An Interpretive Phenomenological study of undergraduate nursing students' navigation of emotionally challenging experiences in health and social care practice.

A thesis submitted in partial fulfilment of the requirements of Kingston University in partnership with the University of Roehampton for the Degree of Doctor of Education

by

Laurence LEONARD

October 2020

Declaration of authorship.

I, Laurence Leonard, declare that this research study and the work presented in it is entirely my own. Where I have consulted and drawn from the work of others, this is always clearly stated or referenced. I confirm that none of the materials have been previously submitted for an award at an institute of Higher Education either in the UK or overseas.

Laurence Leonard

Date: 9th October 2020

Abstract.

Introduction.

Many of the skills, knowledge, behaviours and conduct for nursing practice are set out in professional codes and standards. However, these give limited guidance on how nursing students should navigate emotionally challenging experiences (ECEs), such as ill health, disability, and patient death, whilst in health and social care (HSC) practice. This study examines lived ECEs in practice among participating students undertaking a BSc honours degree in the adult field of nursing in a Higher Educational Institute (HEI) in Northern Ireland (NI). In doing so, the study seeks greater understanding of influences that inform and shape nursing students' responses to such experiences. It also examines participants' lived experiences of formal and informal preparation and support offered, available or utilised (if any) regarding ECEs in practice.

Methodological approach.

In the study I adopt an Interpretative (Hermeneutic) Phenomenological (IP) approach to the collection, analysis of data and reporting of findings. In doing so I provide attention to important ethical and legal issues, including evidence of ethical approval. I also provide justification for using data from semi-structured interviews with twelve nursing students undertaking the programme who consented to participate in the study.

Findings.

Participants in this study encounter a range of ECEs and use various strategies in navigating such experiences, including suppression of emotions and avoidance of patients and relatives. While cognitive knowledge seeking is a strategy used by participants in navigating ECEs, there is limited evidence of participants' self-knowledge or recognition of their own emotional needs in navigating the complexities of ECEs in practice. There is evidence of a

range of support sought and utilised, but also a view that students could be better prepared and supported specifically in relation to ECEs. While the current undergraduate programme, includes provision of formalised support to nursing students through mentorship, personal tutor (PT), link lecturer (LL) and other roles; the findings suggest that the nature, quality, and access of such support varies in relation to ECEs. Participants' experiences and perceptions of the function of these roles and how they are performed has an important impact on students' access of support. This study indicates that there is a need for demarcation between pastoral support and disciplinary aspects in LL and PT roles, so that students do not get confused about whether they are being supported, assessed, or disciplined. The findings also suggest that there is a need to better prepare nursing students for ECEs in advance of placements, particularly, speciality and 'taster placements' in other fields of nursing practice. These taster experiences often occur in first year of the programme and often present particular ECEs for students. This preparation might include teaching and learning strategies that facilitate reflections on ECEs and how students might recognise their own responses and emotional needs.

Table of contents of the thesis.

Declaration of authorship. 2
Abstract. 3
Introduction. 3
Methodological approach. 3
Findings. 3
Table of contents of the thesis. 5
Acknowledgments 8
List of Tables. 9
List of Appendices 10
Common abbreviations used. 11
Chapter One. Introduction, background, and outline of the structure and aims of the thesis. 12
1.1. Introduction to the chapter and structure of the thesis. 12
1:2. Overview of the focus of the study. 14
1:3. The personal and professional context of the research. 19
1:3.1. My personal practice as a professional registered nurse. 20
1:3.2. My professional practice in nurse education. 22
1:3:3. An overview of the BSc undergraduate nursing degree programme. 23
1:3.4. Existing sources and types of support for nursing students on the programme. 24
1:3:5. Differing experiences regarding engagement with emotional aspects of nursing practice. 29
1:4. The wider professional context of preparation of nursing students for professional practice. 32
1:5. The aims and specific questions of this study. 39
1:6. Summary of the chapter. 41
2:1. Introduction. 43
2:2. Literature search strategy. 43
2:2.1. Key topics and terms used in the literature search. 48
2:2.2. The databases search. 49
2:2.3 Search Outcomes 54
Identification 55
Screening 55
Eligibility 55
Included 55
2:2.4. Quality Appraisal of the literature 56
2:3. Key themes emerging from the literature review. 57
2:3.1. Emotional challenges and emotionally challenging: clarifying terms. 57
2:3:2. Emotion management, emotional labour, and emotion work. 60

2:4. Potential negative implications of using surface acting as a strategy in navigation of ECEs........67
2:5. Nursing and nursing students' navigation of ECES. 69
2:5.1. Emotional detachment, distancing, and avoidance from ECEs. 78
2:6. Social, organisational, and professional display rules and expressions of emotions. 91
2:7. Sources and types of student support. 98
2.6. Summary of the literature review...106
Chapter Three. Theoretical and methodological perspectives and research design. 109
3:1.1 Introduction. 109
3:1.2. Theoretical framework and rationale for adopting a qualitative approach. 110
3:2. An overview of Phenomenology and justification for an Interpretive Phenomenological approach to this study. 118
3:3. My methods used in the collection of data. 125
3.3.1. Participants. 126
3:3:2. Interviews as data collection. 130
3:3.3. Setting up the interviews. 136
3:4. Ethical considerations. 138
3:4.1. Gaining Research access. 138
3.5. Data analysis. 142
3.5.1. Application of Interpretative phenomenological analysis. 144
3:6:1. Reflexivity and myself as researcher and instrument in data collection. 149
3:7. Chapter conclusions. 154
Chapter Four. Findings arising from the data. 156
4:1. Introduction to the chapter. 156
4:1.1. Profile of participants and context of interviews 158
4.1.2. An overview of emerging themes. 159
4:2. Emotionally challenging experiences, exemplars, and commonalities. 161
4:3. Strategies used by participants in navigation of ECEs. 172
4.3.1. Answer seeking, early exposure and dialogue with a knowledgeable other. 172
4.3.2. Suppression and non-displays of emotions as a strategy in navigation of ECEs. 175
4.3:3. Detachment and avoidance of potentially emotionally challenging experiences. 181
4.4. Planning, preparation, and preparedness for ECEs. 183
4.5. Support sought, offered, and utilised in navigating emotionally challenging experiences.........190
4.5.1. The participants experience of support from personal tutors. 192
4.5.2. Participants experience of support from Link Lecturers...194
4.5.3. Participants experiences of support from other students in relation to ECEs. 196
4.5.2. Family and friends as sources of support 200

4.5.4. Barriers and facilitators to accessing support or sharing experiences. 201
4:5. Chapter conclusions. 205
Chapter 5: Discussion. 207
5:1. Introduction to the chapter. 207
5:2. Nursing students' emotionally challenging experiences in placements. 207
5.3. Strategies used by nursing students in navigating ECEs in practice. 210
5:3:1. Knowledge and answer seeking and early experience as strategies in mitigating ECEs. 211
5:3.2. Avoidance, distancing, non-engagement, and disengagement from ECEs. 214
5:3:3. Suppression of or non-displays in relation to ECEs as an expected professional norm. 219
5:4. Support sought, offered, utilised, and received. 222
5:4.1. Barriers to support seeking 224
5.4.2. Support from mentors and registered nurses. 225
5:4.3. Experiences of support from personal tutor, link lecturers and others. 228
5.4.4. Peer support and shared reflections among peers. 230
5:5. Preparation and preparedness for ECEs in HSC practice. 232
5.6. Chapter conclusions. 235
Chapter 6. Conclusions and implications and recommendation for nursing education and future research. 240
6.1. Contribution to new knowledge. 240
6.2. Study Limitations. 244
6.3. Recommendations for nurse education. 245
6.4. Recommendation for future research. 253
6: 5. Conclusions of chapter and thesis. 256
6.6. A post-script on the Covid-19 pandemic and the importance of this study. 258
References 260
Appendices. 292

Acknowledgments.

I want to express my heartfelt thanks to those who supported me at various stages of this study. I begin with my immense gratitude to the participating students, as without their willingness to share their lived experiences the study would not have been possible. Thanks also to fellow Ed. D students whose support, encouragement and sharing of ideas at study weekends and informal communications, helped me to face many challenging aspects of the programme. I also want to thank friends, colleagues, and family whose support and encouragement helped me to persevere when the tasks ahead at times seemed daunting.

My special thanks to the teaching team on the Ed. D programme, especially Dr Ruth Wood and Dr Julie Shaughnessy. I am extremely grateful to them for sharing their expert knowledge and providing constructive, critical insights to the study. I express a special thanks to Professor Keith Grieves who, before his retirement, patiently steered me through early aspects of the Ed. D programme and the data collection period of the study. I wish him many happy years in his retirement and will remember him for his quiet, kind, considered and significant intellectual advice regarding my work.

Finally, but not least and importantly, I wish to extend my immense gratitude to my supervisors, Dr John Hammond and Professor Kathy Curtis, who patiently provided me with detailed critical scrutiny, insightful feedback, support, encouragement and guidance throughout the write up of this thesis.

List of Tables.

Table 1. Key search words and subject terms. Page 49

Table 2. Overview of the number of articles found after the search terms were applied to the selected databases. Page 53.

Table 3. Inclusion and exclusion criteria for recruitment of participants. Page 129.

Table 4. Emerging themes from analysis of participant Stella's transcript. Page 146

Table 5. Subordinate and Superordinate themes from the analysis of participant Stella's transcript. Page 147.

