absenteeism, retaliation and the development of an 'I don't care' attitude. Staggs (2013) work also found high levels of assault rates prevalent in Acute Mental Health Services.

Currid (2009) also found that P/MH nursing staff in acute mental health care settings were frequently subjected to violent and aggressive behaviour from patients. As a result P/MH nursing staff became reluctant to engage largely because of their anxiety about being hurt or experiencing further intimidation, because of the pace of

work. Currid (2009) suggested without investment the quality of service provision would deteriorate and P/MH nurses' health and wellbeing would suffer.

What the literature around why qualified P/MH nurses might leave the profession so far shows is that P/MH nurses do have to deal with people with complex needs and there is an increasing risk of workplace violence and aggression (Ward 2013, Burns 2014, Ridenour et al. 2015). In both of the settings for this study, the UK and USA, there is an increasing desire for P/MH nurses to shift away from restrictive practices and physical restraint (Huckshorn 2006, Bowers et al. 2012, Maguire, Young and Martin 2014, Duxbury 2014, RCN 2016). Muir-Cochrane and O'Kane (2018) looked at the implications of this, they carried out a qualitative study with 44 P/MH nurses in Australia around ending restraint in mental health settings. They found that P/MH nurses expressed genuine concerns and fears about being blamed for both, the use of restraint, and any consequences for patients, visitors and staff, in the event of not using restraint. The P/MH nurses in the study acknowledged the shift in acute P/MH nursing care to a more risk and medication focused model which conflicted with their efforts to care in a person-centred, trauma informed way.

The evidence of P/MH nurses' workplace difficulties is extensive. Iyamuremye and Brysiewicz (2010) survey explored how exposure to mental health clients' psychological trauma may lead to secondary traumatic stress in P/MHNs working in mental health services in Kigali, Rwanda. The majority of P/MH nurses' survey scores indicated very high or extremely high risks for secondary traumatic stress. Iyamuremye and Brysiewicz (2010) argued that supportive clinical supervision, with

sustained open communication channels, should be provided to P/MH nurses in Rwanda.

Becker and de Oliveira (2008) quantitative study looked at the rate of absenteeism of nursing professionals in a psychiatric center in Manaus. They found high levels of illness in nursing and they argued that further studies are needed in order to improve professionals' health, allowing for better quality of life, and provide better health care to service users. Repique and Matthew (2015) also found that fatigue amongst P/MHNs was a pressing work force issue.

Wang et al. (2015) found that P/MH nurses who are exposed to highly stressful work environments can experience depression over time. Their study aimed to explore the relationships among work stress, resourcefulness, and depression levels of P/MH nurses. 154 P/MH nurses were recruited from six medical centers in Taiwan. P/MH nurses' work stress was found positively correlated with their depression level, and negatively related to resourcefulness. Work stress significantly predicted depression level. However, Wang et al. (2015) concluded that developing resourcefulness skills to reduce P/MH nurses' work stress may improve their mental health.

Whilst much of this literature considers the negative impacts of P/MH Nursing in relation to stress, PTSD and psychological help, it is not all negative for P/MHNs, as Wang et al's (2015) conclusion indicates, adaptation, education, support and clinical supervision may provide useful mechanisms to improve P/MH nurses' job

satisfaction. Jacobowitz (2013) identified that training in the management of aggressive patients, participating in Critical Incident Debriefing, and having routine structured debriefing meetings may play a role in facilitating the development of resilience in nurses with respect to the risk of PTSD.

In Madathil, Heck and Schuldberg (2014) work they sought to consider ways in which nurses can be protected from experiencing the effects of burnout. They examined the relationships between leadership style of P/MH nurse supervisors, work role autonomy, and psychological distress in relation to P/MH nurse burnout. Eighty-nine P/MH nurses from Montana and New York hospitals completed an online survey that assessed their work-related experiences. The results of the study indicated that the participants experienced high levels of emotional exhaustion and depersonalization when compared to a normative sample of mental health workers. Madathil, Heck and Schuldberg (2014) study also showed that leadership style and work role autonomy are likely to be environmental factors that protect against burnout in nurses. Their study highlighted the relationship between depressive symptoms and the burnout component of personal accomplishment and suggested that this may be influenced by P/MH nurses' perceptions of the leadership style in their work environment. They contend that these findings are important because nurse supervisor leadership styles and amount of autonomy are characteristics of the work environment that may be amenable to change through training and intervention.

Senining and Gilchrist (2011) considered causative factors for stress in P/MHNs

working in Acute Care settings. They found that P/MHNs who used self-controlling, planful problem solving and positive reappraisal in the work setting were able to cope more effectively. They argued that if P/MHNs were educated about the coping skill set of self-controlling, planful problem solving, and positive reappraisal, with the goal of helping the acute mentally ill client to also learn these coping skills, then P/MHNs would expand their own understanding and benefit from coping with their own stress. They suggested education on beneficial coping mechanisms to help reduce stress levels, alongside the formation of a staff support group to assist with relieving stress. They also found that encouraging extra-curricular activities or forming different recreational activities helped to decrease P/MHNs stress.

As Souza, Passos and Tavares (2015) argue nursing is double-sided, that which produces pleasure, because it allows you to create and transform reality and that which, in capitalist societies produces suffering because it limits the human possibilities of choice, creation, and enjoyment from working within the confines of a marketed health care system, is clearly visible in P/MH nursing and reiterates the ongoing dilemma of recovery versus restraint.

Hurley and Lakeman's (2011) paper focused upon the process of how P/MH nursing identity development is influenced, rather than what that identity may or may not be. Their findings highlight that P/MH nurses formed their identity around service user centred education and training, but that many also used this education as a means to leave the front line of the profession. Hurley and Lakeman (2011) contended that P/MH nurses become aware of the importance of clinically focused mental health

within education programmes, there are rewards for P/MH nursing skills specialisation, and the importance of the service user in P/MH nurse education helps with identity formation. However, they conclude that this identity formation lead to nurses leaving front line P/MH nursing, therefore considering how education may help to keep P/MHNs at the front line and satisfied is worth further consideration, although not within the remit of this thesis.

Traynor and Evans (2014) argue that nursing has a gendered and religious history where ideas of duty and servitude are present and shape its professional identity. Nursing, Traynor and Evans (2014) suggest, also promotes idealized notions of relationships with patients and of professional autonomy both of which are, in practice, highly constrained or even impossible. Their paper draws on psychoanalytic concepts in order to reconsider nursing's professional identity. It does this by presenting an analysis of data from two focus group studies involving nurses in England and Australia held between 2010 and 2012. These studies gave rise to data where extremely negative talk about nursing work seemed to produce, or to be expressed with, a high degree of energy, and a particular kind of enjoyment. In Traynor and Evans (2014) analysis they focused on,

> the nurses' apparent enjoyment derived from their expression of a position of powerlessness in which they describe themselves as 'slaves' or 'martyrs' in the health care system. They interpreted this as ‘jouissance’ and suggest that the positions of slave or martyr provide a possible response to what they argue is the impossibility of the nurse's role. Traynor and Evans (2014) contend that a remnant of a quasi-religious ethic within the profession makes it acceptable for nurses to talk about self-sacrifice and powerlessness as part of their working subjectivity.

> They further contend that this analysis offers a new consideration of the issue of power and professional identity in nursing that goes beyond seeing nurses as simply overpowered by, or engaged in, a gendered power struggle with other professional groups. They suggest that powerlessness and victimhood hold particular attractions and advantages for nurses and are positions that are more available to nurses than to other occupational groups.

Traynor and Evans (2014) are perhaps, all be it coherently, arguing for a re-branding of nursing where stress, hardship and the inevitability of failing to meet exhaustingly high, self-imposed nursing care standards are instead seen as an acceptable, expected, even pleasurable, part of nursing. Alternatively suggesting that nurses enjoy being powerless victims is akin to victim blaming and arguing for P/MH nurses to re-think their perception of P/MH nursing work as 'faulty' may potentially be pathologising the individual?

What the literature review demonstrates is that P/MHNs do the work largely because of the nurse – patient relationship and the potential to work therapeutically; they are supported in this work through clinical supervision, good leadership and team working. However, working conditions for P/MHNs appear to have worsened and P/MHNs are experiencing high levels of stress. When comparing both groups the literature suggests that student P/MHNs are similar in that they also chose their career based on ideas of working therapeutically; they are likely to stay in P/MH nursing with positive education and clinical experiences and they too are experiencing significant levels of stress like their qualified counterparts.

1:11 Summary and conclusion.

This chapter has set out the rationale for this study, the aims, objectives and research questions that will be answered in this work. The chapter explores and critically discusses literature considering why student P/MH nurses choose their profession; why they stay and why they might leave alongside why existing P/MH nurses might stay in the profession and why existing P/MH nurses might possibly be leaving the profession. What this literature review has demonstrated is that there is limited evidence on the initial question - why do student P/MHNs choose P/MH Nursing? Ong et al. (2017) describes several factors which may contribute to this, including ethnicity, parental approval, and previous experience of people with mental health issues, however, their study was carried out in Singapore and the cultural relevance to the UK and USA may be difficult to establish. The other relevant work, carried out by Edward et al. (2015), indicated that personal experience of mental health issues was a influencing factor in career choice. Student P/MHNs are keen to be engaged with quality patient care and a therapeutic nurse-patient relationship appears significant. Positive clinical placements and education experience are retaining factors.

Literature which considers student P/MHNs choice also showed that a lack of exposure to people with mental health issues; poor education around mental illness, anxiety, stigma and stereotyping have a negative impact on career choice. The literature review demonstrated that student P/MHNs do experience stress during their course however, apart from Rhodes and Bouic (2007) work there is no

indication that this stress is detrimental to student retention. When comparing literature of student P/MHNs to what is published on why qualified P/MHNs stay in the profession there is evidence of commonalities between the groups, both groups demonstrate a desire to engage in therapeutic nurse-patient work.

The literature indicates that existing qualified P/MHNs stay in the profession for a range of reasons including good leadership (Beckett et al. 2013); supportive clinical supervisor (Dickens, Sugarman and Rogers 2005, White and Whitstanley 2010, Cathy, Noak and Wadley 2012, Hubbard, Beeber and Eves 2017); trauma informed care, compassion satisfaction, a greater sense of personal accomplishment (McTiernan and McDonald 2015), perceived reward (Johnston et al. 2016); a sense of satisfaction and an opportunity to work creatively (Souza, Passos and Tavares 2015); self-sacrifice (Traynor and Evans 2014); co-operative working relationships with colleagues and patients (Yada et al. 2014); practice of self-defence; social support, supportive workplace culture with access to counselling services (Baby, Glue and Carlyle 2014), training in the management of aggressive patients and participating in Critical Incident Debriefing may also help to develop resilience in P/MHNs (Jacobowitz 2013). Literature on student P/MHNs also recognises the importance of these factors.

Finally in response to the third research question why do existing P/MHNs leave the profession; the literature indicates that qualified P/MHNs leave largely because of perceived stress (Zerach and Shalev 2015), limited resources (Goodare 2017), poor leadership and an inability to deliver the quality of care they seek to (Madathil, Heck

and Schuldberg 2014); increasing levels of disturbed and violent service users (Currid 2009, Ward 2013, Burns 2014), increasing levels of sexual harrassment, substance misuse and difficult to work with service users (Gani and Meikle 2015), emotional exhaustion, psychological distress (Iyamuremye and Brysiewicz 2010), overcrowding, rapid patient turnover, staff injuries, staff shortages (Griffin 2016), unhelpful coping strategies; PTSD, secondary traumatisation, (Bimenyimana et al. 2009); and depression (Wang et al. 2015). Both groups demonstrate work related stress, for qualified P/MHNs this is particularly evident in Acute In-patient P/MH nursing, interestingly student P/MHNs express a preference to work in those areas in comparison to Community P/MH nursing, however, there is limited evidence and analysis available on this currently (Henderson, Happell and Martin 2007).

The 21st century has not just presented negative challenges to P/MHNs in both the US and UK many nurses have embraced new ways of working, incorporating evidence based psychological interventions in their work, becoming advanced clinical practitioners, leaders, nurse consultants and academics. Arguably P/MH nursing both in the UK and USA has been, and is, a positive, rewarding and fulfilling career (House of Commons Select Committee 2018). This literature review does highlight a clash in relation to therapeutic work with service users that is seeking recovery and the realities in P/MH nursing of restraint. This work does return to these issues throughout as the participants try to negotiate this clash. This review of relevant literature also offers the investigation useful mechanisms with which to compare the participants' data and reflect on any new learning. In the next chapter the philosophical and methodological aspects of this study will be explored.

Chapter 2 – Research method and process.

2:1 Introduction

This chapter provides the reader with an understanding of the method used in this investigation. As indicated in the literature review, there is limited specific evidence focused on why students choose their profession and how their experiences might influence that choice. This investigation is beginning the process of considering student P/MH nurses' reasons for choosing their profession. This chapter will discuss why phenomenology is an appropriate method to answer the research question; detail the underpinning philosophical influences, Husserl, Heidegger, and Jaspers in a single section; and provide an overview of the interpretative analytical frameworks being used to analyse the participants' data. This chapter also sets out the research method implemented in this study. The phenomenological start point for this study is to explore P/MH nursing students' experiences and to ask broad, open questions around their perceptions of these experiences and their impact on the student P/MHNs motivation to choose P/MH nursing. This clearly required a qualitative approach to data gathering (Denzin 2005).

2:2 Why is phenomenology an appropriate method to answer the research question?

As the investigation is attempting to explore student P/MHNs perceptions of their experiences as student nurses a phenomenological approach is an appropriate

method to answer the research question, as it emphasises the importance of getting close to the 'participants personal world' (Alase 2017).

The phenomenological approach in research is focussed on exploring human experience; no attempt is made to reduce that experience (Smith, Flowers and Larkin 2009). IPA is clearly situated within the phenomenological perspective. As Smith et al. (2009) acknowledge, IPA is the examination of how people make sense of their experiences. IPA also requires interpretation, and uses a double hermeneutic. That is; the investigator tries to make sense of the participants' data, while they themselves are trying to make sense of their experiences (Smith, Flowers and Larkin 2009).

IPA is not only phenomenological however, it also recognises social constructionist perspectives. Personal experiences require interpretation in research and to interpret meaningfully there needs to be a consideration of context. IPA is concerned with the particular, with revealing something about the experience of the participants involved, and being able to say something meaningful about the participant group. This is demonstrated in IPA through detailed analysis. Smith et al. (2009:29) state,

> IPA is committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context.

In this investigation that means the experience of being a student P/MHN, and how student P/MHNs try to make sense of that experience during their educational programme.

2:2a. Why phenomenology and not other research methods?

IPA has a more broadly psychological approach than, for example, the more sociological focus of grounded theory. It is concerned with giving a more detailed and nuanced account of the personal experiences of a smaller sample (Smith, Flowers and Larkin 2009), than grounded theory studies employ. Narrative Analysis was considered as an alternative approach in this research study, since it is also a social constructionist approach and is focused on making meaning from the participants' data. However, IPA felt less restrictive, offering as it does an inclusive analytical interpretative process which includes psychology, phenomenological philosophy and social constructionism. IPA of course includes narrative discussion but is not constrained by it.

I was keen to adopt an analytical lens that was wide enough to interpret the participants' experiences and responses, one which acknowledges a large psychological component. IPA (Smith and Osborn 2008) emerged as a useful and appropriate approach. Smith and Osborn (2008:55) recognise that

> IPA is a suitable approach when one is trying to find out how individuals are perceiving the particular situations they are facing, how they are making sense of their personal and social world. [IPA is], 'concerned with complexity… broad and open questions… the aim is to explore, flexibly and in detail, an area of concern.

2:2b. How was IPA implemented in this study?

In this investigation data collection was carried out through semi-structured interviews. The data was analysed using the interpretive analytical framework identified on pages 126 -130. In adopting IPA to carry out this work there are stages that were worked through:

1. Carrying out the interviews with participants and listening to their responses.
2. Reflecting at the end of each interview and recording thoughts, ideas and emerging themes in a reflective research diary.
3. Re-listening to the recorded interview.
4. Transcribing the interviews.
5. Reading and re-reading the transcripts of the interviews.
6. Analysing emerging themes – detailed work on each transcript, what experiences and ideas appear consistently, where are the differences (Diagram 2:1 illustrates the underlying focus of the semi-structured interviews).
7. Using psychological language to redefine the participants responses
8. Clustering themes together. (See section 2:9 for further details).
9. Interpreting themes.

Having established the relevance of the phenomenological approach to this work and presented a rationale for IPA as the chosen research method the next section considers the philosophical theories that inform the investigation undertaken in this thesis.

2:3 Introduction to the Philosophical underpinnings for this study

Before outlining the methodology in the next sections, it is worth first defining terms and setting out the philosophical underpinnings of the study method here. This section sets out the applicability and influence of three phenomenological philosophers relevant to this study: Jaspers (1968 focus on empathic engagement) has influenced the way the participants' data was collected; Husserl (1901, 1913 descriptive stance) has influenced the data presentation; and Heidegger (1927, interpretative stance) has influenced the analysis of the data.

This investigation employs an IPA framework to examine why P/MH student nurses choose their profession, and explores their P/MH nursing experiences, how they attempt to make sense of these and how these experiences might influence their career choice. There is likely to be complexity emerging from these data, which requires an analysis of the participants' 'life worlds', (Heidegger 1927, 1962 translation cited in Lopez and Willis 2004:729) and an acknowledgment that 'individuals' realities are invariably influenced by the world in which they live' (ibid. 729). It involves exploring how the participants' social, cultural and personal experiences influence their narrative and perceptions. The research has adopted a partnership or collaboration in this work, one that recognises the participants as the experts; by constantly using and referring to their own words, this is also clearly in keeping with the aim of an IPA inquiry (Brocki & Wearden 2006).

Husserl's philosophy offers a useful approach, not only on describing the data collected but also on how to subject that data to phenomenological reflectivity, and to

examine the ‘essence’ (Moran and Mooney 2002) or meaning of participants’ experiences. Marcuse (1968) discusses Husserl's work on essence and confirms that it refers not to what should or could be, it aims only at describing what is, as it is, and as it presents itself, without interpretation. Being aware of one’s preconceptions, beliefs and prejudices and attempting to put them to one side (bracketing) to reveal the essence of others’ experiences is a worthwhile endeavour (Denscombe 2003) in order for the researcher to work at limiting their bias. Husserl’s work supports the need for an intuitive, reflective description of the participants’ experiences and the need to focus on and examine the ‘essence’ of their experiences in order to make a clear attempt at understanding what these experiences mean to the participants. Using open ended questioning fits both Husserl’s approach and IPA, as both require the investigator not to predetermine but rather to allow the participants’ personal perceptions to emerge. Husserl (1970) refers to the essence of phenomena. He indicates that much of this may be pre-verbal a point emphasised by Dowling (2007:132), 'The focus is on the primeval form, what is immediate to our consciousness'. Crotty (1996) similarly contends that Husserl's lifeworld is understood without interpretation, pre-reflectively.

However, the only way to capture the participants’ experiences for this study was to encourage them to describe these verbally. Husserl’s approach strongly influenced what I asked the participants and how I presented their experiences as data. An example of this can be seen in the interviewing process to gather the data presented in chapter four.

I specifically asked the participants to tell me about their experiences; several of them were uncertain and asked me what I wanted or what I meant, and I clarified this by asking them what was important to them, what did they want to talk about, what was a typical day like for them as a student P/MH nurse. I made every effort not to influence what they told me, by returning the choice of our interview back to them and avoiding leading questions. From a phenomenological philosophical perspective Husserl's rich descriptive way of presenting data is ideal for dealing with the participants' narrative responses.

The ways in which humans construct their world is not only through the physiological/psychological 'eye' or perception but is also social. Heidegger, the second philosopher to influence this work, acknowledges that human reality is complex, both social and individual, and he refers to this as 'dasein' or 'being there' (Heidegger 1927, Moran and Mooney 2002). What humans perceive of the world is never passive; as humans we:

> bring into being the colours, shapes and sounds of the world. Furthermore, we experience the world, not as a collection of discrete items, but as a totality, something that 'holds together'. We experience it as meaningful. But we do this as a social group, not as a collection of individuals. Thus, any individual act of perception has a social dimension. It is dependent on our human physiology but also on our social embeddedness; our involvement in a world socially ordered through human practice, language and culture (Bracken 2002:89-90).

The intriguing dichotomy in adopting a phenomenological philosophical stance is:

Firstly, the emphasis on subjective, individualistic experience, as the phenomenon investigated using Husserl's approach. Secondly, that this is then subjected to analysis by the researcher and commonalities, themes and/or groupings are identified and considered, moving the focus from the individual to the group or community, using Heidegger's work. There is a risk that this may force the researcher to abandon the phenomenological stance, but in reality any research will have to work within the tensions that occur in all philosophical investigative endeavours. For human experience to be intelligible or to have meaning, in Heidegger's context, requires a holistic approach, one that focuses on the practical world and is, 'generated through an embodied engagement within a social world' (Bracken 2002:96).

The Husserlian philosophical perspective has provided relevant approaches for this work, then, in the form of underpinning its description, reflection and its examination of the essence of the data collected. Heidegger in turn has enhanced the philosophical understanding of human experience and this thesis focuses on the importance of recognising the social context and the interpretation of data. Within IPA the interpretation of data is through a psychological framework and this is outlined in the interpretive analytical frameworks section next in this chapter. Alongside these two phenomenological philosophers, this thesis also draws on the work of Karl Jaspers. Walker (1995:248) states that Jaspers referred to phenomenology as an 'understanding, empathic representation of the other person's psychic life'.

Jaspers explored the importance of empathy. He distinguished between two kinds of empathic understanding: the static and the genetic types (Jaspers cited in Walker 1995). According to Ouli's (2014) work, static understanding 'consists in the empathy-driven re-experience of patients' actual mental experiences - during the diagnostic interview without any human prejudices or preconceived theoretical assumptions'. Whereas, genetic understanding is made up of the 'empathy driven detection of meaningful connections between patients abnormal mental experiences - including the psychological impact of adverse life events or processes on their current mental state and behaviour.

Empathy has subsequently re-emerged from initial phenomenological work in both existentialism and humanism, particularly in the work of Carl Rogers (1951) and both of these theoretical concepts are still contemporary approaches and continue to inform the field of P/MHN today (Department of Health 2006, APNA 2014). Arguably the role of empathy as defined in Jaspers' phenomenological research and phenomenological philosophy has an affinity with the existing framework of both practice and research within P/MH nursing. Jaspers (1968) acknowledges the role of empathy in a phenomenological approach; he suggests that this involves 'an empathetic re-living… in order that he or she may grasp what it's like, in a way that cannot be communicated' (Fulford, Thornton and Graham 2006:220).

Whilst Jaspers' original work focused on psychopathology and the place of phenomenology within this field, his work on empathic understanding has some bearing on this investigation. As Jaspers (1968) states:

> empathic understanding is psychology itself…but if we understand that content of the thoughts as they have arisen out of moods, wishes and fears of the person who thought them, we understand the connections psychologically or empathically. What we grasp in empathic understanding appears to be incredibly subjective; we only have access to it through an imaginative re-living of someone's mental life in our own minds. In other words if we are no longer concerned with strictly logical connections between thoughts, then any other forms of meaningful connections between them is something that can only be found in our subjective mental realm (Fulford, Thornton and Graham 2006:220).

Clearly Jaspers seeks, through the application of empathic understanding, to access the essence of people's lived experiences through 'an imaginative reliving' of the participant's experience. This is not something that is immediately achievable, and in one way it could be viewed as another layer to Husserl's concepts of understanding building on a deep reflective process. This also leads us to question whether the researcher could demonstrate their ability to develop an empathic understanding. Jaspers' work was considered contentious at the time; Weber, a colleague who influenced his work, rejected his concept of empathetic understanding. Weber provided a useful cautionary note that there is, 'no guarantee that our imaginative reliving of someone's mental state will bear any resemblance to what the person actually experienced' (Weber 1975:185).

Jaspers (1968:10) argues that, 'feeling oneself into empathy and understanding and immersing ourselves in others' self-description and grasping their expressive phenomena will enable us to reach meaningful empathic actualisation'. He explains that to carry out phenomenological analysis, and determine what people really

experience, requires the employment of three specific methods, these are identified as: –

1. Immersing oneself in a person's gestures, behaviour and expressive movements.
2. Exploring through direct questioning and listening closely to the accounts people give of themselves and their own experiences.
3. Written self-description, which Jaspers acknowledges may have the highest value in considering psycho-pathology.

Informed by both Husserlian notions of description and Heidegger's interpretation of experience the lived experience of the participants is central to this investigation. Jaspers' work on empathic understanding and the methodology employed to establish this are also relevant to this study. Note however that Walker (1995) and Oulis (2014:73) both acknowledged that Jaspers' work on empathy is 'far from clear'.

In this work I have used Jaspers' discussion of static empathy in the interview process with the participants through making an effort to re-experience, with them, their experiences during their course. Where I have found that empathic understanding was perhaps achievable was in the participants' retelling of their clinical work with service users as I have also worked with people with serious and enduring MH problems for over thirty years. As Donise (2015:40) notes, 'the telling of the experience. becomes .. one of the key tools to empathize with the other'. I recognised the stories they told me, I could picture them in those situations and shared their responses.

In the analytical processes used in this thesis I have sought to demonstrate genetic understanding by deliberately looking at meaningful connections between the participants' experiences and their psychological impact. This is evident particularly in chapter five where the participants' data is analysed in relation to trauma. It is unlikely that all of the participants would have perceived their experiences in terms of psychological trauma yet through the application of genetic understanding a meaningful connection has been established. This thesis recognises that aspects of the participants' experiences are traumatic, making that connection is meaningful as it leads to a requirement to investigate further, to respond and take action as recommended in chapter six.

In the process of constructing the semi-structured interview schedule I integrated these three philosophers' approaches within an IPA context. I was keen to explore the participants' life worlds by engaging with their own detailed descriptions of their typical day as student P/MH nurses. This could include their interactions with others and, internally, their relationships with others, their feelings about now, the past and future. As the examples above demonstrate. I wanted to use my own experience of P/MHN as a tool to search for a richer understanding, one partly based on empathy as described by Jaspers.

Attempting to demonstrate empathic understanding would help me to work towards ascertaining or uncovering the 'essence' of the phenomena participants were disclosing. Empathic understanding also promotes deep reflective thinking, and it is also a core quality for P/MH nurses. As such a P/MH nurse researcher would hopefully be able to transfer this practice based skill and apply it effectively in the

research context and in utilising this strategy enhance the richness of the data collected and its analysis and finally enhance the agency of the participants through the researcher's efforts to interact within an empathic framework. The participants' willingness to engage, their openness and frankness and the length of time they spent with me during the interview process are indicators that our interactions demonstrated some empathic understanding.

2:3: a. How philosophical differences were reconciled.

IPA as an approach to research is commonly associated with the combined use of both Husserl and Heidegger (Turner 2017). Within phenomenology Van Manen's (1990) work demonstrates that the work of Husserl and Heidegger is not mutually exclusive, in carrying out phenomenological research his work suggests that, they can be compatible. His approach combines both the descriptive (Husserlian Phenomenology) and interpretative (Heideggerian phenomenology) in uncovering thematic aspects of the studied experience (Reiners 2012). Van Manen (1990) utilised this method to identify and interpret the meaning of the phenomenon. As Cronin and Lowes (2015) indicate IPA research typically may include elements of both Husserlian and Heideggerian philosophy they confirm this when they state that, 'IPA builds upon the … work of both Husserl and Heidegger'.

In this work philosophical differences were reconciled through a strategy to use the principles of all three philosophers informing this work but in differing ways and in differing contexts within the research process. For example the interviews were conducted with Karl Jaspers (1968) empathic approach in mind in an effort to fully

engage with the participants. In gathering data and presenting data Husserlian perspectives promoted the use of broad open questions about experiences and the opportunity to include rich, detailed and descriptive data from the participants, this helped to ensure that the participants' voices were heard not just mine during analysis. From Heidegger I was able to apply a psychosocial lens to analyse and interpret the participants' data this also reduced the risk of producing purely descriptive work based on Husserl's perspectives. This work uses the strength of all three phenomenological philosophers in differing way, I do not deny significant differences in the original philosophical theories presented certainly by Husserl and Heidegger however, this work adapts and uses aspects of these theories to carry out a mixed philosophical approach. In the next section of this chapter the lens through which the participants' data will be interpreted and analysed is presented.

2:3: b. Interpretative Analytical frameworks for possible reasons for choosing P/MHN as a profession.

In this section I outline the interpretative analytical frameworks that I will use in analysing the participants' data throughout chapters three – five. The information here will offer the reader a sense of the frameworks I will be using. Discussion of the choices made by individual student nurses and their experiences must be approached with some trepidation. Clearly I do not wish to be over-prescriptive or make assumptions. To avoid these dangers, I need a range of interpretative analytical frameworks to help me explore these issues and the participants' choice and experience not only with some consistency, but also using psychosocial theories that reflect the underpinning philosophy and methodology of this investigation,

Interpretative Phenomenological Analysis (IPA). The frameworks are those most commonly associated with IPA.

Firstly this work refers to Maslow's (1943) classic work on human motivation throughout in order to consider the participants' responses. Maslow (1943) set out a hierarchy of human needs that motivate people to achieve goals and take action. These are as outlined below:

Diagram 2:1 Maslow's Hierarchy of Needs (1943)

(Maslow 1943).

The application of Maslow's work will be seen throughout the data chapters in this investigation. For example (see page 191) Morrissette's (2004) comment that the desire the helping professions have to help others may be linked to their sense of self-worth and can be mapped against Maslow's level of "esteem".

From a cognitive behavioural psychological position (Beck 1977, Ellis and Grieger 1977, Trower, Casey and Dryden 1988) the influence of belief systems (schema) in

human motivation is well documented, as humans will construct their world into something with meaning and purpose and will strive to reinforce or convince themselves of that meaning and purpose. I shall refer to this framework implicitly throughout the work. For example, within the context of choosing P/MHN an example may be that personal experiences of being a MH service user has led an individual to believe that the service should/could be better, and their endeavours, career wise, fit their belief system and help provide meaning and purpose to their life. This thesis, in keeping with IPA, also refers to a range of other recognised psychological theories to analyse the participants' reasons for choosing P/MH nursing. These theories include Freudian (1979) concepts, and Berne's (1964) work on Transactional Analysis. Examples of how these theories have been applied include utilising Freud's (1979) work on defence mechanisms to explore participant's responses and consider concepts such as denial, intellectualisation and mastery (see pages 178, 179, 185, 188, 200, 2005, 206, 215, 217 for further details). From Berne's (1964) work acknowledging potential psychological gains from helping others and positioning themselves as rescuers to 'victims', and exploring repeating patterns of behaviour from established life scripts (see pages 181,182 for example). These interpretative analytical frameworks therefore fit, both in terms of analysing the participants' data, and also potentially helping to explain their motivations. This thesis also includes social perspectives to encourage breadth of analysis.

Including sociological considerations (Rogers and Pilgrim 2003) can help suggest the ways in which humans construct society and themselves, offers insights into, as well as determine, individuals' choices. For example, the gender of P/MH nurses both in the UK and USA is still predominantly female (Palmer 2008, National Nursing

Research Unit 2012). Traditionally women are seen to be responsible for the caring and nurturing roles in society and nursing has been seen as an extension of the mothering role (Turner 1995). Therefore the motivation to become a P/MH nurse has been seen as a desire or need to conform to norms within society for women (McLaughlin, Muldoon and Moutray 2010). Alternatively it could be seen less as a desire and more as a choice that is made in the context of constraint and limitations placed on women by society (Ford and Walsh 1994).

However, there are more men in P/MHN than in general or paediatric nursing (Hanrahan and Aiken 2008). For men entering P/MH nursing, the traditional role of nursing is somewhat subverted to be acceptable for men as the focus is on people with MH problems, which includes notions of violence and aggression in the cultural imagination, and therefore male involvement could also be seen to conform to acceptably constructed roles for men (Evans 2004).

Again within the UK there are significantly higher proportions of student P/MH nurses from minority ethnic backgrounds (Edward et al. 2015). Possible explanations include how racist recruitment and selection procedures may exclude people from minority ethnic backgrounds from other more 'socially' acceptable fields of nursing (RCN 2006, Nolan 2012). There is also an over-representation of people from minority ethnic backgrounds within the UK as MH service users (Kirkbride et al. 2008); the desire to become a P/MH nurse might arise from personal experience of MH problems within one's own particular ethnic or cultural group? This also raises the question of whether coming into, or being raised, in a racist society leads to higher recruitment into P/MHN from people desiring empathic understanding.

Alternatively, choosing P/MHN may be seen as an altruistically motivated decision to work to provide a service for the general good of society on the part of students of all ethnicities (Edward et al. 2015). Having identified the interpretative analytical frameworks that will be used to interpret participants' data the next section sets out the study method.

2:4 Study Method

There are several approaches to gathering qualitative data generally with a requirement for direct interaction with the participants. Core qualitative methods for investigating human subjects include structured or semi-structured interviewing, focus groups and participant observation. This investigation used semi-structured interviews in order to encourage rich, descriptive data in line with Husserlian phenomenology (Husserl 1901, 1913) as discussed in section 2:2. This type of data can be more easily generated by allowing participants to have greater ownership of the subject matter. This also allowed me significantly more autonomy of response, to ask probing questions, to ascertain hidden meanings and interpret the data, in keeping with both Heidegger (1927) and the Interpretative Phenomenological Analytical (IPA) approach (Smith and Osborn 2008) also referred to earlier.

2:4:a Semi-structured interviews

The semi-structured interview is viewed by Smith and Osborn (2008), as an 'exemplar' of the IPA method. Smith and Osborn (2008:58) stipulate that for the semi-structured interview in IPA, 'there is an attempt to establish rapport with the

respondent; the ordering of questions is less important; the interviewer is free to probe interesting areas that arise; the interview can follow the respondents' interests or concerns.' The semi-structured interview used in this study focused on why P/MH student nurses chose their profession and asked open, exploratory questions about their experiences as student nurses. Similarly to a structured interview I had a set of questions (see table below) but this was used as a guide rather than a diktat.

Table 2:1 Semi-structured interview questions

Semi-structured Interview Questions –
These are based on broad phenomenological research themes, which will be explored through supplementary questioning during the student interviews. Consistent with the theoretical position of this investigation the students will be asked their perceptions in relation to their past, present and future life context; influences; student experiences and feelings about potential post qualifying experiences. Students will also be asked to consider how nurse educators and practitioners could engage with them to promote positive outcomes and strengthen their mental health and resilience. Depending on the students' responses these will be followed up with supplementary questioning during the interview process.
Examples of interview questions:-
What are your feelings about being a student psychiatric/mental health nurse at the moment?

If I could ask you to reflect on your experiences of being a student nurse and tell me about these?

How do you feel so far about your time as a student nurse?

How do you feel about working as a qualified psychiatric/mental health nurse?

When you look back on your personal experiences in relation to nursing do you feel there are any issues of importance emerging for you personally?

What do you feel would have been helpful to hear from qualified nurses, educators and your fellow students when you were a new student nurse?

Can you look back to when you first considered becoming a psychiatric/mental health nurse and tell me what was going on in your life at the time?

Do you feel these circumstances may have influenced your choice?

In adopting a semi-structured approach, rather than structured, it is important that the interviewer be aware that this can lead to less control over the direction that the interview may take; often interviews will go on for a longer time period than anticipated and therefore the data will typically be harder to analyse. However, the strengths of this approach include the opportunity to effectively establish rapport and

engage with the participants' life worlds (Heidegger 1927, 1962 translation cited in Lopez and Willis 2004:729).