Table 6. Profile of participants. Page 159.

Table 7. Subordinate and Superordinate themes. Page 160.

List of Appendices

Appendix A. Participant information leaflet explaining the nature and purpose of the study. **Page 276**.

Appendix B. Schedule of questions included in the interviews. **Page 275.**

Appendix C. Consent form agreeing to participation in the study. **Page 282.**

Appendix D. Ethical Approval.

a). Application to the Faculty of Health Social Care and Education, Research Ethics Committee (FREC) at Kingston University. **Page 284.**

b). Favourable letter received following application to the Faculty of Health Social Care and Education, Research Ethics Committee (FREC) at Kingston University.

c). Waiver from the chair of the SNAM, REC to undertake the study. **Page 304.**

Appendix E. Transcriber confidentiality agreement. **Page 306.**

Appendix F. Examples of notated transcripts. **Page 307.**

Common abbreviations used.

ECE-Emotionally challenging experience (singular)

ECEs-Emotionally challenging experiences (plural)

Ed.D. Educational Doctorate.

EL-Emotional Labour.

FREC-Faculty of Health Social Care and Education, Research Ethics Committee.

FtP-Fitness to Practice.

HCA-HealthCare Assistant.

HCAs-Healthcare Assistants (plural)

HSC-Health and Social care.

HEI-Higher Education Institution.

IP-Interpretative Phenomenology.

LL-Link Lecturer.

NI-Northern Ireland.

NMC-Nursing and Midwifery Council.

PAL- Peer-assisted leaning

PT-Personal Tutor.

SNAM-School of Nursing and Midwifery.

UK-United Kingdom.

Chapter One. Introduction, background, and outline of the structure and aims of the thesis.

1.1. Introduction to the chapter and structure of the thesis.

This chapter begins by providing an overview of the thesis and aims of this study on how students, studying in the adult field of a BSc honours degree programme in an Higher Education Institution (HEI) in Northern Ireland (NI), navigate experiences in health and social care (HSC) practice, which they consider as emotionally challenging.

The chapter first provides discussion on my own location within the study, with consideration of my personal and professional experiences as a registered nurse and nurse educator. This is intended to highlight the personal, professional motivations and context influencing my rationale for undertaking the study. This leads to further discussion of issues on which I seek greater understanding of nursing students' lived experiences and navigation of emotionally challenging experiences (ECEs) in HSC practice. In the final part of the chapter, I provide specific aims and questions of the study, before concluding with a brief summary.

Chapter Two provides my critical review of relevant literature, indicating what is already known and gaps in current understanding that justify the need for this study. I also discuss literature, which arise out of and help to inform the

methodological approaches to answering the study questions and provide greater understanding of nursing students' lived ECEs in practice.

In Chapter Three, I provide detailed evaluation of theoretical and methodological approaches underpinning data collection to meet the aims of the study. I explain my reasons for choosing an Interpretative Phenomenological (IP) approach. Legal and ethical considerations and reflexivity are also discussed and explained.

The findings of the study are provided in Chapter Four, using relevant quotations from participants' interview transcripts. Data obtained from interviews, my notes and reflective diary are analysed using an IP approach from which several super-ordinate and sub-ordinate themes emerge. These themes describe the essence of, and my interpretation of participants' lived ECEs in practice.

Chapter Five includes discussion and summary of the findings. Themes are discussed in relation to related literature, relevant polices and the aims and questions set out in the study.

Chapter Six provides discussion on the contribution to new knowledge and limitations of the study. Recommendations are articulated for the development of nurse education programmes and future research in this area before conclusion of the chapter and thesis.

In the following sections of Chapter One, I provide information and discussion on the focus of the study and how my personal and professional experiences drive the research focus and approach.

1:2. Overview of the focus of the study.

This section provides an overview of the study and outlines how it is driven by my personal professional experiences in previous and current practice. The study is undertaken in partial fulfilment of a Degree of Doctor of Education (Ed.D.) joint award of Kingston and Roehampton Universities, London. I am undertaking this in part-time study, while in full-time employment as a lecturer in nurse education in an HEI in NI.

In this Interpretative (Hermeneutic) Phenomenological (IP) study, I enquire as to how nursing students from the adult field of an undergraduate BSc honours programme, navigate lived experiences in practice which may be emotionally challenging. While I provide more detailed discussion later in the thesis on terms such as ECEs, I first provide a brief explanation of such terms, before discussing my own experiences and how they influence, shape, and inform the study aims and questions.

Studying in higher education for many students (including nursing students) can be a stressful experience. Students can face challenges to cope with an array of changing situations including adjusting to more self-directed learning

and participating in peer learning groups both face to face and virtually. Other ECEs include preparing for examinations, moving away from friends and family home and the establishment of new networks and friendships. In nursing programmes, the use of HSC practice placements forms an integral part of the learning development and formation of nursing students. While students may encounter many challenges including ECEs across any site of learning while studying in HEI, there has long been a recognition of the particular stressful nature of such practice placements. As Meier & Beresford (2006) highlight, practice environments can be emotionally challenging for patients and healthcare staff, including nursing students. Illness, disability, and death often raise a range of emotions and may impact consciously or unconsciously on the emotions of nursing staff, including nursing students.

Freshwater and Stickley (2004); Le Blanc et al. (2007) and Wenzel et al. (2011) argue that there is a need for those involved in nurse education to understand how such emotional experiences impact on professional practice. In response to such arguments, it is important that nurse educators such as myself, have a clearer understanding of the lived ECEs of nursing students in practice, so that we may prepare and enable students to navigate such experiences in ways that are not detrimental to themselves or patients in their care. I am concerned that inability or failure by nursing students to engage with ECEs arising within

practice, may lead to perceptions of nurses as uncaring, or may have detrimental effects for nursing practice or for nursing students themselves. This concern became pertinent prior to commencement of the Ed.D. programme, when several unrelated, but significant issues arose within UK, HSC practice which gave rise to questions regarding the quality of nursing practice and education.

Among criticisms in reports on scandals regarding patient care, such as, Francis (2013), The Keogh Report (2013) and the Care Quality Commission Report (2013) were that nurses involved were often perceived as cold, uncaring, and devoid of emotions. This perception was voiced by the then UK Health Secretary, Jeremy Hunt, in a speech to the Kings Fund: Quality of Care Conference (2012) when he spoke of, 'coldness, resentment, indifference, even contempt' in HSC practice. Darbyshire and McKenna (2013, p.305) refer to such practice as, "nurses who couldn't care less". Elliot (2017, p.1072) suggests, "that it is possible that a lack of compassion/commitment resulted from burnout following excessive emotional labour". While there is no evidence to support this and the term emotional labour requires clarity (and will be discussed in Chapter Two), such examples of lack of care and abuse of patients by some nurses, have the potential to undermine trust by the public in the professional standing of nurses.

There is a plethora of published research on how emotions impact on the work of a range of professionals, especially in HSC settings. However, Gray and Smith (2009) examining the emotional work of registered nurses suggest that this aspect of the work of nurses often remains invisible. The authors emphasise that recognition of emotions is an important aspect of nurse education and suggest a need to further study emotional work in healthcare. Dwyer and Hunter Revell (2015) argue that how nursing students learn to deal with, what they refer to as the 'emotional toll' of practice is not clearly understood and that research is needed to develop a more critical understanding of nursing students lived emotional experiences in professional practice. However as Sturdy (2003, p.82) argues the study of emotions is multi-dimensional and yet to be "fully colonized by a discipline" with different disciplines taking particular focused perspectives on emotions. Van Veen and Sleggers (2006); Zembylas (2007); Holland (2007); Gendron and Feldman (2009); Linnenbrink-Garcia and Pekrun (2011); Scherer, Clark-Polner and Mortillaro (2011) all suggest, that there are different theoretical perspectives into the study of emotions, ranging from those that seek to understand the nature of emotions, to those that seek to understand the significance of various emotions for the individual. While the context and focus of this study is on the ECEs of nursing students, many publications around emotions build on

work arising from psychodynamic theory which originated in Sigmund Freud's psychoanalytic theories and subsequent theories based on his ideas. Such theories advocate that it is unconscious fears and feelings and different structures of individual personalities that drive human actions and behaviours (Rustin, 2003). According to psychodynamic models, early experiences including those occurring during the first weeks or months of life are the antecedents that set in motion personality processes that give rise to how emotions and emotional reactions are generated in later life (Blatt & Levy, 2003). Hayward and Tuckey (2011) have highlighted that in the psychodynamic literature the focus is on how and why emotions are regulated. Theodosius (2006) and Theodosius (2008) examining emotional aspects of nursing work argue that there is a need for greater understanding of how to engage with both conscious and unconscious emotional processes. In the psychodynamic literature the focus is on anxiety provoking situations and the unconscious mechanisms and early childhood experiences which shape individual's reactions to such experiences (Gross, 1998). However, in this study I do not seek to understand the deeper unconscious processes or childhood experiences which give rise to individual's reactions to emotional experiences, but rather to seek to understand how emotions are lived, experienced, and displayed. Mesquita & Boiger (2014, p.298) argue that "the large majority of

our emotions occur in the contexts of social interactions and relationships and unfold in conjunction with these interactions and relationships" Gooty et al. (2009) suggest that theories and studies of emotions need to consider the context in which they occur. As such I seek to understand behaviours and social context of nursing students' lived ECEs.