This can lead to significantly richer data, and novel and intriguing areas for consideration introduced by the participants themselves rather than assumed by the interviewer. A major influence in employing this method was a desire for the participants to have a positive research study experience carried out by a fellow nurse, an experience in which they genuinely felt listened to and in which their views would be fairly and accurately represented. In an effort to provide this positive experience, I actively sought to use my own interpersonal skills and personal experiences, in an attempt to encourage empathic engagement (Jaspers 1968).

After the first interview I shifted the order of the questions asked and the question regarding the participants' rationale and motivation to choose P/MHN was asked towards the end of the interview. The rationale behind this change was the first participant's apparent reluctance to answer this question during the early stages of the interview. Apparently, this may have been due to a lack of trust or insufficient time to build rapport. Establishing trust and developing sufficient rapport took time with the participants before they were able to share honestly why they had chosen P/MH nursing. This is also in keeping with the IPA approach which recommends that sensitive questions are asked towards the end of the interview, although initially I had not anticipated any reluctance or sensitivity to the question about motivation (Smith and Osborn 2008).

2:4:b Data sample

The size of the sample needs to be sufficient to ascertain and confirm meanings, and ensure that the researcher works towards data saturation, a point at which new themes cease to emerge. Whilst initially there were no set parameters, having actively recruited participants across four university campuses I worked with those participants who were willing to be involved. This complied with IPA methodology which usually involves small sample sizes as it requires detailed individual case interview transcript analysis, and findings are targeted at the particular group of individuals studied. Whilst this can lead to general recommendations, IPA tends to be an idiographic (interpretive) rather than nomethetic (descriptive) mode of inquiry. As Smith and Osborn (2008:63) point out, IPA does not attempt to make large generalisations; as an interpretative study, its emphasis is on 'painstaking analyses' and detailed examination of individual case studies.

The sample is usually purposively selected in IPA, with the investigator deliberately setting out to select a group of people who will find the research question/s significant. In this case one can claim a certain level of homogeneity to comply with IPA requirements, as all of the participants were student P/MH nurses.

In this investigation the sample was entirely comprised of those students who, to some extent, were self-selecting; they expressed an interest in, or were willing to be interviewed for, the study. The advantages of a self-selecting sample include effective time management as potential participants tend to contact the investigator and opt into the study. Secondly, the participants are likely to be committed to

completing the study. However, there are also some disadvantages; these include: self-selection bias as the participants may demonstrate some particular traits or opinions which could lead to an unbalanced emphasis on particular data which is not representative of the study population (Saunders 2012).

The size of the sample is strongly influenced in IPA by the investigator's commitment to detailed analysis. Smith and Osborn (2008) acknowledge that some work has been carried out on individual case studies and in studies of fifteen people and more. The initial sample size for this study was sixteen participants; however, not all interviews are included in the thesis. One participant was excluded after discussion with the research supervisor as they were too distracted during the interview process and generated no workable data. The included sample of fifteen was drawn from four different Higher Education Institutions. These were the University of Birmingham, Birmingham City University and Ulster University all in the UK and Boston College in the USA.

2:4:c. Why is the sample size adequate?

This section provides supporting evidence for a smaller sample size in IPA and responds to the contentious question of data saturation. In 1995 Sandelowski (1995:179) discussed sample size in qualitative research. She recognised that researchers needed to be mindful that sample sizes,

> may be too small to support claims of having achieved either information redundancy or theoretical saturation, or too large to permit the deep, case oriented analysis that is the raison-d'etre of qualitative inquiry.

Elliott and Timulak (2005) acknowledge that the qualitative nature of IPA research results in much smaller sample sizes. Alongside this Hefferon and Gil Rodriguez (2011) suggest that researchers, research students and their supervisors have experienced misplaced pressure on the conduct of IPA studies to increase the sample size. Alase (2017:13) suggests that the sample size of participants in an IPA study, 'can be between 2 and 25'. The important factor in IPA research is that there is a homogeneity within the sample. As Creswell (2013:155) states, 'it is essential that all participants have similar lived experiences of the phenomenon being studied'. Smith, Flowers and Larkin (2009) acknowledged that IPA is concerned with 'a detailed account of individual experience'. They also acknowledge that the sample size needs to be tailored to each individual study's context, they suggest up to 6 participants in undergraduate research and larger groups for post graduate work. Reid, Flowers and Larkin (2005) also confirmed that a smaller sample size allows greater detailed analysis in IPA. Ziebland and McPherson (2006:405) state that,

> Careful sampling, the collection of rich material and analytic depth mean that a relatively small number of cases can generate insights that apply well beyond the confines of the study.

Whilst there is controversy over specific sample size in IPA one criterion often referred to as a mechanism to determine it is data saturation. Data saturation is when, during data collection, no new data emerges. Determining that 15 participants was an adequate sample size for this study was based on the quality of the information gathered, the ability to carry out detailed analysis of the data generated, little new data emerging during data collection (saturation) and to be honest no

further willing participants coming forward. There is no one-size-fits-all method to reach data saturation. This is because study designs are not universal. In a phenomenological study reaching data saturation is different to other qualitative approaches. However, researchers do agree on some general principles and concepts: no new data, no new themes and an ability to replicate the study (Guest, Bunce and Johnson 2006). Fuchs and Ness (2015) propose that data triangulation, using data from multiple sources can support data saturation. In this study participants from four different Higher Education Institutions and two different countries were interviewed as a result I found similar data emerging; similar themes; and a reiteration within interviews of the same concerns, experiences and joy of P/MH nursing, meeting the data saturation general principles of no new data and no new themes (Guest, Bunce and Johnson 2006).

According to Bernard (2012) interviewing as the method employed in this study is also a recognised method by which a study's results can reach data saturation. The number of interviews needed for a qualitative study to reach data saturation is not quantifiable however, Bernard (2012) also suggests that 'the researcher takes what he can get'. As in this study, no further willing participants came forward. However, as in this study, adopting interviewing as the study method also means that interview questions can be presented in a way to participants that provides an opportunity to replicate the study, again meeting the data saturation general principle of being able to replicate the study (Guest, Bunce and Johnson 2006).

2:4:d. Ethical considerations

In preparing for ethical approval it was necessary to draw up a participant information sheet (Appendix 3). This provided participants with information on the purpose of the study, investigator contact details, and risks and benefits of participating, as well as issues of confidentiality, consent and information on how to get further support or register concerns or complaints about the research process. Participants were also required to provide written consent at the time of the interview (Appendix 3). Participants were advised regarding the confidential nature of the research and that the interview would be recorded and last for up to ninety minutes or longer depending on the participants' discretion.

As this inquiry sought to explore P/MH student nurses' life worlds (Heidegger 1927, 1962 translation cited in Lopez and Willis 2004:729), I was keen to explore participants' perceptions of their typical day as a student P/MH nurse, this included their interactions with others and their subjective experiences and internal reflections. As a P/MH nurse, I wanted to utilise personal experience of P/MHN as a tool to search for a richer understanding, demonstrating empathy. Arguably as a fellow member of the P/MHN profession this work could be viewed as 'insider' research (Naples 2003:46) where, alongside the benefits of knowledge, ease of interaction and access to the insider group (Greene 2014) I had to be mindful of the associated limitations. These include: being too subjective (Aguiler 1981:15); being too closely allied to the group which may risk objective perception and analysis (Drake 2010); a risk of bias and compromised validity (Greene 2014).

This inquiry was informed by both the NMC (2008) and the British Psychological Society's (2008) ethical recommendations. It is important to recognise how ethical concerns have informed the development, implementation, analysis and planned dissemination of this work. One of the key considerations was the issue of non-maleficence, that one should do no harm. In working with student P/MH nurses questions of the potential vulnerability and disempowered nature of student nurses were discussed, as well as the possibly difficult psychological content that student nurse participants would be asked to consider. However, these risks needed to be balanced against the potentially empowering impact participating in research may offer to student nurses and the possibility of improving and enhancing the education of student P/MH nurses and influencing the research outcomes. As Liamputtong (2007:25) recognises, 'morally speaking, many sensitive researchers strongly believe that the benefits of undertaking the research need to be measured against the risks of being involved in research'.

As Paradis (2000) acknowledges, there is a risk in any research that the participants may be exploited, that painful memories may be evoked and that the researcher may distort or misrepresent the participants' inner worlds. The researcher is accountable for their actions and as such needs to ensure that the research questions do not stigmatize the participants, reinforce existing stereotypes or contribute to discrimination. In carrying out the data collection for this thesis I actively encouraged the participants to disclose, and to feel relaxed in an informal setting which may have led the participants to disclose more than intended. Power differentials between researcher and participants may also lead participants to feel coerced into giving greater detail than anticipated (Daly 1992). It is in response to these ethical

concerns that I asked participants to give their written consent to participate on a form which clearly stated that they may withdraw, without prejudice, from the study (Appendix 3). I reiterated this at the beginning of each interview.

Despite these not insignificant risks, participating in research also has some potential benefits. For some it can be quite therapeutic, and due to the confidential nature of research some participants may be able to disclose issues of real concern they had felt unable to disclose beforehand; for others the benefits are simply being able to talk and be listened to (Hess 2006).

In engaging in ethical practice it was necessary for me to be respectful and look to forge reciprocity with the participants where possible (Oakley 1981, Harrison, MacGibbon and Morton 2001). Reciprocity can be giving something back to the participants' community or the individual. This inquiry aims to enable positive change in P/MH student nurse education derived from the participants' experiences and recommendations.

In an effort to demonstrate reciprocity in this work, part of the process of interviewing the participants was to ensure that they left feeling positive about their contribution to future generations of P/MH nurses (Trainor and Ahlgren 2012). Asking how the participants thought their course could be improved, towards the end of the interview, was one way of demonstrating this. The inquiry arose from a position of respect for the participants, as colleagues, and as people embarking on a demanding professional career.

Of the fifteen participants, all disclosed personal or family experiences of MH problems. The first interviewee disclosed this at the end of the interview, having avoided answering the question initially. Recognising this led the investigator to review the order of questioning, and to provide participants with the opportunity to spend time with the investigator, develop a sense of ease and camaraderie, before asking this question. The investigator spent time during the interviews sharing experiences, at times both participant and interviewer would laugh, express concern, surprise and shock. Working in this way was part of demonstrating empathic understanding as advocated by Jaspers (1968). As a P/MH nurse, I used personal life experiences to establish a connection with the participants, a common understanding. This was an intentional part of the research process, as indicated earlier, in seeking to establish empathic engagement. The participants were also asked to talk about their experiences of P/MHN broadly in an effort to gather rich experiential data from participants as Husserl's (1901, 1913) approach to phenomenology recommends. This aspect of the study was unstructured and deliberately left open and led to detailed responses (see chapter four).

At the end of the interview process participants were given the opportunity to raise any issues they wished to, or return to any questions that they wanted to add commentary to. If there was nothing further, participants were provided with a short debrief. This consisted of a reminder of where and who they were. A response was elicited from all participants in regard to any support systems they had available to them personally that they could utilise. Alongside this, there was a brief discussion of what actions they could take if the material considered during the interview process were to later raise any issues or concerns for them. I also reminded the participants

of their individual university or college support systems including a free confidential counselling service where applicable. I provided participants with email details if there were any follow up queries or concerns (see Appendix 3 Participants information letter).

As part of the research process it is also useful to acknowledge some ethical issues that may arise for the researcher. The researcher needs to have clear strategies in place to deal with personal safety issues, guilt and actionable disclosure by participants (Where participants may disclose unsafe clinical practice or abuse requiring action, such as informing the NMC). In this inquiry, effective use of the University supervisor and engagement with a critical friend were the methods employed to respond to these issues. Prior to and post interview the researcher contacted, via text message, the supervisor and informed them of progress and safety. There was an agreed response in the event of failure on the part of the researcher to contact the HEI supervisor post interview. In relation to guilt, which Glesne and Peshkin (1992) acknowledge may arise in response to the rich data participants provide and where the researcher's response is limited, it is also important for the researcher to utilise the supervisory relationship effectively. To achieve this part of the supervisory process during the data collection period included time for reflection and a review of my reflective diary to discuss any relevant issues.

In working within a health and social care context the researcher has to be aware that the participants may disclose unsafe and/or illegal practice. In these circumstances, the researcher is bound by their professional code of ethics/conduct

and their action is a matter of professional judgement and conscience. It was therefore necessary to advise participants of the bounds within which I was working and explain how issues of patient safety and confidentiality would be responded to.

However, it is also worth noting that several researchers have referred to the feelings of gratitude, debt and privilege that they have experienced in relation to the participants in their studies (Liamputtong 2007, Cannon 1992 Cook and Bosley 1995 Sullivan 1998). During the interview process I was very grateful to the participants and my feelings of debt have helped me to continue with this thesis. I still believe I was extremely privileged to have shared the participants' experiences during this study.

It is also necessary to note that this research study utilised the resources of a transcriber and the participants were made aware of this. Before allocating this work I agreed contractual obligations from both parties, including confidentiality and secure maintenance of work. Also in line with Gregory, Russell and Phillips' (1997) recommendations, the transcriber was informed of the nature of the work, alerted to sensitive or difficult interviews, completion time and offered debriefing. Potentially, the employment of a transcriber could be detrimental to the rich analytical and descriptive processes that the act of transcribing the collected data may encourage. However, employing someone with the necessary skills to transcribe the work allowed me the time to listen and correct the work so that I was intimately engaged with both the process of transcribing and the work itself even before formal analysis took place.

2:4:e Ethical approval process

An essential part of the research undertaking was to ensure ethical approval from the participating Higher Education Institutions (HEI). HEI Ethical Committees have a clear requirement that researchers identify both the potential risks and benefits for participants and develop strategies to reduce the risks to participants. Before any actual research was undertaken, in order to meet ethical approval requirements for both the UK and USA a short course of on-line study on ethical principles required for carrying out research was undertaken successfully with Boston College and ethical approval was gained.

All UK universities agreed to accept the University of Birmingham's ethical approval in lieu of separate approval. However, both Birmingham City University and Ulster University required the investigator to seek agreement from designated senior staff (for confirming materials please see Appendix 3 Ethical approval and permissions). Ethical approval for UK universities were in place by March 2008 and participants were recruited from that point on. International ethical approval was granted by September 2008 and all research interviews were completed by the end of March 2009.

This study sought access to potentially traumatic and painful memories, experiences and issues. In response to this, the participants were advised that their respective HEI student counselling service was aware of the study and had agreed that if issues did arise for participants post interview, they would be willing to provide confidential counselling support from student self-referral. Participants were also offered a short,

focused psychological debrief at the end of the interview. This ensured that participants were grounded back in reality, were fully oriented and were aware of their own personal and HEI support services. HEI also require researchers to ensure the security and confidentiality of data collected and the safe maintenance of data throughout the duration of the study. The centre for this study is the University of Birmingham and it is through their formal ethical approval process that this inquiry gained ethical approval (see Appendix 3). All ethical approvals were in place prior to any undertaking of the research.

2:5 Study procedure

The physical location, specific language and note taking employed in the interview also had an impact. All interviews were held in as neutral a place as possible, usually an empty classroom in the participant's university campus. The semi-structured guide to the interview was provided to all participants in advance of the actual interview to reduce any possible anxiety about interview content.
The interviewer did not make notes during the interview, as they were digitally recorded. However, this was still no guarantee that the participants would feel at ease and contribute readily. In evaluating interview material as well as considering the participants' 'inner life' and experiences this inquiry also sought to address issues around locality and reflected on the social practices involved in the interview process.

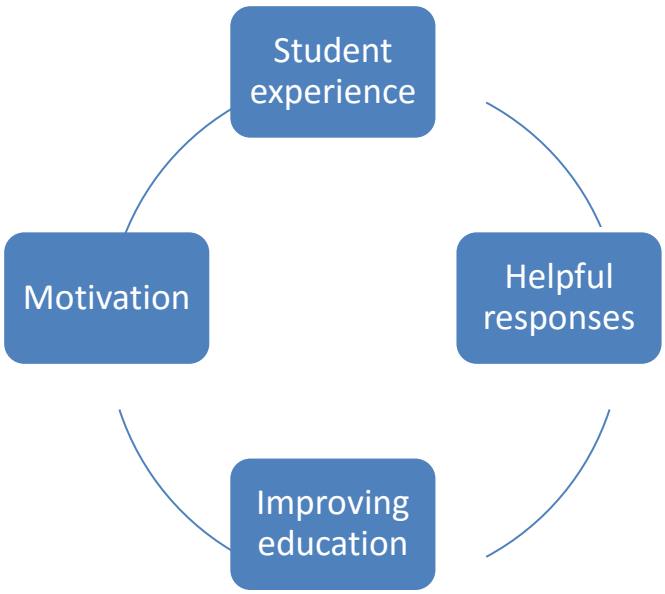
Smith and Osborn (2008) acknowledge the need to identify the broad areas for consideration in the interview process. The researcher needs to attempt to put these

topics in a logical order, check that they put sensitive questions later, identify questions for each of the areas identified and possible prompts to elucidate information from the participants. In the development of the research, the interview plan moved through stages from a very structured detailed schedule of interview questions, which felt very pre-determined, almost like an assessment tool rather than a semi-structured interview schedule, to the much more open and broad schedule (see pages 131-132). This focused on tapping into the participants' perceptions. Key words contained in asking questions about how participants 'felt'; or what they 'saw', were attempts by the investigator to access the participants' perceptual world. Smith and Osborn (2008) recommend open, jargon free, non-judgemental and neutral questioning. Smith and Osborn (2008) also recommend that the interview schedule be a useful prompt for occasional lapses in memory by the interviewer, not something that the researcher is dependent upon.

2:5:a Research data collection process

There were four core areas being considered in the semi-structured interviews: the participants' student nursing experiences, helpful responses, suggestions to improve P/MH nurse education and the participants' motivation for choosing P/MHN (See Diagram 2:2). This study focused on these four core stated themes I wished to explore but also considered any themes that emerged inductively from analysing the participants' interview transcripts.

Diagram 2:2 Four Core Research Themes



In line with Interpretative phenomenological analysis, participants' perceptions and data are presented and analysed in relation to the established themes and those emerging themes directly from the participants' data.

In some research, in an effort to record immediate thoughts, feelings and reflections from the researcher and aid interpretation, summary notes are made following each interview and self-reflective notes are maintained throughout the research study (Collins and Nicholson 2002). Likewise, I maintained a reflective research diary where post interview reflections were recorded in relation to all of the study participants, and this was later utilised to enhance the data analysis. The next part of this chapter maps out who, when, where, how and why the research was undertaken.

2:5:b Who was involved in the research?

In total there were fifteen research participants included in this study. All of the participants were self-selecting. Four students were from the University of Birmingham. They were the first participants recruited to the research study. All of these participants were white British and female and were aged between nineteen and thirty five years old. Four of the participants were from Birmingham City University; these participants were also all female, however, two of the participants were white British and two of the participants were black British, of African-Caribbean descent. These participants' ages ranged from twenty-five to forty-five. The four participants from Boston College were all white, three were female, and one was male. These participants were aged between twenty-one and forty-nine. Three participants were recruited from the University of Ulster, two males and one female, all white aged between twenty-one and forty.

One of the original five participants from the University of Birmingham was excluded from the study. The participant seemed distracted and unfocussed and after discussing this with the study's supervisor it was agreed that this participant's data would be removed from the study. The rationale for this was that it was unlikely that the participant was providing detailed answers to the questions or responding fully about their experiences as they appeared to be more interested in commenting on the interview environment rather than engaging with the interview, so there was little data available.

2:5:c When was the data collected?

The participants were interviewed between March 2008 and March 2009. University of Birmingham participants were interviewed between March 2008 and June 2008, Birmingham City University participants were interviewed between May 2008 and July 2008, Boston College participants were interviewed between September and October 2008 and Ulster University participants were interviewed in March 2009.

2:5:d How were participants recruited and where were the research interviews held?

Participants from the University of Birmingham were canvassed during an informal teaching session on P/MHN with a group of thirteen student P/MH nurses. The researcher's contact details were provided and participant information sheets and consent forms were handed out to students to take away and consider. Five student P/MH nurses made follow up contact with me via email and interview appointments were made at the students' convenience.

Three of the interviews were held in University of Birmingham classrooms after usual teaching hours, one in the student's own home and one at my home. All of the participants were second year students. There were twenty-six P/MHN students studying at the University of Birmingham. The participants made up around eighteen percent of the total P/MHN student population. (Student nurses at the University of Birmingham choose their branch of nursing after one year of core nursing).

Participants at Birmingham City University were canvassed through a range of posters and adverts circulated throughout their campus and posted during the students' P/MHN conference. Potentially, over one hundred and fifty students were canvassed, of these, four students across the range of years, contacted the investigator and participated in the research. Students were interviewed in empty classrooms or interview rooms in their clinical placement area with permission from their nurse mentor. The sample was slightly over one percent of the total population and just over two percent of the P/MHN student population canvassed.

At Boston College there were two groups of post graduate P/MH student nurses, in total fourteen students, both first and second years. All of the students (who attended) were canvassed by both Faculty staff and the investigator. Information on the research was also sent out via email to all potential participants. Four students volunteered and participated in the research. Approximately thirty-five percent of the student P/MH nursing population of Boston College contributed to the study; students were interviewed in empty Boston College classrooms at times convenient to them and their timetable.

At Ulster University, I was introduced to a group of eight third year student P/MH nurses as a research student, who had been given the opportunity to present on the investigation to the students and canvass them as part of their undergraduate research dissertation module. The students were given an overview of the study, consent details and participant information sheet. Three students participated in the investigation (approximately thirty-six percent of students canvassed, no data

available on total P/MHN student population at Ulster University at the time). Participants were interviewed in a vacant staff office at their convenience.

2:5:e Critical issues emerging from the recruitment process and role of investigator

Several interesting and relevant factors emerged during the recruitment process that may have influenced the study and participants' responses. At the University of Ulster the potential participants were introduced to the investigator as a fellow research student, the students clearly identified with the investigator as they were undertaking their initial undergraduate research work and of those that participated they were keen to support someone in a 'similar' position to their own.

At Boston College, as part of their course educational requirements students were expected to contribute extra-curricular hours to supporting faculty research and recruitment. Despite being unknown and having a relatively short window of opportunity to complete the research interviews, recruitment was not difficult. However, the possibility that the investigator was being seen as foreign, and so may have piqued participants' interest, should not be dismissed. At the University of Birmingham I was presented as a very experienced P/MH nurse and P/MH nurse educator, the potential participants were keen to gain insights, knowledge, and support and really engaged with teaching contact. There was the risk of possible manipulation of potential participants. I was presented in this powerful role, one which could have been useful in helping the participants feel a sense of identification with, a desire to emulate, and expectation of empathic understanding and help from me, if they contributed to the study. Certainly at Birmingham City University there

appeared to be potential conflict over the investigator's role (Head of Department), in terms of preconceived ideas, and the response this generated from potential participants. Some students seemed to fear the possible outcome of participation in the study, for example, that it may lead to failure in some way; others were keen to use the opportunity to discuss their concerns with someone of perceived power. Across all sites all of the participants appeared to demonstrate a genuine desire to contribute to understanding P/MHN and to developing the body of knowledge around the profession and for the researcher it was a privilege to carry out this investigation with them. This section of the chapter now goes onto a detailed description of the application of IPA to this study.

2:6 Data collection

2:6:a Interviewing

It is appropriate at this juncture to consider how interviews were employed in this study and to discuss critical issues in relation to this. In similar ways to those within a therapeutic context (Rogers 1951), I sought to establish trust, rapport and engagement. This is viewed as necessary in order to explore the participant's own inner world. Alvesson (2002:109) acknowledges that a researcher adopting this interview stance is likely to participate 'in a real conversation with give and take and empathic understanding'. The suggestion is that this is more likely to render the interview honest and reliable, in treating the participant as a partner in this work and as an equal it enables them to realistically represent and express their personal world. By employing empathy and trust, it shifts the participant from a 'repository' of

ideas and feelings into a source of knowledge who can also actively interpret. However, one cannot ignore the post-modern critique (regarding the interplay of power/knowledge/relationships and the rejection of one objective understanding and acknowledgement and understanding of the plurality of interpretations and meanings) of this approach and it is important to acknowledge that the research interview setting is no guarantee of this way of working, irrespective of the skills of the researcher (Foucault 1980). Alongside deliberate interpretative approaches it is worth considering how I brought my own intentions and motivation to the situation as would the interviewee. My intentions were to find out what led people to choose P/MH nursing. I was motivated by a desire to understand, to see if the reasons were relevant to nurse education. But I also wanted to know if the participants had considered their reasons, if they were self-aware and reflective about their choice and how this may have been influenced through and during their experiences as student P/MHNs.

This demonstrates how an interview can be seen as a complex social situation. On one hand, the interview situation could be viewed in positive terms where both are agreed on knowledge production; alternatively, both parties could be anxious and defensive and the interview itself thus becomes an increasingly complex matter. It is necessary to acknowledge the role of power and authority within the interview context. In an effort to reduce interviewer bias and to enhance objectivity, Alvesson (2002) recommends that two interviewers be present, one active and one passive observer. However, it is arguable that rather than reducing interviewee anxiety or potential reluctance to participate, Alvesson's (2002) approach potentially mirrors a

police interrogation. The implication is that the interviewee will become increasingly reluctant to share their personal worldview and experiences.

However, it is naive to assume that the interviewee acts only in the interests of the research endeavour. P/MH student nurses may well have their own agenda in participating in research, but this does not equate to dishonesty. Considering the local context of the interview can assist in devising an appropriate approach to interviewing. Both participants - interviewer and interviewee - realistically are likely to structure the situation and to minimise awkwardness and rebalance any power differential. It is necessary for the interviewer to be active in making the interviewee comfortable and engaged. There is a fine balance between neutrality versus friendliness and the possibility of too much interference, so maintaining an appropriate balance falls to the interviewer's judgement.

The interviewer needs to be fully aware of 'the interplay between two people with their own gender, age, professional background, personal appearance, ethnicity' (Alvesson 2002:115) and how this impacts on the data produced. In the context of this study the participants showed great respect towards me and I sought to reciprocate that. The participants were willing to share intimate personal information to help me. In terms of the data produced I believe it is valuable. But as Alvesson (2002:111) argues, 'the person to whom a research subject speaks is not the person an interviewer thinks herself to be'.

The research participants could position the researcher as any of the following: Educator, P/MH Nurse or Research student. All of these different identities and how

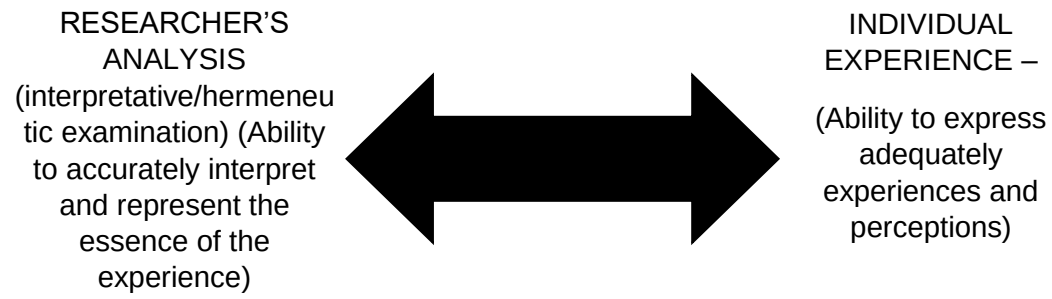
the participants read them will influence the accounts bought forth by participants. This reality has led me to reflect on each interview and to revisit them to try and draw out what each of the participants wanted to convey, as well as respond to the questions I am trying to answer.

2:7 Data analysis

IPA requires the researcher to enter into a sustained engagement with the text and interpretative processes.

IPA Diagrammatically represented

(*Diagram 2:3*)



Adapted from Brocki and Wearden 2006

This engagement starts with the detailed analysis of one case study. The transcript is read several times and interesting or significant issues are annotated (Giorgi 1985). Smith and Osborn (2008:67) refer to this as 'free textual analysis'. It is useful to sum up comments or suggest possible patterns or connections during this initial stage of analysis. It is relevant to consider the language used to express ideas

and the sense of the person that emerges. Smith and Osborn (2008:67) go on to say that the investigator should also consider the 'similarities, differences, echoes, amplifications and contradictions', in the transcripts. Having made this initial commentary on the transcripts, it then becomes necessary to recommence this process, considering both transcript and commentary on the transcripts and to begin documenting emerging themes. Earlier commentary is used to produce concise information on what has been found in the transcript. The emerging themes will utilise significantly greater levels of psychological language but the links directly to each participant's response are kept clear.

> An important concept that was articulated by Heidegger was that of co-constitutionality. This concept indicates that the meanings that the researcher arrives at in interpretive research are a blend of meanings articulated by both participant and researcher within the focus of the study… there could be more than one interpretation of the narratives depending on the focus of the research… the researcher must go further by interpreting the meanings for practice, education, research and policy to create informed and culturally sensitive… knowledge
> (Lopez and Willis 2004:730).

There are risks of over romanticising the role and work of the author: care must be taken that the text does not become expressive rather than productive or reproductive. Denzin (2005:323) acknowledges that 'clear description', 'provides the basics for interpretation, understanding and verisimilitude'. IPA requires a rich or thick description which provides, 'the context of the experience, states the intentions and meanings that organised the experience and reveals the experience as a process' (Denzin 2005:505). From this rich description arise claims for truth. Inscribing creates the opportunities for the reader, through the researcher's

representation, to engage, interact, and 'see' the research participants. Denzin (2005:325) states,

> Building on what has been described and inscribed, interpretation creates the conditions for authentic, or deep emotional understanding. Authentic understanding is created when readers are able to live their way into an experience that has been described and interpreted.

This process can be seen to be closely allied with Jaspers' (1968) concept of empathic understanding intertwined with an empathic hermeneutic.

There are different story telling and writing styles that directly influence the interpretation of material. Boelen (1992) has criticised some research work for severe misunderstandings, where the researcher does not understand local language or culture and has therefore misrepresented the participants. Every effort has been made to avoid this in this work, through checking understanding directly with the participants during their interviews and revisiting interview recordings and transcripts. But as Denzin (2005) points out, drawing on post-modern theory, this could just offer an opportunity for different stories to emerge.

In line with Denzin's (2005) comments this thesis has attempted to adopt an interpretative, multi-voiced narrative, in which the researcher includes interpretation of the experiences of the study participants. A multi-voiced narrative has been sought by maintaining the participants' voices within this thesis. This work is also influenced by interpretive interactionism as described by Denzin (1989); 'the task is to produce richly detailed, inscriptions and accounts of such experience' (Denzin 2005:335). The research is centred on what experiences in P/MHN or in life have

altered and shaped the meanings the participants attach to themselves and their identities as student P/MH nurses. This process enables the researcher to illuminate those life changing moments or the 'essence' of the participants' experience (Husserl 1901, 1913). These personal experiences are, in analyses, connected to the historical, social and cultural contexts.

In this investigation a double hermeneutic means that both the analysis of the historical, social, cultural and political forces that influence and sculpt student P/MH nurses' making meaning of their experiences is required, as well as the analysis of their data from a psychological perspective by the investigator. Therefore the analysis engages with the issues of power and the dominant socio-cultural and political discourses which influence P/MH nursing in keeping with Heidegger's interpretative stance. Denzin (2005) identifies how interpretation can be viewed as storytelling; he argues that the researcher adopts a public persona from a paradigmatic perspective, which enables the person to hide behind and write their story from, for example, a phenomenological position, which prescribes the form of the story. 'An interpretative or phenomenologically based text would, emphasize socially constructed realities, local generalisations, interpretive resources, stocks of knowledge, intersubjectivity, practical reasoning and ordinary talk' (Denzin 2005:318).

2:7:a Critique of interpretative process in data analysis

In moving from data collection or 'field research' to textual or data analysis, Denzin (2005:313) suggests that in order to provide a coherent sense of what has been

learned through the research study one requires ‘the art of interpretation’. The practice of this art, ‘allows the field worker-as-bricoleur’ (Levi-Strauss 1966:17) ‘to translate what has been learned into a body of textual work that communicates these understandings to the reader’ (Denzin 2005:314). Denzin (2005) points out that these texts constitute tales/stories or narratives of the field. Interpreting data requires a retelling, as participants also tend to provide their data in the form of a story or narrative. As Ricoeur (1985:4) points out, ‘these tales always embody implicit and explicit theories of causality, where narrative or textual causality is presumed to map the actual goings-on in the real world’.

It is essential to acknowledge the difficulties facing any claim to knowledge derived from interpretive work. Post-structural and post-modern challenges have removed claims to a ‘privileged place’ for any research, and any interpretation is now judged on its adequacy in relation to a range of contexts and communities and it is imperative that interpretation does not, ‘devalue …objectify or displace motivations’ (Denzin 2005:15). Alternatively Richardson (1991:173) argues for interpretation that ‘articulates an emancipatory, participative perspective on the human condition and its betterment’. As Smith & Osborn (2008) have observed IPA does not attempt large generalisations. Instead the focus is placed on detailed analysis of individual cases. In seeking to provide some reliability and validity to this process it is, however, worth noting the following. A specific guide to the semi-structured interview was used in this investigation, which would in part make it repeatable (Morse et al. 2002). The same interviewer carried out all interviews. An interpretative approach does not lend itself to confirmation or legitimation in traditional terms of reliability, validity and generalizability (Stevens et al. 2007). However, whilst some effort to address these

issues is necessary, a post-modern sensibility would lead one to acknowledge a more local, political and personal legitimation, as appropriate (Whittermore, Chase and Mandle 2001).

2:7:b Representativeness of the data as a whole

In writing up the research a researcher attempts to represent each participant's voice, however, this is always 'directly connected to the writer's self-presence in the text' (Denzin 2005:319). Denzin (2005:320) argues, 'even when we allow the 'Other' to speak, when we talk about or for them, we are talking over their voice'. Alongside this is IPA's recognition of the double hermeneutic that both researcher and participants will interpret the data offered. In this thesis data is presented through my interpretation. I do seek to allow the participants a voice wherever possible, but I must acknowledge that in both presentation and interpretation, as the researcher, it is my voice which is loudest.

2:7:c Researcher effects

The recognition of the researcher as moulding the work, developing the focus, and 'guiding the inquiry' (Smith 2008:36) is well acknowledged in IPA. In recognition that the researcher has a role in constructing the findings they present in phenomenological work the conclusions and findings presented by the researcher 'have to be regarded as interpretations' (Ashworth 2008:18). The researcher uses personal knowledge and experiences to inform this study. Therefore:

> personal knowledge, according to hermeneutic scholars, is both useful and necessary to phenomenological research… bracketing is ..questionable within a hermeneutic approach, although making preconceptions explicit and explaining how they are being used in the inquiry is part of the hermeneutic tradition (Lopez and Willis 2004:730).

Within the process of IPA the acknowledgement of the impact of the researcher is clear. Traditionally, research that incorporated the researcher's perspectives had been treated as biased. However, more recently referring directly to experiential evidence has gathered support. For example in qualitative approaches such as emancipatory inquiry (Stanley 1990) there is clear engagement with the researcher's perspective or standpoint throughout the research study. This use of experience, sometimes referred to as 'critical subjectivity', involves reflecting on and utilising the researcher's experience in ways to potentially enhance the inquiry (Maxwell 1998).

Arguably, in all research, there needs to be acknowledgement of the unavoidable mutual influence between the researcher and the research participants (McQueen & Knussen 1999). As the researcher begins to produce the text, political, personal and experiential, (Maxwell 1998) discussion needs to inform this process. How the researcher makes sense is derived from their personal, beliefs, feelings and consciousness, in concordance with the researcher's experience. Initially this requires the researcher to be 'experiencing experience' (Denzin 2005:316).