While nursing students may encounter experiences in practice that raise a sense of joy, reward, or satisfaction (which may be considered to be 'positive' emotional experiences), the focus of this study is on emotional experiences which might be deemed as stressful or emotionally challenging. While Dwyer and Hunter Revell (2015) suggest that the term 'emotionally challenging' lacks clarity, it is used in this study to refer to experiences in placements that have potential to be stressful, distressing, disturbing, upsetting or frightening. In order to avoid continual repetition of these terms, for the purpose of this study the term emotionally challenging experiences (and the abbreviation ECEs) is used.

1:3. The personal and professional context of the research.

In this section, I provide information and discussion on my personal professional experiences and the wider professional context of nursing practice and education, which shape, influence and give rise to the rationale for undertaking this study.

1:3.1. My personal practice as a professional registered nurse.

As a registered nurse (RN) and registered nurse teacher with the United Kingdom (UK) Nursing and Midwifery Council (NMC), I have extensive experience, expertise and understanding of nursing practice and nurse education. Since completing initial training and registration, I have worked in varied practice environments and completed a number of Continuing Practice Development (CPD) and post-graduate studies in relation to HSC practice and education.

An early position was in an operating department (OD), where nursing practice largely focuses on technical, surgical, or anaesthetic procedures. In such environments, patients are mainly sedated or recovering from sedation and there are limited opportunities for interpersonal interactions between nurses, such as myself and patients. Often the focus of nurses, is on undertaking and ensuring correct technical and clinical procedures, i.e., the surgical instrument or swab count. Later experiences, working in emergency departments (ED), medical or surgical wards, nursing homes or patients' own homes, provided opportunities for more interpersonal interactions between patients and myself as a nurse. In such practice environments, I encountered a range of ECEs. These included those arising with unexpected and traumatic deaths in the OD/ED or the death of patients with whom I had more interpersonal interactions, i.e, patients dying from Human immune-deficiency virus (HIV)

conditions, for whom I had been caring for in a hospice over several months. On many occasions, I felt upset, distressed, and overwhelmed by such experiences, but received varied and sometimes contrary advice on how to navigate such experiences. On occasions, I was advised by colleagues or senior staff to keep a 'professional distance', 'to put on a brave face', or 'not to let emotions get in the way'. I recollect, as a nursing student, being reprimanded by a ward sister, who found me discreetly crying in the sluice room, following the death of a patient for whom I had been caring. I recollect her words to the effect, that I 'would never make a nurse', if I did not learn to control my emotions. At later times in my career, I recall suggestions from a different perspective, such as, 'the day you stop feeling, then it is time to leave nursing'. Such discourses at times left me unsure and confused as to what extent I should engage, or not, with emotional aspects of nursing practice.

Overall, my experiences as a nurse have brought me many feelings of joy satisfaction and reward, but many times I felt sad, overwhelmed, frightened and unsupported. On reflection, these latter emotions may have been among many reasons leading me to move from providing direct patient care to an educational role. My own lived ECEs in practice, are one reason to engage in this study, so that ultimately, I may support nursing students in my current

area of practice, so that they can navigate ECEs in ways that are not detrimental to themselves or patients in their care.

1:3.2. My professional practice in nurse education.

In 2000, I moved from clinical practice as a specialist nurse in a London teaching hospital, to a senior lecturer role in a school of nursing in an HEI in London. Since then, I continue to be actively involved in nurse education at both undergraduate and post-graduate level and am currently employed as a lecturer in nurse education within an HEI in NI.

Much of this present role involves preparing students in the adult field of the BSc Honours nursing degree programme, to practice effectively and safely in a complex and changing healthcare environment. Such preparation includes facilitating and supporting students' learning with both theoretical and practice aspects of the programme. I work alongside a range of colleagues from both the HEI and HSC practice to contribute to the overall professional education of students on the programme. In doing so, I aim to support students' learning so that they meet eligibility requirements for professional registration with the NMC and standards required by the Quality Assurance Agency (2018) and the HEI for the award of a BSc honours degree.

1:3:3. An overview of the BSc undergraduate nursing degree programme.

The BSc honours nursing degree programme in my HEI, at the time of undertaking the study, is similar to others in the UK, whereby students undertake approximately 50 % division of learning experiences within the HEI and in practice placements. In first and second year, students undertake three, six-week periods of modular theoretical study at the HEI, each followed by periods of supervised practice placements. In third year, following a twelve-week period of theoretical learning in the HEI, students consolidate their learning with longer periods in practice. First year placements include periods which focus on other fields of nursing, such as care of those with mental health issues, children, and young people, or those with learning disabilities. Such placements are often referred to as ‘taster’ placements. Overall, the placements include a variety of HSC contexts. These range from acute hospitals in urban areas, to community and social care settings in rural, geographical locations extending as far as 120 km across NI, some of which have poor transport links. The HEI tries to allocate students to placements as near as possible to their main place of residence. However, this is not always possible, and students sometimes must take nearby temporary accommodation when in such placements.

It is widely accepted that HSC settings can be arenas of heightened emotions (McQueen, 2004; Hunter & Smith, 2007; Funk, Peters & Steiber, 2017) and that nursing students are likely to be exposed to a range of ECE. Kellogg, Barker & McCune (2014) highlight a range of stressors that may impact upon nurses, including experiences such as, witnessing death or dealing with emotional needs of patients and families. Thus, an important question arises in this study, as to how nursing students navigate such experiences and what support, if any, do they receive and utilise in relation to ECEs.

1:3.4. Existing sources and types of support for nursing students on the programme.

While students are attending the HEI and in relation to theoretical aspects of the programme, several formal roles are undertaken by lecturers such as myself to provide support to students. Such roles include academic year leads, module co-ordinators, tutorial group leads and personal tutors (PT). I have specific responsibility for co-ordination of a module within the second year of the programme. In addition, I normally act as tutorial lead for teaching and learning of three tutorial groups in other modules, each of approximately 25 students within the second year. I also deliver lectures on my own areas of specialism in nursing across the entire programme.

In a further addition to these roles, the HEI requires lecturers such as myself to undertake a PT role. At the time of writing, I am PT to approximately 30

students and expect to meet with them individually towards the end of each theoretical learning period and prior to their practice placement. In addition to monitoring these students' academic and professional progress, there is an expectation to provide pastoral and other support around issues which they might be experiencing. However, there are specific difficulties, which arise in relation to opportunities for face-to-face meetings between PT and such students. There are occasions when students have less face-to-face contact or visits to the HEI campus, such as when undertaking self-directed or online learning, but particularly while in practice. Students allocated to placements at a geographical distance or who live far from the HEI, often do not wish to travel to meet a PT or tutorial lead. Opportunities to access support from HEI personnel when in placement are also hindered with students undertaking varying shift patterns, such as night and weekend duty. Direct in-person meetings therefore often tend to be 'ad hoc', or in response to a crisis or difficulty or deferred until the students return to the HEI at the end of placements.

There has been much debate about how best to support nursing students while they are in practice, with some arguments focusing on the role of mentors (McSharry et al. 2010; Borneuf & Haigh 2010; Price et al. 2011). A more detailed discussion of such debate is beyond the scope and focus of this

study. However, importantly, the NMC (2008, p.3) made a requirement that, “students on NMC approved pre-registration nursing education programmes must be supported and assessed by mentors”. Mentors are registered nurses based and employed in practice (Andrews and Roberts, 2003) who are required to ‘sign off’ students achieving NMC (2008) defined standards for learning in practice. These standards and the role of mentors have since undergone change with the implementation of the Standards Framework for Nursing and Midwifery Education (NMC, 2019). Nonetheless, the earlier standards remain relevant to this study, as they are in place at the time of data collection. In relation to this study, I consider it important to seek greater understanding of nursing students lived experiences of support from mentors especially in relation to ECEs. An assumption may be, that mentors themselves have the knowledge, skills, and time to support students through ECEs in the practice environment. Carr (2008) and more recently, Jones-Berry & Munn (2017) highlight that the practice arena has its own problems for mentors, relying upon practitioners with heavy workloads. An RCN (2013) report suggests that mentors are so stretched in many HSC areas that student support is at breaking point. In my own geographical area, Bennett & McGowan (2014) found that mentors often feel unsupported or unprepared for the demands of the role. These are important factors in relation to this study and I am

concerned about how they impact on the support of nursing students, especially in relation to ECEs.

In the NMC, Quality Assurance Framework for Nursing, Midwifery and Nursing Associate education (NMC,2019) the importance of HEI and placement learning partnerships is emphasised in the professional preparation of nurses. The National Nursing Research Unit (2015) highlights that such partnerships have been the ‘lynchpin’ of mentorship delivery since nursing education moved into HEIs. In my own HEI, as part of this partnership, there is an expectation that lecturers such as myself continue to support students in practice, through a link lecturer (LL) role. This role involves providing support and dealing with ‘trouble shooting’ issues such as responding to concerns regarding students’ progress and practice. However, as Price et al. (2011); Leigh (2014) and MacIntosh (2015) highlight, the precise nature of the LL role is often of an ‘ad hoc’ nature and open to interpretation by lecturers, mentors, and students. The format, purpose, quantity, and quality of contact between LL and student varies between email, telephone contact and direct face-to-face visits. Such visits can be impacted upon by the large geographical range of placements. In addition, a focus on one aspect of the role can conflict with other aspects, i.e., tension between a pastoral and a trouble-shooting role. These issues concern me, as despite various support roles outlined within both

the HEI and in practice, such difficulties and tensions may affect nursing students' learning and support, especially in navigating ECEs. As Eick, Williamson & Heath (2012) and Crombie et al. (2013) highlight, negative experiences in placements can be one of the most important factors contributing to nursing students' attrition from nursing programmes.

Sawbridge and Hewison (2011) responding to concerns about poor nursing care, stress the need for a systematic approach to supporting nurses with emotional aspects of practice. However, given the difficulties as highlighted earlier, it is important that nurse educators such as myself, gain greater understanding of nursing students lived experiences in accessing support in relation to ECEs. Such an understanding may help nurse educators such as myself, to prepare and enable nursing students to navigate ECEs in ways which are not detrimental to themselves or patients in their care. Having had varying levels of support and advice as to how to navigate ECEs in my own professional practice, I am mindful of how similar experiences might affect nursing students. Thus, in undertaking this study, I also seek greater knowledge of nursing students' lived experiences of both formal and informal preparation and support offered, available or utilised (if any) prior to, during and after ECEs in practice. As an educator and researcher, I also seek to gain an understanding of influences that nursing students encounter as to how they should engage

with ECEs in practice. In the next section, I discuss some differing experiences that nursing students may encounter in relation to working with emotional aspects of practice.

1:3:5. Differing experiences regarding engagement with emotional aspects of nursing practice.

In my experiences as a nurse and nurse educator I have observed varied preparation of undergraduate nursing students for ECEs in practice. Attitudes among some nurses and nurse educators appear to conform to a discourse of distancing, detachment from or non-expression of emotions in nursing professional practice. In my experience, it is not an uncommon expectation that nurses should put on a 'brave face' or present themselves in a manner unaffected by sadness or suffering. This perception was reinforced at the outset of this study, when during a meeting in my role as PT with a first-year nursing student, the student became tearful, subsequently apologising for doing so. When I asked why she was upset, she recounted that a patient for whom she had been caring had recently died. This was her first experience of the death of a patient, and she expressed concern that she had been 'unprofessional' by showing emotions. She asked me if it was appropriate to cry when a patient died. My response was to reassure her that it was appropriate to express feelings of sadness, but later I found myself considering on what basis I was providing such advice. Reflecting on my own experience,

my advice appeared contrary to a view in which suppression of emotions may be considered part of professional nursing practice. This has been an impetus for me to examine further how nurses navigate ECEs in practice.

Littlejohn (2012, p.365) contends there is a traditional expectation that nurses "more or less check their emotions at the door". Others such as Freshwater and Stickley (2004); McCreight (2005) and Elliot (2017) suggest that there is a dominant emphasis on objective scientific knowledge in models of care provision, with emotional and relationship elements being secondary. McQueen (2004) argues that control of one's emotions is seen as professional norm and that nurses have been expected to maintain a professional barrier. More recently Barratt (2018, p.44) writes, "nurses are expected to manage their feelings and emotions so that they appear 'professional' at all times". However, there appears to be differing views as to what such management of emotions should entail.

Henderson (2001, p.133) contends that there is a divergence of views about the value of detachment (objectivity) versus engagement when applied to nursing care and often a dissonance "between emotional engagement versus emotional detachment in caring work". Others such as Curtis (2014) suggest that in nurse education, there is lack of clarity as to where the boundaries of emotional engagement should be. Cadge and Hammonds (2012) highlight a

tension between expressions of emotions as part of empathic relationships with patients and a view of professional practice as one of detached objectivity, where the professional does not express or display emotions. Cadman and Brewer (2001) suggest that while engagement with the emotions of patients may be an important aspect of nursing care, over-engagement, and inability to deal effectively with emotions can lead to nurses being overwhelmed and emotionally exhausted. Challenges thus arise for nurse educators such as myself, as to how best to guide students with appropriate engagement or disengagement, given the complexity of ECEs that arise in diverse HSC practice placements. Of concern to me, is how nursing students experience and navigate potentially contradictory discourses regarding professional nursing practice. While a detached approach may be appropriate in relation to some aspects of nursing practice, I am concerned that this may be a dominant discourse among nursing practitioners or practice teams and that a culture of emotional distancing may arise. This in turn may influence nursing students' understanding of how they should navigate ECEs in practice. Thus, in undertaking this research I seek to extend greater clarity of the lived experiences of undergraduate nursing students' and how they engage with ECEs in practice. Furthermore, I want to examine nursing students' perceptions of influences, which inform and shape the development of their responses to

such ECEs. I am particularly concerned as to whether influences from individuals or teams within the HEI and/or practice settings may lead to an emotional detachment by nursing students from patients and ECEs. My concerns became prominent when considering examples of lack of care and empathy by nurses, which I discuss in the next section.

1:4. The wider professional context of preparation of nursing students for professional practice.

As highlighted earlier, scandals regarding care of patients in various UK HSC settings gave rise to questions regarding the quality of healthcare practice and education (Francis, 2013; Keogh Report, 2013; Care Quality Commission Report, 2013). Such scandals are at odds with popular notions forwarded by writers such as Bassett (2002); Rhodes, Morris & Lazenby (2011) and Andersson et al. (2015) of nurses as caring professionals with feelings of empathy.

Frowe (2005) argues that the moral legitimacy of a profession is based upon trust, but as Groundswater-Smith and Sachs (2002) contend, trust is based on confidence in the behaviour of another person, group, or institution. In the context of nursing, Dinc and Gastmans (2012) argue that trust and trustworthiness are essential to the professional nurse role. Quicke (2006, p.327) suggests that lack of trust in professionals can stem from how they

behave in practice, but also, “from the critique of professional knowledge”. An assumption arising from scandals such as at Mid-Staffordshire, National Health Service (NHS) Trust (Francis, 2013), may be that nurses involved did not possess appropriate knowledge associated with their roles as professionals.

In my role as a nurse educator, I want to reconsider the professional knowledge required of nursing students to provide professional care and to maintain trust, especially in dealing with ECEs. In this section, I examine some of the expectations and requirements around the nature of knowledge required in the preparation of nurses for professional practice.

As highlighted earlier, accreditation of the BSc honours (adult) nursing degree programme is based on the HEI meeting standards set by the NMC. At the outset of this study, the (NMC, 2008) “standards for learning in practice” (SLAIP) outline expectations of students’ eligibility for registration and practice as a professional nurse. At the time of data collection and write up of this thesis, these inform and influence the study, but have since been superseded by the Future Nurse: Standards of proficiency for registered nurses (NMC, 2019).

To be eligible for registration, students are also expected to have ongoing adherence to the NMC professional code, “The Code” (NMC, 2018) and fitness to practice (FtP) guidance (NMC, 2018). These set out expected behaviours by

which nurses, including nursing students' FtP is measured. While many aspects of skills and professional conduct are set out in such normative codes and standards, these give little guidance on how nurses and nursing students should navigate ECEs in practice. As Vanlaere and Gastmans (2007) argue, the principles of right actions alone, as summarised in codes, are an insufficient basis for provision of good practice. Knowledge of codes or other principles does not necessarily mean that individuals will convert them into their own practice. My perception is that despite recognition that nursing practice is emotionally charged, within nurse education there has been limited focus in the formation and preparation of nursing students, on how best to navigate ECEs arising in varied practice settings.

Freshwater and Stickley (2004, p.91) argue that while many nursing curricula refer to the notion of an emotionally intelligent practitioner, much of this is "little more than rhetoric when the surface is scratched". Horton-Deutsch and Sherwood (2008, p. 947) contend that nursing students, "receive little assistance in learning how to cope with the intense emotional labour of nursing". Sargent (2012) suggests that historically there has been little attention from educational institutions and employers to developing nurses' ability to navigate the emotional demands inherent in their role. More recently, Foster et al. (2015, p.511) reviewing literature on preparation in pre-

registration nursing programmes, “for the mastery of personal and interpersonal emotion management in nursing practice”, suggest that there is lack of clarity and construct definition in educational approaches.

Discussion on the knowledge and attributes needed in nursing is ongoing, especially at the time of writing, in the development of new undergraduate nursing curricula in response to NMC Future Nurse Future Midwife (FNFM) (2019) standards. While such discussion is ongoing, among recommendations from The Francis Report (2013) was the need to reinforce the significance of emotions in care work and to further understand the emotional experiences of health professionals in providing care. Commenting on the report, Wallbank and Proctor (2013, p.136) contend that the provision of good care is “dictated by the ability of the professional to engage in the emotional aspects of their work”. While this has been argued in this context, greater clarification of the knowledge required by nursing students in my own context in NI in navigating ECEs in practice is required. Therefore, this study will explore how nursing students navigate ECEs. Ultimately, I hope that such an understanding may inform the development of nursing students’ professional knowledge to enable safe and compassionate care when dealing with ECEs in practice.