Some IPA research studies have included multiple researchers in the hope that including multiple perspectives during interpretation will lead to greater sensitivity to

the data (Tourini and Coyle 2002, Reynolds and Prior 2003). The frameworks from which a researcher is working will influence what is 'heard' in an interview, what gets priority of representation and how included certain aspects are in the interpretative process. Therefore bias may well be present in some areas, yet not in others. Brocki and Wearden (2006) suggest that if the researcher makes an obvious declaration of their focus and concepts which inform their research practice it demonstrates clearly how the interpretation of the data will reflect both the participant's and the researcher's voice. The adoption of the interview as an unproblematic method is clearly flawed and should lead to tentativeness in any reading of both interview process and outcomes. Despite this, as Alvesson (2002:126) admits, 'the shakiness of the interview material should not necessarily prevent us from using it as an indication of people's beliefs and meanings or of social practices and conditions'.

2:8 Comparing and contrasting data

IPA as a method anticipates that the researcher will be examining significant psychological themes. On the one hand the strength of this approach is that it focuses on the individual and their experiences however, it is the aim of this research to ultimately go beyond the individual and to include the social and cultural context. Viewed in this way, the focus on the individual psychological approach can be seen to de-contextualise and potentially pathologise the individual and may rather be seen as a weakness in adopting IPA. However, in this work the themes that I sought to examine are largely psychological in nature. The inquiry has a specific focus on

motivation and personal interpretations of experiences, it is worth noting that an initial focus on the individual does not exclude the social and cultural context. Denzin (2005) recognises that in the process of interpretation the researcher needs to follow a cyclical approach, which would include making sense of the data; seeking to represent the voice of the participants; legitimating which would require establishing some kind of validity; and lastly desire or intention. In sense making Denzin (2005) refers to how the researcher begins the writing process and makes decisions about the content. In IPA this involves a range of analytical strategies including free textual analysis, establishing emerging patterns or connections, drawing out emerging themes, psychological interpretation, seeking out co-constitutionality and interpreting the blend of meanings.

The process for this study (see section 2:2b) included listening to and reading the entire transcription in order to develop a general idea of the whole and to understand the participants' language (Giorgi 1985).

This required me to read the text freely to gain an overall sense of what was being said. It also required me to seek to comprehend meanings and use my own personal experiences of being a P/MH nurse and potentially the same common understandings, to help interpret the work. Further stages required a revisiting of the transcripts and recordings with the aim of identifying themes from a psychological perspective. Once established, a further revisit to the transcripts seeks to ensure relevant meaning. Giorgi (1985) recognises the importance of transforming everyday language into psychological language and exploring the meaning and symbolism of language used in the interviews along with cultural, class and educational

differences, which may influence language. This involves a process of ‘reflection and imaginative variation’ (Koivisto, Janhonen and Vaisanen 2002:261) so the original language of the participants is shown and the psychological explanation of meaning carried out and reflected by the researcher is interspersed within the descriptive account provided by the participants.

Giorgi (1985) refers to synthesizing the transformed meaning into consistent statements or structure. This requires that the investigator offers the following: - a specific description and a general description of the situated individual structure and situated structures of student P/MH nurse experiences.

2:9 Thematic analysis

2:9:a Connecting the themes

The next stage of IPA (Smith and Osborn 2008) requires connecting the themes. The initial list is purely chronological as they appear in the transcripts, at this stage though, the researcher seeks to make sense and establish links or ‘clusters’ of themes, issues that are inter-related, directly linked or referential, and the investigator consistently returns to the transcript to validate this process. Smith and Osborn (2008:72) suggest that, ‘it may help to compile directories of the participants’ phrases that support related themes.’ The cluster of themes is then presented in table form see example below.

2:9:b Clustering the themes

Table of themes from UB1 (example from participant's data for illustrative purposes only)

1. Psychological Trauma occurring during the course
    a. Vicarious trauma – 'how would I be able to cope with that'?
    b. Physical Trauma – 'they had a few times where they were violent'.
    c. Burnout – 'I've had days when I've thought oh what am I doing? I'm not sure if I can cope with this'?

2:9:c Widening the analysis

In the next stage the researcher continues the analytical process with the other participants' transcripts. The researcher can adopt either a fresh start to each transcript and seek out entirely new emerging themes, and this is the recommended approach for small sample size groups, or use the themes from the first participant's analysis to help with the on-going analysis. As this study involved a large sample size for an IPA study (Smith and Osborn 2008), this study utilised the existing themes identified in the semi-structured interview process deductively to support the analytical process (Trochim 2006). So for example further instances of vicarious trauma were found, participants distanced themselves (BC2:221) and reflected the mental health service users fears as BC4 demonstrated:

> She was kind of scary in a way, she would have hallucinations and say, "I'm going to kill my kid, I'm not safe".

2:9:d Presentation of data

In the final analytical process a master table of themes for all participants is produced. The investigator reduces and prioritises the data; this may be based on richness of the data or prevalence of a recurring theme. It is useful to consider where themes converge; Smith and Osborn (2008) acknowledge that with limited convergence the investigator is likely to attempt higher level analysis to reconcile these disparities which can be a useful mechanism. In this work the analysis of the themes are explained, discussed and explored critically. The master table of themes for all participants was based on prevalence of recurring themes and sub-themes. As Denzin (2005:322, 323) acknowledges,

> the writer invests experience with meaning, showing how everything has suddenly become clear'. Writing then, relives and re-inscribes experience, bringing newly discovered meanings to the reader. Their problems and their crises are bought to life. Their lives gone out of control are vividly described. Their lives suddenly illuminated with new meanings and new transformation of self are depicted. What is given in the text, what is written, is made up and fashioned out of memory and field notes. Writing of this order, writing that powerfully re-inscribes and recreates experience, invests itself with its own power and authority.

2:10 Critique of IPA

2:10:a Weaknesses of IPA

There is recognition that phenomenology, particularly Husserlian, may focus on pre-cognitive knowledge which could make it incompatible with IPA. However, this study

applies a range of phenomenological philosophies (Heidegger 1927, Jaspers 1968, Smith and Osborn 2008) to the data, which allows for participants' cognitive processes but does not exclude Husserlian theory either (Willig 2001). The application of the differing philosophies can be seen when examining the participants' data. The participants' responses to the semi-structured interview questions are analysed from a Heideggerian perspective, whereas the participants are encouraged to discuss their experiences much more richly, fully and descriptively in concordance with Husserl as acknowledged earlier.

There is a risk that participants might seek to represent their experiences and meanings in a way that they assume is desirable to the researcher. Reynolds and Prior (2003) found that this could be overcome through the interpretative analytical process and by explicitly examining this. Indeed, this raises the issue of interview structure; whilst a semi-structured approach is an exemplar of IPA method there is a risk that the questions posed will determine the participants' emerging themes and therefore, may indicate to some extent the researcher is pre-prescribing the data analysis, rather than responding directly to the lived experiences and meaning making of the participants. However, in using a deductive approach, adopting a broader perspective and working downwards to the more specific, rather than inductive, allows the specific issues to emerge from the participants data (Trochim 2006).

It is perhaps relevant at this point to acknowledge that in this research the structure and focus of the interview did inform the framework for data analysis (Swift et al. 2002) as I am exploring particular aspects of the participants' lived experiences and

seeking to ask specific research questions, this does still leave space for the analysis of the participants' emerging themes.

As Brocki and Wearden (2006:92) recognise, 'it seems unlikely that researchers could embark upon a project without having at least some awareness of the current literature and issues surrounding the area'. Golsworthy & Coyle (2001) acknowledge the subjective nature of data analysis in IPA and that no two analysts working with the same data will duplicate each other's findings. It is arguable that reliability is not a useful criteria with which to measure IPA based research, as the objective is to offer one possible interpretation (Smith and Osborn 2008). Similarly in relation to validity, the attempt in IPA is not to provide a 'singular true account but to ensure the credibility of the final account' (Brocki and Wearden 2006:98).

Collins and Nicholson (2002) argue that the in-depth analytical and interpretative process required in IPA can lead to a detrimental dilution of the participants' data, Smith (1999) counters this argument by suggesting that in the writing up phase the rich participant data can re-emerge. Willig (2001) emphasises the value of IPA in understanding the individual personal experience rather than the social processes, but this may reinforce the de-contextualising impact of a purely psychological approach and is potentially a further weakness with IPA.

2:10:b Strengths of IPA

IPA has particular strengths in relation to explaining meaning, context, and complexity (Johnson, Burrows and Williamson 2004). Clare (2003) recognises that

IPA is compatible with the use of social cognition and discourse analysis and therefore has potential in multi-method research as well. Brocki and Wearden (2006:88) also argue that IPA has a particular relevance to health. They acknowledge the 'importance of understanding patients' perception of and interpretation of their bodily experiences and the meanings, which they assign to them. IPA allows us to explore these subjective experiences, and helps us to describe and understand a respondent's account of the processes by which they make sense of their experiences'.

IPA deliberately selects participants in order to focus on a specific research area. Smith (1999:413) argues that such research should be judged first and foremost on how illuminating it is of the particular cases studied and that the 'micro-level theorising should be richly informative of those particular individuals and may well be fairly modest in its claim to generalization'. Clearly a strength of the IPA approach is the potential for rich, illuminative data, although its weaknesses can be seen to be a lack of reproducibility and generalizability (Duncan et al. 2001). IPA does not actively seek generalizability but neither does it simply expect a retelling of participants' experiences (Hunt and Smith 2004). Rather, IPA encourages researchers to consider and interpret the data in relation to existing psychological concepts and within this, acknowledge the strengths and weaknesses of their own data.

Additional strengths of the IPA approach include that IPA has accessibility in terms of language and a straight forward approach and as Reid, Flowers and Larkin (2005:21) acknowledge IPA is flexible and able to engage, 'with both new areas

without a theoretical pretext and existing theoretical frameworks'. Tourini and Coyle (2002:196) contended that in adopting IPA they were able to provide useful understanding, 'into the subjective perceptual processes involved in their participants' relationships'. Kay and Kingston (2002:171) found IPA very valuable, 'where one is interested in complexity or process or where an issue is personal'. Swift et al. (2002) also acknowledge the contribution IPA can make in examining complex issues. Willig (2001:69) suggests that IPA, as a relatively recent method in research, allows the researcher, 'room for creativity and freedom'.

2:11 Summary and conclusion.

This chapter has considered the implementation and application of three phenomenological philosophers to this study, Husserl (1901, 1913 descriptive stance), Heidegger (1927, interpretative stance) and Jaspers (1968 focus on empathic engagement). The Husserlian philosophical perspective has provided relevant approaches to this work, in the form of description, reflection and examining the essence of any data collected. Heidegger's double hermeneutic enhances this work through its focus on the importance of recognising the 'holistic'; meaning, the social context and interpretation of the participants' data. Both of these philosophers' work has shaped the nature of this study. Jaspers' (1968) concept of empathic engagement informed my personal approach as the researcher, throughout this investigation.

The chapter has also offered a critical review and explanation of why and how IPA is used in this study and how the research was carried out. In order to do this some

discussion of examples of phenomenological research evidence of both best practice and recognition of weaknesses or critical concerns relating to this approach were examined. This chapter argued that IPA best fits the research questions.

This chapter has outlined how the philosophical foundation of this study, phenomenology and IPA, was employed in the actual method of carrying out this research study, whilst acknowledging the strengths and weaknesses of this approach and how this research seeks to address these critical concerns. The chapter provides an overview of the data collection process and how the research methodology was initially implemented. In the following chapters the work considers the implementation of this research method and the resulting data which is presented and analysed.

Chapter 3 Data presentation and analysis: Reasons for choosing P/MH nursing.

3:1 Introduction

This first data chapter explores participants' motivation for choosing P/MH nursing. Having informed the reader of the initial process of undertaking the research - the who, what, where, when and why of data collection and the rationale for this process in the methodology and literature review chapters - this chapter presents the results and analysis of the data directly answering the main research question using an interpretive phenomenological methodology. Initially data are presented thematically alongside concurrent analysis and exploration of the potential meaning of the data. The data are then considered in relation to practice issues such as power and socio-cultural issues and how the participants may make meaning of and inform their sense of identity as P/MH Nurses from an interpretive phenomenological perspective.

3:2 Data presentation – Why do student P/MH nurses choose P/MH nursing?

The data presented here focuses on the participants' possible reasons for choosing P/MH nursing. Descriptive data are interwoven with discussion, analysis and interpretation followed by a summary and review of specific IPA themes arising from the data. Having identified reasons for career choice as one of the main research questions three clear sub-themes emerged from the participants' responses. These were:

Sub themes

a. **Learning about self**
b. **'Fixing' self**
c. **Improving the service**

3:2a. How were these themes derived?

These themes were derived from analysis of the participants' data. Initially during the interviewing phase and listening to participants direct verbal responses these ideas were often being reiterated. Again in the re-listening to the taped interviews and reading and re-reading the written transcripts the participants often implicitly referred to these themes. The analysis and interpretation of the participants' data using psychological language (Giorgi 1985) also reinforced the idea of these themes as they consistently emerged in the data.

Participants' responses are presented and considered in relation to the sub-themes of why they chose P/MH nursing and this discussion offers rich Husserlian descriptive data (see Chapter two). This discussion is placed within a theoretical framework of psychological, psychodynamic and social concepts that offers interpretations from phenomenological perspectives (Beck 1977, Freud 1926 -1979, Goffman 1961). There were other motivations that emerged such as economics however, these were not consistently referred to and therefore not considered as sub-themes.

3:3 Participants' motivations to undertake P/MH nurse education.

The participants broadly indicated that they chose P/MHN due to both their own personal experiences of MH problems and/or those within their close family networks. These experiences ranged from depression, eating disorders, chronic bereavement reaction, post-traumatic stress disorder, severe stress, relatives' experiences of schizophrenia, drug addiction to bi-polar disorder. The data suggest that nine of the participants had chosen P/MH nursing to seek answers for their own personal difficulties. Some also indicated their motivation was to largely improve and enhance services. This was due to two differing factors: on the one hand, their negative family experiences in MH services and on the other a desire to emulate MH staff who had worked successfully with them and apparently inspired them to choose P/MH nursing.

The following discussion provides a detailed overview of the participants' responses to this issue in relation to the emerging sub-themes.

3:3:a Learning about self

The first sub-theme to emerge in this data was that participants wanted to 'learn about themselves'. This was indicated by one of the participants, who stated,

> That I find what I am as a human being... When you're attentive to other people's needs I think you also become attentive to yourself?
>
> (BC4).

This offers an interesting insight into this participant's motivation. They are not unaware that helping others requires a personal investment but one which includes increasing levels of awareness and learning about their motivations and sense of self. Several of the participants considered this within a desire to learn about oneself but placed this in terms of a need to acquire knowledge. For example,

> In high school I was part of a group called the peer help programme and we're just trained in kind of therapeutic listening
>
> Interested in psychology, psychiatric since school and I had graduated with a degree in psychology and had been working for a year and a half with emotionally disturbed violent youngsters
>
> (BC3).

This participant indicates the route of their interest lies in their high school experiences and how they then pursue a career associated with mental health. This participant's own experiences of family mental illness and Post Traumatic Stress Disorder occurred during their school years. It suggests a possible link between their own experiences and studying MH related subjects in order to understand these experiences.

But the risks for this participant is that helping others is fuelled by living through one's own problems as Clarke (2006) acknowledged earlier. This does recur in other participants' responses as indicated here:

> I finished the counselling course. I thought to myself I really need to get over onto MH because I need to find out more of what happens in the mind
>
> (BCU1).

Following a counselling course undertaken to assist with their personal issues this participant actively sought a transfer from Adult or General Nursing to P/MHN specifically. Two of the participants from the United States indicated that their motivation originated in part from exposure to psychological and counselling theories which have influenced MH practice (APNA 2014):

> Even just classes in college really has influenced me
>
> (BC2).

> I started taking psychology courses as a requirement and I really like them and so I decided to minor in psychology and my way in was nursing
>
> (BC1).

Another of the participants, again from the States, linked their motivation to become a P/MH nurse to both philosophy and psychology courses:

> I went into college and I took a few philosophy and psychology courses and I was incredibly stimulating and was like “ok that’s where I’m going”
>
> (BC4).

Expressing motivation for P/MH nursing through knowledge based activities may be linked to various theoretical explanations. The participants may typically be expressing or fulfilling a cognitive need to understand (Maslow 1943). However, considering the amount of mental illness, either personal or familial, and the apparent desire to establish some distance from serious and enduring mental illness that several participants demonstrate, this may be interpreted as an attempt to defend one’s sense of self, against stigma and limit the potential damage to both one’s own sense of self and others perceptions through Intellectualisation (Freud 1926-1979). However, it is worth acknowledging at this point that all of the participants from the United States are required to hold a graduate level qualification in nursing as a minimum prerequisite to entering P/MH nursing Masters level education programmes.

This may in part explain the recurrence of education and theoretical knowledge as a motivational force for these participants (Happell 2009, Happell, McAllister and Gaskin 2014, Thongpriwan et al. 2015) at a noticeably higher level than United Kingdom participants or it could suggest a more effective self-defence process (APNA 2014). The literature review suggests that enhanced education around P/MH nursing and mental health specifically has a significant influence on career option (Porredi et al. 2015, Ong et al. 2017).

Other participants were much more personally revealing about their motivation to learn about themselves. For example, the participant quoted below distanced themselves from any personal experience of mental illness, yet in offering an explanation as to why they did not want to work in child nursing, might have revealed some of their possible motivation. The death of a close childhood/adolescent friend is likely to have left them feeling vulnerable and unable to cope with the loss, so the participant avoids this area of work but also uses the mental defence mechanism of denial in relation to working in MH (Freud 1926-1979). This may also reflect an effort to distance themselves from the potential stigma attached to mental illness (Goffman 1961) and working with people with mental illness (Strang 2007):

> Before I entered university I had no experience of mental illness whatsoever there's absolutely nothing, there are reasons why I didn't, I always knew I didn't want to do child nursing and I always knew I didn't want to do that and that was because one of my best friends died when he was well I was 14 and he was 15 so I knew I couldn't. I couldn't do that so that ruled that out for me but it wasn't it didn't push me towards P/MHN sorry
>
> (UB2).

This participant does reflect on their unresolved loss and subsequent grief and correspondingly a desire to understand why their close friend had to die and their own responses to this. They also recognise their inability to work with people of a similar age at the time of their loss, however, they do not link this to their motivation to work in mental health. As the literature review (Alzayyat and Al-Gamal 2016) indicated those student nurses who used avoidance strategies were more likely to experience higher levels of stress.

This may hint at an unrecognised pool of psychological distress that student nurses, or this individual, bring to their course. Student nurses may be potentially unaware, or even reluctant to address their distress (Richards et al. 2006, Freeburn and Sinclair 2009):

> I think obviously (XXX) died ... that was only five years ago which isn't really a very long time so I think obviously sort of maybe down the line, think about it in a different way that I think about it now, I think especially he died as such, he was 15 and it was very much he didn't even finish his GCSE's. We all say like pretty much every year one of us would bring like one of my good friends would bring up like what would you be doing now and that's very sort of, it's still, it's still we're all be like he'd be 20 now I wonder what he'd be doing, I wonder if he'd gone to university and that sort of thing
>
> (UB2).

This participant might have been motivated to choose P/MHN in a perhaps unrecognised desire to address their own loss issues, but this was not the only motivating factor. They also demonstrated a desire to challenge themselves and recognised that P/MHN provided situations where they were likely to have to explore their identity and sense of self (Smith and Osborn 2008):

> I'm very much a person I don't make things easy for myself I will do things that sort of challenge myself …and so perhaps because with mental illness often your challenging the unchallengeable so I think that drew me to it a little bit and perhaps because my mum and dad are like are you sure, are you sure you want to do this perhaps that pushed me to do it a little bit which is a really bad reason for joining a career cause your parents don't think it's a good idea. But they're really supportive now they're absolutely fine about it now
>
> (UB2).

This participant is acknowledging that their motivation to work in P/MHN is against expectations, specifically from their parents (Brimblecombe 2006). This may suggest a desire for attention, affirmation or rebellion in terms of their position within the family (Berne 1964). The idea expressed that they are challenging the unchallengeable in relation to mental illness suggests that they have, to some extent, accepted existing notions and classifications of mental illness (WHO 2016, APA 2010), whilst holding a contradictory desire to work against this.

In motivational terms, this participant may hold cognitively dissonant views, which may reflect their desire to identify with the group. Maslow (1943) clearly identified the human motivation for a sense of love and belonging. This participant may want to be accepted by their parents as the primary group and by P/MH nurses as their chosen occupational group, but also alongside MH service users, as the oppressed and damaged. This identification with MH service users may be another example of mental defence mechanisms (Freud 1926-1979). This participant's apparent mismatch or dissonance could also be viewed through a framework of Transactional Analysis (Berne 1964, Harris 1973). On the one hand, they are seeking to champion the cause of MH service users, yet on the other, and parallel to this, to champion themselves within their family. The notion of champion, hero or rescuer emerges in both Berne's (1964) earlier work and Harris' (1973) work; this way of responding to situations, this way of adopting a particular position in relationships, can become established in people's life narratives and this theory suggests it then becomes a recurring pattern of behaviour.

Another of the participants described their motivation for choosing P/MHN mainly in terms of learning about themselves. For this participant, growing up and caring for family and friends clearly influenced them (Edward et al. 2015). Unlike the participants who referred to a desire for knowledge, the following participant acknowledged how their experiences led to a desire to understand mental illness (Ong et al. 2017):

> My mum has a very caring nature, a lot of children and my sisters cared for me as I was growing up because my brother was ADD so my mother had to spend a lot of time with him, and she didn't really have a job so used to spend a lot of her time helping people in the community that she didn't necessarily know, so when I was growing up and all my brothers and sisters were living at school I used to go with mum and spend time with an autistic boy down the road, got quite into fundraising for him, got quite involved in his care as well and really enjoyed it, I found it really rewarding (UB5).

As did having close relatives with MH problems (Granados-Gamez et al. 2014):

> I mean I've had some family, I've got a cousin who's got learning difficulties and he is now more like an adoptive son to my parents as his family left. So again he's very sort of part of my life and something that I've been involved in and my uncle had schizophrenia as well (UB5).

These experiences left UB5 with a desire to understand mental illness and their own personal context as is clearly indicated from this statement:

> So for me going into MH is really interesting to sort of learn what I'd been seeing for the past however many years

(UB5).

These participants were female student nurses and gender theories may offer some explanation in relation to their motives and compliance with perceived traditionally female caring roles (Guberman, Maheu and Maillé 1992). One of the participants from the USA acknowledged their motivation very specifically and this was very clearly focused on learning about themselves:

> I could identify very clearly three motivations. The first one was...a family member who had schizophrenia, my uncle, and we the family like just being part of the whole struggle of helping manage and being supportive and being confronted with something that none of us were very well equipped to handle was a pretty informative experience for me so… When I got older.. 'Ok, that's where I'm going.' You know addressing situations of the human condition, not necessarily MH but that's (where I) ended up. My first job was as a MH case manager which is someone who works with people with mental illness and access to community services and help people
>
> (BC4).

Another participant also indicated that learning about others helps a person learn about themselves, and there was an element of self-exploration indicated in their response:

> I think that's part of why I wanted to do this because it's not factual you know, someone can't hand me a textbook and say you know, 'here's all the answers go out and discover it', it's almost like learning as you go in the profession, because every day is learning
>
> (UU2).

Barker (2000) confirms the need for P/MH nurses to be self-aware if they are to engage in the therapeutic use of self in working with people with mental health problems. This participant indicated a personal history of MH issues as a motivator, whilst recognising the importance of learning about themselves when they stated:

> Mainly because I know how painful it can be, and that, what a difference it can make, you know, understanding yourself (BC1).

Yet they also appeared to withdraw from their own MH problems and distance themselves from these, when they said:

> I mean I grew up with my Mother and she was very depressed, you know and that's as traumatic as it got for me so I think I was very fortunate (BC1).

Again BC1, like several of the other participants, sought to distance themselves from the possibility of associated stigma due to MH problems (Strang 2007). This could be viewed as an illustration of denial (Freud 1926-1979) in action, where the participant has effectively blocked their own MH issues through using this defence mechanism.

Another participant from the USA also acknowledged the influence of their mother's MH problems and that their context had influenced their motivation to learn about themselves through P/MH nursing (Thongpriwan et al. 2015):

> I would say a lot of it is personal experience my own experience realising that I had grown up with someone having to struggle with mental illness and never even knew it and definitely even just classes in college really has influenced me and I think overall the big reason in wanting to go into it is I think that, I mean I have this drive to help people which think is why all nurses go into it (BC2).

When acknowledging a desire to help others BCU3 revealed a need to learn about themselves:

> Just love to have that input into someone's life to be a positive influence and just to, to show that all that shit I've been through just doesn't stop you, you know it may delay things it may put a hold on your life, but at the end of the day it's not to be all and end all…. I just wanted to put my experiences into something useful and something I could learn from (BCU3).

This participant clearly demonstrates Clarke's (2006) contention that P/MH nurses may risk not helping others by inadvertently living through their own problems in the context of the caring relationship. UB3 indicated that initially their interest was generated by their sister's MH problems:

> I was quite interested in it from a personal point or view because my sister spent some time as an outpatient at XX unit so I spent a lot of time at the XX hospital with her'. 'My sister probably had quite an impact like introducing me to the fact it was there (UB3).

However, this participant expressed a keen desire to understand both people and MH issues (Ong et al. 2017), and underpinning that desire might be a desire to understand their own responses to others:

> I guess part of the fact is that I can see that other people get MH problems because they've had horrific things happen to them. In P/MHN you're just trying to understand people and I really like that, I really like hearing peoples' stories. It's multi factorial, on one hand it's the underdog, I quite like that on the other hand human beings are just so interesting
>
> (UB3).

This motivation to understand others and therefore oneself is reflected in UB1's comments:

> I thought all the various problems the patients had interesting, but you would be encouraged to talk to them and build a relationship with them'. 'I think part of my personality is curiosity and that I liked fitting in, being able to have a good conversation with someone and build kind of therapeutic relationship
>
> (UB1).

In considering the participants' responses to why they chose P/MH nursing this apparent desire to understand themselves fully in terms of their own mental health, their motivation, their relationships, their personal and familial history and context, in other words their sense of self and identity, is closely related to the notion of fixing themselves or wanting to fix themselves. Understanding can lead to change, healing and an enhanced sense of self and identity. Within this interpretative phenomenological analysis it is conceivable then that becoming a P/MH nurse is motivated by a desire to understand oneself within a MH context and therefore to fix

oneself. Several of the participants readily acknowledge close family members' MH issues yet appear to struggle with recognising their own. As indicated, the possible theoretical explanations for this may include Freudian mental defence mechanisms, specifically denial or, in line with Strang's (2007) work, that participants fear the potential stigma attached to mental illness. UU1 also recognised their motivation to learn about themselves:

> There's a history of suicide in my family, one of my (relative) was, so I sort of have an understanding towards that, how that can affect a family so I, I haven't had to deal with it yet.
>
> (UU1).

But in concluding that statement they hinted at unresolved issues and suggested that at some point they would need to face their personal and family history and context and fix themselves and that P/MHN was the mechanism through which they intended to try to do this. This next part of the chapter explores the sub-theme of fixing self.

3:3 b Fixing self

From the data, it becomes apparent that one of the participants' key motivations for choosing P/MH nursing is a desire to fix themselves. Specifically, this is in relation to experiences of MH problems or psychological distress (Edwards et al. 2015, Ong et al. 2017). The educational process undertaken to become a qualified nurse is identified by several of the participants as the key mechanism by which this fixing process appears to take place.

Whilst initially one of the participants appeared very reluctant to discuss their reasons for entering P/MH nursing, they hinted that their response was not a full answer:

> My mum is an occupational therapist worked in physical and MH and she said she enjoyed MH and I did speak to her quite a lot about it, her experiences so yeah that's probably a little bit. She mentioned working on a ward with people who'd self- harmed and I think she also worked with people with anorexia as well and that was an area that interested me as well the eating disorder area, she said at the time she found a challenging group to work with, that got me interested in and she said the same about the psychiatrist she preferred working with a psychiatrist, to the physical health doctors so
>
> (UB1).

They also inadvertently disclosed that anorexia was a specific aspect of MH that held special interest for them; eventually they revealed more about their motivation. In their first response, the participant projected their own personal interest onto a family member. This led me to change the semi-structured interview sequencing, moving the question on asking why the participants chose P/MH nursing to the end of the interview. The participant became less nervous and more interactive over time. The participant demonstrated a real reluctance to disclose their own personal history of MH issues and even when they did eventually disclose these, there was an attempt to distance themselves from an actual mental illness. The participant suggested instead that they had 'come close', to the disorder but managed to 'avoid the extremes of it'. They also offered an attempt to justify and explain their MH issues when stating:

> Yeah, I, the eating disorders, I always had issues with food and dieting, I've never got to that stage where I was anorexic or was classed as obese, not gone to either extreme, but when I was at school I was very, when I was about 15 I remember weighing myself one day and I weighed about 7 stones, something 7st 10lb, I think. Even now I remember the weight I was that focused on it and I thought ooh, this is horrible I'm really fat and there was a part of me that probably thought if I could lose weight then cause I never had a boyfriend or anything up to that stage, that's when the girls just starting going out with each other (boys) and I think part of it was ooh if I could be slimmer I'd be like with the girls in the popular group and I lost a lot of weight very quickly and the school actually rang up and said to my Mum did she want me to go and see the school nurse cause they noticed I'd lost so much weight so I think I can identify a little bit with some of the issues they have with their eating I think that's what attracted me to that but also I think (I'm) a complete obsessive organiser I think I've got definitely identifiable OCD characteristics so I quite like that area as well. I think it will I think as I go on through the course when I qualify I think it will affect what areas I'm interested in as well
>
> (UB1).

However, there was awareness that these personal MH issues had influenced and informed their career choice and would continue to do so (Gunusen et al. 2017). Alongside this there was an attempt to re-label their own MH issue, Obsessive Compulsive Disorder, a disorder, seen as more amenable to treatment, than Eating Disorders (Warin 2010).

UB2 just barely hinted at a need to fix themselves when they made this statement:

> And perhaps because my mum and dad are like, 'Are you sure? Are you sure you want to do this'? Perhaps that pushed me a little bit, which is a bad reason for joining a career cause your parents don't think it's a good idea
>
> (UB2).

This participant recognised that this response was not exactly healthy but they did not demonstrate any awareness that the P/MHN course might be their choice to understand and repair themselves and their relationship with their parents.

The participant followed this statement with a laugh which, whilst it was a dismissive gesture meant possibly to undermine the seriousness of the statement, did not negate the apparent need to fix self. When asked about their motivation for choosing P/MHN UB5 spoke about their family experiences and again this statement provided useful insight into the participants' motivation:

> My mom has a very caring nature, a lot of children and my sisters cared for me as I was growing up because my brother was ADD so my mother had to spend a lot of time with him (UB5).

The participant recognised the caring role that their mother undertook, but they acknowledged that they were then cared for by their sisters and, in this context, the statement suggests that a need to fix self is linked to their choice of career; possibly in nurturing others they can experience vicarious nurturing (Morrissette 2004).

This participant used humour to disclose their recognition that P/MH nurses appeared to have their own set of MH issues:

> Well funnily, I heard somebody say from another course, another section of general nursing and they said, 'I think all the student nurses on the MH branch they've got MH problems which is why they have chosen MH nursing'. So, I sat down one day in class and I started to assess everybody (laughs) and I was at the back of the room and I started to assess people individually and I thought, 'hmm, maybe there is some slight truth in that', (laughs) (BCU1).

Again, however, like several of the other participants BCU1 attempted to put some distance between themselves and mental illness, when they said:

> Not that they have MH problems but I think people with any sort of, how do I put it, any sort of problems, like depression or anxiety, panic attacks, people who are searching almost for their own, for things to solve their own life problems I think you know, 'cos for me I felt like it has been a journey… (BCU1).

This participant also indicated that they had some desire to learn about themselves:

> So, I guess the fact that I had a (child) who was unwell and the fact that I had problems, it's life problems you know, I felt that the MH course would help me (BCU1).

Yet at the same time, mixed in with this desire to learn about themselves, to be able to resolve their life difficulties through learning, there is still a basic drive or motivation to fix themselves which remains apparent. This participant also recognised that the P/MHN course itself was a means to try and fix themselves. This was clearly demonstrated when they stated:

> as my problems unfolded I felt like the course helped me to understand and to cope better with the problems I was having (BCU1).

BCU2 indicated that they needed to work through their own MH issues, but unlike several of the other participants, they felt they needed to do this before commencing P/MH nursing, rather than by virtue of the course itself:

> at the time back then, there was no way I could be a professional and go through a university education, the state I'm in. I was too busy trying to find someone to prop me up most of the time, I had no spine, I was nothingness I have actually overcome all of those ideas and found some part of me that was worth anything and decided ok I've got my children, I've got four children now this is my turn and now I'm going to fulfil that ten years ago, little, little idea that was possibly just a joke, I'm going to have a bash at it and now here I am (BCU2).

However, in reading this participant's statement there is a sense of disdain for the person this participant used to be and an attempt to dismiss them as 'nothingness', and a hint also that the course will provide a new potentially healed identity. BCU2 also revealed significant loss in relation to MH and their family:

> I've had family members who are not well and didn't make it to be quite honest (BCU2).

However, they did not really explore this issue in relation to their motivation to choose P/MH nursing. In relation to Maslow's (1943) theory the participant may have been seeking to regain a sense of belonging and love. Entering the P/MHN profession might have been a mechanism for them to belong and identify with a new group, replacing the primary group or family.

On the other hand, one of the participants talked openly about their experiences as a MH service user and how both positive and negative experiences helped motivate them to become a P/MH nurse:

> I've had some terrible CPNs in the past, absolutely atrocious, but there was one I was working with for the last two years, so was absolutely fantastic, inspired me to think is that really possible you know the nurse can give so much in course of…I just became fascinated with the interactions…. and just to allow me to develop personally, it worked with my recovery to make me a stronger person and I want to do the same thing to help others in the same way, so it would be like a mutual journey or development…I really wanted to make something positive out of the pretty crap two or three years of my life
>
> (BCU3).

Their statement indicated that they would need to continue to fix themselves, yet they seemed to hope that this could be carried out both within and potentially through their practice as a student P/MH nurse. BCU4 discussed their own personal life experiences, as a teenage mother and abused wife as the motivation for choosing P/MH nursing:

> I don't see myself as a victim but as a survivor…I was a teenage mum and got married to the father who turned out to be a bully and abusive control freak and I was with him for fourteen years and that impacted on my life. It came to a point where I had to start thinking about myself and put myself and my children first in XXXX where my ex-husband attacked me
>
> (BCU4).

This participant also declared that their working experience influenced their choice (Porredi et al. 2015):

> Seeing people with like the youth work I did with social services the whole thing it's been a good experience, there's people worse off than yourself, things that happen to people are circumstances
>
> (BCU4).

This participant indicated that they believed they had worked through their issues before commencing P/MH nurse education. However, they still hinted and perhaps acknowledged, to some extent, that they had changed during the course, when they stated:

> but then it's up to you as a person to, if you can, change it given the right tool, right encouragement, the right resources
>
> (BCU4).

And P/MHN had helped this participant to fix themselves:

> I don't think I could've done this profession without my personal experiences cause I am the living breathing end produce of if you want to change you can, if you want to get better you can, the support is out there but its bloody hard work, you know
>
> (BCU4).