A view of professional knowledge forwarded by Higgs, Burns and Jones (2001) helps to provide a framework to understand the nature of knowledge that

might be required in the preparation of nursing students. Higgs et al. (2001) suggest that professional healthcare practice requires three types of knowledge: professional craft knowledge; propositional knowledge (theoretical knowledge) and personal knowledge of self and in relationship to others. In considering this view of knowledge, in my experience, historically the emphasis in undergraduate nursing programmes and practice has been on craft and propositional (theoretical) knowledge. My perception of both nursing practice and education in the care of adults, is that it is influenced by a dominant focus on undertaking a range of technical and/or clinical tasks, with patients sometimes being objectified recipients of such tasks. I have observed nurses who had excellent theoretical knowledge, performing technical aspects of their role to a high standard, but in a manner which I perceived as unemotional, cold, and distant. In one personal experience at the bedside of a terminally ill relative, I witnessed a nurse correctly undertaking routine procedures. These were undertaken in such manner which left me with the impression of the nurse as cold, lacking in compassion and engagement with their own emotions or those of others, such as my relative and myself. My perception was that the nurse may have been lacking in the third aspect of Higgs et al's. (2001) concept of knowledge, i.e., personal knowledge of self and in relationship to others.

Smith and Allen (2010, p.222) take the view that "emotions are an important feature of learning and nursing, despite a culture which does not recognise their importance". Others such as Bulmer-Smith, Profetto-McGrath & Cummings (2009); Williams & Stickley (2010); Patterson et al. (2011); Dewar & Cook (2014) and Wilson (2017) argue for more explicit recognition of relationship aspects of care and understanding of how nurses connect with ECEs in practice.

Within the NMC (2019) standards' domains of 'Communication and interpersonal skills competencies', there is an expectation that nurses, "engage, maintain and, where appropriate, disengage from professional caring relationships". In the NMC (2019, p.5) standards for nurse education there is also an expectation that students, "develop the inherent strengths of emotional intelligence and resilience". These suggest that nursing students should have developed a level of self-knowledge and be able to work effectively with the experiences and demands of professional practice. This includes knowledge of ECEs on their health and well-being and to engage in self-care and accessing support when required. How, specifically nurses achieve such 'competencies' is not made evident. In addressing this issue, this study will investigate how students navigate caring within interpersonal

experiences and what professional knowledge they might require to do so, especially with the ECEs of practice.

Hunter and Smith (2007) argue, that unless nurses are competent to deal with their own and others' emotions there may be detrimental and negative effects for both patients and nurses themselves. In relation to this study, I want particularly to explore nursing students' emotional competence and resilience and any negative impacts that might arise when encountering ECEs. A necessary component of the study, therefore, is to enhance understanding as to how students develop and learn to manage such experiences. For example, what resources beyond those in the programme that students utilise? Of interest to me are, what awareness and understanding, nursing students have of their own emotional responses in extending themselves (or not) to care. It is anticipated that by exploring these issues in this study, new insights as to how nursing students develop and learn to navigate ECEs and learn to attend to their own needs and stressful interpersonal relational aspects of practice will be exposed.

Jordan, Ashkanasy & Hartel (2002); Slaski & Cartwright (2003) and King & Gardner (2006) suggest that if individuals can recognise and understand emotions, they are more likely to use effective coping strategies and resources to deal with stressful emotional situations. The latter views are particularly

important considerations for me, as in examining previous research and in undertaking my own study, I seek to gain comprehension into strategies that nursing students in my own context in NI, may use in navigating ECEs and what support (if any) that they seek or receive from both formal and informal networks.

1:5. The aims and specific questions of this study.

In this chapter, I have provided the personal and professional context to the study. I have demonstrated that the context in which nursing students experience and navigate ECEs in practice is both complex and ambiguous in my own HEI and in the wider nursing education arena. As an educator and researcher, I consider it essential that I explore these issues further. As highlighted earlier, I aim to examine how nursing students undertaking the undergraduate BSc honours degree programme in my own HEI, respond to ECEs in various practice placements. Within such settings they are likely to encounter a range of ECEs, which raises the question as to how they navigate such experiences. Thus, an overarching question arises in relation to this study as to:

- How do undergraduate nursing students navigate and respond to ECEs in practice?

I also aim to explore further, whether there are particular strategies that nursing students utilise when encountering ECEs in practice. Therefore, the following question is explored:

- What particular strategies or approaches do nursing students adopt to maintain their own emotional well-being while engaging (or not) in the ECEs of practice?

While having professional learning experiences in a range of placements, nursing students are likely to work alongside a range of nursing and other HSC professionals. These may range from professionals working closely in established departmental teams, to community nurses working independently and/or in more isolated circumstances. How these teams or individual professionals influence, inform and shape nursing students' responses to ECEs, forms an important aspect of this study. Therefore, I also aim to gain an understanding as to dialogues and conversations that nursing students encounter as articulated by HSC teams or individual professionals, about how they (nursing students) should engage with ECEs in practice.

This invites the further question:

- What are nursing students' experiences of influences which inform and shape the development of their responses to ECEs in practice?

Gaining greater knowledge as to how students learn to navigate ECEs is an important aim of this study and thus necessitates examining students' lived experiences of support and supportive interactions prior to, during and after ECEs in practice. Therefore, a further question will be explored:

- What are undergraduate nursing students' lived experiences of both formal and informal preparation and support offered, available or utilised (if any), regarding ECEs in practice?

1:6. Summary of the chapter.

Overall, I am aware that nursing students experience ECEs and yet we do not fully understand how they learn to navigate such experiences. I am concerned that the support required by students may not always be given an appropriate focus in my own HEI and related practice. Consequently, in undertaking this study and to answer the questions set out earlier, I intend to provide new knowledge as to how nursing students in NI learn to navigate ECEs. I also want to provide understanding into nursing students' lived experiences of support offered, available, sought or obtained (if any) regarding such ECEs. This study therefore aims to develop greater insight into the lived ECEs of nursing students in placements in NI and what approaches, if any, they utilise to navigate such experiences. I also aim to explore approaches that nursing students adopt to maintain their own emotional well-being while engaging in

ECEs of their work. Ultimately, such an understanding may provide a basis for developing students’ ability to navigate experiences that are problematic or responses that may be deemed as inappropriate. In the next chapter, I review the literature in order to ascertain current knowledge as to how nursing students navigate ECEs in practice.

Chapter Two. Literature Review.

2:1. Introduction.

The purpose of this literature review is to identify published information which will guide this study and help to answer the questions raised in Chapter One. I want to examine literature which will inform my study into undergraduate nursing students' navigation of lived emotionally challenging experiences (ECEs) in health and social care (HSC) practice. I also seek to gain insights into strategies that nursing students may use in navigating ECEs and experiences of both formal and informal preparation and what support (if any) offered, available or utilised (if any) regarding ECEs in practice. In examining such literature, I endeavour to synthesise and clarify concepts and to identify potential appropriate methods for collection and analysis of data. The chapter is divided into sections which includes the search strategy and retrieval of relevant papers, followed by discussion and analysis of such papers. A brief explanation of the methodological approach to retrieving relevant literature is first given in the next section.

2:2. Literature search strategy.

As this study is concerned with gaining knowledge of nursing students' ECEs in placements, I want to seek out literature to guide my own research into the lived experiences of nursing students. Boell and Cecez-Kecmanovic (2014)

highlight that there are different and often conflicting understandings of the nature of the literature review process and confusing instructions on how it should be conducted. Weed (2008); Williamson & Whittaker, (2014) and Jeffery (2016) highlight, that traditionally in healthcare practice, there is emphasis on literature reviews involving meta-analysis and/or systematic reviews. Whitemore and Kaff (2005, p.547) suggest that while literature review methods, such as systematic reviews are important for evidence-based practice, they do not “include the depth and breadth of nursing research as they overemphasize the randomized clinical trial and hierarchies of evidence”. Weed (2008) points out that they are shaped by positivist epistemologies, where objectivity and generalisability are sought; whereas in qualitative research, underpinned by an interpretivist epistemology, the purpose is to seek a greater depth of understanding. Weed (2008) and Jeffrey (2016) argue that traditional positivist approaches can result in loss of rich data or insights into phenomena and often miss important studies. The aims and objectives of this study are concerned with gaining a deep understanding of ECEs, rather than causes and effects or aggregating data as in quantitative research. McDougall (2015) emphasises that non-systematic reviews have different ways of engaging with literature as their aims are different. Snyder (2019) argues that there are a number of approaches to literature reviews and of

synthesising research findings to show evidence and uncover areas in which more research is needed. They argue that an integrative review can be useful as a method to synthesise research and insights from different fields or research traditions. Whittemore and Knalf (2005) suggest that integrative reviews are the broadest type of research review method that allow a simultaneous inclusion of experimental and non-experimental studies. In such an approach the purpose of the review is not to cover all articles published on the topic, but rather to combine perspectives or to use the literature to inform one's own research.

One argument by Finfgeld-Connett and Johnson (2013) suggests that from interpretive (hermeneutic) perspectives, iterative literature searches are open-ended processes with the purpose of finding contextually consistent and rich research related topics. Barroso et al. (2003) and Finfgeld-Connett & Johnson (2013) refer to such as 'berry picking'. Barnett-Page &Thomas (2009) use a similar term, 'pearl growing', where the researcher is an active interpreter in evaluating the relevance of studies for inclusion. This allows researchers such as myself to look for similar themes and concepts in different studies. However, Winchester and Salji (2016) caution that selection of articles is where bias in literature reviews is often most apparent. Smith and Noble (2014) caution that although the term bias is rooted in the positivist paradigm, in

different study designs, bias can occur at each stage of the research process and researchers such as myself need to be concerned about possible selection bias. However, as Denzin (1984) and Galdas (2017) argue it is not possible to have a complete absence of personal knowledge or bias in relation to a phenomenon. Polit & Beck (2014) and Galdas (2017) recommend that researchers should be transparent and critically self-reflective about their own preconceptions and about the processes by which data is collected, analysed, and presented. Dahlberg, Drew & Nystrom (2008) highlight the need for reflection at all stages of the research process in order to restrain and limit any bias. It is therefore important that I engage critically and reflexively during the collection of literature. To help ensure reflexivity, I used a diary recording reflections on how my own experiences may have shaped the review of literature. (A fuller discussion on reflexivity is discussed in Chapter Three).