This participant acknowledged that they were motivated by their personal experience but there is a strong indicator that they were hoping for healing through the educational process. This participant did not, however, make any link between these experiences and a need to fix themselves. Instead they externalised the helping process, directing it at others rather than themselves and suggested that their motivation was to help others:

> That is my buzz that I am helping somebody who can't at that particular time, help themselves, because I know what it's like to feel you're on your own
>
> (BCU4).

Yet it is very clearly indicated that this participant had experienced real psychological distress and had a need to fix self (Richards et al. 2006, Pryjmachuk and Richards 2007, Nolan and Ryan 2008). One of the participants from the USA did eventually acknowledge their MH issues as a motivating factor in choosing P/MH nursing:

> I was always dealing with depression during my life, but I never really did anything about it, I might have seen a therapist from time to time, but never really finished it'…At the time it was kind of a difficult time in my life, I was having trouble in my marriage having a mid-life crisis probably in my late 40s
>
> (BC1).

This participant recognised a need to fix self but was reluctant to suggest that this motivated their choice of career. There were arguably two processes going on in parallel reflected in their apparent inability to act decisively in relation to their life problems at the same time as their MH problems were deteriorating resulting in a crisis. That crisis had clearly led to a career change was not acknowledged by this participant. Another of the American participants recognised the need to fix themselves and they referred to the work they had undertaken before starting the course when they said:

> To attempt this [course] I have post-traumatic stress disorder, it's very under control now. So I have had this personal experience with it and on top of my having to see past the stigma of it and I was in fact someone who was affected, I think, the very thing that got me to go to therapy was when my Mum told me she had depression…Perhaps because of my personal experience I think that's like the area of most need, I really do
>
> (BC2).

Interestingly this participant's own personal and familial experiences of MH problems raised their awareness of the commonality of mental distress. However, rather than distance themselves from mental illness, this participant expressed the notion that their own family's mental illness enabled them to choose their career in psychiatry:

> I never, would've known that my Mum had depression.. you know, is what really made me go and so definitely that experience myself and knowing how hard it was by knowing that I got through it
>
> (BC2).

However, there is a hint of this distancing and a suggestion of prejudice, when they state:

> she was really sad but the fact that I would never have thought of her as a typical crazy person (referring to their Mother) (BC2).

Again there are aspects of seeking to fix oneself also present in this participant's response. Another one of the American participants openly discussed their own MH issues with MH service users in a work context:

> I tell my patients that I too have benefitted from psychiatric help and have been able to overcome a lot of sadness and stuff like that so, and look where I am and you know I once felt like I wanted to die and that would help them, and they knew that I knew where they were coming from, not just some perfect, always happy, always knowing person, that could only ever empathise and they take me a little more seriously (BC3).

They recognised that they had worked through some of their personal MH issues and that their experience had motivated them to work in a similar way with others (Gunusen et al. 2015) as is indicated in this statement:

> I think another reason why I chose to do this profession was because of how much therapists had helped me and how much my advisor in High School helped me grow as a person and become more happy with life and stuff (BC3).

This participant also talked about their motivation to become a P/MH nurse in altruistic terms (Edward et al. 2015):

> my mum had a bone marrow transplant and so day to day I just wanted to do everything with her to have her happy and healthy. I transferred that relationship with my friends and I always wanted to be the friend who, you know, friends went to when something went bad and I was the supportive listener
>
> (BC3).

Arguably this could be seen as altruism, a desire to help others being the motivating force for this participant. However, they also suggested that they took on the role of rescuer (Harris 1973) within their friendships and at the same time they indicated that they spent time during school receiving psychological support:

> I met the school therapist in high school. I always thought she was a wonderful woman and I was so happy to, you know, bring all these issues out into the open'…. 'I felt comfortable with her. I just gained so much from her and I started hoping that one day I could give back to other kids
>
> (BC3).

This participant was clear that this was a positive experience and identified with the school therapist. However, Morrissette (2004) would suggest that a lack of parenting had led BC3 to self-nurture through parenting others. One way to interpret BC3's comments is to suggest that underpinning their altruism could be a need to fix self and that their comments belie this and are evidence of denial of this need. The last American participant very openly admitted that the course had the potential for fixing them and welcomed the opportunity:

> I feel like at some point at some way it's going to come that I find what I am as a human being and I like myself and what I've become through learning in a way in which you can be with people so, and plus you get like this free access to...inside yourself you know and you would normally have to pay hundreds of thousands of dollars for it kind of thing for an analyst kind of thing so, when you're attentive to other people's needs I think you become also attentive to yourself in the way you like now it's always the case but it's a grand opportunity
>
> (BC4).

The participants from Ulster also demonstrated similar motivational factors (Thongpriwan et al. 2015) although their life experiences were more obviously extreme. The first participant from Ulster revealed their personal motivation when exploring why they chose P/MHN and the context around their choice during their interview:

> It's coming from my background, I am from xxx, there was the xxx bomb in xxx, which made me leave the country. The bombs at the time affected me really badly, because I lost some friends in it and it was a worry for my dad at the time. My dad was the first on the scene and he clammed up after it, he couldn't talk about it, so it was hard in that respect… And then came home after 6 years…. At university, I did the whole meet someone, fall in love, lived together, so I was there 6 years and then when we split up it was very nasty for me. I was very depressed and never got outside help for that, I kept it to myself and turned to drugs, a lot of marijuana and went through a vicious cycle of a downward spiral and got to the point where I had a suicide plan and was going to carry it out and then didn't
>
> (UU1).

Like BC4, UU1 acknowledged that they were motivated to undertake the course in the belief that they would be able to fix themselves and this was apparent when they stated:

> I applied for the nursing but I think initially I really wanted to do it, I always did but I was hoping that I could find some answers myself while doing it and that would've affected my thinking through my first year, I dealt with it through my own networks but it could have drastically affected what I was doing now if I hadn't been able to do that. I've got I think from my experiences a lot of empathy with those who come in with depression, particularly after a relationship break up
>
> (UU1).

However, it is arguable that this participant had not really resolved their inner conflict over choosing P/MHN as this contradictory statement demonstrates:

> I think some are attracted towards it as self-help and sort of think that helping others and myself there is an element of that to it. Anyone going into it would really need to look at the reasons why. If they're going in to primarily sort out their own problems, they need to take a step back, sort out the problems, and then see if they still want to go into it
>
> (UU1).

Initially the second participant from Ulster was also very honest about seeking to fix themselves:

> I myself have come from a background where I was a patient, in MH therapy, and so probably I think the danger was that I was going into this as self-therapy, so I had to be signed up from

> Psychologists before I could actually come on board and do the course… In reality I had a MH background but I didn't disclose it to anyone in the workplace. When I was sixteen/seventeen I took an overdose, I don't know if I wanted to die or not, but I definitely regret it, it wasn't the best thing I've ever done, and I was quite void, I was eighteen, nineteen and developed eating disorders as well and I think it was a combination of I was studying (topic) at the time and I had a lecturer who made advances on me when I said 'No', I automatically went from being at the top of my class.. I had a bad relationship, an abusive relationship…It lowers your self-worth and I suppose that's…a straw that broke the camel's back...just kind of felt shit, so I took an overdose one night and I was assessed by (MH Service)
>
> (UU2).

UU2 indicated that MH issues, like addiction, were too much for them to cope with in their employment context, but they then chose to work in P/MH nursing, suggesting that they needed to focus on MH to address their own needs, to some extent:

> I used to work in a homeless hostel, started when I was eighteen, I was too young, I wasn't old enough to cope with the concepts of alcoholism and drug addiction especially as it was men in their forties and fifties and I was an eighteen year old, I just thought I was too young to do that, so I focussed mainly on mental health...I reached the top of my pay scale, I wasn't going anywhere else, and so I decided that I would go and do MH Nursing, 'cos that fitted the profile of what I wanted to do
>
> (UU2).

Taken in the context of their other statements about their motivation this participant may perhaps have become overwhelmed both personally and within their work. During the interview process this participant also revealed that their father was an alcoholic and their mother had addiction issues and left the family home when they were young. However, a potential correlation between these issues and the

difficulties they experienced at work or personally was not apparent to the participant and no connection was made during the interview. During the participant's discussion of their MH assessment when admitted to hospital they suggested that this experience also motivated their career choice: they discussed the process and impact it had on them at the time:

> I talked about the initial relationship and my sexuality .. He said something really flippant like he seemed to be uncomfortable with my sexuality and like it was that why I took an overdose, (I) was going, 'how could you come to that conclusion?'...And so I just felt that the service was horrible…I just thought the service itself was appalling, .. Was referred then to the Psychiatrist who felt that the problem was behavioural so I had a referral to the Psychologist…It took maybe three years after the overdose before I was properly seen…By that point I had overcome the wanting to die, but had developed eating disorders, and subsequently tackled that myself.. My self-esteem wasn't so good so I spent nine months with a Psychologist to build my confidence…So by the end of it I kind of just thought I could easily complain about how bad the service is or I could do something about it and its easier to change it from the inside that the out so I kind of, it was probably one of the big driving forces for the direction
>
> (UU2).

However, woven within this discussion there was a sense that the participant was working through their personal issues and the course remained a mechanism for this and their motivation was, in some part, to fix themselves. This perhaps becomes more apparent when this participant discussed who, what or why they chose P/MHN and stated:

> I was probably working with a patient trying to, of my age, with quite bad psychosis, the history of sexual abuse which was never disclosed, I think because of the age of the two of us we built up a rapport ...I always associate him with the reason I do mental health. He's the patient I identify that with
>
> (UU2).

This disclosure suggests a level of denial that is intriguing, this participant's own history parallels the patient's yet they make no connection. The third participant from Ulster acknowledged their own MH problems which had bought them into services and then nursing:

> I had history of MH illness myself, I've had postnatal depression, which lasted for ten years. My mother and my sister both had it, my mum has it quite severe, really just on-going illness, it's chronic, it started off as clinical depression'…. I took my postnatal and spiralled completely out of control with it, I attempted suicide a few times…. My clinical psychologist, she applied for my place for me, she actually got me through the interview
>
> (UU3).

This participant was deeply embedded in the process of fixing themselves but they had separated out P/MHN itself from this process, rather identifying their motivation as a desire to improve services. However, the course itself was a measure of change for this participant; that other MH professionals now deem them ready to undergo this, seemed to indicate that this participant could emerge from the course healed and with a new professional identity, fixed.

These data indicate that 13 out of the 15 participants were motivated to choose P/MH nursing in part through a desire to fix themselves. Freud (1926-1979) would suggest that this could be an attempt to regain mastery within the context of mental illness. Morrissette (2004) also acknowledges the significant number of people undertaking helping roles in an attempt to help themselves. Freud (1926-1979) would also suggest that the participants' experiences around mental illness have led to psychological trauma and the participants are seeking to re-enact this trauma, regain mastery over it and therefore be healed. What emerges from the data is this recurring theme of trauma, I will delve into this more explicitly in chapter five. Another method for the participants to potentially regain mastery would be to improve the service. In this next part of the chapter the participants' data is explored in relation to this sub-theme.

3:3c Improving the service

The third sub-theme that of improving MH services, should be viewed as a continuation of the other two sub-themes. The participants want to help services improve partly because this sits within a context of fixing both themselves and ensuring better care for people with MH problems, which may also include them. Several of the participants indicated that they were strongly motivated by a desire to see MH services improved, largely in relation to their own or close family members' experiences of actual services. The first of these participants was intrigued by people:

> I really like hearing people's stories so I guess that's part of it as well
>
> (UB3).

And also intrigued by MH issues. They were also aware of the social stratification that occurred in relation to people with MH problems (Gilburt 2015):

> I came to uni with the idea that I was going to choose P/MHN and it didn't manage to put me off my first placement, so when I started I wanted to go into drug and alcohol, subsequently I did a couple of days with drugs and alcohol and I don't think that's really what I'd like to do anymore, but it's really hard isn't it because it's multi-factorial but I guess on one hand it's the underdog, I quite like that, on the other hand human beings are just so interesting to be quite honest the people that get like treated the most shit by society tend to get MH problems, so I think I'm a lot of it is the fact that, and also then get further treated badly because they've got MH problems so I guess part of the fact is that I can see that often people get MH problems because they've had really horrific things happen to them, and as a result get a MH problem and they shouldn't really be penalised for that
>
> (UB3).

This participant also recognised that their knowledge and awareness of P/MHN was generated by their sister's mental illness:

> I guess I was quite interested in it from a personal point of view because my sister spent time as an outpatient at the XXX Unit, so I spent a lot of time with her at the XXX Hospital with her, I guess that's built up quite an interest, so because, I guess some people must, but at school you don't, well I certainly didn't realise that MH Nurses existed so I guess there have been a number of things that led me down this path.. my sister probably had quite an impact, like introducing me to the fact that it was there
>
> (UB3).

The next participant refers to their history and experience as a MH service user and was very clear about their motivation to improve MH services when they stated:

> I was probably sitting in the smoke room on the day unit thinking I could do a better job than this, you wait until I'm on your side of the fence! No joking apart there is probably some truth in that and also that I've sort of, I've had family members who are not well and didn't make it to be quite honest and, I believe that there's the attitudes of some people who I also came across when they were nursing me, very unhelpful, very detrimental to the patients at times they could be, and I used to sit there when I was in for a short time and talking to the other patients and taking an interest and wanting to help them through their day
>
> (BCU2).

This participant also emphasised their desire to improve MH services and reduce the stigma attached to mental illness when they stated:

> I can help other people get through it and also knowing that I don't belittle it, what happened to me but I also realise that there are people who go through even more hurting things than that… I really want to let patients know that like, people understand that they have a disease and also like let the public know that it is a disease and that it's no one's fault that they have a mental disorder
>
> (BCU2).

In the next statement one of the American participants indicated that they were also highly motivated to become a P/MH nurse in order to improve the service, recognising its shortfalls whilst at the same time acknowledging excellent role models (Cleary, Horsfall and Happell 2012, Walsh 2015) within the service:

> Fast forward like ten years there was this one patient…but suffering horribly by virtue of the fact that he couldn't manage his symptoms very well and there's a Nurse Practitioner that performed extraordinarily well with this guy and just connected. And I started bringing other patients to her because she was so effective with people and she was doing good therapy and keeping people engaged and very well motivated to continue... which leads me to the point that I'm at now, on the psychiatric nursing programme. I love working with people with mental illness and substance abuse
>
> (BC4).

One of the participants, a recovered MH service user, showed somewhat mixed motivation they had, both a desire to learn about their self, as referred to earlier (see pages 175-188) , and to improve the service because the service had been awful and yet al.so very restorative and healing when they found the right practitioner. This participant talked very honestly about their motivation to choose P/MH nursing:

> I had a history of MH illness myself… My (family member) was in a bomb very young, lost limbs and had two very young children ... My memories of being in the psychiatric unit and visiting and (family member) …was detained and it was awful and scary.

> I took my post natal [depression] and spiralled completely out of control with it, I attempted suicide a few times …I had an excellent GP …Got me seen literally within a week, with my own CPN who was an absolute darling and stayed with them for almost getting on ten years, and actually went on the foundation course through my clinical psychologist… I wanted to go down the line of counselling and that was my first initial, I wasn't even going to touch the nursing, at all. Its seeing it from both sides definitely has influenced in a big way. I know what way I would like it done and what way I definitely don't
>
> (UU3).

They certainly implied a strong motivation to improve the service and yet within this response the participant was also indicating that their motives included learning about themselves and inevitably fixing themselves. Several of the participants talked about the importance of the nurse patient relationship (Gunusen et al. 2017) and patient care, not unlike their qualified nurse counterparts (Van Sant and Patterson 2013, McAllister, Happell and Bradshaw 2013) as a mechanism for improving patient services as these quotations indicate:

> My whole reason for going into nursing was the client experience (UB5).

> Just love to have that input into someone's life to be a positive Influence (BCU3).

> So to me, that, I always say, got to make a difference (UU3).

> I think overall the big reason in wanting to go into this, it is I think that, I mean I have this drive to help people (BC2).

> And I think because I feel empowered as a black women from the inner city helping a client who is not able to advocate for themselves because they're unwell, that's my power trip – if that can be allowed (BCU4).

> Getting to know someone being actually able to build a rapport with them (UB5).

Other participants recalled their own MH service experiences as mentioned earlier and stated (see page 208/209 BCU2 verbatim quotes) that they were motivated to work within the system to improve it for others:

> So I had a bad relationship, abusive. I just kind of just felt shit, so I took an overdose one night and I was assessed the next day by psych liaise service – you know I talked about the initial relationship and my sexuality and being gay and things. He said something really flippant like he seemed to be uncomfortable with my sexuality and like it was that why I took an overdose…And I just thought the service was appalling...I could do something about it and it's easier to change it from the inside...It was probably one of the big driving forces for the direction (UU2).

Another participant noticed a gap in the service for young people:

> it came to me, that I wanted to work with children, and I had two friends that were really trying to get children who had been through traumatic events and they couldn't find anybody to see, but their own kids inspired me too (BC1).

In relation to improving the service, participants indicated that they were driven by a desire to champion or rescue service users. Be this because of family or personal experience or altruism, there is a definite risk that the participants will become disappointed at the reality of the service and their ability to effect change (Rhodes and Bouic 2007, McLaughlin 2010). Rescuing ultimately requires a victim and this is not a sustainable or healthy motivation for a career choice (Harris 1973). Some of

the participants noted excellent nursing staff as role models that they had identified with and whom they wished to emulate (Cleary, Horsfall and Happell 2012, Walsh 2015). This is possibly a more realistic motivator but again unrealistic personal expectations and demands can lead to perceived failures which can impact on the participant's own MH (Morrissette 2004). This elucidates how this sub-theme in particular is inter-woven with both the learning about and fixing self sub-themes. The motivation to improve the service can be seen to correlate to the participants' desire to experience care, understanding and kindness, to either themselves or their family members, while receiving or delivering care. This can be interpreted as a motivation to reduce the stigma attached to mental illness by enhancing MH services. The concurrent impact on themselves would be positive, both as a patient in receipt of care, but also as a P/MH nurse in delivering care. These sub-themes can be seen to recur throughout the participants' data.

3:4 Analytical Interpretation of data

On analysing these data the participants demonstrate their desire for understanding of both themselves and mental distress. The data indicate that participants held beliefs that P/MH nurses must be mentally healthy, strong and able to cope, and knowledgeable about relevant biological, psychological and social theories. Conversely therefore they felt that P/MH nurses must not be weak or demonstrate that they are experiencing difficulty. Emotionally, participants indicated that they held expectations of feeling relaxed, capable, caring and altruistic, and thus they were not and would not feel anxious, uncaring or unable to cope. Whilst the participants'

beliefs indicated a somewhat idealised view of P/MH nurses (Rhodes and Bouic 2007, McLaughlin 2010), how they make meaning and identity from these beliefs is considered in the next section.

Other issues also emerged around socially constructed concepts such as ethnicity, power and gender. The gender profile of the participants is eleven women to three men. Female participants might have been influenced to choose P/MHN by socio-cultural expectations to conform to female traditional caring roles (Guberman, Maheu and Maillé 1992), whereas the male participants might have chosen P/MHN as a more acceptable male caring role (Nolan 1993). However, the participants do not refer to gender as a significant influence. Whilst the data suggested a significant level of motivation based on cognitive need, a further example of potentially influencing socio-cultural factors may be in relation to ethnicity and power.

One of the Black British participants demonstrated an over-identification with MH service users' disempowered position at times. The data suggest that the participant may have had an internalised position of being previously oppressed, both within her marital relationship and as a black woman in British society (Pilgrim 2009). As becomes clear in the next chapter this led to difficulties for this participant in socialising within the role of a P/MH nurse and their educational course also proved difficult at times. The data suggested that this may be evidence of the impact of her cognitive dissonance (Festinger 1957) in identifying with both the oppressed, MH service users, where black and ethnic minority service users are statistically over represented (Littlewood and Lipsedge 1997), and the potential oppressors, P/MH

nurses. This next section further examines how the participants make meaning of and inform their sense of identity from an IPA perspective.

3:5 Making meaning of and informing a sense of self and identity from an IPA perspective.

In the first sub-theme, learning about self, participants demonstrated a need to understand mental illness; they identified a desire for knowledge across areas related to mental health, and several participants mentioned previously undertaking psychology and counselling type courses. This could be interpreted within the framework of ego defence mechanisms (Freud (1926-1979) particularly intellectualisation, where the participant is using cognitive processes such as using learning to avoid dealing with emotional issues. For example, there may be evidence of some intellectualisation in UB2's response; that mental illness is unchallengeable, this apparent desire to challenge whether mental illness even exists could be viewed as an effort and desire to reduce the stigma of mental illness from one's own family. However, UB2 referred to notions of mental illness when they said that, 'you're challenging the un-challengeable'. This participant did not accept that mental illness was a given, and agreed, an uncontested concept. Rather they were verbalising their own doubts which draws attention to a possible reason to work with the MH system in a way that challenged the existing status quo. This would fit within the classic anti-psychiatry perspective that mental illness is manufactured (Szasz 1971). This participant's sister had required extensive treatment and the treatment offered her was dominated by the bio-medical model. What the participant appeared to be

indicating was some cognitive dissonance (Festinger 1957) in relation to existing concepts of mental illness and methods of treatment.

For this participant there could well be a conflict in their beliefs from joining a profession such as P/MHN which in the UK is closely allied to psychiatry and the biomedical explanations of mental illness and physical treatments for service users. Yet at the same time being unsure if they really believe in mental illness, this may lead them to cognitive dissonance.

On the other hand, Maslow (1943) suggests that human motivation does indeed include a cognitive need and this participant might have been motivated to choose P/MHN because of this cognitive need. This UK based participant was disinclined to accept a purely biomedical explanation for mental illness. In comparison, the Boston College participants, whose post graduate programme includes diagnostic and psycho-pharmacological prescribing responsibilities, expressed greater confidence in the disease model. For example their acceptance of physical treatments for mental illness such as psychopharmacology were more apparent during subsequent discussion of their experiences in practice.

Other defence mechanisms deployed included denial; the denial of one of the participants that the loss of a young childhood friend had left any residual damage is a possible example of this (Freud 1926-1979). Similarly, one participant's suggestion that they always wanted to do nursing, but that it was for no specific reason, could be

interpreted as an effort to distance or protect themselves from the emotional realities of their choice of career.

This motivation to learn about oneself can be interpreted as being within a knowledge or cognitive framework. However, the participants' responses suggest that they were motivated because of their personal experiences, family context and a desire to learn about their own coping strategies and mental health (Edward et al. 2015, Ong et al. 2017).

Undertaking P/MH nursing appears, in part, to be motivated by a desire of the participants to process their own personal experiences of mental illness and integrate these into an aspect of themselves (Gunusen et al. 2017, Granados-Gamez et al. 2017), which possibly benefits others and yet, at the same time, leads to greater self-understanding. A key aspect of this is evident in the participants' responses around coping skills (Alzayyat and Al-Gamal 2016), and ways and means of responding to people with MH problems therapeutically. Here the participants identify what they can do - 'be a supportive listener' (BC3) and help them 'solve their own life problems' (BCU1) - or should do 'build a relationship with them' (UB1) and 'in P/MHN you're just trying to understand people' (UB3). The emphasis is clearly on therapeutic activities such as listening, communicating and therefore building relationships (Henderson, Happell and Martin 2007, Happell 2008, Cleary, Horsfall and Happell 2012). A significant aspect of developing these skills leads to learning about oneself emotionally as well as cognitively. The participants also refer to their

family context as a motivational force and influential in learning about themselves (Ong et al. 2017).

The participants appear to be using their prior personal experiences around mental distress, and working to make these meaningful within the context of their choice and motivation for choosing P/MH nursing as their careers. They are using these experiences to help form their identities in learning about themselves and becoming increasingly self-aware, as P/MH nurses. It appears that their sense of self and feelings become reconfigured into their perceptions of the role of a 'good' P/MH nurse. They are using their own personal experiences and their experiences of people who have become their role models to determine these meanings. Therefore, it might be that participants are incorporating their existing sense of self and feelings associated with their personal experiences of mental distress, and reconstructing and processing these, whilst becoming P/MH nurses.

Alongside this, their experience of other MH professionals means that this 'new' identity as a P/MH nurse fulfils the requirements of 'fixing self', as MH professionals are perceived to be 'whole', 'healthy' people and the participants take on this new identity in order to nurse others.

Whilst evidence presented in the literature review (Happell 2009, Happell, McAllister, and Gaskin 2014, Thongpriwan et al. 2015, Porredi et al. 2015, Ong et al. 2017) acknowledges the importance of education on mental health issues in retaining

student P/MH nurses what the participants' data suggests is that potentially, then, the educational process is required to be a transformative one, providing the student P/MH nurse with a new identity, as one of the 'healed and healing' P/MH nurses. In terms of IPA the participants are making meaning by learning about themselves; and seeking out understanding of the human condition. This is within a recognised scientific framework, that of psychiatry, in order to understand their own and others' disorders. In order to make meaning in relation to their own disorder they are utilising P/MH nursing to fix themselves, and through the practice of nursing, caring and healing others, they are hoping to heal themselves. Several of the participants have configured this hope of fixing self in relation to MH services and explain their motivation to become nurses in terms of improving MH services. This suggests that the participants are searching for a new, healed sense of self and identity and that they are using their careers to provide them with a new way of making sense of their experiences of mental illness. Evidence presented in the literature review (Edward et al. 2015, Ong et al. 2017) identifies the impact personal experience of mental health issues can have in relation to motivation to choose P/MH nursing and the participants' data confirms this.

3:6 Summary and conclusion

This chapter has demonstrated that the participants' motivations to choose P/MH nursing as their career is focussed around three key sub-themes. These are the desire to learn about themselves; the desire to fix themselves; and the desire to improve MH services. Reflecting on the participants' data in relation to the literature

review there is a clear correlation between work on the importance of education for student P/MH nurses and their desire to learn about themselves (Happell and Gough 2009, Happell, McAllister and Gaskin 2014, Thongpriwan et al. 2015, Walsh 2015). Similarly the participants desire to improve P/MH services can be viewed as confirmation of the importance of being able to provide quality patient care (Cleary, Horsfall and Happell 2012, Gunusen et al. 2017) which is also significant for qualified nurses in job satisfaction and retention terms (Hautala-Jylha, Kikkonen and Jylha 2007, Van Sant and Patterson 2013, McAllister, Happell and Bradshaw 2013), where this study differs is in the recognition that student P/MH nurses are in part motivated by a desire to fix themselves. What also emerges from the data is the apparent psychological trauma participants experience, this will be returned to in chapter five and explored further.

The data demonstrate that there is some effort on the part of the participants to distance themselves from their own experiences of MH problems/illness (Strang 2007), and an expectation that the educational process will provide transformative 'healing', and enable the participants to become rebranded as P/MH professionals, and therefore by virtue of this, healthy. In the next data presentation and analysis chapter the participants' experiences during the course will be explored. The practice of nursing and its impact on the participants will be considered and analysed in relation to emerging themes and the research questions from within an interpretative analytical framework.

Chapter 4 Data presentation and analysis: In relation to the participants' experiences and how these experiences might have influenced them to choose P/MH nursing.

4:1 Introduction

In the previous chapter the participants' responses to specific questions, on why they chose P/MH nursing and what motivated them, were presented and analysed. In this chapter the focus is on exploring the participants' experiences of P/MH nursing and how these experiences might have influenced their career choice. Their experiences and discussion of these emerged as an inductive theme from the semi-structured interviewing process. As indicated in chapter two the participants were encouraged to talk freely in the interview, about their experiences, without specific questions. This chapter presents that data through the themes considered within the literature review around student nurse motivation to choose P/MH nursing; why stay in P/MH nursing and why they might leave the profession or factors that increase the risk of them leaving P/MH nursing.

4:2 Data presentation

Discussion of the participants' experiences and themes are presented as rich Husserlian descriptive data (Husserl 1913. See also chapter 2). The data are presented, analysed and discussed in relation to evidencing the themes and then from an interpretative analytical framework (Smith and Osborn 2008). The analysis and discussion go on to consider how the participants make meaning, form their

identity, sense of self and feelings from their experiences of being student P/MH nurses. This chapter also explores evidence around why student P/MH nurses might leave nursing and how their experiences appear to be linked not just to stress (Nolan and Ryan 2008) but also to psychological trauma occurring during their course.

4:3 Experiences as a student P/MH nurse and their impact on career choice.

4:3a How might the participants' experiences have motivated them to choose/continue with their course.

This section presents the participants' data on aspects of their experience which might in part explain their reasons for choosing P/MH nursing. Initially the participants indicated that their experiences of working with qualified P/MH nurses, how those qualified nurses worked with service users, and how the participants were able to work with service users; were significant influencing factors, this corresponds to evidence presented in the literature review (Henderson, Happell and Martin 2007, Happell 2008, Williams et al. 2009, Cleary, Horsfall and Happell 2012, Trenoweth 2013, Walsh 2015.) In this first section of data presentation the 'positive' experiences of participants and potential retentive factors are presented.

Several of the participants spoke about how qualified P/MH nurses needed to be passionate about their work. One of the participants suggested that qualified nurses:

> would stand up for their [MH service users] rights (BCU2).

In other words, there is an expectation that they would seek to represent the service users' best interests, or act as an advocate on their behalf. This was in a response from an English participant where specifically both the nurses' professional body, the NMC (2008), and the MH Act (MHA) (1983/2007), require and expect P/MH nurses to advocate for people with MH problems.

Several of the participants referred to the qualified nurses' ability and responsibility to administer medication, as a key component of P/MH nurses' responsibility, this was something that they identified with. The following responses were from US participants. P/MH nurses in the US (APNA 2014) are expected to have prescribing rights and there is more general acceptance of a biological explanation for mental illness than currently in the UK and Europe where there is more debate and consideration of closer links to environmental and socio-cultural issues (Barker 2009).

> I'm with a Nurse Practitioner and I observed her just you know reviewing medications with clients...she quickly assessed them (BC1).

Another of the Boston College participants confirms this when they said:

> I really did everything the nurse would do…I would see what meds they needed, give their meds, and sometimes that took a very long time (BC2).

There was also some acknowledgement by individual participants that the qualified nurse's role includes assessment; this is a recognised part of the nursing process, a problem solving cycle adopted by nursing in the US in the 1970s and in the 1980s by

nurses in the UK. The cycle requires nurses to assess a service user's needs; plan their care in collaboration with them; implement the care plan and evaluate its effectiveness, leading to (re)assessment and so on in a cyclical continuation of care (Binnie et al.1984). This participant's comment recognises that the qualified nurse has overall responsibility for patient safety and care. In order to do this the qualified nurse needs to assess each patient regularly. This process is sophisticated, with the qualified nurse applying knowledge and skills to assess the biological, psychological and social, state of service users (referred to as holistic care in nursing). See Norman and Ryrie 2009). They need to appraise this state and determine the necessary responses and actions. This also includes supervision as BC2 highlights:

> supervision and...I would go and do the rounds in the morning (BC2).

The qualified nurse is often part of a team delivering care, and they are required to delegate activities to team members and provide overall supervision to these staff including student nurses. Handing over relevant information is also part of the qualified nurse's role which was recognised and referred to by the participants.

> hear from the last nurse who worked with my four patients…what had been going on (BC2).

Handover is literally handing over responsibility to the on-coming shift or community team colleagues. The qualified nurse (primary nurse) takes responsibility for co-ordinating and providing all aspects of care for a small group of service users; they

may also have overall responsibility for all patient care and safety in a unit on a specific shift. The handover is a formal process of nursing where the nursing team discuss all service users' care delivered, changes in that care and the prescribed care due to be delivered on the following shift (Binnie et al. 1984). Participants also acknowledged that the qualified nurse is required to take part in multi-disciplinary team working and negotiation of care with service users (NMC 2015):

> Every morning we would sit down with you know ourselves, and the patient and the social worker and case manager, and the physician who was writing all the prescriptions for that patient…and it was really a discussion into like, work with the patient, 'How are doing? What do you think you need?' and it was really like this great collaboration
>
> (BC2).

Several of the participants identified aspects of the P/MH nurses role that they identified with, they indicated that they had emulated qualified nurses in their clinical practice experiences, they wanted to become as skilled and work in similar ways with service users. Interestingly many of the participants chose to emphasise aspects of the qualified nurse's role considered to be part of the art of P/MH nursing and indicated clearly in the literature review as of significance both to student P/MH nurses (Gunusen et al. 2017) and qualified P/MH nurses (McAllister, Happell and Bradshaw 2013). As the APNA (2014:14) concur, 'P/MH nursing, …employs a purposeful use of self as its art'. One of the participants referred to a P/MH Nurse Practitioner they worked with and indicated that they were exposed to good practice,

where the nurse had effectively engaged in a therapeutic relationship with the service users:

> I really respected her work, she really seemed to really to connect with each client in a different way, you know. She's a good role model
>
> (BC1).

This reflects the APNA (2014:18) expectations of the practice of P/MH nurses that: 'the work of P/MH registered nurses is accomplished through the nurse-client relationship, therapeutic intervention skills and professional attributes'. This notion of connectedness also appears in the literature when considering why qualified P/MH nurses stay in the profession, Van Sant and Patterson (2013) indicate that whilst it can enhance service user healing it may also promote nurse satisfaction and growth. Another of the participants recognised the art of P/MH nursing and the importance of interpersonal work (Barker 2009) when they stated:

> At the same time I feel like you can just by being human be incredibly helpful to people… there's enough people who improve by virtue of your existence that you know, you feel like that it's something very worthwhile pursuing
>
> (BC4).

This participant acknowledged the importance they attached to being genuine with people with MH problems. This is a core component of person centred care (Rogers 1951). Further participants referred to this aspect of the P/MH nurses' role in interpersonal work and psycho-social intervention terms:

> I just loved that it's more sort of like counselling effectively, sitting down and talking, getting to know someone being actually able to build a rapport with them … it enabled me to build relationships (UB5).

This participant's comment perhaps hints that moving away from more traditional aspects of a nurse's role - for example carrying out personal care - into a psychotherapeutic role, matches their expectations of P/MH nursing, this idea of making a genuine connection and working therapeutically is also very highly valued and meaningful for qualified P/MH nurses as McAllister, Happell and Bradshaw's (2013) work indicates. Some of the participants compared their earlier generic nursing practice experiences with P/MH nursing, they recognised the differences in nurses' roles, and they also seemed to indicate that P/MH nursing matched their preferred way of working:

> then I got to my MH placement but you would be encouraged to talk to them and build a relationship with them (UB1).

One of the UK participants acknowledged both the art (working interpersonally) and the science (evidence based and National Institute of Clinical Excellence approved, Norman and Ryrie 2009) of P/MHN when they stated:

> I realised as a MH nurse you could make significant positive changes to people's lives if it's done in an effective way (BCU1).

Increasingly in the UK the emphasis on evidence based approaches in relation to therapeutic work has led to the inclusion of a range of psychosocial therapies being relabelled ‘talking therapies’ and offered to people experiencing diverse MH problems from mild to moderate to severe (DH 2007a). One of the participants, who had already acknowledged the need for an effective approach to MH services, referred to this aspect of the qualified nurse’s role when they said:

> Meeting these people, qualified bank clerks, managers and stuff all came in to have therapy, talking therapy and I sat there with my mentor and I found it absolutely fascinating over eight sessions, how people made significant improvement in their mental health… she allowed me to undertake some of these sessions by myself so I had a little bit of dipping the feet in it and I loved it [laughs]
>
> (BCU1).

This participant reflected on their experiences of talking therapies offered. They suggested that they were perhaps a little surprised at the types of people experiencing MH problems and the professional status of many of the service users. This could suggest a pre-existing belief that people from lower socio-economic status are more inclined to mental illness. There is some evidence to support this belief (Rogers and Pilgrim 2003), albeit contestable, in terms of social drift theory (mental illness leads to poorer socio-economic status as the person is unable to attain educational or economic potential and therefore their status drops).
This participant also seemed to indicate surprise at the recovery rate of people attending therapy. This could be interpreted as a held notion that MH problems are long term, even life long, and recovery is rare. Alternatively it may have been

surprise at how little direct intervention is necessary and how relatively simple therapeutically helpful input by a qualified nurse can be (DH 2007a).

Both in the UK and the USA the role of the P/MH nurse is associated with therapeutic use of self, as indicated earlier in the introduction (Barker 2009; APNA 2014). Participants acknowledged their experiences of this way of working and appeared to want to identify with working with service users in this capacity. Qualified nurses may impact on student nurses in a range of ways and for a variety of reasons the literature recognises the importance of ways of working but also the need for positive, supportive role models in developing student P/MH nurses (Walsh 2015). In common with the work of Williams et al. (2009), Cleary, Horsfall and Happell (2012), Walsh (2015), Gunusen et al. (2017), the participants' data in this study suggests that the experience of working with positive role models seems to be a key factor in why the participants both chose P/MH nursing and stayed on their course.

Most of the participants in both countries acknowledged many positive experiences and attitudes from nursing staff in practice, examples of these include:

> my mentor was great
>
> (BCU2).

> I'm with a Nurse Practitioner...I really respected her work…she's a good role model
>
> (BC1).

These first two responses indicate that the participants found the qualified nurse responsible for working with them was effective, good in practice, someone to base their own practice on. The responses also show the potential that some of the participants may idealise (The Melanie Klein Trust 1997) qualified nurses. This also hints at the possibility that the beliefs they hold around the way qualified nurses 'should' behave, whilst reflecting positive values around how to care for people with MH problems, are possibly unrealistic (Evans and Kelly 2004, Rungapadiachy, Madill and Gough 2004, Mackintosh 2006, Rhodes and Bouic 2007, McLaughlin 2010). The next two statements indicate the importance that student nurses, like qualified P/MH nurses (Nakakis and Ouzouni 2008, Van Bogaert et al. 2013) attach to good working relationships with all of the members of the clinical team including service users:

> the team itself was brilliant
>
> (BCU4).

> I really fitted in quite well I got on really well with the staff and patients
>
> (UB5).

These examples indicate the similarities and differences between the UK and the US participants on the one hand in finding clinical staff and mentors helpful, welcoming and supportive. However, as will be explored later the UK participants found mentor relationships more difficult at times and there was greater variation in experience (Nolan and Ryan 2008). Whilst all of the participants had positive experiences in the clinical setting they also experienced difficulties or challenges in working with MH service users with complex needs (Happell and Gough 2009, Porredi et al. 2015)

The participants in both the US and UK worked with clinical nursing staff where they experienced clinical nursing staff who were passionate, engaged and interested in both MH service users and students (Charleston and Happell 2005, Happell 2008, Walsh 2015 and NMC 2015):

> one particular staff nurse who was very passionate about caring for these people and I admired her a lot and she would stand up for their rights and everything and she was brilliant (BCU2).

> I loved meeting people who were as passionate about MH as I was (BCU3).

Several chose to discuss case examples relating to their experiences of positive patient relationships. Their re-telling of their experiences offered a real sense of attachment and progress for both the service user in MH terms, and themselves in identifying with their profession. The first of these is where a participant discussed working with an individual client, supporting them in a community setting. This participant found their working relationship to be really positive:

> I was in a community placement yet again and I was working with this lady and she was obese and she was a black Afro-Caribbean lady and I remember she had lot of different mental diagnosis and she was struggling with this weight for many years… But I remember I was doing a health checker, what they call like an MOT a health MOT clinic and then she came in and you know had a chat with her and soon after I found myself working very closely with her and she's signed up at the gym you know, we started healthy eating programmes we would go to market together in

> [suburb of Birmingham], we would hand pick our fruit and vegetables and I could really see you know that she appreciated this attention and I really appreciated my mentor allowing me to do this you know and when I left this placement I was very saddened it was almost I wanted to stay there much longer… I still have her in mind because I heard she is still asking for me, she lost some weight, she changed the way she, you know her dietary regime, they said to me she really did miss me and I really did miss her because I felt I had my own personal client and I was actually making a difference in somebody's life.
>
> (BCU1).

The participant acknowledged the attachment and sense of loss for both the service user and themselves (Bowlby 1973). The participant indicated a sense of pride and achievement in their work with this service user (Williams et al. 2009, Trenoweth 2013). Appreciation of the qualified nurse allowing them the autonomy to do this work is reflected. Here the participant is working, albeit with a case load of one, as a qualified nurse. They said how sad they were to leave.

Some of the participants seemed keen to share their experiences of service users with whom they had had a measure of success; the next participant refers to a girl they had worked with:

> I guess I worked with one girl closely who was about ten, diagnosed schizophrenic, her mother was schizophrenic, she was adopted, from Russia aged three and was really traumatised and from an orphanage and so she had, a shower was a big thing with hygiene, and she had been traumatised by the way they bathed her and so we never really figured it out how to get her to be not afraid of the water and the shower…
> She didn't have problem with the pool, she go to love the pool, but personal hygiene was an issue and she also had Hep C [Hepatitis C] and, kind of, liked the idea that she could infect other people and so trying to not get her to pick her nose and wipe it all over

> the furniture and, she had some incontinence issues and so, coming up with plans and reward plans or discussing it with her, and then she was very depressed, she heard voices that, you know told her she was awful, obviously and so trying to, you know get her to come to us and tell us about that so we could you know help her… she didn't have a lot of friends she wasn't a popular kid and that was tough too and I started writing a journal with her so she would write an entry and then I would comment on it and write something and that seemed to help.
>
> (BC3).

What appears to have stayed with this participant, alongside the overall complexity of the girl's need and their team's efforts to help, was their own effort to engage with her effectively. This experience demonstrates a sense of achievement and hope for the participant, that they had found something in common with the service user, in this case personal journal writing, something they could do with the service user (Williams et al. 2009). This notion of belonging recurs in several of the participants' retelling of their experiences. It may suggest a desire to be part of the in, as opposed to out, group, not marginalised, being positioned on the edge of the group (Eichenbaum and Orbach 1982).

For example these positive experiences, where the participants refer to greater autonomy and practice more closely aligned to the role of the qualified nurse could be interpreted as acceptance into this 'in' group and indicates they feel they belong to the qualified nurses group. The final case example referred to in this section is from one of the Ulster participants. In chapter three they refer to their own motivations and personal experiences which led them to P/MHN which included a suicide attempt at eighteen years of age. This participant had experience of working

with homeless men, many of whom had MH problems and addiction issues. In discussing their experiences they referred to clinical placement and said:

> I found them quite challenging, I didn't think that it would be, I sort of went in a bit cock sure of myself, thought I had all the answers so, it was definitely for me a new challenge… I chose to specialise in suicide. And the first person I worked with was…it was probably the day that he was discharged and he was quite a laddish eighteen year old and I just kind of thought that that was somebody how just needed somebody to listen to him and make him feel valued, and I suppose that, to me felt so small and insignificant.
>
> (UU2).

The participant expressed some surprise at how little effort and expertise was necessary to work therapeutically. Several of the participants focused on what they viewed as therapeutic aspects of their experience but that also had special significance for them personally. For example, one participant who was very keen to discuss working therapeutically with the serious and enduringly mentally ill had indicated that one of their motivations for undertaking the course was their experiences with their Uncle who was diagnosed with schizophrenia (Edward et al 2015). Another focused on working with an over-weight woman and had some weight issues themselves; others focused on service users with depression which reflected their own personal MH issues (Ong et al. 2017). The participants discussion of their experiences also hints at the expectations of transformation and healing as discussed in chapter 3.

There were some notable contrasts between groups in how they spoke about their experiences. Interestingly when asked to talk about their experiences as student P/MH nurses University of Birmingham students explored differences between their initial experiences in other fields of nursing in comparison to P/MH nursing, Ulster University students tended to cite their experiences in other fields of nursing as a motivational force, whereas both Boston and Birmingham City students offered no comparison. For the University of Birmingham participants this appeared to reflect their time spent in adult and/or child nursing clinical practice during their foundation year:

> I enjoyed the MH side of it…I loved the informality of it the fact that you were home clothed, the fact that it's not get up, wash everyone, do the beds
>
> (UB5).

They indicated that they found P/MHN more egalitarian:

> I found adult quite hierarchical...everyone respected each other's opinions and the nurses, doctors and pharmacists, I liked that about MH nursing.
>
> (UB1).

University of Birmingham participants were second year students and their first year or foundation year had consisted of a range of clinical practice placements including adult, child and mental health before they chose their field. Therefore, when asked about their experiences, these participants had fewer clinical placements in mental health. Three out of four of the Birmingham City participants and all three of the

Ulster participants were third year students, and all the Birmingham City participants' placements were in MH and they chose their field before commencing their student nursing course. It is likely that the University of Birmingham participants reflected on this and compared placements across fields as these were more recent than other participants' experiences.

What the participants have revealed in this exploration of their experiences as student P/MH nurses is the importance they place on positive, supportive role models (Walsh 2015) and having the opportunity to work therapeutically with service users (Gunusen et al. 2017). They clearly enjoy these aspects of their work and as the literature review indicates the participants have similar concepts to qualified P/MH nurses in terms of what keeps them in the profession and provides job satisfaction (Nakakis and Ouzouni 2008, Williams et al. 2009, Cleary, Horsfall and Happell 2012, McAllister, Happell and Bradshaw's 2013, Van Bogaert et al. 2013).

The next section of this chapter presents the participants data in terms of how their experiences might lead student P/MH nurses to leave the profession. This work will consider their negative experiences in the context of their relationships with service users and qualified nurses and what issues emerged that might result in them leaving their course.

4:3:b. How the participants' experiences might have motivated them to consider leaving their course.

Whilst many of the participants referred to their positive experiences of working with service users they also acknowledged elements of uncertainty and fear in terms of the requirements of the nurse-patient relationship (Charleston and Happell 2005):

> I always struggled initially with how you should approach someone and sort of where the boundaries are sort of what you can talk to them about
>
> (UB5).

Another participant spoke of their concerns in relation to managing human distress and observed inadequacies within MH services (Jaffe 2014, Gilburt 2015):

> Not seeing an improvement is incredibly frustrating…I guess the lack of effective treatment is incredibly frustrating and I don't necessarily see that changing.
>
> (BC4).

The participant recognised the limited nature of most treatments, and lack of support, for people with MH problems (Szasz 1971, Gilburt 2015). They also envisaged no real change to this in the near future and expressed their own personal frustration at their apparent inability to make a difference (Rhodes and Bouic 2007). They went on to recognise their personal limitations and that they may be falling into the trap of wanting to rescue service users (Berne 1964, Harris 1973):

> like you can't rescue and you can't do a whole lot of other things so I guess like observing suffering all the time does wear you down.
>
> (BC4).

However, they then suggested that ultimately as a P/MH nurse one of the aspects of the role that is rarely acknowledged is to observe human suffering (Herman 2001, Iyamuremye and Brysiewicz 2010, Sweeney et al. 2016). This requirement in P/MH nursing is something that the participants return to in various guises, charting the impact it has on them personally:

> Like I said I'm not being a drama queen it is a hard course, it's demanding, physically and mentally and emotionally because you're coming across all types of people, and I don't know how I've come through do you know what I mean, there's been times where I have, where I've thought I'll have to give this up because of personal circumstances and not making, ignoring my girls and things like that.
>
> (BCU4).

This participant described their own personal difficulties during clinical placement impacting on their family life (Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Freeburn and Sinclair 2009), suggesting that a qualified nurse has to be able to cope with all of these situations, and maintain their own mental health at the same time as promote that of others in their care (NMC 2015). Similarly another participant spoke about their own anxieties around observing the professional boundaries of the role safely, and wanting to reduce suffering and distress. The participant was also acknowledging that it is not the role of the qualified nurse to rescue, this is alongside

expressing fears that one may become overwhelmed by personal issues (Clarke and Flanagan 2003, Gibb et al. 2010, Wang et al. 2015):

> There's a split in my feelings; on one hand I'm very anxious to start working as MH nurse… and on the other there's a bit of a fear because there's always the toss between, how much can you do for somebody before your actions become maternalistic because you know you're driven to want to satisfy or to solve things when that is not really your role. I think one needs a very clear head…to take on the role of a MH nurse because it can be very stressful and you cannot allow in any way your personal life to infringe on the relationship between staff and client as you practice your daily duties.
>
> (BCU1).

Other participants indicated that they were anticipating the role of the qualified nurse as a challenge:

> I fluctuate between feeling overwhelmed with the amount of things that I want to do in the field and just really excited to do it all, I'm ready to take it all on.
>
> (BC3).

It is perhaps noteworthy that this participant referred to 'feeling overwhelmed' which may reveal that, like several of the other participants, and as the literature review clearly indicates many qualified nurses do (Heinen et al. 2013, Fischer 2014, Goodare 2017), they still wanted to take on the role but remained uncertain of their abilities to do so. A particular area of concern emerging from the participants' experiences was dealing with violence and aggression (Antai-Otong 2001, Walsh 2015). Several of the participants spoke about their fear around dealing with violence and aggression and this mostly centred on how they would manage their

acute in-patient unit/ward experiences (Bimenyimana et al. 2009, Staggs 2013, Jacobowitz et al. 2015, Zerach and Shalev 2015).

Three of the University of Birmingham students referred specifically to responding to violence and aggression during their interviews. For example when discussing working with aggressive service users, they 'found it difficult' (UB1). The participants also experienced heightened anxiety (Happell, McAllister and Gough 2014) as demonstrated here, 'I was quite nervous about beforehand' (UB2). They indicated that they felt unprepared when they said, 'heard the rumours of what acute's like and just felt like I wasn't really prepared for it before going' (UB5) (Happell, McAllister and Gough 2005). These participants were concerned about how they personally would react to incidents of violence and aggression. For example, one participant questioned, 'how would I be able to cope with that' (UB1) with another saying, 'it was really chaotic, busy and really quite violent' (UB2) (Charleston and Happell 2005). The participants did not seem surprised at the levels of violence and aggression; rather they were more concerned with their own responses, but again this could reflect the participants' currently lower levels of exposure to clinical practice (Happell and Gough 2009).

Several of the participants indicated that their experiences including being involved in incidents of control and restraint and two participants also suggested that they were expected to be actively involved:

> there was a fight, a big fight broke out and you know, I, I was a bit worried because they wanted me to do stuff that I was not pleased with and I said, 'listen, you know, as a student I am

> limited in, in sort of restraining and all that and I'm not going to, you know,'
>
> (BCU1).

> I saw you know like a major restraint a woman sort of slashed all her arms and there was just blood everywhere.
>
> (UB2).

This area of concern was more focused in the Birmingham participants; the Ulster participants did not really refer to this and the Boston College students were more focused on their experiences of working with the service users. This also perhaps reflects the different approaches adopted in the three areas and previous exposure to violence and aggression. As a red brick university, the University of Birmingham is more likely to recruit from a pool of white middle class candidates (Hodges and Judd 2000) whereas both Birmingham City and Ulster University's students are more likely to originate in a socially deprived environment where incidences of violence and aggression are possibly more present (Northern Ireland Statistics and Research Agency 2010, Department for Communities and Local Government 2015). The Ulster University students are also more likely to have been exposed to violence and aggression within their social experiences because of the long term 'troubles' in the province (Ventura Miller 2008). It is also useful to acknowledge that the Boston College participants did not raise this issue personally although one participant did refer to other students' concerns:

> I was the only one who was actually interested in being a Psych nurse, but everyone has to do it… some people were like, terrified, like some people were like, 'I cannot believe I'm going to a locked unit, I might get hurt.
>
> (BC2).

Of course this difference may also reflect the approach of P/MH nurses to dealing with violence and aggression in the US. There, physical restraints (including manacles) are still used (APNA 2014), so the participants from Boston College may have been less concerned than their UK counterparts where physical restraint is delivered by a team of staff usually alongside medication, which arguably acts as a chemical restraint (UKCC 2001, Bowers et al. 2012). The participants gave examples of their own experiences of being in violent and aggressive situations and their reflections on these:

> It was quite funny when I was on my acute placement a woman tried to hit me on the head with a bowl, which was my own fault because she was a diabetic and she was eating packets of sugar so I took them off her and obviously she's not very happy about that she tried to hit me on the head with a bowl…told my mom that night laughing…they were absolutely…worried about that I just didn't know, I really shouldn't have mentioned it.
>
> (UB2).

This participant immediately trivialised the situation by indicating it was humorous. They went onto say that it was their own fault the patient reacted the way she did. They also shared their experiences with their parent and shared their response of worry, questioning whether they should have shared it.

This participant had arguably been acculturated into the norms and values of P/MH nursing in the UK where these minor acts of violence and aggression and the mundane everyday physical assaults on nurses are accepted as part of the role

(Antai-Otong 2001, Richards et al. 2006, Steinert et al. 2007, Bimenyimana et al. 2009, Jones et al. 2010, Staggs 2013, Jacobowitz et al. 2015). Therefore, when their parent challenged the acceptability of this type of behaviour, it may have raised suspicion that this was not appropriate and staff would have needed to respond to manage the situation more effectively. Another participant referred to a vicarious experience of violence and aggression:

> had a girl on my placement yesterday who was hit and had been in the past and it was obviously something that did affect her and the staff I was working with just didn't really, I mean they went and told off the woman who had done it but there was no support for her for it and asking whether she was ok, just the smallest of things [physical assault, risk,] but I think just generally you're asked to do a lot and not necessarily with the knowledge, and it's just accepted and left with you.
>
> (UB5).

In this situation staff acted; they responded and reinforced acceptable limits of behaviour with the patient. But as the participant indicated neither the patient, nor the staff member involved were offered support, debriefed or even, 'asked whether she was ok', which, as this participant suggested, represents 'the smallest of things'. This participant referred to the existing culture within P/MHN in the UK, which includes expectations that qualified nurses would be able to deal with these everyday occurrences. This participant acknowledged that the fear and experience during these situations was 'left with you', suggesting it remained, unresolved with the potential to cause cumulative psychological, physical and emotional damage (Iyamuremye and Brysiewicz 2010, Baby, Glue and Carlyle 2014, Madathil, Heck and Schuldberg 2014).

This next participant shared how they had spent time (up to twelve weeks during a clinical placement) on a unit with a patient who made continuous attempts to attack, assault and verbally abuse them:

> When I was in shift a couple of weeks ago…I was involved in what we would call a fracas between staff and client, which normally happens in an inpatient setting like this one, and there was a fight, a big fight broke out and you know, I, I was a bit worried because they wanted me to do stuff that I was not pleased with and I said, 'listen, you know, as a student I am limited in, in sort of restraining and all that and I'm not going to, you know,' so you have that you know sort of go between in terms of how far you can go to, act to manage a situation as a student you know. I have a client on [ward details] she had a diagnosis of bipolar and I remember one day I was walking down the passage as I usually do down the hospital corridors doing my checks and she opened the door suddenly and she said (excuse my French), 'You fat fuck, what the hell do you find to be smiling about?' and she just started shouting all these expletives and before I knew it I became public enemy number one and any time she saw me she would spit at me and things.. I said to the manager you know, 'I'm really upset by it you know'. Because I didn't really understand how the actual illness presented itself and then she was ok, when she was done with her ok moments, she was nice to me and then she would suddenly flip again and so it made working with her very, very difficult. On that placement she tried to slap me at one stage, she wasn't successful of course because I was pre-empting her, her actions you know, but yes I found her to be very difficult because you know within this ward itself there wasn't much space to like if we were having a one to one interaction it was very close I had to sit in very close proximity so I was always on edge not knowing what she would do next. I reported it to the manager…she sort of pulled her up in the office and explained to her that this sort of behaviour was unacceptable and all of that…I find that there are some service users who, they're oblivious to the rules so she didn't take on board what was told to her.
>
> (BCU1).

This participant's experience demonstrates the unpredictability associated with working with people with MH problems (Jaffe 2014, Gilburt 2015). Clearly, they endured these verbal attacks and physical threats for some time. They actively sought help from the Unit Manager. The Manager reaffirmed levels of acceptable behaviour with the service user. However, no reference was made to supporting the student or working with them and the service user to try to role model the management of such situations or offer the student psychological debrief or critical incident review support (Le Brocq et al. 2003, Jacobowitz 2013). The participant may have internalised the blame for this situation.

In analysing their statement, 'because I didn't really understand how the actual illness presented itself', the participant may be looking for some way of explaining or justifying the service user's behaviour towards them as a result of their own behaviour, or a failure to communicate effectively, which has then triggered the aggressive response from the service user. The participant continued to make efforts to engage with this service user and looked for ways to manage the situation. In an apparent effort to do this they refer to 'pre-empting her'. At no point did they indicate that staff could have been more supportive, could have role modelled strategies to work effectively with this service user, or even limited the participant's contact with the service user. The participant appears to either blame themselves or the service user as indicated in their statement, 'there are some service users who, they're oblivious to the rules so she didn't take on board what was told to her'.

Many of the participants were anxious or fearful about their own reactions to violence and aggression. Those who had experienced or witnessed violence and aggression and were directly involved in these situations were concerned about others' expectations of them and the unspoken residual effects of the experiences (Walsh 2015). One of the participants spoke of their personal experiences differently. The participant had carried out a placement on a Psychiatric Intensive Care Unit (PICU), where, service users may be placed when there are difficulties in managing their needs and they have particularly high risks. Staff patient ratios are usually significantly higher, and patient numbers are lower to reflect this risk, which is often associated with violence and aggression but includes suicidality and vulnerability. During this placement the participant was on the unit when, 'it was quite settled'. As a result the participant felt untrained, untried and untested in this area personally and therefore unable to assess their own responses to violent and aggressive situations. This was perhaps evident in their statement:

> I know one of them [fellow student on an open acute admission ward] walked in and she'd [patient] used a cord I think in the disabled toilet [patient had made an attempt to hang themselves]…and things like that obviously didn't want them to happen but I thought what a fantastic learning opportunity to be able to go in and cope with that.
>
> (UB1).

This may have been directly linked to existing P/MH nursing cultural norms, with the expectation that nurses will respond appropriately and effectively, and manage unpredictable and risky situations well (Richards et al. 2006). The participants appear to want to be tested so that they can assess and deal with their own

responses. In a risk situation humans are instinctively programmed for fight or flight (Boyd 2006). The participants, as P/MH nurses, have to over-ride this evolutionary protective process. Therefore, to some extent they must seek to control both themselves and others safely, until the situation is resolved. The participant's experiences indicate a potential gap in their education as to how to manage themselves and violence and aggression, safely (Bowers et al. 2002, 2009 and 2011, Muir-Cochrane and O'Kane 2018). Several of the participants referred to a felt need for training/education in this area.

Another of the American participants provided case examples from their experiences working in a community setting:

> There's this fascinating gentleman who had, it was typical (of) substance (abuse) induced psychosis or like acts of schizophrenia or a combination of the two because he was constantly using cocaine and magic mushrooms…there was sometimes he was doing awesome and he was such a delight to be around…other times when he was talking really sort of aggressive, mad hallucinations and stuff which made him super hostile…other times he would be…brutalising other people, physically and mentally it was such a tangled situation… he brings out ..some of the values I really hold high and it was about helping him develop an effective relationship which you could then use (as) leverage in treatment.
> (BC4).

This participant referred to some of the wider social issues impacting on communities, families and people with MH problems and therefore on P/MH nurses' practice. They acknowledged that qualified nurses are expected to work with high

risk, and with serious and enduringly mentally ill service users, and this impacts on their ability to provide appropriate safe care (Jaffe 2014, Gilburt 2015).

They express a sense of fascination in attempting to work with and understand 'the psychotic mind', at the same time as recognising their own levels of fear about the context of the service user's communication and risks. The complexity of this service user's needs, history and presentation stayed, unprocessed, with the participant (Van der Kolk, McFarlane and Weisaeth 1996, Jacobowitz et al. 2015). They referred to becoming an effective practitioner in order to work with this service user group. This participant was particularly keen to work with the serious and enduringly mentally ill as their second case example indicates:

> This one fascinating woman who lived in this area of XXX there was this suburban community and there's this horrible crystal amphetamine stuff going on there, cos you know it's just ravaging the community and she was one of the sensitive people who had psychosis after…using it for an extended period of time…she was kind of scary in a way, she would have hallucinations and say, 'I'm going to kill my kid, I'm not safe'…there are such poor systems, you know, you couldn't just bring people to the emergency room and say, 'Oh they're threatening suicide or homicide', and get them hospitalised… it was just a dreadful situation.. she wasn't really engaged in treatment, you know she wasn't calm every single time and the talks we had were super interesting to me, sometimes scary because she'd be talking about these things…she refused treatment from thereon [court order completed] so it just happens a lot, you hope that you can like be an effective practitioner but certainly that sticks out in my mind. (BC4).

Again, this quotation demonstrates the complexity of the service user group's needs and the unpredictability of their behaviour. The participant acknowledged the role of the qualified nurse to engage with this service user, to use their self therapeutically and use the nurse-patient relationship to support the delivery of care and treatment (APNA 2014). However, not all qualified nurses appeared to want to work in this way or encourage their students to, as one participant observed:

> I actually did get in trouble with one of the nurses because they said I sat on the bed and talked too much.
>
> (UU1).

Whilst at the same time the participant also acknowledged the difficulties associated with working in this way:

> There are pressures you know [laughs] in the actual placement areas, you have to take that into consideration and you're not able to spend enough time as you would like, you know with, clients or patients.
>
> (BCU1).

This participant's comment may indicate that they felt burdened by practice, or thought they were failing to meet their own expectations for practice and feared this potential failure (Nolan and Ryan 2008, Alzayyat and Al-Gamal 2016), but it also suggests that they identified with and preferred the therapeutic aspect of the qualified nurse role (Gunusen et al. 2017).

Qualified nurses featured strongly when participants spoke about some of their more negative experiences also (Galvin et al. 2015). One of the participants spoke about their experiences in relation to their mentor and they hinted at the impact that having a sudden change had had on them:

> I've had to find out off a piece of paper that my mentor's changed, and I felt I…
>
> (BCU 4).

Initially they referred to the way they were informed, not even personally, but on a note. In the telling of this experience the participant also failed to complete their sentence, 'I felt I...', which may suggest that they had not resolved the grief or sense of bereavement from this loss of their placement mentor. They were not the only participant to have a sudden change of mentor:

> I was on this particular community placement and basically I had this lovely mentor who had some personal problems within her family I think a family member was dying of cancer and she had to go off so I was then passed on to somebody else.
>
> (BCU1).

This quotation offers a real insight into the conflicting experiences of student nurses on placement. The participant's response indicates both the positive and negative effects qualified nurses can have on their students (Nolan and Ryan 2008, Walsh 2015). For participant BCU1 initially their experience was positive, their use of the word 'lovely', perhaps suggesting a positive attachment to the qualified nurse who

was their mentor (Bowlby 1969). However, this is followed at the end of the earlier sentence by the statement, 'I was passed onto somebody else'. This may demonstrate the participant's sense of loss, bereavement and grief, as 'passed on' can be a term used to indicate that a person has died. This example demonstrates how much potential bereavement student nurses are experiencing during their course. The participants may be experiencing multiple losses throughout their educational programme. There was some hint that this is not only true for clinical placements, in terms of mentors, staff and service users, but also applicable to losing educational staff as students complete academic years (Kubler-Ross 1969). This sense of loss may have been reinforced by the participant's subsequent experience:

> Well this person I was passed onto she ignored me for the rest of my placement, completely ignored me, and I used to sit at the table and cry because at first I tried to make myself very busy you know because I know that I had these competencies to fill so I would go to other people even when she ignored me.
> (BCU1).

The qualified nurse ignored the participant. This can be viewed as a kind of bullying (Bradbury-Jones, Sambrook and Irvine 2007). In response the participant begins to demonstrate signs of helplessness and hopelessness, in other words despair (Freeburn and Sinclair 2009, Galvin et al. 2015.) (See also NICE Depression Guidelines 2012b):

> And when it came to the final stages of the placement and I said right, 'are you going to sign my final thing?' and she said, 'No, I

> haven't got the time'. Well she looked at me with such disgust that you know I said, 'Hold on a second it's your duty to help me sign this thing', you know and she says to me, 'Well you know you've got to make, you've got to come back', I said 'When am I going to come back?' and she said, 'Well you, how do you make appointments,' and she was really rude to me and I said to her, 'listen', I was cool, calm and collected but inside I was really torn apart and I said, 'what do you mean?' She said, 'Well you've got a brain, haven't you? So use it'. All these things were said in solace without the glaring view of other people you know and I didn't know what to do I didn't know how to manage the situation. (BCU1).

In this participant's later experiences on placement this possible despair is replaced by some incredulity in response to the qualified nurse's dismissive behaviour. However, this seems to quickly dissipate and they return to a seeming state of despair as suggested by their statement, 'I didn't know what to do, I didn't know how to manage the situation.' Some of the participants appear to be demonstrating depressive patterns of thinking and behaving (Trower, Casey and Dryden 1988), their emotional responses also match those indicative of a diagnosis of depression (WHO ICD 10 - 2010), and is mirrored in qualified P/MH nurses (Wang et al. 2015). It may be that the initial loss of their mentor results in a sense of sadness and loss but that this is then compounded by the responses of other qualified nurses who take on the students' mentor role:

> It was very upsetting because in the…placement that followed that one I was very timid. I was extremely timid you know it was almost like I didn't want to cough I didn't want to shout. You don't know what to do, if you're going to turn to the left, if you're going to offend somebody, you start to think there were things racing through my mind thinking, 'what if they're thinking that I'm out of place, what if they're thinking..' until I sort of therapied myself to

> understand that everybody wouldn't be like that and it's a matter of putting that behind me and tried to embrace people with a fresh start
>
> (BCU1).

This participant expressed elements of feeling anxious, their statement suggesting that their cognitive processes were showing aspects of uncertainty in relation to being timid and in directly challenging staff. They indicated that they struggled to cope with the realities of being victimised, bullied and losing a mentor (Bradbury-Jones, Sambrook and Irvine 2007, Galvin et al. 2015) and that it required a particular effort on the part of the participant to continue with their nursing course: 'I sort of therapied myself'.

Considering the impact of nursing staff's attitudes in clinical practice from the participants' experiences sheds light on a range of issues. Some participants experienced very negative attitudes towards themselves as student nurses (Bradbury-Jones, Sambrook and Irvine 2007). They very clearly experienced themselves as a burden to nursing staff (Galvin et al. 2015). For several of the participants it appears that the lack of welcome and the sense of being an outsider in clinical practice that they have experienced can lead them to feeling marginalised (Evans and Kelly 2004, Charleston and Happell 2005, Nolan and Ryan 2008). One participant referred to their personal experience of this:

> I've felt that the staff have seemed to think having a student is a burden, most unwelcome by others … at the beginning people would be arguing over your head… 'I'm not taking a student'
>
> (UB3).

This participant stated their feelings in response to this apparent lack of welcome and this might perhaps be reflective of their internalisation of a sense of being a burden, almost that they have experienced this as being rejected. This reaffirms that qualified nurses are very significant in the experiences student nurses have (Walsh 2015), and in total five of the participants spoke about how nursing staff, and sometimes their mentors, would not engage with them (Bradbury-Jones, Sambrook and Irvine 2007, Tummey and Tummey 2008, Galvin et al. 2015):

> on an acute ward...there I didn't find the staff as helpful or committed to student learning they were all so busy and you were kind of walked past
>
> (BCU2).

One of the other participant's response hinted that they were trying perhaps to excuse the qualified nurse's behaviour towards them, or find alternative reasons to them actually being a burden or rejected:

> I did the home treatment team…. There was three students I think that was too many for the team to be honest. Cos they couldn't get them mentored properly for the, you know I didn't have a mentor for a couple of weeks and that's precious time at the beginning your latching on to who you can.
>
> (BCU 3).

This participant attempted to justify the qualified nurse's lack of time and attention but also suggested that they may have felt abandoned. In their choice of language they refer to 'latching on', as an infant does to the mothers breast for nutrition and comfort (Bowlby 1969). This may be the participant's metaphor for how they felt like

an infant trying to get the emotional succour and intellectual nurturing for them to be able to grow and develop into an effective P/MH nurse (Clarke and Flanagan 2003).

Another participant's experiences of their purpose in clinical practice appeared to be a mixture of doing what no-one else wanted to do:

> as a student, you're identifying that when on placement there are a lot of people who see you more as a slave…you're there to do all the rubbish jobs
>
> (UB5).

Other participants expressed similar emotions but in relation to other aspects of working with qualified nurses. This participant's statement illustrates feelings of being oppressed and helplessness. Yet the participant was unemotional in expressing this highly emotive accusation against qualified nurses in relation to their apparent treatment of student nurses. It is perhaps worthy of note that in terms of power the participant's statement may indicate a personal feeling of disempowerment, whilst experiencing qualified nurses as powerful in relation to them (Bradbury-Jones, Sambrook and Irvine 2007). This may reflect one of two things. Identification with MH service users' oppressed and marginalised position or qualified nurses' own sense of disempowerment in relation to other MH professionals such as psychiatrists (Nolan 2012).

This participant's response may also suggest that staff, who may perhaps feel burdened by student nurses who need to be supported and nurtured, have adapted to make use of them by giving them those tasks others are reluctant to do (Boyer

2012). Qualified nurses have not only learnt and adapted to student nursing numbers in the UK, but they have also realised that the student nurse can be subjected to hostility, with little if any response, and that they are easily positioned as a ready recipient for blame (Bradbury-Jones, Sambrook and Irvine 2007), as this participant's statement indicates:

> The ward manager questioned me about a member of the ward who'd gone awol [Absent without leave] he did this on the corridor and he was basically in my face…that upset me. I then subsequently was blamed for a client who had gone walkabout…the next thing I know I'm called into the office in front of my old mentor and I was absolutely slated…that moment in time I just wanted to cry and go home.
>
> (BCU4).

The participant appeared to become distressed in the clinical situation they were discussing, they felt victimised and this led them to express their felt need to avoid dealing with the realities of the situation and go home. In terms of coping strategies avoidance behaviour, such as withdrawal, is a common response to anxiety or stress provoking situations (Evans and Kelly 2004, Orton 2011, Alzayyat and Al-Gamal 2016). Alternatively, the stated desire to 'cry and go home' is a possible indicator of regression (Freud 1926-1979), a desire to be home, safe and sound. This participant's experience seems to refer to the status of student nurses in some clinical areas and suggests that their perceived lack of power can lead to abuses (Bradbury-Jones, Sambrook and Irvine 2007). This time, perhaps less emotively, the participant reiterated their felt lack of power when they said:

> I also find a lot of the time nurses who have a big power trip over you and it's not a nice environment to be in but you meet people that you don't necessarily get on with anyway.
>
> (UB5).

There is an attempt to explain and distance themselves from possible rejection but their comments may indicate that whilst qualified nurses have significance in relation to the participants' experiences (Walsh 2015), this is not always positive, and several of the participants may have found it quite bullying (Galvin et al. 2015). There are also notable differences between the UK and US participants; specifically the US participants seemed to have experienced more supportive clinical supervisors. However, this UK participant was not in isolation in having these experiences in clinical practice as BCU4 indicates in this statement:

> Actually in my first and fifth placement…it could be soul destroying basically cos it was challenging me as a person and making me feel uncomfortable with myself and I had to dig deep to turn around and say look, this is who I am this is what I am here for, I'm here to learn, if you've got a problem then you need to discuss it professionally and not be unprofessional. They [the staff] carry their transference from whenever they've had bad students in the past and just label everybody the same…I don't agree with it but I can understand it.
>
> (BCU4).