Snyder (2019) suggests that a practical approach to enable transparency and aid the quality and rigor of the review, is to write decisions down to enable the reader to understand how the literature was identified and reported. In keeping with this recommendation, I have endeavoured to outline sequential steps of this literature review process.

Winchester and Salji (2016) argue, that a useful approach to reduce bias, is to identify broad search terms and keywords relevant to the subject and concepts

that directly relate to the research questions. Sucharew & Macaluso (2019) recommended a scoping review to provide an overview of the available research evidence and what information has been presented on the topic. Suri (2011); Gentles et al. (2016) and Benoot, Hannes & Wilson (2016) also recommend firstly undertaking a broad overview of the field, followed by a more focused review. With these recommendations and as suggested by McDougall (2015), I first undertook an introductory review of literature in order to identify concepts which shape debate or knowledge and gaps on the topic, but not requiring all work related on the subject. This provided a basis to identify key terms and subject headings relating to the research questions.

My approach involves initial scoping of literature to find easily accessible papers relevant to the study questions, but then seeking those that have important implications for the design and conduct of my study, rather than those simply dealing with or related to the topic. In particular, looking for new information or gaps in knowledge around the questions of my study. As such, the literature search is expansive rather than exhaustive, commencing with a few sources which may broaden to find others. The reference lists contained in each article are also reviewed for further relevant information sources.

Booth (2016, p.12) suggests that such an approach allows for exploration of research and “emerging lines of inquiry”. These are significant arguments for

me, in that I want the process of the literature search to be current and ongoing rather than confined within a specific period or research paradigm. This enables me to return to the literature seeking new insights and knowledge as they emerge.

2:2.1. Key topics and terms used in the literature search.

While there is a plethora of literature regarding emotions and their management in many organisational settings, initial perusal of literature suggests that there has been some limited empirical research specifically into how nursing students navigate ECEs encountered in practice. Kellogg, Barker, and McCune (2014) argue for more extensive research into reactions, responses, and grieving processes of nurses. Others such as Dwyer and Hunter-Revell (2011) argues that published research about nursing students' experiences in practice placement is scarce. My view is that there is a need for further exploration, by those charged with the educational preparation of nurses, such as myself, into how nursing students learn to navigate ECE

Gentles et al. (2016) suggest that while there are numerous methods of literature review, criteria for identification and retrieval of published research should include inclusion and exclusion criteria, and that selection procedures should be chosen to match specific objectives. The initial search of literature

involved key words and subject terms arising from the study aims and questions as outlined in Chapter One. These include terms outlined in **Table 1.**

Table 1. Key search words and subject terms.		
"nursing students OR student nurses OR undergraduate student nurses OR pre-registration nursing student)"	AND	"emotional labour OR emotional labor OR emotional work) AND (emotional labour OR emotional labor OR emotional work"
student nurses OR nursing students	AND	emotional challenges OR emotionally challenging
"nursing students OR student nurses OR undergraduate student nurses OR pre-registration nursing student)"	AND	emotional challenges OR emotionally challenging
"nursing students OR student nurses OR undergraduate student nurses OR pre-registration nursing student"	AND	"emotional support"

Levy and Ellis (2006) emphasise that the major base of the literature review should be leading peer-reviewed journals, as they provide theoretical background as well as leads for additional references on the specific subject matter. Winchester and Salji (2016) highlight the importance of searching online citation databases to identify peer-reviewed original research articles, review papers and book chapters that encompass such keywords. These are used in searches of databases which I outline in the next section.

2:2.2. The databases search.

As recommended by Booth (2016) the search of literature involves multiple online databases via the University library where the research study is

registered. These include the Cumulative Index for Nursing and Allied Health Literature (CINAHL), PubMed and Medline.

Boland. Cherry and Dickson (2013) suggest that such databases assist healthcare professionals in finding research related to their field. Besides having the university affiliated subscription, these databases are sources of literature in the domain of nursing, biomedicine and healthcare. CINAHL indexes 5,500 biomedical, social sciences, and consumer health journals; 492 of these are nursing titles, of which 144 are also indexed in Medline. CINHAL is the largest source of nursing and allied health peer reviewed journals (CINAHL Complete (EBSCO, 2020), whereas Medline out of 4,600 indexed journals includes 8% of nursing titles. Thus, I consider that they are likely to hold relevant literature relating to nursing students' ECEs in practice. My search also includes Scopus as this is an index of international health and medicine journals. Psycho Info database was also included as this pertains to psychology. In each database the option of advanced search and specific filters and Boolean operators 'OR' and 'AND', are used with the combination of keywords, as shown in Table 1. ETHOS database of doctorate theses and a search of literature using Google scholar are also undertaken.

Non-English papers are excluded, as I want to ensure that the work can be accurately read, interpreted, and reviewed by myself. Levy and Ellis (2006)

advise that literature should be evaluated on its applicability to the proposed study and that when an article is only remotely relevant it should not be used as foundation literature to the study.

Initially a plethora of papers were revealed and in consideration of the advice of Levy and Ellis (2006) titles of papers and key words were viewed for relevance to this study. While many broadly relate to the topic of ECEs, some were around testing of instruments to measure emotional intelligence (EI) or relate to population groups beyond nursing or healthcare, i.e., social work or teaching. From these preliminary findings, I also excluded papers unrelated to the aims and objectives of this study. The findings were furthered narrowed on the basis of availability of open/free access or availability of access through university library databases or library shared access. Those which initially appeared relevant, were retained for further analysis. With a more detailed review, such as of abstracts and aims, those not relevant to the topic or aims of this study were omitted. For example, research that focused on patients or families' emotions were excluded, as the focus was on nursing students' ECEs, rather than those of patients or relatives. While some papers related to the topic, the focus often was on the impact of emotional labour or emotionally challenging experiences on the well- being of the individuals involved. While such studies are important in providing a wider understanding of the negative

impact of ECEs, this is not the focus of this study and therefore these were not included. While some papers, did relate to the search terms including nurses, some were specifically around nurses working in neo-natal settings. As this is a specialist areas of nursing, involving specific training to work in these areas and unlikely to be part of undergraduate nursing students' experiences in clinical placements, I considered that these papers would be different to the focus of this study.

Winchester and Salji, (2016) suggest that it is essential to read published peer-reviewed original research to formulate the literature review. They suggest the importance of striking a balance between old and current established papers which refute as well as support a particular idea or research finding. BEME (2021) suggest a ten-year period for retrieval of studies on the topic. In keeping with this suggestion and as I commenced my literature search in August 2017, peer-reviewed empirical articles in the ten years prior to this are explicitly included in order to capture contemporary understandings. However seminal work prior to 2007, is also included to provide explanations and exemplars of concepts. As Boell andCecez-Kecmanovic (2014) suggest, conducting a literature review is not a linear process and emphasize the importance of ongoing reading. Therefore, I also set up EBSCO host alert notification and email alerts by Academia to bring to my attention and to

explicitly include newly published and/or material relating to my study topic up to the period of writing and reviewing this chapter in August 2020.However, the review is not confined to primary research, but includes grey literature such as reports, literature reviews and policies seminal work is also included to provide explanations and exemplars of concepts.

Table 2, gives an overview of the number of articles found after the search terms were applied to the selected databases.

Table. 2.							
Search	**Keywords**	**CINHAL Excluding Medline**	**OVID Medline ALL**	**Complimentary Index**	**Psycho Info Library**	**Scopus**	**Academic Search Complete**
S1	"nursing students or student nurses or undergraduate student nurses or pre-registration nursing student) AND (emotional labour or emotional labor or emotional work "	3463 (74 retained)	3885 (48 retained)	24	2803 (10 retained)	2217 (22) retained	(27 retained)
S2	"nursing students OR student nurses OR undergraduate student nurse AND "emotional support"	4935 (68 retained)	1881 (84 retained)	36 (36 retained)	682 (10 retained)	657 (15 retained)	47