The participants' experiences indicate that they might be required to negotiate any residual effect that pre-existing or placed student nurses may have had upon the team. At the same time they have to manage their own earlier experiences as the data here demonstrate.

However, these apparent negative attitudes and behaviour from qualified nurses towards student nurses do not appear to be replicated in the American participants' experiences, and they made no mention of this. One possible reason for this is that US student nurses pay considerable fees, another is that they already hold a nursing (generic) qualification.

The participants also spoke of the attitudes of the qualified nurses towards MH service users that they had experienced and discussed an apparent sense of hopelessness (Rungapadiachy, Madill and Gough 2004, Richards et al. 2006):

> Oh what's the point in this, I'm never going to help them, they'll just carry on drinking
> (UB3 reporting staff comments).

This participant viewed the qualified nurse's response as demonstrating a lack of compassion. The statement made may be a reflection of the qualified nurse's sense of hopelessness in relation to seeing service users improve, but for this participant, hopelessness was the likely response of service users to these negative attitudes from qualified nurses (Clarke and Flanagan 2003, Rungapadiachy, Madill and Gough 2004). This may be a result of identification with MH service users and their marginalised position, and an attempt to distance themselves from this apparent despair and position themselves as the good nurse, but also as the patient's champion or hero as recognised by Berne (1964) in terms of psychological games people may engage in. On the other hand it could be a growing awareness of the realities and limits of the service and the participants' own internalised sense of

hopelessness in the face of the MH service user's complex needs (Richards et al. 2006, Jansen and Venter 2015, Walsh 2015, Gilburt 2015). Other participants also indicated a desire to separate or 'split' (The Melanie Klein Trust 1997) themselves from those qualified nurses who did not appear to care, reflecting their unresolved conflict in relation to insisting on offering compassion to service users (Rhodes and Bouic 2007) but demonstrating an apparent lack of compassion for nurses (and therefore potentially themselves) (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013):

> I didn't like the attitude of a couple of the staff to be fairly honest with you it was just a job to them; and little if any caring,
> (BCU2).

This participant's response distances them from the uncaring nurses but may also reveal a belief that nurses' work is dedication, requiring devotion, even a calling, not just a job. This belief may be linked to traditional assumptions and beliefs around nursing and the historical ties to religious orders and gendering of care (Wingfield 1896, Turner 1995, Traynor and Evans 2014).

These participants expressed genuine concern about negative attitudes of qualified nurses towards service users. However, others referred to attitudes which resulted in behaviour that was unprofessional and below acceptable standards of practice. This participant's statement indicates some cognitive dissonance (Festinger 1957) between their expectations of what a qualified nurse would do with MH service users, and the realities of the service (Rhodes and Bouic 2007):

> I was a little surprised actually that there really wasn't a lot of time for that talk therapy because it was an acute unit and people were in and out and sometimes in three days…wasn't really an organised like, 'ok, here's an hour, someone's going to sit and talk with you today' and I think that could've benefitted a lot of the patients there.
>
> (BC2).

This participant recognised the limited levels of care that were being provided (Gilburt 2015), but also hinted at organisational issues and institutional failures rather than individual staff inadequacies. However, they seemed to retain a sense of hope when they referred to the benefits of talking with service users. There was also some evidence of possible prejudice and discrimination from qualified nurses towards MH service users on the grounds of ethnicity:

> the professional involved wasn't as sympathetic as if it hadn't been an asylum seeker because, 'they are stealing all our resources' and whatever were the usual argument…generally staff attitudes towards people receiving care, cos they really cause me a lot of anger
>
> (UB3).

This demonstrated that qualified nurses may reflect attitudes and beliefs that are held within society more widely (Barker et al. 2008), despite professional standards and requirements to be respectful to all service users and ensure that all care and treatment is provided in a way which protects the service user's privacy and dignity (NMC 2015). However, the participant did not indicate that they took action in response to this unacceptable practice (Galvin et al. 2015), but they referred to their feelings of anger. This lack of action may indicate a feeling of disempowerment and inability to act in relation to the qualified nurse because of their subordinate position

(Nolan 2012). One of the participants reflected on their own prejudices in relation to working with particular MH service user groups and said:

> I think there is too much of a conflict in myself towards certain groups. I always think I could work with certain people and I could work with others but crimes, …but it's just my experience of a couple of forensics, I just didn't like the person and I don't think it could work, if I'm honest with myself I think there could be problems working with that group…
> When you get a person who isn't particularly nice with quite a serious crime it sort of makes it a little bit harder, you lose, I think you lose a lot of empathy towards the person, when you realise they've done something pretty nasty and couldn't really give a damn because they are just nasty people it just sort of compounds the things they've done so.
>
> (UU1).

Whilst this participant demonstrated some aspects of self-awareness, they challenged notions that it is realistic to expect nurses to like all service users. They also presented differing values and attitudes and beliefs around criminality and mental illness; that they do not really co-exist (Busfield 1994). The idea that madness is not the same as badness, and is not an excuse for unacceptable behaviour, may have been transmitted by several qualified nurses. Therefore people entering the mental health system following a criminal act are perceived as bad, not mad, and therefore not in need of care but prison. The lack of empathy and desire to care for this client group, and the participants' own perceived inability to do so, may also have been given permission cognitively, behaviourally and emotionally by qualified nurses that they have worked with (Clarke and Flanagan 2003, Rungapadiachy, Madill and Gough 2004, Jansen and Venter 2015). This study acknowledges that poor practice might happen however, this directly conflicts with ethical codes of practice for nurses in both the US and UK (APNA 2014, NMC 2015).

Another of the participants indicated that they may have become inured to inappropriate care for MH service users and were beginning to accept poor care without challenge (Rungapadiachy, Madill and Gough 2004). Again this may reflect feelings of hopelessness, or a belief that they do not have sufficient power or influence to change things positively (Nolan 2012, Galvin et al. 2015), but like their colleague in this study they do not discuss their behavioural response or any action on their part, when they say:

> there's poor practice happening everyday
>
> (BCU4).

Only one participant actually discussed physical abuse of service users observed in their experience, although others hinted at it:

> I witnessed some patients getting assaulted by the staff nurse and complained about it. She told me all the gory details about him being a child molester and, you know, smacking his bare backside and it was just totally degrading and I didn't like it and I didn't want to go back after that day.
>
> (UU3).

This participant took action and whistle blew. However, this was not a positive experience for the participant. During their interview they reported that the staff from this practice area had found out their home address and they had received threats escalating as far as having bricks thrown through their windows. They felt abandoned by their HEI during the process and had resolved not to whistle blow again as a student nurse, which reflects other qualified nursing whistle blowers'

experiences (See Pink 2013). Whilst the participant did talk about the situation they also referred to their horror at what they had observed and their reaction, which was to challenge the staff immediately. The staff response was to justify their actions on the grounds of the patient's history of sexual abuse of children. However it is relevant to note at this point that the participant did not provide any evidence to support their remarks.

This participant also spoke about their feelings of anger in response to this situation and their behaviour. They indicated that they physically threatened the member of staff in order to prevent them continuing with their abuse of the patient. This apparent readiness to resort to violent threat, by the participant, and violent action by the staff, may reflect the existing levels of aggression present in the culture and society of Northern Ireland (Ventura Miller 2008).

Whilst all the participants hinted at concerns over dealing with and responding to violence and aggression from mental health service users in practice (Porredi et al. 2015), during their interviews, this was the only example of both staff violence towards a MH service user and participant threat towards staff. On reflection, the participant data on MH service user interaction in the US demonstrated higher levels of risk and threat to themselves, the service user and to the participant than in the UK although this is from a very small sample size. The MH service users participants spoke about in the US appeared to use more extreme measures, self-immolation, threats to the lives of their children, deliberate attempts to infect others with a life threatening infection. However, it is worth noting that the higher risk service user may well be more readily recalled. The Birmingham participants found

service users tended to externalise their frustration with the MH system, sometimes towards them as student nurses, with chronic verbal and physical abuse of staff. In Northern Ireland the experienced levels of violence within society were large scale and life threatening (Kapur and Campbell 2004). Interestingly the Ulster participants did not refer to violence or aggression perpetrated by MH service users. Perhaps because they have come to accept it in everyday life, it is not viewed as unusual, it seems unlikely that service users are less violent and aggressive within MH services there, as McCracken (2013) points out Northern Ireland Health Trusts had recorded over 30,000 assaults in the preceding four years.

What the participants' re-telling of their experiences demonstrated in relation to qualified nurses is that they were often overwhelmed, and unable to respond effectively (Clarke and Flanagan 2003, Rungapadiachy, Madill and Gough 2004, Murrells, Robinson and Griffiths 2008, Gibb et al. 2010, Mangoulia et al. 2015, Jacobowitz et al. 2015). They reflected many of the prejudices present in society in carrying out their work with people with MH problems, one even going as far as physically abusing a patient (Tummey and Tummey 2008).

The participants spoke at length of the impact their experiences of working with or being with service users had. The participants tended to focus on those that had the greatest impact on them because the service they received was poor, as UB3 indicated below, or their circumstances were so complex; or as indicated earlier the participants found their working relationship to be really positive:

> It was working with a gentleman who had post-traumatic stress disorder who is very new to England he was seeking Asylum, his

> asylum status was very tenuous, and he didn't speak English so we were working with an interpreter, and he was so traumatised, he couldn't, he was sat there shaking, he was hunched up, sort of crying, very, very distressed, so of the things that he was opening up 'cos we were only scratching the surface 'cos it was duty assessment so, he, you know, really horrific and just think anyone would be traumatised after that and not being able to do anything for him because he was an asylum seeker so perhaps the professional involved wasn't as sympathetic as if it hadn't been an asylum seeker because, 'they are stealing all our resources' and whatever were the usual argument, and he wasn't eligible for any service, and that, I still think about, like him and just want to take him home.
>
> (UB3).

This participant's experience with this vulnerable service user stayed with them; they were able to recall details, feelings and these appeared to remain unresolved. The service user began to disclose 'really horrific', things and the participant recalled him to mind regularly, as indicated by their statement, 'I still think about him'. This aspect of P/MH nursing which requires observation of human suffering without alleviation recurs (Herman 2001, Sweeney et al. 2016) as in the next participant's experience of working with one service user:

> Emotionally speaking, a lot of the things that I dealt with were very difficult, a lot of the patients had made suicide attempts and I heard very, very sad stories about abuse or, or you know, I had one patient, her daughter had been murdered, and she was just, understandably, she was just a mess, and it was very hard to hear, it was very sad…I will never forget her, she had committed, tried to commit suicide by pouring gasoline over her head and setting it on fire, and, she was the first, like patient admission that I ever did. And so you know, she comes in, she's horribly disfigured, she's burnt over 35% of her body, including like her entire face and her head and arms, and, and I'd never seen a burns patient before either, so if nothing else it was already emotionally difficult to listen to her and she couldn't really speak, she had inhaled smoke and everything she said was like a real harsh whisper, and, and asking her you know, what happened, and the story she told us was just, she was crying, 'I did this to myself six months ago', and you know she was in a fight with her

> abusive boyfriend who had said, she's trying to get him to leave and he's like, 'if you kick me out of the house I'll have your kids taken by DSS' [Department of Social Services] and, and so she was just at the end of her will, and she started saying she was going to hurt herself, and he's like, 'you'll never do it, you always say you're going to hurt yourself', just egging her on, so she set herself on fire and you know she was in the burn unit for a long time. …
> She…lost custody of them [children] for being mentally unstable, and she knew she would never see them again…she was refusing tube feeding, she was like, ' I just want to be allowed to die, you know I don't have anything else to live for'. I was there for a couple of hours talking to this woman and I wanted to go home and I was just overwhelmed…coming into to work with her was quite difficult, I had so much compassion for her but she got very, very, she did a lot of splitting and sometimes I was on the negative of splitting…she was... pretty verbally abusive with some of the staff (Nurse Manager offers to bring in alternative staff to work with this woman) I just really wanted to work with her, so, so we did.
>
> (BC2).

This participant recognised their own emotional difficulties in responding to this service user. As is clear from the context above, the phrase 'I will never forget her' is easy to interpret, here, as meaning an inability to process cognitively. The complexity of the service user's needs appeared overwhelming. There is current evidence of stress in student P/MH nursing as seen in the literature review (Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Freeburn and Sinclair 2009, Galvin et al. 2015, Alzayyat and Al-Gamal 2016) however, there does appear to be a gap in recognising the potential levels of psychological trauma student P/MH nurses may experience in their work with service users. The participant also conveyed a sense of the service user's despair, their desire to cease suffering and die. They acknowledged that in the circumstances this is understandable yet hard to hear and sad for the participant. This is an aspect of P/MH nursing that is rarely considered -

allowing someone autonomy over their life and rights to choose to end it. This is not assisted suicide, rather P/MH nurses are required, within both a legal and ethical professional framework, to do everything to preserve life and prevent suicide (NMC 2015). In this case the service user's food refusal may have indicated their chosen method of suicide. Starving to death is a horrific process for both the person starving and any family or staff involved in their care (Tallis 2008). In the event of a service user seeking to employ this method of suicide P/MH nurses are expected, under MH law, to physically restrain and compulsorily assist feeding service users where necessary and appropriate (MHA 1983 as amended 2007). The service user failed to engage, became abusive and aggressive at times, making it extremely difficult to work with her. This participant's discussion of their experiences with this service user indicates a level of psychological trauma occurring because of this experience. There is acknowledgement of qualified P/MH nurses' potential psychological distress and trauma in existing literature (Jacobowitz et al. 2015, Wang et al. 2015, Zerach and Shalev 2015, Lee et al. 2015, Baby, Glue and Carlyle 2014, Madathil, Heck and Schuldberg 2014, Mangoulia et al. 2014, Iyamuremye and Brysiewicz 2010, Bimenyimana et al. 2009, Currid 2009, Morrissette 2004) however, this does not appear to be replicated in relation specifically to student P/MH nurses.

Several of the participants referred to their experiences of working with people with serious and enduring mental illness. The American participants indicate a marked difference in this particular client group where dual diagnosis with substance mis-use is more usually referred to. This client group are viewed as the most difficult for MH professionals to work with and to engage with therapeutically (Dickens, Sugarman and Rogers 2005). One participant referred to the process of engaging with a

seriously ill service user with regard to a relatively simple task of taking oral medication:

> I remember a particular patient who was very, very mad, and just getting her to focus and take her meds was, it would take us like forty-five minutes, you know we would all say, 'take your medicine' and she'd be like, 'oh, okay,' and then look somewhere else, you know, and it was very difficult and it was hard to balance sometimes, like, I mean, we might start out with a four patient load and this particular patient would be one of them and she was just so, so time consuming. Getting the patients to eat was difficult if they had an eating disorder, getting the patient to take their medication was difficult if they were a paranoid schizophrenic, getting them washed up was difficult if they were a paranoid schizophrenic you know, or if they'd recently been really traumatised and didn't want anyone touching them and so. There were a lot of people who were there for substance abuse there were a lot of homeless people there, many of who were very, very schizophrenic, there were people who were like bipolar, there's just all across the board. The aim of the floor was for, it was kind of like to stabilise you and send you back out and hopefully hook you up with some outpatient therapy.
>
> (BC2).

This demonstrated the participant's sense of frustration, and perhaps lack of expertise in working with the serious and enduringly mentally ill, alongside work pressures and the need to ensure particular activities and tasks in nursing are carried out within an appropriate time scale, the constant need to move service users out of the service and the expectations of qualified nurses to manage all of this (Richards et al. 2006, Jaffe 2014, Gilburt 2015).

Other participants were less specific about particular service users, but they spoke broadly about their experiences and how working in practice with the serious and enduringly mentally ill impacted on them:

> Some of the things that I saw and heard and experiences of the people was quite, was a bit of a reality check really it, there was a part throughout that placement where I felt a bit of a low because being, these people were mothers and children and things and looking deeper into it, you know I felt that they really needed the care how you would look after or how you would want to be looked after yourself
>
> (BCU2).

This participant recognised the psychological and emotional impact working with people with MH problems had on them as a senior student nurse their reflection on their experiences may indicate increasing awareness of the realities of the role of the qualified nurse and what they are attempting to become but also be indicative of the increased levels of stress that final year student P/MH nurses experience (Nolan and Ryan 2008, Alzayyat and Al-Gamal 2016). Participants discussed service users who had complex needs, were difficult to engage with, those that impacted highly on their psychological welfare mostly, detrimentally.

Despite asking participants to talk about their experiences during their course, what is interesting to consider, alongside the issues raised, is the limited reference to the participants experiences in university. Any reference appears to be linked to clinical experiences where participants have returned to raise concerns with the university

‘You’re going back [to university] and saying look I’ve seen the most awful thing you know’ (UU2). Or the participants are particular about aspects of nursing that need to be taught in the course or in more detail which is considered in the next chapter of this work.

4:4 Analytical interpretation of data.

In this analysis of the participants’ experiences the participants established an apparent cognitive focus on the interpersonal therapeutic work P/MH nurses are required to undertake (APNA 2014). One possible interpretation of the data is that the participants believe P/MH nursing should be therapeutic, talking therapy based, and this way of behaving with service users fits within their belief systems (DH 2007a, Gunusen et al. 2015). Surprisingly little if any emphasis was placed on personal care, working with older people with dementia and challenging behaviour despite this being a significant aspect of the role (Barker 2009). Perhaps this reflects society's negative attitudes toward older people (Sweiry and Willitts 2012) and the serious and enduringly mentally ill (MIND 2013). This may be evidenced through the apparent lack of recognition or discussion of these matters by the participants.

The data in regard to the participants experiences of working with qualified P/MH nurses also demonstrated some dichotomy of thinking; for example their experiences of nurses as either good or bad. When student nurses are faced with this possible split in terms of beliefs and expectations it may result in cognitive dissonance

(Festinger 1957). A mismatch between their belief systems, the educational input, which also emphasises the values of person centred, evidence based and excellence in caring, and the pragmatic issues experienced by student nurses in their clinical practice placements, may then manifest itself in a variety of ways. This splitting of good and bad qualified nurses may be a strategy to process this dissonance. The Melanie Klein Trust (1946-1997) refers to splitting as an early primitive ego defence mechanism.

According to Klein's (The Melanie Klein Trust 1946-1997) theoretical position, when an adult is placed under significant psychological distress, they are likely to employ infantile coping strategies. This includes taking into oneself what one wants and expelling anything they wish to be rid of. In this example the participants are projecting the bad onto qualified nurses whom they perceive as uncaring and introjecting the good, specifically around psychotherapeutic practice carried out by qualified nurses, into themselves (The Melanie Klein Trust 1997). On the one hand the good qualified nurse reinforces their held beliefs and confirms that it is possible to practice well (McAllister, Happell and Bradshaw 2013); the same contention would be that the bad nurses are rogue, a small number of nurses, who should not be in the profession. On the other hand, qualified nurses who occasionally fail to reach the standards of the participants' held beliefs are likely to be more than just a small number (Rhodes and Bouic 2007, McLaughlin 2010). This means that the student nurse needs to hold conflicting beliefs. This has implications for the way student P/MH nurses form their professional identity and work out their sense of self and how they feel about their profession. This dichotomy in thinking was also further evidenced in the participants' discussions around qualified nurses' roles in respect to

service users. The participants also sought to match their behaviour to the 'good' qualified nurse. The data may also show that participants have an emerging belief in the need for P/MH nurses to be strong, capable and caring. Participants do not focus on exploring, or trying to understand, some of the qualified nurses' hopelessness, or the pragmatic reality of a financially struggling service, to meet the complex needs of people with MH problems (Jaffa 2014, Gilburt 2015).

The data on the participants' experience of witnessing human suffering without being able to alleviate it (Herman 2001, Iyamuremye and Brysiewicz 2010, Sweeney et al. 2016) was associated with fear and anxiety. Much of this fear also related to dealing with violent and aggressive behaviour (Walsh 2015), and if the participants would cope, and what they would do. The UK participants were more likely to express beliefs that they needed to be able to cope, that it was their fault if a service user was aggressive towards them, and that it, and therefore the P/MH nurse, was not important. But the data suggest they believe themselves to be relatively unprepared for this aspect of the P/MH nurse's role and indicates that there is a potential gap in the educational process for student P/MH nurses (Walsh 2015).

The participants recounted experiences that were meaningful to them and many of these reflected extremes of practice for P/MH nurses. At times the participants, like qualified P/MH nurses, seemed to struggle to respond to human suffering and distress, and were uncertain of what to do in the face of complex needs from the serious and enduringly mentally ill; how to allow patient autonomy and control, but in relation to suicide how to maintain safety; and several of the participants seemed to

demonstrate signs of psychological trauma arising from their experiences (Sweeney et al. 2016). Many of the participants shared experiences that reflected their own personal issues and were particularly meaningful for them. Several participants referred to positive examples of working with service users. One participant expressed surprise, possibly even some shock, at how little effort was necessary to be therapeutic. It appears that clinical practice challenges some, and reinforces other, beliefs and the participants seem to try to match both their beliefs and behaviour to the 'good' qualified nurses. How then do the participants make meaning from these experiences and inform their sense of self and identity?

4:5 Making meaning of and informing a sense of self and identity from an Interpretative Phenomenological Perspective.

The participants' apparent idealisation of the role of the P/MH nurse is clear in their data (Klein 1997). They discuss what they think qualified nurses should be doing and refer positively to hopeful engagement with MH service users and therapeutic work. The participants do appear polarised in their thinking about how qualified nurses work. In order to make this meaningful the participants seem to attach priorities to therapeutic interpersonal work (APNA 2014) and aligning their sense of identity to this aspect of P/MH nursing (Happell 2008, Barker 2009, Gunusen et al. 2017). However, for several of the participants identifying with service users may have been easier, considering their own personal MH experiences (Granados-Gamez et al. 2017). The participants appear to have held a concurrent desire in relation to their identity on one hand seeking to relinquish their illness identity and on

the other taking on the mentally healthy qualified nurse identity. In order to achieve this the participants have to differentiate themselves from MH service users, and their sense of self becomes based on the qualified nurses they work with (Williams et al. 2009). The participants' sense of identity as a qualified nurse is clearly influenced by the existing culture in the areas in which they work (Cleary, Horsfall and Happell 2012). Several of the participants appear to have internalised the cultural message that P/MH nurses must be strong. They 'should' be able to cope with human suffering, violence and aggression, the serious and enduringly mentally ill and people with very complex MH problems and life experiences (Antai-Otong 2001, Clarke and Flanagan 2003). In chapter three the participants' data suggested they viewed their educational course as both transformative and healing. The participants' experiences has in part given them insight into what they hope to transform into and they strongly identified with qualified nurses who worked therapeutically with service users. However, the data in this chapter also indicated that the participants had to negotiate difficult, challenging and potentially damaging experiences. Whilst the hopes of healing generated from being on the course may inform their sense of self, this is also undermined during the course. The participants' experiences demonstrate ongoing conflict over recovery and therapeutic engagement with service users and restraint in negotiating service users with complex and challenging needs.

Some of the participants were verbally and physically assaulted and abused, and some were overwhelmed by the complexity of the service users' needs and they confirmed this stayed with them unprocessed mentally and emotionally and therefore

unresolved. Part of the participants' identity that becomes clearer in analysis of the data is that of a person psychologically traumatised by their work (Morrissette 2004).

4:6 Summary and conclusion

In response to the research questions how might the participants' experiences influence their career choice and their desire to stay on their educational course? The data has shown that in terms of the participants reasons for choosing P/MH nursing the most significant factors in their experiences appear to be the opportunity to work with committed, therapeutic and positive role models (Walsh 2015), this is vitally important as is the ability to be involved in purposeful and good quality patient care where the participant has the opportunity to develop a working therapeutic relationship with a service user (Gunusen et al. 2017). The participants discussion of their experiences also indicate, like qualified nurses, that engaging in intense working with a service user where 'connectedness' is possible (Van Sant and Patterson 2013) keeps them motivated to stay on the course along with the ability to learn and become skilled by working with an effective role model (Williams et al. 2009).

On the other hand in response to the research question on how might the participants' experiences lead to an increased risk of them leaving their educational course the data has shown that experiences of being unwelcome and bullied (Bradbury-Jones, Sambrook and Irvine 2007, Galvin et al. 2015), dealing with

service users who are potentially aggressive and violent and a lack of support from colleagues all had a detrimental effect on the participants (Walsh 2015), several of the participants indicated that they questioned their career choice, kept going despite grave concerns and had many stress inducing experiences (Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Freeburn and Sinclair 2009).

This chapter has demonstrated that several of the participants have become enculturated into the existing P/MH nursing culture. That culture, particularly in the UK, requires qualified nurses to be strong and cope (Cleary, Horsfall and Happell 2012). At the end of chapter three the data suggested that the participants expected or hoped the course would be transformative and healing. What the data in this chapter have indicated is that the participant experiences clearly acknowledge the stress student P/MH nurses have in clinical settings (Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Freeburn and Sinclair 2009) but the data also provide evidence of the participants' psychological trauma. In the next chapter exploration of trauma as an emerging theme in student P/MH nurses' experiences in relation to the research questions is undertaken.

Chapter 5 Data analysis in relation to evidence of psychological trauma and participants' strategies to stay on their course.

5:1 Introduction

The previous two data chapters have established firstly, that participants have chosen P/MH nursing to learn about themselves, to fix themselves and to improve MH services, whilst recognising that they have significant MH issues and secondly, that their experiences during the course have led to real distress. There is evidence of stress in both student (Tully 2004, Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Freeburn and Sinclair 2009, Galvin et al. 2015, Alzayyat and Al-Gamal 2016) and qualified P/MH nurses (Richards et al. 2006, Gibb et al. 2010, Hanrahan et al. 2010, Senining and Gilchrist 2011, Wang et al. 2015, Johnson et al. 2018), and some existing work on trauma experienced in and through P/MH nursing (Iyamuremye and Brysiewicz 2010, Jacobowitz et al. 2015, Lee et al. 2015, Mangoulia et al. 2015, Zerach and Shalev 2015). What the first section of this chapter will consider is whether there is evidence that the participants experiences as student P/MH nurses can also be seen as psychologically traumatic. Therefore the aim of this chapter is to explore the participants' experiences, via their interview data, through the critical lens of psychological trauma and how the participants respond to this. The chapter goes onto explore the strategies that the participants already employ to deal with their experiences, and considers if these strategies might help student nurses stay on their educational course.

5:2 Defining terms:

In defining terms it is worth noting that the concept of trauma being examined in this research is very much focused on psychological trauma. This recognises that trauma will have a holistic impact on the person, it will affect their beliefs about themselves, the world and others and it will affect them emotionally and physically. Different types of trauma can be caused by natural disasters such as volcanos or earthquakes, catastrophes such as car or rail accidents, conflict such as war or inflicted traumas such as abuse, neglect, rape or terrorist attack. Green (1993) identifies seven dimensions of traumatic experiences: these are:

> threats to life and limb, severe physical harm or injury, receipt of intentional injury or harm, exposure to the grotesque, violent or sudden loss of a loved one, witnessing or learning of violence to a loved one, learning of an exposure to a noxious agent and causing death or severe harm to another (secondary cited in Carlson 1997:26).

Clarke (2008:14) states, 'our current understanding of trauma is historically and socially constructed. Freud expanded the existing concept of trauma, violent shock, injury or whole system impact, into a psychoanalytical framework early in the 20th Century.' Psychological trauma, according to Saari (2005), is a relatively recent phenomenon: one hundred years ago a recognisable definition of psychological trauma did not exist, and the actual ability to help people who have experienced 'trauma' remains contentious to this day. Much of the existing work and insights into our current construction of psychological trauma are based around experiences of

war, most significantly as experienced by American servicemen during the Vietnam War (Kimerling, Ouimette and Wolfe 2002, Kendall-Tackett 2005). However, it is worth offering a cautionary note here that deliberately constructing this notion, of psychological trauma, may merely serve the purpose of providing MH professionals with work in a new genre, and to convince a generation of their own personal trauma.

5:3 Pre-existing trauma:

There were three participants who showed marked evidence of pre-existing traumatic experience before undertaking their P/MH nursing courses. These were BC2 who witnessed their family members being viciously attacked by a neighbour's guard dogs; UU 1 who experienced serious personal loss and trauma following a large scale bombing; and UU3 who's family had been severely physically and psychologically traumatised by a bombing. For example, during the interviews with participants the following comments were recorded:

> My mum was in a bomb very young, lost limbs and had two very young children. My young memories of being in the psychiatric unit and visiting and she would have been detained at the time. And it was awful scary
> (UU3).

This demonstrates that the participant recalled both traumatic events, her mother being detained in a psychiatric ward, and the traumatic person, her mother's altered body and mind. One of the participants, BC2, spoke of their trauma before

beginning P/MH student nursing, when both they and their family were attacked by a neighbour's guard dogs. This participant had the experience of seeing their mother being attacked by the dogs after pushing them to safety. This pre-existing experience of trauma in student P/MH nurses is not within the remit of this study.

As the work of Edward et al. (2015), Ong et al. (2017) and this investigation have established there is a link, even if somewhat tenuous, between P/MH nursing career choice and personal experiences of mental health problems. Nine out of the fifteen participants readily discussed their own pre-existing MH issues. Having stated this there is also clear recognition that people with MH problems and mental illness are some of the most traumatised people in society (Carlson 1997, Seeman 2002, Jones et al. 2010). As Walton (2000:85) points out, 'the most challenging task in interpersonal MH work is in retaining a positive perspective while being in almost continual contact with mental pain and confusion'.

As the literature review demonstrated P/MH nurses work closely with MH service users with traumatic experiences and these potentially difficult working conditions are a daily occurrence in practice (Steinert et al. 2007, Iyamuremye and Brysiewicz 2010, Gani and Meikle 2015, Wang et al. 2015). Herman (2001:122) also found that, 'abuse in childhood appears to be one of the main factors that lead a person to seek psychiatric treatment as an adult' (see also Read et al. 2003 and Read and Bentall 2012). This acknowledges that qualified P/MH nurses have to work with consistent service user pain and distress, some of this arising from the service users' early traumatic experiences alongside these working conditions student P/MH nurses may

also be bringing their own mental health issues which could therefore limit the students ability to respond to service users increasingly complex needs (Jaffe 2014, Gilburt 2015, www.nhsdigital.uk NHS Digital KP90/ Mental Health Services Data set (MHSDS) cqc.org.uk – accessed 22/02/2018).

5:4 Evidence of trauma from the participants' data on their experiences:

Several of the participants were clearly exposed to events during their educational course which were a potential source of trauma or re-traumatisation, depending on the participants' prior experiences; some were exposed to severe physical injury or threat. For example, during the participants' interviews the following comments were made:

> Because in placement I saw you know like major restraints woman sort of slashed all her arms and there was just blood everywhere
>
> (UB2).

> There was a fight a big fight broke out and you know, I, I was a bit worried because they wanted me to do stuff I was not pleased with
> (BCU1).

For an experience to be traumatic it must be sudden, where the individual is unable to control the event and there is a 'subsequent threat to the individual's physical safety and psychic integrity' (Carlson 1997 defines this as a person's sense of self). An example of this is when one of the participants stated:

> She (patient) tried to slap me. I had to sit in very close proximity, so I was always on edge not knowing what she would do next (BCU1).

This suggests that the participant was experiencing emotional apprehension, they were unable to control the situation, and felt anxiety and fear for their own safety. Another participant raised this in relation to a fellow students' experience:

> I had a girl on my placement yesterday who was hit and had been in the past and it was obviously something that did affect her and the staff I was working with just didn't really... there was no support for her (UB5).

Foa, Zinbarg and Rothbaum (1992) contend that this 'lack of controllability of events is a defining element of trauma' (secondary cited in Carlson 1997:32). During one interview (previously referred to in chapter four) one of the participants described this phenomenon during their student nursing clinical experience:

> She (patient) opened the door suddenly and she said, excuse my French "You fat fuck, what the hell do you find to be smiling about?" and she just started shouting all these expletives and before I knew it I became public enemy number one and anytime she saw me she would spit at me. I said to the manager "I'm really upset by it you know" (BCU1).

Here the participant demonstrated emotional shock and distress at their apparent lack of control. UU3 spoke about their experiences of seeing a patient smacked by a nurse, who justified this by disclosing that the patient had been guilty of child abuse, and the participant's subsequent shock and anger in response to this.

Carlson (1997) argues that the more sudden the experience the greater the trauma potential. During one of the participant interviews they very clearly demonstrated how traumatic events can become stuck in the mind and intrusive:

> I will never forget her, she had committed, tried to commit suicide by pouring gasoline over her head and setting it on fire. She's horribly disfigured, she's burnt thirty-five percent of her body including like her entire face and her head and her arms and I'd never seen a burns patient before either (BC2).

This illustrates the participant's recollections, intrusive thoughts, emotional shock and intrusive imagery:

> I find myself getting, I mean especially with the one patient, the burns patient, I find myself just thinking about it all the time (BC2).

Again the participant comes back to this particular experience demonstrating that this event has become stuck and therefore traumatic. However for others this was not always the case, for example, despite some initial anxieties, one of the

participants indicated that they were able to adjust healthily to what was potentially a traumatising situation:

> I was quite nervous about (unit) beforehand, but actually loved it and it was really chaotic, busy and really quite violent (UB2).

What this first section of data presentation has principally sought to demonstrate is that some of the participants acknowledge prior experience of or pre-existing traumas whereas others indicate traumatic experiences directly from their experiences as student P/MH nurses. From the participants data there is evidence that out of the fifteen participants several of them had traumatic experiences ranging from (as some but not all of the examples) –

<u>Before the course</u>:

Being in an abusive domestic relationship; Being present at a serious bombing; Lecturer makes sexual advances; Unable to cope with work and taking an overdose as a cry for help; Being required to visit, from an early age, a family member who was not only seriously physically injured in a bombing, but who also required regular in-patient psychiatric treatment. As a result of this experiencing intense fear and avoidance of visits during family member's psychiatric admissions; Family member receiving treatment for Eating Disorder; Having a close family member diagnosed with schizophrenia; Experiencing MH problems such as post natal depression, depression, drug and alcohol problems, eating disorder, and PTSD.

During the course:

Observed older people being physically abused during clinical experience as student nurse; Seeing a fellow student physically hit on placement; Witnessing major self-harm and fights; Working with an actively suicidal person with severe life threatening burns; Being assaulted on placement.

Some of the participants seemed unaware or denied that their own experiences impacted on their work with individuals with MH problems. One of the participants who had been in an abusive marriage, would always champion the service users' rights, regularly arguing with nursing staff and often finding them oppressive. Yet they never made a connection with their own personal experience, instead stating that they would not let it influence them, or stop them from progressing. Others chose to work directly with their own experiences. One of the participants, whose mother had been severely disabled in a bombing and had developed serious MH problems, discussed their work with one individual in particular, which perhaps demonstrates this. This participant had experienced their own MH problems for several years, worked through these with a counsellor and psychologist and was subsequently working with a person who self-harmed and had a history of abuse. The participant discussed how they had disclosed their own story so that the service user did not feel they were alone, unable to change or to turn their life around. The participant indicated that this was very positive for this service user; however, there is some risk that the service user could see this as avoiding dealing with their pain and may question whether the MH professional is sufficiently robust and resilient

enough to deal effectively with their (the service users) trauma. Alice Miller (1990:316) contends:

> only therapists who have had opportunity to experience and work through their own traumatic past will be able to accompany patients (clients) on the path to truth about themselves and not hinder them on their way...for they no longer have to fear the eruption in themselves of feelings that were stifled long ago, and they know from their own experiences the healing power of these feelings.

One of the participants from Ulster spoke at length about their experiences following a major bombing incident. Both of their parents were MH professionals, one a nurse who attended the scene of the bombing. This participant experienced their parent becoming withdrawn, uncommunicative, and emotionally unavailable, whilst at the same time several of their own friends had been killed or injured during the bombing. The participant responded by flight; they left the country, went to university elsewhere and escaped. However, when a serious personal relationship ended they retreated into drugs and alcohol. Eventually after contemplating suicide they returned home. But in order to be able to function they underwent lengthy personal therapy. After that they began their education as a student P/MH nurse. This participant was emphatic that student P/MH nurses ‘deal with their own baggage’ before working with people with MH problems.

These sections highlight that the participants have been exposed to a significant numbers of traumatising experiences both before and during the course. In this next section of the chapter secondary trauma/helper trauma is considered in relation to

student P/MH nurses against evidence from the literature review which has shown how qualified P/MH nurses can and do experience helper trauma. Bimenyimana et al. (2009) focused on P/MH nurses responses to aggression and violence and found that nurses were overwhelmed, Iyamuremye and Brysiewicz (2010) work indicates a high risk of secondary traumatic stress in P/MHN, Jacobowitz et al. (2015) talks about the risks for P/MHN of developing PTSD, Mangoulia et al. (2015) refers to the high risks of secondary traumatic stress that P/MHN are exposed to, Zerach and Shalev (2015) refer to risks of both PTSD and secondary traumatization, and Lee et al. (2015) acknowledge the likelihood of PTSD and psychiatric caseness in their study of P/MHN.

5:5 Evidence from the participants' experiences of helper trauma

One aspect of helper trauma is referred to as vicarious trauma,

> 'Vicarious traumatisation is commonly understood to refer to the cumulative transformative effect on the helper of working with people who have experienced traumatic life events, both positive and negative; or the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' traumatic material. The impacts on the workers thoughts, feelings, behaviours and general sense of self can be similar to the difficulties faced by the people we are working with. The term 'vicarious traumatisation' is often used specifically to refer to professionals 'secondary traumatic stress' or 'secondary victimisation.' It is often used more broadly to refer to those in a significant relationship with the person directly affected'. (https://www.livingwell.org.au/professionals/confronting-vicarious-trauma/ accessed 23/03/2018)

This participant, certainly in response to an individuals' psychosis, demonstrated some evidence of vicarious trauma, feeling unsafe and overwhelmed emotionally, when they stated:

> She was kind of scary in a way, she would have hallucinations and say "I'm going to kill my kid, I'm not safe" (BC4).

Here the participant reflects their own fear, 'she was …scary' and mirrors the service users feelings of being unsafe. There is some emotional matching, both the participant and the service user lack the ability and resources needed to deal effectively with this situation. This emotional matching is indicative of the participant becoming overwhelmed by the service user's experiences and is closely linked to vicarious trauma (Izzo and Miller 2010).

At times individuals with MH problems presented the participants with particular difficulties in the case of BC2 they responded by showing cognitive uncertainty, emotional resentment, and a sense of failure:

> So actually coming into work with her was quite difficult, I had so much compassion for her, but she got very, very, she did a lot of splitting and sometimes I was on the negative of splitting (BC2).

> My initial placement was on an acute ward so I was really apprehensive going into it
> (UB5).

What the data show is that participants have potentially already experienced vicarious trauma during the course. The participants have demonstrated this through disorganised and distancing behaviour, emotional numbing, avoidance, outbursts, apprehension, anxiety and intense fear and physically feeling unsafe all recognised symptoms of vicarious trauma (Morrissette 2004, Koch et al. 2012). The participants' manifestations of vicarious trauma appear to be more evident from within cognitive and emotional areas. They are evidently more cynical, resentful and frustrated cognitively, they also demonstrate a lack of trust. Emotionally there is a heightened intensity in their responses; they express despair, being overwhelmed and a sense of isolation.

> I will never forget her, she had committed, tried to commit suicide by pouring gasoline over her head and setting it on fire. She's horribly disfigured, she's burnt thirty-five percent of her body including like her entire face and her head and her arms and I'd never seen a burns patient before either
> (BC2).

This example demonstrated cognitive effects, participants presented clear recollections of the traumatised person however, in BC2's case, secondary traumatic stress disorder,

> (Secondary traumatic stress is defined as the natural, consequent behaviour and emotions that result from knowledge about a traumatizing event experienced by another and the stress resulting from helping or wanting to help a traumatized or

suffering person. Secondary traumatic stress includes symptoms produced in response to exposure to details of traumatic event/s experienced by a significant other (i.e. not necessarily as a result of acting in the role of therapist or helper). (https://www.livingwell.org.au/professionals/confronting-vicarious-trauma/ accessed 23/03/2018).

Symptoms such as suddenly re-experiencing and reminders of the traumatised person were also evident. Several of the participants also talked about their experiences of working with a person with MH problems where they provided a clear example of an inability to process the traumatic event:

I find myself getting, I mean especially with the one patient, the burns patient I find myself just thinking about it all the time (BC2).

Similarly participant BC3 indicates difficulties with integrating potentially traumatic working experiences when they say:

When times are bad I have a tendency to lie in bed and ruminate instead of sleep (BC3).

The participant demonstrates cognitive intrusive thoughts here, which may also be a symptom of PTSD, there is already evidence of PTSD amongst qualified P/MH nurses (Jacobowitz et al. 2015). In the Diagnostic and Statistical Manual V: Post

Traumatic Stress Disorder (PTSD) the American Psychiatric Association (2013) describe PTSD as follows:

> The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, directly, witnessed in person, indirectly, repeatedly or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties.
>
> The traumatic event is persistently re-experienced in the following way(s) recurrent, involuntary, and intrusive memories. Traumatic nightmares. Dissociative reactions Intense or prolonged distress after exposure to traumatic reminders. Marked physiologic reactivity after exposure to trauma-related stimuli.
>
> Persistent effortful avoidance of distressing trauma-related stimuli after the event, Trauma-related thoughts or feelings. Trauma-related external reminders.
>
> Negative alterations in cognitions and mood that began or worsened after the traumatic event. Inability to recall key features of the traumatic event. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous."). Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame). Markedly diminished interest in (pre-traumatic) significant activities. Feeling alienated from others (e.g., detachment or estrangement). Constricted affect: persistent inability to experience positive emotions. Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event. Irritable or aggressive behavior. Self-destructive or reckless behavior. Hypervigilance. Exaggerated startle response. Problems in concentration. Sleep disturbance. Persistence of symptoms for more than one month.'
> https://www.livingwell.org.au/professionals/confronting-vicarious-trauma/ accessed 23/03/2018.

The traumatic experience may, on one hand, expose people to situations unlike anything that they have imagined and this can seriously undermine the person's previously held attitudes and beliefs. On the other hand, it may simply be that the

trauma reaffirms beliefs that the person has deliberately avoided. Van der Kolk, McFarlane and Weisaeth (1996:8) recognise that for many…'what is most destructive about the traumatic event is that it confirms some long feared belief, rather than presenting them with a novel incongruity.'

> Nothing could, could prepare you for what you would do. And you kinda just think, "I don't really know if I made the right choice (UU2).

Here the participant demonstrates how overwhelmed and shocked they feel.

> In my first MH placement was an elderly dementia unit and I absolutely abhorred the six weeks I was there, I hated it and I thought it was awful, awful, sadly because the way the older people were treated (UU3).

Here the participant, whilst experiencing a situation that was potentially traumatising, indicates their anger, disillusionment, hopelessness and helplessness, frustration and blaming of others as they struggle to accept the realities of care of older people in the UK:

> MH nursing in itself is very stressful and student probably not have the knowledge of what is taking place, so it would be like shock, because for me some of these placements were like a shock at first
>
> (BCU1).

Again the participant is trying to adjust to the realities of P/MHN practice as Rhodes and Bouic (2007) point out student expectations are often disappointed when exposed to the realities of nursing:

> Just pulls you back from the fear of cos' it can manifest into a big irrational you know. "I can't do this I'm going to leave" or "they'll never speak to me again"
>
> (BCU2).

Here the participant is torn between the reality of practice and whether they can function in that context:

> The traditional MH system, which is an utter failure and a waste of money
>
> (BC4).

Here the participant has no qualms about stating their long feared belief that the MH system is basically and fundamentally flawed. The participants may also provide evidence of traumatic disorder arising from their experiences, Van der Kolk, McFarlane and Weisaeth (1996:9) identify how PTSD impacts on people in the following six ways:

1. 'They experience persistent intrusions of memories related to the trauma which interfere with attending to other incoming information'.

> If I had a really busy day at placement I tend to think about it and go over and over it in my head, which isn't helpful a lot of the time (UB2).

Other participants have spoken of burn victims, suicide attempts, violence and aggression, threats to children and how intrusive these memories are. However, this cognitive intrusive thought process may possibly demonstrate how the everyday practice of P/MH nursing is traumatising.

2. **'They sometimes compulsively expose themselves to situations reminiscent of the trauma'. (Van der Kolk, McFarlane and Weisaeth 1996:9)**

> At times in some of the placements I've had days were I thought "oh why am I doing'? Why am I doing MH nursing?" I'm on an ICU I'm not sure I can cope with this
>
> (UB1).

Here the participant indicates their ambivalence about P/MHN and yet they continue to keep exposing themselves to potentially traumatising situations despite clear cognitive uncertainty and being emotionally overwhelmed.

3. **'They actively attempt to avoid specific triggers of trauma-related emotions, and experience a generalised numbing of responsiveness'. (Van der Kolk, McFarlane and Weisaeth 1996:9)**

> I can only think of a technique I use to kind of, I would distance myself a little bit
>
> (BC2).

The participant is trying to avoid trauma through distance and detachment from others. Whereas BCU1 is actively contemplating avoidance altogether when they stated:

> I thought to myself after qualifying, I think I need a little break you know to sort out or gather my thoughts, because it can be very stressful
>
> (BCU1).

4. **'They lose the ability to modulate their physiological responses to stress in general which leads to a decreased capacity to utilise bodily signals as guides for action'. (Van der Kolk, McFarlane and Weisaeth 1996:9)**

Both UU2 and UU3 raise concerns about their health:

> You do find there are times when your MH could slip very, very easily
>
> (UU2).

> I was very close three times to getting the doctor
>
> (UU3).

5. **‘They suffer from generalised problems with attention, distractibility and stimulus discrimination’. (Van der Kolk, McFarlane and Weisaeth 1996:9)**

One of the participants demonstrates how this can affect a person when they state:

> You get to the stage where you're worn out from all the work…I dropped to a fail which was really strange but I know that it's just been lack of motivation and work on placements, assignments on placements. I'd been sick for the first exam…I have got to the stage now where I don't care about marks, I just want to pass (UU1).

6. **‘They have alterations in their psychological defence mechanisms and in personal identity’. (Van der Kolk, McFarlane and Weisaeth 1996:9)**

> I think as a student you're identifying that when on placement there are a lot of people who see you more as a slave, in the role words, I mean you're there to do all the rubbish jobs, you're there to do everything they don't want to do (UB5).

Here the participant experiences a sense of isolation, they appear resentful and frustrated by the identity they are being given.

There is some concurrence (Horowitz 1993, van der Kolk, McFarlane and Weisaeth 1996 and Carlson 1997, APA 2013) that trauma symptoms are evidenced through

re-experiencing and avoidance, alternatively referred to as re-living and denial, and that symptoms are presented biologically, cognitively, behaviourally and emotionally. Carlson (1997) additionally reports secondary symptoms and identifies these as mainly being depression, aggression, low self-esteem, identity confusion, difficulties in interpersonal relationships and guilt. In terms of depression, similarly to evidence on qualified P/MH nurses (Wang et al. 2015) the participants indicated that at times they experienced episodes of this, this was particularly prevalent in the Ulster University participants:

> It's been tough, there's been lots of downs, there's been a lot of person(al) problems that was interfering
>
> (UU3).

> There should be enthusiasm, but the class are all cold, clinical, boring, depressing, no jobs out their classes
>
> (UU2).

There was also evidence of anger:

> Staff attitudes towards people receiving care, cos' they really cause me a lot of anger I guess, that I can't externalise, I have to go home and rant at anyone that will listen
>
> (UB3).

> I get angry at people when they say like "depression why don't they just get over it". I get really angry
>
> (BC3).

> I did a Residential MH placement I just hated it
>
> (UU2).

These participants all expressed anger about experiences in practice and whilst they were prepared to disclose this during an interview situation they don't appear to have vented this in a professional capacity. Alongside this anger appears some hopelessness, and perhaps a sense of disempowerment, and an inability to change things, like qualified P/MH nurses in practice as the literature review evidenced (Clarke and Flanagan 2003, Richards et al. 2006, Bimenyimana et al. 2009, Currid 2009) which may compound any psychological trauma. There is also evidence of the impact the participants' experiences had on their identities in relation to becoming a P/MH nurse leading to possible crisis, two of the participants acknowledged this:

> It has been a fight, you know, there's been times when your backs against the wall and like 'oh should I just quit here'
>
> (UU2).

> Professional attitudes towards me have sometimes been really hard for me to deal with
>
> (UB3).

Other investigations have also acknowledged the difficulties student P/MH nurses can and do experience in practice, Galvin et al. (2015) found negative attitudes from staff and issues around patient care led to some of their participants feeling overwhelmed. Both difficult working conditions and difficulty with staff present a risk to student P/MH nurses in terms of retention. In common with Pryjmachuk and Richards (2007) and Freeburn and Sinclair's (2009) work other participants very

clearly acknowledged how their educational course impacted on their interpersonal relationships:

> Cos at stage(s), our lives have all fallen apart along the way during this degree…we have to pick each other up from time to time
>
> (UU2).

Further evidence of potential psychological trauma from the participants' experiences is visible in relation to their expressions of guilt:

> I didn't feel like I could take it any further than that
>
> (UB3).

> I'm kind (of) disillusioned
>
> (BCU3).

However, there are other ways to interpret the participants data the example considered here demonstrate what Morrissette (2004) refers to as single and multiple events where participants seem unable to cope and may arguably be viewed as critical incident stress rather than evidence of psychological trauma:

> Emotionally speaking, a lot of the things that I dealt with were very difficult, a lot of the patients had made suicide attempts and I heard very, very sad stories about abuse
>
> (BC2).

There is also a further argument that what the participants are demonstrating could be seen as evidence of stress and resultant burnout rather than psychological trauma

> I internalise things myself and I deal with it myself
> (UU2).

> You do find there are times when your MH could slip very, very easily
> (UU2).

> I was very close three times to getting the doctor
> (UU3).

> I'm kind (of) disillusioned
> (BCU3).

> You're going back and saying look I've seen the most awful thing, you know, it's not worth it trust me, and a couple of our students have had it both in adult and MH branches and they've said it wasn't worth it so you tend to go on now and put your head down
> (UU3).

Some of the participants also referred to their experiences of bullying in the work place, however, this was only apparent in the UK participants' interviews:

> They shouldn't close ranks on us if we say something we should be supported and not made to feel as if we're trouble makers
> (UU3).

(Referring to their Mentor) She ignored me for the rest of my placement, completely ignored me, and I used to sit at the table and cry

(BCU1).

I think as a student we're sort of restrained...if you've got a manager who you don't get on with and could use something against you and you tell them something you don't really want to go back down that avenue

(UU1).

I've felt that staff have seemed to think having a student is a burden

(UB3).

At the beginning people would be arguing over your head, "I'm not taking a student" "No I'm not" and you'd just be like "come on I'm human"

(UB3).

I also find a lot of the time nurses who have a big power trip over you and it's not a nice environment to be in

(UB5).

They couldn't get them mentored properly, you know I didn't have a mentor for a couple of weeks and that's previous time at the beginning so you're kind of latching on to who you can

(BCU2).

I feel I was victimised

(BCU3).

The participants demonstrated a range of responses including a lack of trust, cynicism, resentment, frustration, distrust, a sense of isolation, a sense of failure, blaming others, suspicion, anxiety and disillusionment. There was also more of a sense of a slower, cumulative damaging effect from the response of qualified nurses

to participants (Evans and Kelly 2004, Rungapadiachy, Madill and Gough 2004, Nolan and Ryan 2008, Orton 2011, Jansen and Venter 2015) in contrast with the much higher impact that hearing about individual MH service users' life experiences and attempting to work with them had (Walsh 2015, Gunusen et al. 2017).

There is significant evidence of student P/MH nurses stress, in 2004 Tully examined causes of stress and how student P/MH nurses coped with these and she found that students had significantly higher than anticipated levels of stress. According to Tully (2004) several of the students were at risk of developing a physical or psychiatric illness. Things do not appear to have significantly improved for student P/MH nurses as the work of Pryjmachuk and Richards (2007), Nolan and Ryan (2008), Freeburn and Sinclair (2009), Galvin et al. (2015) and Alzayyat and Al-Gamal (2016) indicates.

The students' main causes of stress, which they identified, were academic and financial concerns; professional demands, which were particularly the case in more experienced students; and a lack of autonomy. This range of responses can be seen in the participants' comments below:

> Sometimes I come here (university) myself and I've been really stressed and I've had a lump in my throat and a tear coming down my face and I need to speak to somebody
>
> (BCU2).

> I think that was the only time during my placement that I've been very angry
>
> (BCU1).

These excerpts demonstrate their emotional despair, sense of isolation and anger. One of the factors that often gets overlooked is the traumatic impact that academic processes and staff can have on student P/MH nurses. This first part of the chapter has focussed on the impact of MH service users, practice experience and the support provided in practice and yet perhaps not surprisingly the participants indicate that university lecturing staff also have a significant impact:

> We have lost lecturers that we would've got to know very well in our second year...and it's horrible going through that, having them ripped away when you're, when you think you're fixed up with support and then the time when you most need them they've been ripped away from you
>
> (UU1).

This demonstrates the level of attachment and grief that participants may experience in relation to university lecturers, alongside the potential for further trauma. There is evidence that some of the participants' experiences can be defined as psychologically traumatic and there are multiple examples of where the participants' data demonstrate that they have potentially become disordered through their experiences as student P/MH nurses. However, the concept of trauma itself is not fully agreed, in this next section this debate around psychological trauma, diagnosis and recognising trauma is considered.

5.6 Psychological Trauma – critical issues.

It is important to be mindful of the problems of the PTSD diagnosis itself, which include that there are limited levels of credibility, in relation to this diagnosis and discussion as to whether PTSD should be seen as a dissociative or an anxiety disorder (Rosen, Spitzer and McHugh 2008). Controversy over PTSD has been around issues such as the legal and financial liability in providing 'debriefing' and the imposing of 'false' traumatic memories (Rosen, Sageman and Loftus 2004). The diagnosis of Acute stress disorder which pathologises early and potentially healthy/normal responses to trauma and the over inclusiveness of trauma/language to include everyday stressors has also led to concern (Rosen, Spitzer and McHugh 2008). Therapy with a questionable evidence base and the faking of PTSD diagnosis to receive financial compensation alongside the use of PTSD diagnosis as legal defence for example the insanity plea has led to something of a backlash by the media (Rosen, Spitzer and McHugh. 2008).

The popular response following New York September 11th was, the media suggested, not to think about it. MH treatment was referred to as 'trauma industry'. MH Professionals were referred to like a plague as in a, 'swarm of therapists descended on NYC' (Slater 2003). This response has reinforced notions that individuals with PTSD are mentally and morally weak, or are faking or exaggerating their symptoms. Evidence is that most people who have been traumatised do not develop PTSD therefore the person is portrayed as mentally inferior; they can't handle stress or is not trying hard enough to get on with their life. Kimble (2007:70) acknowledges that, 'the experience of a trauma involves elements of chance, personality, constitution and interpersonal support that will never be completely understood through neurobiological findings alone. He also states, 'less than 30% of

those exposed to even the most horrific traumas (for example combat or rape) develop PTSD suggests that trauma may interact with constitutional factors to cause PTSD in some cases but not others' (Kimble 2007:71).

Carlson (1997) acknowledges that for MH professionals one of the central issues in recognising traumatic experiences is the failure to pay attention or to ask about any trauma history. Interestingly whilst Carlson (1997) working in the US recognised this as early as 1997 in the UK it is only since 2009 (Department of Health 2009) that MH professionals are now being trained and are required to ask MH service users about their abuse histories. Given the prevalence of abuse histories amongst service users (Read and Bentall 2012, Scott et al. 2015, Scott, McNaughton and Nicholls 2015) and what has long been considered part of P/MH nurses practice in the US (Sundeen and Stuart 1987) it is only really now getting the necessary recognition it warrants in the UK, this is in part due to research such as that carried out by Read and Bentall (2012). Of course this has sparked some similar concerns, as raised in the US, around issues of false memories, and how raising the issue of abuse may inadvertently 'plant', or suggest memories to vulnerable service users. Loewenstein (1996) found that following traumatic experiences many people may have partial or complete amnesia for these events. This is confirmed by Williams' (1994) study of women who were sexually assaulted as children and received treatment in hospital; seventeen years later thirty-eight percent of the women had no recollection of the incident and for those who did recall the assault sixteen percent reported amnesia of the event for some time immediately afterwards. Carlson (1997:10) also found, 'a higher rate of amnesia for psychiatric patients' and suggests that this is explained by the fact that, 'people with more severe symptoms and more severe trauma are more

likely to have amnesia for traumatic experiences'. In all work with both adults and childhood trauma there is a significant element of amnesia and this is clearly indicated as memory loss and is a diagnostic category in post-traumatic stress disorder (APA 2013).

Similarities with other psychiatric disorders are abundant, problems with sleep and concentration may be seen as evidence of anxiety or depressive disorders (APA 2013), initial difficulties with reality testing may be a temporary symptom for people with traumatic experiences but could be seen within the diagnostic context of borderline personality disorder or a psychotic disorder (APA 2013), alongside this there are issues of co-morbidity and the increased likelihood of psychiatric disorder following a traumatic experience as well as additional psychiatric symptoms emerging in relation to the trauma (APA 2013). O'Brien (1998:1) acknowledges that:

> The frequency and diversity of traumatic events which may affect one person or thousands are such that the consequences of trauma will probably impinge upon all of us at some time. They will certainly impact upon the work of health and other service workers in general and MH and social work professionals in particular.

Working with trauma does potentially, 'risk the therapist's own psychological health' (Herman 2001:140). Herman (2001:140) goes onto suggest that, 'trauma is contagious', as a witness to the clients' trauma, 'the therapist at times is emotionally overwhelmed'. The therapist experiences, 'to a lesser degree, the same terror, rage and despair as the patient'. Herman (2001) recognises that the same issues

impacting on clients can impact on therapists working with trauma, these include experiencing symptoms of PTSD.

Clearly suggesting that someone has a mental disorder as a result of trauma may not be straight forward, many of the symptoms of PTSD are also symptoms of other psychiatric disorders, however there is evidence that traumatic experiences such as abuse and sexual assault are more likely to have occurred in the psychiatric population (Read and Bentall 2012, Scott et al. 2015, Scott, McNaughton and Nicholls 2015) and therefore MH professionals will be working with trauma. Increasingly P/MH nurses are adopting a trauma informed approach to care (Sweeney et al. 2016) in response to these issues.

This investigation suggests that the participants may be traumatised by their experiences. However, there is a need for caution as there are only fifteen participants in this study and further exploration in relation to the 'type' and extent of this trauma and discussion as to whether this is potentially significant or not in relation to the general populations experience of trauma and a wider group of P/MHN students, would be appropriate. The original research questions asked - what motivates student P/MH nurses to choose their career, what keeps them on the course and what might lead them to leave in this section on psychological trauma what the participants' data indicates that they are still hoping for transformation and healing, a desire to fix themselves, but they are increasingly recognising the difficulties that P/MH nursing presents, along with an increasing self-awareness of the risks of P/MH nursing is a desire to make a difference in service users lives.

Work on intention to stay in P/MHN and job satisfaction states that it starts low and stays low (Murrells, Robinson and Griffiths 2008). The less time P/MH nurses have in the role the higher the level of intention to leave (Alexander, Diefenbeck and Brown 2015, Baum and Kagan 2015), could these factors be potentially worsened through student P/MH nurses' traumatic experiences during their course? The implications of this data is that there is a fine balance between perceived reward and 'compassion fatigue' (Joinson 1992). The next section of this chapter discusses the self-help strategies identified in the participants' data to ascertain if and how these maintain and support the participants on their course.

5:7 What does the participants' data tell us about how they attempt to deal with their student nurse course expectations?

This section provides a consideration of the data generated in response to the research questions, specifically what did the participants do which helped them stay on the course and what did they identify would help them from clinical nurses and nurse educators. The first part of this chapter demonstrated how, like qualified P/MH nurses, traumatising the work of a student P/MH nurse can be, and this section goes onto present data on the strategies participants employed and identified that would help them to keep going on their educational programme.

5:7a What did participants do which helped them stay on the course?

Seven of the participants referred to having good parental, family and or friend support systems in place. On a par with this, seven participants also referred to supervision: mostly they talked of formal clinical supervision (McLeod 1997, Butterworth, Carson and Jeacock 1999, Teasdale, Brocklehurst and Thom 2001, Edwards et al. 2006, Dickinson and Wright 2008, White and Whitstanley 2011, Carthy, Noak and Wadley 2012), which largely sits outside of the mentoring system employed in the UK, and alongside this four participants, like their qualified nurse counterparts, thought that group support including peer supervision and team building work were useful strategies for student P/MH nurses (Hubbard, Beeber and Eves 2017). Six of the participants referred to cognitive behavioural strategies and a further three mentioned reading positive self-help books including cognitive behavioural texts. Three participants referred to accessing university counselling services for support, having teaching staff who are prepared to discuss real life issues was also indicated, but only one candidate directly mentioned Personal Tutor support. There were specific emotional strategies that participants employed - 'having a good cry' and using the support mechanisms of family and friends most notably. Participants also noted a range of behaviours that they found useful including exercise, cooking, eating, listening to music, art, relaxation and socialising. In terms of personal qualities and attitudes participants referred to assertiveness, confidence, being open to people, having faith and being genuine and honest as useful strategies for working with people with MH problems. Whilst the participants broadly suggested healthy and helpful strategies, four of the participants spoke about less healthy responses, including the need to cut themselves off from other people, one spoke about smoking as a strategy to cope and one of the participants spoke about their early experiences and resultant use of drugs and alcohol to cope

with particularly traumatic incidences and life issues. Some participants demonstrated a lack of confidence (Trenoweth 2013, Walsh 2015), in part this could be compounded by the nature of the clinical placements that student nurses experience, student nurses are likely to be placed in at least two different and unknown clinical settings each year of their two - three year course, depending on whether they are UK or USA P/MH student nurses, the course being shorter in the USA.

The majority of the participants acknowledge the importance of family and friend support networks and this indicates positive social functioning which is a component of resilience (Glicken 2006). Evidence of resourcefulness such as actively seeking effective support within a P/MH nursing context (Carthy, Noak and Wadley 2012), not just from family and friends is also referred to by the participants, some indicating that they have identified willing mentors, or 'expert' staff to go to, as well as peers who have common experiences (Wang et al. 2015), suggests that the participants have, in part, adopted help with self-righting, another useful aspect of resilience (Glicken 2006) and as Senining and Gilchrist (2011) found effective in helping to decrease qualified P/MH nurses work-based stress. Alongside this the participants demonstrate a strong desire to help others, combined with determination and hard work, also further evidence of resilience and indicated as a reason for qualified P/MH nurses remaining in the profession (Beckett et al. 2013). Several participants referred to their utilisation of cognitive behavioural techniques in dealing with their experiences as student P/MH nurses which demonstrates problem solving skills, another aspect of resilience (Rethink 2008) and again a recommended coping strategy in Senining and Gilchrist's (2011) work for dealing with qualified P/MH

nurses work-based stress. There were also indications that participants, at times, relied on their faith to help them cope successfully with issues arising and two of the participants specifically mentioned this. Glicken (2006) also referred to a sense of adventure as being an attribute of people with resilience and one of the participants certainly demonstrated this with their training with the Territorial Army.

Seeking support is recognised as important and valuable, but there is a focus on family and friends and relationships outside of the work context, rather than accessing support and building healthy relationships within a work setting (Carthy, Noak and Wadley 2012). The participants' ability to be flexible and adaptable in their approach was variable, some were exposed to very distressing experiences and appeared to work their way through the situation well, others much less so. This reflects the potential importance of self-help and resilience building strategies and the possible need to integrate these skills and attitudes into the P/MHN curriculum.

The data presented in this study suggests that resilience building may need to be considered in curriculum development and become part of student nursing course content in the future (Barker 2009, Glicken 2006, Cairns and BAAF 2004).

5:7b What strategies did the participants identify that P/MH nurse education and clinical nurses could use to help them stay on and complete their course?

Firstly in relation to support from staff in education the participants were keen to see Personal Tutor engagement, staff who shared their experiences, staff who were

available (Charleston and Happell 2005), who listened to the participants, demonstrated caring (Williams et al. 2009), provided detailed feedback, responded quickly, were interactive (Walsh 2015), offered clinical supervision (Felton, Sheppard and Stacey 2012, Maplethorpe, Dixon and Rush 2014), helped with problem solving and putting resources together (Trenoweth 2013). Participants found staff who were positive and proud of their work 'contagious' (BC1). There is a sense that they wanted more individual time with their Personal Tutors and that the Personal Tutor was a crucial relationship for the participants:

> Improve personal tutor support and time with students (BCU4).

The participants talked about what they wanted from their clinical nursing colleagues and there was some reiteration of time and the chance to communicate, particularly with their mentors (Charleston and Happell 2005, Happell 2008, Nolan and Ryan 2008). The participants wanted more detailed feedback on their progress in practice; again they wanted someone who was keen to share their experiences and was positive about students and learning (Cleary, Horsfall and Happell 2012), and that mentors were more supportive and welcoming (Walsh 2015). Several of the participants referred to clinical supervision and being treated as a person, as one of the participants stated:

> I love my clinical advisor…I guess his attitude that the nursing students were also people, with lives outside of school and multi-faceted and we came in with our own emotions and our own issues to deal with and realising that, as well as fostering the students he had to you know focus on the actual person, so he seemed to realise where we came from and you know, ask how our weekend was and how our day was and if somebody said, 'Oh, I've been in hospital for the last 48 hours with my boyfriend',

> he said, ‘Ok, I understand how that’s going to impact you today and take your time and do what you can and if you think the situation isn’t helping, you know take a step back and take some personal time to yourself’. The fact that he was supportive towards people, not just nurses, allowed us to be relaxed in the environment…he was also very open to questions and discussion. He would provide feedback once again in a non-threatening manner
>
> (BC3).

There was some cross over for both university and clinical P/MH nurse educators, around time, communication, clinical supervision and detailed feedback. The UK participants tended to also include unhelpful responses from staff in relation to not knowing course details, being unwelcoming, being negative about future work, not protecting student nurses when exposed to unprofessional practice; and holding preconceived ideas about MH service users with certain diagnoses. The UK participants wanted staff to stop behaving in these ways. They could not always articulate what they wanted, but they knew what they found unhelpful.

When the participants discussed how P/MH student nurses could support each other as peers, (Williams et al 2009), the issue of non-prejudicial responses to disclosure of MH problems was repeated several times. The participants also referred to sharing information, articles and websites to enhance learning. There was perhaps a hint at wanting personal therapy to support the participants: several of the responses included reference to counselling, one to one sessions, as did BCU1:

> I was always fearful of going to counselling ‘cos I’m thinking, ‘all these people, are they going to understand me and understand my problem’, but I think if you had a student rep there it would sort of make it more attractive for people to go in when they’ve got problems

(BCU1).

Coatsworth-Puspoky, Forchuk and Ward Griffin's (2006:491) work on peer support in MH service user groups offers potential applicability to student P/MH nurses, 'feeling welcomed, learning the rituals and language was part of a larger process of building trust,' along with forming friendships, having a sense of being part of a group or community with common experiences, were aspects of peer support appreciated by those accessing this resource. The participants acknowledged the importance of peer support in their responses, one of the participants tried to set up a cross group peer support system, which worked in terms of social events, however, the participant seemed a little disappointed that it had not been more effective or taken up by colleagues to provide support and this notion of peer caring and support is supported in the literature review (Happell 2008, Williams et al. 2009, Cleary, Horsfall and Happell 2012).

Some of the participants referred to needing emotional intelligence to carry out P/MH nursing. Montes-Berges and Augusto (2007:164) define emotional intelligence as 'abilities to identify our own and others' emotions; abilities to regulate and modify our mood in an adequate manner and abilities to improve our own thought'. Being able to assess emotional experience; being confident with attending skills and effectively regulating emotional responses are linked to better adaptation to stress. Montes-Berges and Augusto's (2007) work on emotional intelligence in nursing students, and the links to coping and mental health, casts light on strategies to reduce stress and potentially promote resilience. Along with work referred to in the literature review (Senining and Gilchrist 2011, Orton 2011, Baby, Glue and Carlyle 2014, Alzayyat

and Al-Gamal 2016) they identify social support as a useful mechanism, alongside problem solving, coping and emotional intelligence.

Several of the participants referred to simulation or role play as a means of preparing for the realities of practice. The participants were keen to see social support from their Personal Tutor's: they wanted to be able to access support when necessary. The participants' responses recognised the need for adaptability in all settings, they referred to simulation and role play as opportunities where they would need to be able rehearse coping with rapidly changing circumstances, without becoming overwhelmed, in clinical practice (Cleary, Horsfall and Happell 2012). The participants' responses emphasised therapeutic work with MH service users, they also referred to anti-oppressive and anti-discriminatory ways of working, which demonstrated that the participants were aware of their values and desire to practice P/MH nursing in a particular way (Gunusen et al. 2017). Several of the participants referred to self-help or coping strategies (Alzayyat and Al-Gamal 2017), including relaxation techniques; they suggested:

> if you plan on implementing self-help or coping strategies earlier in the year, students will have already got a grounding so when they come up against problems or obstacles they have already go in their minds strategies to combat or manage these situations (BCU1).

Alongside this some of the participants talked about assertiveness (Trenoweth 2013, Walsh 2015). For some this was linked into control and restraint training and dealing with potential aggression:

> Restraint training, I think that would give people, firstly it would give me more confidence cause when you're going on to an acute ward for the first time everyone isn't going to be worried about violence. Raise assertiveness. Maybe more role play type activities
>
> (UB1).

For others it was more a matter of their ability to communicate more effectively (Cleary, Horsfall and Happell 2012), as BCU2 said:

> There should be some assertiveness training. I think it should be brought in more about how to handle yourself professionally, how to confront…how to look after yourself, how to be assertive, what's the consequences, what's the reality of those consequences and to let them take away a bit of the fear may be and how, what the system would be for them if they did complain so they know what's going to happen if they did open their mouth
>
> (BCU2).

Specific content such as medication, personality disorder, dual diagnosis and recovery from addiction, including the twelve steps programme, were also individually mentioned (Walsh 2015).

In terms of delivery, participants discussed the arrangement of assignment submission periods. During some terms up to seven pieces of work were required yet in other terms only one or two had to be submitted (Nolan and Ryan 2008). The participants also referred to the lack of traditional university holidays, failure by some staff to recognise students' hard work in comparison to other undergraduate courses, and the overall theoretical and practice based assessment spread (Galvin et al. 2015). As UB5 said:

> I think the problem that we have is the huge bulk of work that we have, and it's tough at the beginning and there is no real explanation or help with that and on top of sort of a terms worth of work we also have you know our seven week placement and at the end of that you've got to hand in 4 documents at once (UB5).