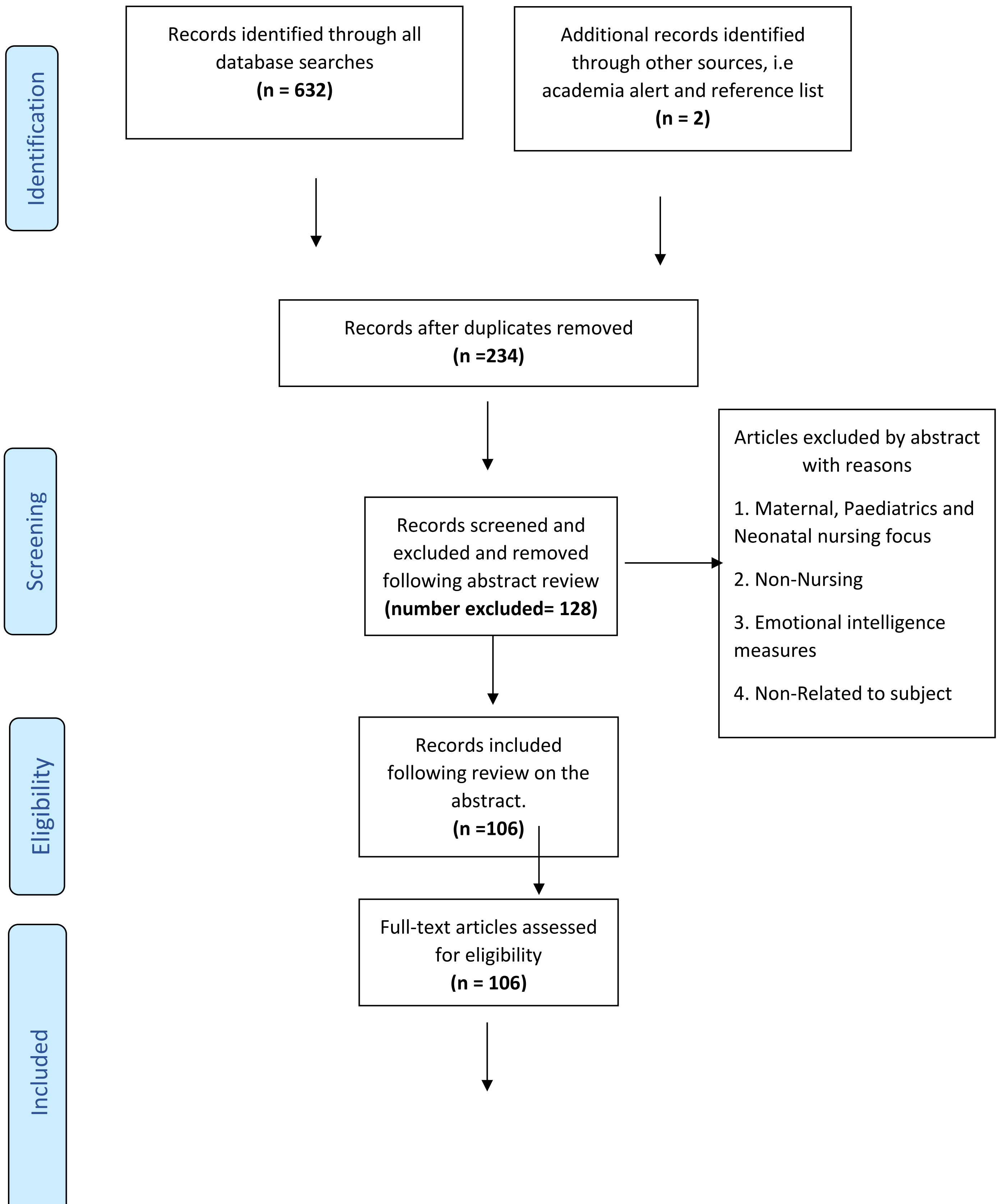
S3	nursing students OR student nurses OR undergraduate student nurses AND "emotional challenges" OR emotionally challenging experiences	4935 86 retained	3885 16 retained	(21 retained)	949 (16 retained)	156 (9 retained)	17
Retained		228	148	81	36	48	91

2:2.3 Search Outcomes

The search from all databases resulted in a total of 632 citations. After deduction of duplicates and further inquisitions for relevancy. These articles were scanned on the basis of their title and abstract for the relevance to the research questions which led to the deduction of articles as not relevant. The remaining articles were examined with their full text for their eligibility with the research questions. The reference lists of the final articles were used in snowballing process (Jalali & Wohlin, 2012) and 2 articles were identified which were not retrieved from the databases search. Snowballing is a technique where articles are identified from the reference lists of the final articles to identify additional relevant articles (Jalali & Wohlin, 2012). This process led to the identification of the articles that are included in this literature review. A summary of this process can be seen in The PRISMA Diagram Figure 1. The Preferred Reporting Items for Systematic Reviews and

Meta-Analyses (PRISMA) (Moher et al., 2009) flow diagram shown in Figure 2 maps out the search strategy and search outcomes.

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analysis



Papers included for the final review
(n = 71)

2:2.4. Quality Appraisal of the literature

Quality appraisal also known as critical appraisal is a crucial aspect of the literature review that ensures that the yielded studies are methodologically credible (Whittemore & Knafl, 2005). The aim of such appraisal is to determine the extent to which a study has excluded or minimised prospective biases in the study design, conduct and analysis. However, Whittemore and Knafl, (2005) also highlight that there is no gold standard for appraising the quality of papers. In this review, the Critical Appraisal Skills Program (CASP) (2019) tools for Qualitative and Systematic reviews was used. Cameron et al. (2011) and Long, French and Brooks, (2020) argue that these enable the reviewer to appraise the strength, limitations and methodological quality of the articles and to make competent judgement about their relevancy. For this review studies that were included for the final review were assessed using the CASP assessment guide (as shown in Figure 2) and none of the studies were excluded from the final review.

Figure 2. Critical Appraisal Skills Program (CASP) Tool (2019)

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

In the next section, I discuss some of the key findings from the literature search.

2:3. Key themes emerging from the literature review.

In this section, I analyse literature relating to the questions outlined in Chapter One, such as those which examine strategies that may be used in navigating ECEs. However, in the next sub-section, I first provide clarification of the term emotionally challenging experiences (ECEs) as this is a central term used throughout this study.

2:3.1. Emotional challenges and emotionally challenging: clarifying terms.

While terms such as ‘emotional challenges’ and ‘emotionally challenging’ have been used in a range of literature, explanation of such terms has not always been provided. For example, while Hegney, Plank & Parker (2006) use the term

'emotionally challenging' in the schedule of questions studying nurses' job satisfaction, they do not offer a specific definition of the term.

Koch (1998) used the term 'emotionally challenging' in reference to situations described by nurses as intensely personal and highly emotional. This term suggests an impact on the individual nurse. More recently, Baesslera et al. (2019) use the term 'emotionally challenging' in a study analysing a German medical curriculum. While not providing a specific definition, the term is used when referring to situations which give rise to healthcare workers feeling helpless, or experiences such as aggression from patients. Pfun et al. (2004) used the term 'emotionally challenging' in an article in relation to nurses reflecting on experiences of patient death. Lindqvist (2019, p.540) in a non-nursing related study of student teachers' work, uses the term 'emotionally challenging episodes' to describe experiences "that could create emotionally charged responses". Others such as Ingebretsen & Sagbakken (2016, p.9) use the term 'emotional challenges', to explain how nurses caring for the dying, were emotionally touched and emotional challenges were "related to dynamic movements between both enriching and draining experiences". While nursing practice involves many enriching experiences, in my study, it is potentially or actual draining experiences of nursing students that I wish to explore. As highlighted in Chapter One, I have felt overwhelmed in my own such

experiences and deem that they are likely to be problematic for nursing students.

Others such as Weurlander et al. (2018) use the term ‘emotional challenge’ in their study with medical and nursing students in discussing situations such as, confronting patients’ illness and death, that might evoke strong feelings. The concept of ‘emotionally challenging’ was also included in a further study by (Weurlander et al. 2019, p.1038) in reference to situations in which medical students are “confronted with illness, suffering, death, patient treatment dilemmas, and witnessing unprofessional behaviour”. As Dwyer and Hunter Revell (2015) and Curtis (2015) highlight HSC environments are complex, challenging in nature, and frequently stressful for students. Curtis (2015, p.641) uses the term emotionally challenging when reporting on a study of nursing students experiences in residential care settings, such as “despair of seeing residents become distressed”. In this study, I use the term emotionally challenging in the context of experiences, which nursing students consider had a significant emotional impact on themselves. The term emotionally challenging reflects that professional practice may impact upon and evoke nursing students’ own emotions and may cause distress to the students.

2:3:2. Emotion management, emotional labour, and emotion work.

As highlighted in Chapter One, there is an expectation by the NMC (2019) that nurses must be resilient and be able to manage emotional aspects of their practice and know when and how to access support. However, how nursing students learn to develop such knowledge and know when to seek support is not made evident. In this section, I examine some of the literature in order to provide greater clarification of concepts, such as, emotion management, emotional labour, and emotion work, as these are often used interchangeable terms to explain individual' experiences and navigation of ECEs. I then critically examine specific literature of such concepts in relation to nursing and nursing students.

A helpful starting point is provided in an integrated literature review by Delgrado et al. (2017) who synthesise findings from studies (some of which are examined later in this chapter) on nurses' resilience and management of emotions. Delgrado et el. (2017) refer to emotion management as "emotional labor", a term used in seminal work by Hochschild (1983) into the work of flight attendants. Emotional labour (EL), as Hochschild conceived it, referred to the work required by individuals in such professions, in managing their own emotions by induction or suppression. Since Hochschild's original formulation of the term emotional labor (or labour) (EL) there has been an array of research on EL covering many occupational groups and the term has been

frequently used when discussing emotional aspects of nursing practice. Brook (2009, p.539) suggests that despite criticisms, the concept of EL is still “applicable to all forms of waged labour involving a degree of emotion work”. Much research and subsequent writing on the subject arises out of the first published work on EL in nursing by Smith (1992) which was later revisited (see, Smith & Gray (2001, a); Smith & Gray (2001, b) and Smith and Gray 2009 and Smith, 2012).