The participants' responses mapped against features of resilience are summarised in Table 7:1 (see appendix 7).

The participants indicated that they found support from the university generally good, that personal tutor and university wide support mechanisms were also good, but they felt that peer support could be improved, and recommended a buddy system, where senior students supported their junior colleagues. In clinical practice the participants suggested clinical supervision (Felton, Sheppard and Stacey 2012, Maplethorpe, Dixon and Rush 2014); one participant had experience of a psychodynamic supervision model and had found this very helpful in working with clients with complex needs and processing inter and intrapersonal issues. Working in a very clinically challenging area with MH service users with severe and complex MH needs, the participant found that clinical supervision, when offered effectively, reduced their time spent ruminating about work, improved their work life home balance and enabled them to feel that they could 'leave work at work'. This demonstrates the restorative (provides the supervisee with the time to process arising issues in the work environment, consider transference and counter transference and devise strategies and responses to working with MH service users with complex needs in a safe, learning and positive environment) potential of clinical

supervision within a student P/MHN context (White and Winstanley 2011). Participants valued mentor supervision that was supportive, constructive and developmental (Walsh 2015). The participants also indicated that they would have appreciated Personal Tutor support in relation to the practice context. There was a particular emphasis on this from the UK participants, along with clinical nurse mentor support and treatment, and the burden of academic work (Trenoweth 2013). The participants from Boston indicated clearly in their responses that University staff maintained their own clinical practice, carried out clinically based research and therefore were regularly present during their own clinical placements. They also found clinical nursing staff welcoming.

Nearly all of the participants referred to wanting an increased course content on dealing with violence and aggression, and this was common to both the UK and USA participants. Several of the participants also referred to more preparation for the realities of practice (Rhodes and Bouic 2007), the types of MH service users, and the levels of stress and distress they would likely experience (McLauglin 2010). In common with their qualified P/MH nurse colleagues the participants were concerned about how they would deal with possible violence and aggression in the clinical setting, and wanted to feel better prepared and able to respond appropriately (Ward 2013, Burns 2014, Jacobowitz et al. 2015). This has been a consistently recurring theme throughout this investigation, and there is debate in the wider P/MHN community over whether in fact teaching student nurses physical control and restraint is appropriate; there is some anecdotal evidence to suggest that in doing so students interaction with MH service users falls and they are quicker to respond to

any potential aggression with restraint. This is in contravention of the ethical code for nurses (NMC 2008) and the principles of the MH Act (1985 as amended 2007) however, addressing participants' concerns with a focus on de-escalation and communication strategies could be a useful alternative. This would only apply to the UK nurses, in the USA nurses still use physical restraints, such as manacles, with MH service users when thought necessary, and education on the application of and removal of manacles might be included in nurse education in the future, in the US too (Bowers et al. 2012, APNA 2014b). The participants' responses also indicated that they were being exposed to MH service users in severe distress and they wanted more opportunities to rehearse responses to these situations. This suggests that far more simulation and role play would be necessary in preparing student nurses for work with MH service users in distress (Cleary, Happell and Horsfall 2012). The participants demonstrated that they have many useful and adaptive cognitive behavioural strategies for dealing with their course expectations. As the literature review found, students who were able to use problem focused and direct coping strategies had less distress than those who became hostile about their difficulties or engaged in wishful thinking (Tully 2004, Orton 2011, Alzayyat and Al-Gamal 2016).

5:8 Making meaning of and informing a sense of self and identity in P/MH nursing from an interpretive phenomenological analytical perspective in relation to trauma and the participants' responses to potentially traumatising experiences.

In terms of meaning, identity and sense of self for the participants, in relation to others' trauma there is evidence in response to traumatised service users, participants' may experience an empathic sharing of the service users' helplessness. They may see the service user as a victim of the traumatic events and specifically seek to help the service user by rescuing them from their experiences. The nurse often feels a compelling need to do something for the patient. Alternatively the student P/MH nurse may be so overwhelmed by the service users' experiences that they disengage from the process and avoid entering a helping relationship in anyway. Bearing witness to the individuals' trauma takes a toll on the participants they can become overwhelmed.

In terms of the participants' sense of identity, becoming overwhelmed threatens the professional status and perceived capabilities of P/MH nurses, this may lead to the emotional despair and desire for behavioural withdrawal that some of the participants demonstrate in this study. The literature review establishes that qualified P/MH nurses experience psychological trauma in and through their work (Bimenyimana et al. 2009, Currid 2009, Iyamuremye and Brysiewicz 2010, Ward 2013, Burns 2014, Jacobowitz et al. 2015, Lee et al. 2015, Mangoulia et al. 2015, Ridenour et al. 2015, Zerach and Shalev 2015), and this has implications for attrition rates, likewise unless we begin to accept these realities for student P/MH nurses and seek to address them we are risking an ever shrinking professional group.

In order for student P/MH nurses to maintain a professional sense of identity they develop a range of coping strategies to deal with their lived realities (Deary, Watson

and Hogston 2003, Tully 2004, Pryjmachuk and Richards 2007, Orton 2011, Trenoweth 2013, Alzayyat and Al-Gamal 2016). Also it is worth noting that P/MH nurses are not immune to employing relatively unhelpful coping strategies, alongside many so-called health professionals, the levels of alcohol and substance use prevalent is significant (Bennett and O'Donovan 2001, White, Gray and Jones 2009). One of the participant's from Ulster University acknowledged their prior reliance on drugs and alcohol. Several others indicated that they used alcohol to de-stress, and going out socially was very important for their ability to cope with P/MH nursing. Some of the participants indicated that drinking excessively was a coping strategy that they employed occasionally and it is recognised as a sign of burnout (Morrissette 2004). Kimble (2007) acknowledges that social isolation a lack of social support and substance abuse are major contributing factors to PTSD however, at the same time it is important to acknowledge that these are also recognised as contributory factors in the development and maintenance of severe and enduring mental illness (Callaghan and Waldock 2006).

Whilst it is interesting to note that P/MH nurses will possibly use these maladaptive coping strategies in response to helping others (Trinkoff and Storr 1998, Bennett and O'Donovan 2001, Lillibridge, Cox and Cross 2002, Dunn 2005, Bimenyimana et al. 2009), many people with MH problems employ alcohol or illegal drugs to escape their reality and symptom manage it is worth noting the potential parallel processing or mutual avoidance, occurring here. This challenges earlier meanings that the participants had identified as part of their identity in Chapter Three. That the participants had by virtue of becoming a P/MH nurse fixed their own MH issues. However, meanings and one's sense of identity are often pluralistic and complex, as

is the case here (Roberts 2007). Both of these positions, being 'fixed' and using substances to cope with others and personal MH issues, appear to be held simultaneously.

Whilst the participants are trying to adapt to dealing with high levels of trauma and distress in the individuals they work with, sadly the use of alcohol and drugs by MH service users has contributed to an environment of increasing physical assault within these services (Jaffe 2014, Gilburt 2015), as evidenced by one of the participant's experience of seeing a fellow student nurse hit by a service user. The participant indicates how unsafe they felt and resentful at the apparent lack of support for staff in these circumstances. This is also true of community provision; formally held clients, higher levels of substance misuse and growing secure provision; alongside clients' refusals to accept treatment and involvement, are all indicative that there are higher levels of physical risk and danger to P/MH nurses (Antai-Otong 2001, Richards et al. 2006, Iyamuremye and Brysiewicz 2010, Ward 2013, Burns 2014, Jacobowitz et al. 2015, Lee et al. 2015). The participants' express these fears clearly:

> I think it's partly because there are risks of violence and how I would be able to cope with that, how assertive I would be able to be, so that's my worries at the moment
>
> (UB1).

> There was a fight, a big fight broke out and you know, I, I was a bit worried because they wanted me to do stuff that I was not pleased with
>
> (BCU1).

> Though I coped with my acute placement in the past and everything, I did find it quite difficult
>
> (UB1).

> I went to (name of a secure unit) – the build-up to that was more intense than the actual placement, the scare stories in the newspaper and you can look on the internet, oh my God
>
> (BCU2).

In relation to the participants' sense of self, this perceived lack of safety in the role presents a real challenge. In relation to making meaning the participants were aware of the cyclical nature of their work, to care for others one must care for oneself and be cared for, but they also appeared to invest in the biomedical model of mental illness and the associated industry around mental health. The participants expressed a desire to be strong and assertive with both colleagues and service users, and also able to control and restrain service users where necessary, they were attempting to make meaning of the work and adopt the professional status of a P/MH nurse, in this way forming their sense of self, feeling and identity as a P/MH nurse. These aspects of the P/MH nurses role were previously referred to in much more negative terms now however; the participants appeared to be acknowledging that these would be part of their work, their identity. Earlier in the interview the participants sought some distance from this aspect of P/MH nursing, now they were acknowledging that this was part of their identity as P/MH nurses. For many P/MH nurses the control aspect of their work can be difficult considering the ethical code that informs practice (NMC 2008) despite this there is an expectation that P/MH nurse will be able to manage these situations safely and effectively, and the participants may be reflecting that reality confirming the ongoing dilemma of recovery versus restraint.

They also reiterated the idea that the course itself was transformative; they had expectations of help from colleagues, professional help, even therapy, to help them process the experience of working with people in distress. Again they identified the role of the qualified nurse as caring, supportive, nurturing and knowledgeable. They referred to positive role models, they associated themselves with qualified nurses who promoted learning, worked therapeutically, whom they viewed as good.

This chapter has presented the participants' data on both the participants' traumatic experiences and the helping strategies they employ. The participants employed a range of helping strategies including problem solving, positive thinking, self-help and self-help books, social networks, relaxation, therapy, exercise, music, faith, good food and meditation. The participants' responses do show some level of resilience (Glicken 2006, Rethink 2008). All of the participants indicated that they wanted greater input on responding to and managing violence and aggression (Walsh 2015), the UK participants desired clinical supervision (Felton, Sheppard and Stacey 2012, Maplethorpe, Dixon and Rush 2014) in the practice setting and more opportunities to rehearse complex nursing situations through simulation and role play (Cleary, Horsfall and Happell 2012). The participants' responses in this chapter have demonstrated some shift in thinking. Previously whenever the participants discussed their own experiences and motivations it was apparent that they sought to distance themselves from the more negatively perceived aspects of P/MH nursing such as medicating, controlling and restraining MH service users, but when considering what makes them stay on the course they acknowledged these aspects, and wanted them to be much more specifically addressed. This may be because, given the time to reflect during the interview, they have recognised that this is part of the role of the

P/MH nurse and therefore also part of their identity along with therapeutic aspects of the role.

5.9 Summary and Conclusion

This chapter acknowledges student P/MH nurses experience stress during their course (Tully 2004, Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Galvin et al. 2016, Alzayyat and Al-Gamal 2016) but in light of the participants' data on their experiences evidenced here, should this more appropriately be viewed as evidence of psychological trauma as many qualified P/MH nurses experiences are (Iyamuremye and Brysiewicz 2010, Jacobowitz et al. 2015, Mangoulia et al. 2015, Zerach and Shalev 2015)? In response to the research questions the participants traumatic experiences are more likely to be linked to higher attrition rates (Rhodes and Bouic 2007) and intention to leave (Baum and Kagan 2015), the profession. Interestingly what this chapter also demonstrated was how the participants indicated they responded to these potentially traumatic experiences in ways which helped keep them on the course. These strategies can be seen as evidence of resilience (Glicken 2006, Rethink 2008) or what Pryjmachuk & Richards (2007) refer to as 'hardiness'? What then are the implications for nurse education, the final chapter will explore these issues, draw conclusions and make recommendations arising from this investigation.

Chapter 6 Recommendations and Conclusions

6:1 Introduction

This chapter will review the initial aim, objectives and findings of this study; summarise the answers to the research questions in relation to existing literature; recognise and acknowledge the limitations of this work; consider how this work may contribute to knowledge of P/MH nursing; and set out the recommendations in relation to P/MH nursing practice and education, future research and future action/policy. The sections of this chapter are as follows:

6:2. Overview of the aims and objectives of the investigation and findings.
6:3 Summary of the answers to the research questions in relation to existing literature.
6:4. Limitations of this investigation
6:5. Recommendations in terms of the practice and education of P/MH nursing; future research and future action/policy.
6:6. Chapter summary and conclusion.

6:2. Overview of the aims and objectives of the investigation and findings.

The purpose of my study was to try and find out why student P/MH nurses chose P/MH nursing. The research was intended to consider how experiences as student P/MH nurses influenced their career choice. In order to do this the investigation had the objectives of exploring possible reasons for choosing P/MH nursing; considering

why student P/MH nurses stayed on the course and discussing what might lead them to leave.

The findings suggest that personal experience of mental health issues is a strong motivational factor in choosing P/MH nursing. I found that a desire to learn more about mental health and illness was a major influence in choosing P/MH nursing. The investigation also found that the participants held expectations of fixing themselves by virtue of undertaking P/MH nurse education, they were motivated to choose P/MH nursing because of an expectation of personal healing, recovery and transformation. The study found that there were also aspects of altruism in their choice evidenced by the participants desire to improve mental health services, not just for themselves, but also for others.

The study also found that participants demonstrated a clear preference for therapeutic ways of working with service users and several held fear around working with service users with complex needs and managing challenging behaviour, specifically violence and aggression. The study also found that participants held high expectations of ways they should work, emphasising a compassionate therapeutic approach to working with service users, yet expecting strength and coping from themselves and their qualified P/MH nursing colleagues. The study also found evidence that the participants had experienced psychological trauma during their P/MH nursing course, most notably in clinical practice settings. The study also found that the participants demonstrated mainly positive coping strategies and showed evidence of resilience. Some of this was in relation to their traumatic

experiences during the course, but also largely in the day to day of being a student P/MH nurse.

6:3 Summary of the answers to the research questions in relation to existing literature.

The findings that the participants personal experience of mental health issues as a significant motivator in choosing P/MH nursing is consistent with previous research carried out by Edward et al. (2015) and Ong et al. (2017). At its simplest, this study comes to the same conclusion as Edwards et al.'s (2015) work, in that both the personal experience of MH issues, and to some extent altruism, motivate student P/MH nurses' career choice. However, the approach to this work has provided a more detailed and nuanced insight into fifteen student P/MH nurses' motivations for their profession choice.

Not only do 13 out of 15 of the participants have personal experience of MH issues, but nine of them have lived experience of mental ill health, and acknowledge this. This study has found that some of these nine participants are also motivated in their profession choice because of an expectation of personal change during the process of the course, one in which they expect to become mentally healthy, strong and capable P/MH nurses. This investigation suggests that these participants are motivated to choose P/MHN in order to be transformed and repaired. This motivation is also perhaps demonstrated in the participants' expectations of personal development and an emerging ability to respond, at all times, with care and

compassion towards people with MH problems. This study also found that a desire to learn more about mental health and illness was clearly influential in the participants' choice. This differs somewhat from existing work in this area, which has focused more on using educational processes to recruit to P/MH nursing (Thongpriwan et al. 2015). Although these findings are compatible with Happell (2009) and Trenoweth's (2013) work on how education can maintain student P/MH nurses on their course or support recruitment to P/MH nursing. The participants were clearly motivated to choose P/MH nursing in part because of an expectation of personal healing, recovery and transformation, whilst this has not been reflected in other student P/MH nurse based research reference to this does appear in relation to qualified P/MH nurses experiences, and Hubbard, Beeber and Eves (2017) do refer to the potential for healing and transformation in P/MH nursing work.

The study found, as in Edward et al's (2015) work, that in part the participants were motivated by altruism. Edward et al. (2015) also found a desire to help others in their survey. In this investigation there were other aspects of motivation around therapeutic work and altruism, which included championing MH service users and wanting to improve MH services; both of these motivators can be viewed as an extension of the participants' desire to repair themselves or to ensure that family members were repaired. Also tied into this aspect of motivation, that of repairing themselves, was the participants' desire to learn about MH issues, an opportunity to learn about themselves too but also about how best to help others.

The participants clear preference for engaging in therapeutic relationships with service users are consistent with previous research studies in terms of why student P/MH nurses choose P/MH nursing (Moir and Abraham 1996, Henderson, Happell and Martin 2007, Gunusen et al. 2017) and why qualified P/MH nurses stay in P/MH nursing (Hautala-Jylta, Kikkonen and Jylta 2007, Duffin 2009, Van Bogaert et al. 2013, Van Sant and Patterson 2013, McAllister, Happell and Bradshaw 2013, Alexander, Diefenbeck and Brown 2015). This investigation shows that the participants identify most strongly with the therapeutic aspects of the P/MH nurse role (Barker 2009, APNA 2014)).

There is little published work on how student P/MH nurses perceptions and feelings towards working with service users with complex needs and managing their potential violence and aggression influence their choice of career. Walsh (2015) acknowledges the concerns of UK student P/MH nurses in this area. However, there is significant work on how this is experienced by qualified P/MH nurses. The literature review provided evidence that in both the US and UK P/MH nurses are dealing with worsening conditions, working under extreme pressure, with more seriously ill MH service users and fewer resources and that this is having a negative impact on their health, including MH (Richards et al. 2006, Mark and Smith 2011, Jaffa 2014, Gilburt 2015, Jacobowitz et al. 2015). Levels of violence and aggression experienced by P/MH nurses has increased over time, whilst job satisfaction has markedly lessened (Quirk and Lelliot 2001, Richards et al. 2006, Hanrahan et al. 2010, Ward 2013, Burns 2014).

The study also found that participants held high expectations of ways they should work (Rhodes and Bouic 2007, McLaughlin 2010), emphasising a compassionate therapeutic approach to working with service users, yet expecting strength and coping from themselves and their qualified P/MH nursing colleagues (Gunusen et al. 2017). The UK participants' motivation also appeared to have been informed by the existing P/MHN culture, one in which nurses should be strong, not weak, and able to deal with any crisis, including violence and aggression effectively (Antai-Otong 2001, Clarke and Flanagan 2003, Richards et al. 2006, Ridenour et al. 2015). The existing culture of P/MHN can be seen as a coercive element or socialising aspect of the participants experiences (Bracken 2002, Tummey and Tummey 2008, Cutcliffe and Happell 2009, MIND 2011, CQC 2012). Participants may internalise the culture, in a desire to be part of the group and this is likely to influence the choices they make in relation to their career (Eichenbaum and Orbach 1982, Cleary, Horsfall and Happell 2012). However, all of the participants were not only motivated to become P/MH nurses but they also appeared to want to be a particular kind of P/MH nurse: one who worked therapeutically, was compassionate and caring, but also a P/MH nurse who coped with everything thrown at them, one who was strong and capable.

In some cases the study found evidence that the participants had experienced psychological trauma during their P/MH nursing course as a result of dealing with violence and aggression and service users with severe, enduring mental illness and complex needs, most notably this occurred in clinical practice settings. What also emerged from the participants' data was the amount of psychological trauma the participants experienced during their course. Whilst there was some limited evidence of pre-existing trauma the participants' narratives indicated significant

levels of trauma and their responses ranged across the spectrum from PTSD, vicarious trauma to burn out (Morrissette 2004, APA 2013). With only fifteen participants it is not appropriate to extrapolate this to suggest that all P/MHN students have some level of psychological trauma. Other studies, (Tully, 2004, Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Freeburn and Sinclair 2009), have acknowledged the levels of stress student P/MH nurses experience whilst undertaking their educational courses, what this study does is recognise that P/MHN work can be psychologically traumatic to student P/MH nurses. This finding is supported by the clear evidence of trauma in P/MH nursing work (Bimenyimana et al 2009, Currid 2009, Iyamuremye and Brysiewicz 2010, Baby, Glue and Carlyle 2014, Jacobowitz et al. 2015, Mangoulia et al. 2015, Zerach and Shalev 2015,Lee et al. 2015).

The study also found that the participants demonstrated mainly positive coping strategies and showed evidence of resilience. Some of this was in relation to their traumatic experiences during the course, but also largely in the day to day of being a student P/MH nurse. As noted in other research studies (Charleston and Happell 2005, Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Orton 2011), the key coping strategies employed by the participants were problem solving, exercise, talking, specifically using family and friends as support networks. As indicated there is a range of evidence to confirm student P/MH nurses adaptations to their career realities (Charleston and Happell 2005, Pryjmachuk and Richards 2007, Nolan and Ryan 2008, Orton 2011), and evidence that these adaptations show resilience (Glicken 2006, Rethink 2008). These adaptations are also noted in qualified P/MH nurses (Zhong-Xiang, Kun and Xun-Cheng 2008, Senining and Gilchrist 2011, Van

Sant and Patterson 2013, Alexander, Diefenbeck and Brown 2015, Hubbard, Beeber and Eves 2017).

6:4. Limitations of this investigation

This section considers both the limitations in terms of the investigation and any difficulties encountered along the way. Using Jasper's (1968) approach to empathy to inform this work was in part successful however, my ability to fully empathise with student P/MH nurses thirty years my junior in career and experience terms is debatable and a limitation of this work. Also as a P/MH nurse there is the potential to miss relevant information; participants may not have shared specific issues or concerns with me because of fear of repercussions, because they assumed that I was aware of how things are in P/MH nursing or that I might 'inform' faculty or university staff. Of course a further limitation to this study could be the 'halo' effect, seeing the participants perhaps through an unrealistic lens. One of the recognised limitations of adopting IPA is the relatively small sample size. Another limitation of this study is that the participants were self-selecting, and therefore their personal agendas were highly likely to be committed to P/MHN which would influence their career choice.

This study has also made no response to recent economic changes for student P/MH nurses in the UK and overall had not considered the economic and social realities for choosing P/MH nursing in either country.

There were some difficulties encountered along the way these were Supervisory changes, demands of a full time job and ill health, not altogether untypical of a mature student. However, this did impact on the duration of the study period and limits the works currency. This work also now mirrors others work such as that of Edward et al. (2015) and Ong et al. (2017), whereas at the onset of this study (Moir and Abraham 1996), the subject matter had been accorded far less consideration.

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6:5. Recommendations in terms of the practice and education of P/MH nursing; future research and future action/policy.

6:5 a. Practice

Reposition P/MH nurse academics in the practice setting (Hurley and Lakeman 2011) to support clinically based nurses in the following:

Supporting clinically based P/MH nurses to demonstrate greater compassion towards student P/MH nurses and offer a better welcome to them in the practice setting (Evans and Kelly 2004, Rungapadiachy, Madil and Gough 2004, Charleston and Happell 2005, Bradbury-Jones, Sambrook and Irvine 2007, Nolan and Ryan 2008, Hunt et al. 2012, Galvin et al. 2015). This would require dignity in care; as Schofield (2016:65) states, ‘dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others’. P/MH nurses in practice need to be treated with dignity so that they can treat those in their care with

dignity; nurses need to be viewed as valued within society in order for them to be dignified in their caring work.

Support clinically based P/MH nurses in recognising their role in restraint (Huckshorn 2006, Bowers et al. 2012, Maguire, Young and Martin 2014, Duxbury 2014), shifting emphasis towards psychical holding (Evans 2007), moving away from abusive and potentially re-traumatising practice and role modelling for student P/MH nurses (RCN 2016, Muir-Cochrane and O'Kane 2018).

6:5.b. Education

Provide clinical supervision for student P/MH nurses (Felton, Sheppard and Stacey 2012, CQC 2013, Maplethorpe, Dixon and Rush 2014, NMC 2018). Providing a regular and appropriate opportunity to reflect on their experiences may help the students mentally process their experiences more effectively (Williams et al. 2009). It may also help them to identify the reasons for their choice of profession and to accept these.

Provide more simulation and skills development (Clearly, Horsfall and Happell 2012) around dealing with challenging behaviour and specifically in working with service users who are violent and aggressive (Walsh 2015). The lack of preparedness for the realities of P/MHN particularly in relation to dealing with violence and aggression

(Ward 2013, Burns 2014, Jacobowitz et al. 2015), does appear consistent in both participant groups. Therefore it seems appropriate to conclude that education such as simulations of these types of situations and teaching about causes of violence and aggression would be helpful. This would firstly allow student nurses to rehearse their responses. Then secondly become more knowledgeable about why MH service users may react in this way and both of these methods would hopefully enable student nurses to respond as compassionately as possible.

In recognising student P/MH nurse trauma it is necessary to acknowledge the link between trauma and mental illness in the people P/MH nurses work with, MH service users. This work would recommend the following response: -

- More education around psychological trauma and associated MH issues (Herman 2001, Bowers et al. 2009, Boscarino, Adams and Figley 2010).

- More simulation on sensitive approaches to trauma issues such as interviewing and assessments of service users (Cleary, Horsfall and Happell 2012, DH 2009, Read and Bentall 2015).

- More education on trauma informed approaches to care (Sweeney et al. 2016) including Compassion Focused Therapy (Gilbert 2009) and recovery over restraint (Bowers et al. 2012, RCN 2016).

- Support student P/MH nurses in resilience building to address stress, trauma and PTSD through encouraging effective self-caring strategies and promoting

compassion to self, colleagues and service users (Glicken 2006, Rethink 2008).

(Utilising Glicken's (2006) work to demonstrate an educational strategy may help illustrate how this could be implemented in P/MH nurse education. Glicken (2006) considers what the attributes of resilient people are. He identifies thirty one attributes. Table 7:1 presents the attributes and identifies how P/MH nurse educators could incorporate resilience promoting strategies into their work with student P/MH nurses - see appendix 7).

Previously the participants had sought to distance themselves from the more negatively perceived aspects of P/MH nursing such as medicating, controlling and restraining MH service users, but when making recommendations to enhance the course they wanted these to be much more specifically addressed. The US participants had less concerns over medication. They engaged with this aspect of their role as future nurse prescribers. They saw themselves as being able to mitigate against the excessive use of medication in service users care. The US participants expressed less concerns over managing situations requiring service user restraint. This may reflect the reduced exposure to clinical work of the US participants. The UK participants spend significantly more hours in clinical practice as part of their course than their US counterparts. Their expressed need for more education on managing violence and aggression and dealing with medication administration may reflect their experiences and expectations of their role as a qualified nurse.

6:5.c.Future research

The participants' expectations/desire for the course to be transformative in terms of repairing their pre-existing MH issues, whilst at the same time providing them with the opportunity to develop into healthy MH professionals. Further investigation might explore where this desire comes from, whether it is true for all student P/MH nurses? Is it an aspect of UK culture that to work in MH one must be mentally healthy? Is it also relevant within US nursing culture? Is it a part of student P/MH nurses schema, belief systems too? Expecting change through education is nothing new however if the participants do achieve some level of 'mental health' this might that have implications for future work on recovery with service users? This could certainly be worthy of further investigation.

Supporting student P/MH nurses with loss – some of the participants talked about the impact of losing close supportive relationships during their experiences, particularly around clinical mentors but also about working relationships with service users and their relationships with P/MH nurse academics. This work has acknowledged their loss, and exploring this aspect in detail may be valuable to our understanding of P/MH nursing. Further investigation might explore; is loss an aspect of all student P/MH nurses' experience? How do student P/MH nurses process these losses? Do student P/MH nurses grieve? Should there be help and support for this aspect of their experiences? If so what type of help and support should be offered? For P/MH nurse educators the ability to prepare students for loss in practice and to work with them during their course to help them process their loss might be supportive for the students but also help them to complete their studies and

reduce attrition rates.

6:5.d.Future action/policy.

What this study does recognise is that future generations of P/MH nurses want to emphasise their positive work with service users and the importance of the therapeutic relationship. They do not want to control and restrain people with mental health problems, they see the therapeutic relationship as central and a priority of their work. Hopefully this study will encourage P/MH nurses to bring their work with service users out of the 'shadow' (Mehrnoosh et al. 2015) and retake a central position in mental health services by focusing on their recovery based work. This work suggests the importance of both further research to evidence the impact of the nurse patient relationship in terms of outcomes, measures and metrics but also action on re-emphasising and developing the potential of the therapeutic relationship. Lakeman and Molloy (2017) contend that P/MH nursing has become increasingly 'zombified', lacks leadership, and is ultimately dying, despite increasing numbers of vacancies in P/MH nursing globally and an apparent inability to recruit and retain student nurses to the field; up to twenty-three percent of P/MHN students in the UK do not complete their nursing courses (Mullholland et al. 2008); in the US the figures for nursing course completion can be as low as twenty-five percent (Sayles and Shelton 2003, Wells 2007); this study indicates that there is still hope for P/MH nursing. This work demonstrates that student P/MH nurses want to see qualified P/MH nurses who prioritise their work with service users, and acknowledge the powerfully, positive impact they have on people's lives (Duffin 2009, #MHnursingFuture 2018).

The current nursing review (NMC 2018) presents many challenges, opportunities as well as threats. The P/MH nurses of the future need to be educated to respond to service users' complex needs through being skilled in psychosocial interventions; mental health law; psychotherapy and psychopharmacology as are our counterparts in the US. These nurses would have the existing skills to deal with service users complex physical needs and work in a multi-professional context well.

6:6. Chapter summary and conclusion.

In conclusion further detailed work on how, why and in what way P/MH nurse education prepares student nurses for the realities of practising clearly would be helpful following this investigation. Whilst the influences of socio-economic realities on student nurse career choice have not been discussed in detail in this work, considering these would be appropriate, but would also require a much larger scale study.

The American educational approach to P/MHN education at post graduate level does appear to have some small, current advantages. Student nurses were less concerned and much happier about their clinical supervisors and support from faculty staff. They appreciated clinical supervision and faculty staffs' involvement within both theory and practice settings.

The nursing review in the UK (NMC 2018) may well lead to a P/MHN educational course that is more closely aligned to the international model of nurse education. On a positive note there already appears to be a place for resilience building, clinical supervision and teaching staff integration within clinical practice settings (NMC 2018). These will go some way to address one of the conclusions of this study, that P/MHN should carry a warning because of the potential risk of psychological trauma to participants, however, one would have to recommend several further studies on much larger sized sample groups before taking action.

This work talks at length about the importance of the therapeutic relationship to student P/MH nurses. As this work clearly demonstrates compassion, as expressed through the therapeutic relationship, is important to keep both student P/MH nurses on their course and qualified P/MH nurses in the job (Moir and Abrahams 1996, Duffin 2009, Gunusen et al. 2017). Compassion in nursing is a key motive to choose nursing (Mackintosh 2006, Hautala-Jylha, Kikkonen and Jylha 2007, Gilbert 2009, Cleary, Horsfall and Happell 2012, Gunusen et al. 2017). However, when compassion fails, or what Joinson (1992) suggests the nurse, or in this case student nurse, experiences compassion fatigue, they might be more likely to leave the profession or their course. This work refers to a range of strategies employed in P/MH nursing to support them in dealing with the stress/trauma/secondary traumatic stress disorder/vicarious trauma/PTSD of their work. The literature review refers to enhancing leadership (Nakakis and Ouzouni 2008, Williams et al. 2009, Hanrahan et al. 2010, Beckett et al. 2013) work based decision making and autonomy (Van Bofaert et al. 2013, Madathil, Heck and Schuldberg 2014), clinical supervision (White and Whitstanley 2011, Hubbard, Beeber and Eves 2017), problem solving and

building resilience (Senining and Gilchrist 2011, Baby, Glue and Carlyle 2014, Wang et al. 2015). However, a word of caution is necessary in talking of building resilience with P/MH nurses and student P/MH nurses. It is important not to 'victim blame' nurses and student nurses for systemic failures. Inadequate resources, long term underfunding and understaffing need to be recognised as part of the equation of compassion 'failure' (US Department of Health and Human Services Health Resources and Services Administration 2010, Francis Report, Mid Staffordshire NHS Foundation Trust Public Inquiry 2013, Quallington 2015, APNA 2016, RCN 2016, WHO 2016, Goodare 2017, HEE 2017, Lakeman and Molloy 2017, Marangazov et al. 2017, Health Select Committee 2018, Johnson et al. 2018). The need to adopt a more compassionate approach has been acknowledged in nursing for several decades Joinson's original work on compassion fatigue in nurses in 1992 and the Frances Inquiry of 2013 (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013), twenty years later are clear evidence of this. There have always been expressions of concern over all fields of nursing practice in the UK. Some of the more recent include issues over restraint in P/MHN practice (MIND 2011); abusive care for vulnerable adults in MH and learning disability nursing practice (Care Quality Commission 2012); and lack of care for seriously ill adults in adult nursing care (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). However, it is the last of these, the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013) which has generated the greater response.

Hewison and Sawbridge (2016) have suggested that the issues emerging from the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013) from nurses' actions, or lack of, have led to accusations of a lack of moral and ethical

principles in practice. The response of the Department of Health and NHS Commissioning Board (2012) was to produce Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy (Cummings and Bennett 2012). This sets out how nurses need to incorporate care, compassion, competence, communication, courage and commitment, or 'the 6C's' into their practice. The ideas behind this are good but in the six years since inception the impact appears to be minimal.

I would argue from this work that we need to start developing compassion in student nurses before they go into clinical areas and work with service users. This would require considering dignity in care; as Schofield (2016:65) states, 'dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others'. P/MH nurses in practice need to be treated with dignity so that they can treat those in their care with dignity; nurses need to be viewed as valued within society in order for them to be dignified in their caring work. In order to be compassionate in care, nurses need to be able to understand human distress and suffering and to engage with people empathically. Gilbert (2009) suggests that developing self-kindness, within compassionate mind training, promotes compassionate caring. Ghisoni (2016:110) argues for a 'co-creation approach' where both service users and staff 'articulate what would constitute a compassionately caring environment'.

This work suggests that student P/MH nurses start from a position of compassion but that over time and with consistent exposure to human suffering and distress and an

increasing recognition of the inevitability of this their ability to remain compassionate may become compromised. Alongside ever decreasing resources (Health Select Committee 2018) and an emerging global crisis in nursing recruitment (Goodare 2017), expecting nurses to accept individual responsibility for these endemic failures within the system is not only de-contextualisation but basically flawed. Critically then in recognising the importance of the therapeutic relationship and compassion as a significant component of that and therefore a motive for student P/MH nurse career choice, as this work does, advocating for nurse educators to build resilience needs to be implemented mindfully with due regard for the social context and realities of mental health services.

In drawing this work to a conclusion P/MHN in both countries are now facing change and challenges. This study has sought to provide some insight into how P/MH nurses chose their profession, why they stay, why they might leave and how the experiences undertaken during their course impacts upon them. Mental health services in both the US and the UK are shifting constantly and P/MH nurses need to be flexible and adaptable to these changes. What this study demonstrates is some of the conflict between reality, high pressure workloads, and services that are stretched beyond their limits. Within which we ask P/MHNs to provide effective role modelling for student nurses and excellent care for service users. Rather than holding onto the past and traditional notions of P/MH nursing, with ties to institutional and custodial care and restraint, actually considering what service users need and how we can best deliver recovery might be a more appropriate start point. The current nursing review in the UK (NMC 2018) is an opportunity to work towards real and positive change across all fields of nursing, making sure that we take account of

why student P/MH nurses choose their profession, their hopes and expectations, their desire to engage with service users and enabling that, means that P/MH nurses could reverse the chronic decline in the profession (Lakeman and Molloy 2017).

I would argue that in response to this work P/MH nurse education needs to acknowledge student nurses' motivations and expectations, and work to prepare student P/MH nurses in such a way that they are service user, recovery focussed, resilient nurses. Whilst preparing student nurses to respond skilfully and knowledgably to service users' complex bio-psycho-social needs, P/MH nurse educators also need to encourage student nurses to develop into a nurse who actively looks after themselves, and seeks out supervision, in order to be safe in practice. I hope that the new NMC (2018) standards may go some way in delivering this.

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