Elliot (2017, p.1072) in an article examining the concept of EL argues that EL is “understood to be an intrinsic part of nursing care”. However, Huynh, Alderson & Thompson (2008); Pisaniello, Winefield & Delfabbro (2012) and Dwyer & Hunter-Revell (2015) argue that the term EL lacks conceptual clarity and is often used interchangeably with others such as ‘emotion work’ and ‘emotional work’. Therefore, I first briefly examine the concept of EL in the literature before considering its relationship with studies into nursing students’ ECEs.

Wilson & Carryer (2008) suggest that EL is sometimes used with the term emotional competence. This term ‘emotional competence’, arises out of work by Gardner (1993) who viewed it as the understanding and management of emotions, encompassing both interpersonal and intrapersonal relationships. The former involves an ability to understand others, whereas the latter involves self-awareness and recognition of one’s own feelings and being able

to take account of these in social situations. These latter are important concepts as they relate to the aims of my study, where I endeavour to examine how nursing students recognise and manage their own emotions and EL in relation to emotionally challenging situations in practice.

Hochschild (1983, p.7) defined EL as “the management of feelings to create a publicly observable facial and bodily display”. An earlier seminal study by Ekman, Sorenson and Friesen (1969) first used the term ‘display rules’ to explain how facial expressions of emotion could be managed and even modified according to social context by people of different cultures.

Hochschild (1983) argued that people often manage emotions, in order to portray publicly and organisational perceived acceptable displays of emotions. She distinguishes this kind of EL as ‘surface acting’ by which a person displays what they deem as expected emotions, irrespective of how that person is truly feeling inside. Hochschild also uses the term ‘deep acting’, as changing outer expressions by altering feelings from within. Addison (2017, p.11) while criticising this notion of deep acting as being “difficult to untangle”, suggests that it involves trying to make emotional displays authentic by sincerely trying to embody the emotion in oneself. Badolamenti et al. (2017, p.48) explain the concept of deep acting as, “trying to experience the desired emotion” as opposed to surface acting, as faking expressions of felt or unfelt emotions. For

Hochschild, both surface acting and/or deep acting involve individuals alienating themselves from their true self, which Hochschild and later Grandey (2000) argued may lead to emotional exhaustion, burnout, detachment, and depersonalisation. These arguments are of concern to me and therefore in relation to my own study, it is essential to explicate whether nursing students describe their navigation of ECEs in ways that could be considered as surface acting or deep acting.

As Choi and Kim (2015) highlight there have been many criticisms and attempts to modify Hochschild's concept of EL. For example, Ashforth and Humphrey (1993, p.94) argue that the term EL should also include, "spontaneous and generous emotions" as individuals may actually feel what they are expected to express. Bolton (2000), Bolton and Boyd (2003) and Bolton (2005) argue that Hochschild's definition is too absolutist and presents workers as "emotionally crippled actors". They argue that it is not applicable to occupations where individuals have greater autonomy and are not constrained by organisational display rules and expectations. They suggest a wider definition of EL to include "prescriptive" and "philanthropic" emotion management. In the former, the employee may follow occupational display rules, whereas in the latter, they may give freely of their true emotions regardless of organisational display rules. In doing so they can draw on different sets of emotional display rules

according to the situation. While these are valid arguments and while some nurses have become more autonomous in their practice, nurses are still constrained by expectations of employing organisations such as the NHS. As Sawbridge and Hewison (2011) suggest nurses are working in highly regulated environments where numerous external agents impact on the provision of care and on the individual professional.

A further criticism of Hochschild’s concept of EL, made by Brook (2009), is that it over-simplifies the complexities of emotions, by differentiating between emotions displayed in public and private spheres. Theodosius (2006, p.894) argues that Hochschild’s study of emotions only “addresses conscious, observably managed and rationally understood emotions”. Despite this Theodosius (2006) acknowledges the difficulty in accessing hidden emotional processes. This view is shared by Sturdy (2003, p.101) who in discussing theoretical issues in research around emotions, argues that many aspects of emotions are unknowable or cannot be “observed, accessed, identified, controlled or labelled”. However, for Zembylas (2007, p.59) such a view is too simplistic, as while the experience of emotions may be specific to the individual, emotions are frequently expressed, consciously or unconsciously and can be observed by others, in behavioural reactions or expressions in language. Callahan and McCollum (2002, p.6) in presenting various concepts in

the study of emotions, argue that emotional expressions are “the public performance of feelings, either authentic or simulated”. Scherer, Clark-Polner & Mortillaro (2011) in examining studies on cultural expression of emotions, suggest that emotional states may define how people behave and perceive situations. This notion is also forwarded by Peeters et al. (2005) and Brion & Van Veldhoven (2012) who view EL as the individual’s responses to demands in the workplace that put the person in emotionally stressful situations. These are relevant arguments to the present study, as nursing students’ behaviours and expressions may be influenced by underlying emotions in response to ECEs. However further robust and rigorous evidence supporting such arguments need to be explored. I therefore want to investigate nursing students’ responses to ECEs and whether these are influenced by concepts of deep or surface acting.

Grandey (2000) forwarded the idea that EL is an emotional management strategy, whereby emotions are often suppressed or faked in the workplace to comply with organisational display rules, according to the nature of various roles of those working in organisations. Grandey (2000) argues that in these roles, employees can modify how they perceive the situation in order to adjust their emotional response, by changing the attentional focus and appraisal of the situation. With surface acting, individuals can modify and control their

emotional expressions, for example by portraying a fake smile when in a bad mood. Deep acting is the process of controlling internal thoughts and feelings to meet mandated display rules. Like Hochschild, Grandey (2000) contends that surface and deep acting, requiring a level of effort by the individual, which may have both positive benefits and negative implications. Writers such as Burston and Stichler (2010) and Littlejohn (2012) propose that inability to understand, manage and deal with stressful emotional experiences can lead to fatigue and burnout and impact on care provided. Hunter and Deery (2005) in examining the work of midwives, suggest that burnout may occur as a result of a dissonance between inner emotions and outer portrayal of perceived socially acceptable emotions. Mark (2005, p.281) proposes, that the impact of emotions can lead to problems for healthcare staff, “both in the way they absorb the toxicity of such emotions or by their denial of it”.

In conclusion of this section, while such literature suggests that surface or deep acting can lead to burn-out and/or fatigue among health professionals, the specific evidence of emotion management among nurses and nursing students require a more rigorous exploration. In the next section, I investigate literature which supports some of the arguments made regarding the impact of surface acting strategies in management of ECEs.

2:4. Potential negative implications of using surface acting as a strategy in navigation of ECEs.

Brotheridge and Grandey (2002) using a self-report questionnaire, compared the impact of emotional demands on a convenience sample of participants working in service jobs, sales, and caring professions, against other occupational groups. The study found evidence to support the view that a surface acting approach to EL had negative effects on individuals' well-being. Brotheridge and Grandey (2002, p.22) found that, what they refer to as, "inauthenticity" of surface acting and showing expressions discrepant from one's true emotions, led to higher stress levels and emotional exhaustion. The authors acknowledge limitations to their findings. For example, the sample sizes of service/sales employees were higher than numbers of employees in other occupations. Brotheridge and Grandey (2002) also acknowledge that their study did not include other variables associated with burnout, such as role stressors. Nonetheless, such attempts to supress emotions and emotional expression as highlighted by Grandey (2000) and Brotheridge and Grandey (2002) concern me in relation to my study. Such a strategy among nursing students may have negative implications for individuals when encountering ECEs. Therefore, a necessary component of my study is to examine further how nursing students navigate ECEs.

A study by Grandey, Fisk and Steiner (2005) set out to ascertain the impact of emotion regulation strategies, such as faking and suppression of emotional expressions. Comparing 116 participants from across a sample of occupations in the USA and 99 participants in France, the authors found a significant positive relationship between emotion regulation and emotional exhaustion. Overall, they argue that these results, are consistent with the earlier study by Brotheridge & Grandey (2002) and propose that regulating emotional expressions, drains energy and motivational resources. However, Grandey et al. (2005) suggest that in the USA there are more cultural, organisational and role expectations, where expressions are commoditised for the public, whereas in France, they argue, there is less rigidity regarding emotional expressions. While there was no specific mention of nurses or student nurses in this study and the cultural context differs to my own, it has relevance to my study, in that I seek to ascertain what emotional regulating strategies, nursing students might be utilising.

To summarise this section, while the focus of these studies is not on nursing and they are set in a different context and time, nonetheless they are of importance to my own study. They provide evidence that when navigating ECEs one approach can be through adopting surface or deep acting. However, the studies leave unanswered questions as to what strategies might be helpful

to individuals in maintaining their well-being in the context of ECEs. Therefore, a necessary aspect of my study is to understand how nursing students in my own context, experience and navigate ECEs in practice. In the following sections, I examine literature specifically particular pertaining to nurses and nursing students and how they navigate ECEs.

2:5. Nursing and nursing students' navigation of ECES.

As highlighted earlier, the earliest study of the emotional aspects of nursing was undertaken by Smith (1992) who applied the notion of EL to the study of nursing students and ward sisters working practice. From interviews with participants, the author concluded that EL was often hidden, suppressed and unmanaged, leading to burnout among nurses. The findings of the Smith (1992) study echoed with Hochschild's claim that emotion work can lead to emotional exhaustion and 'burnout'. Burnout is defined by Maslach, Jackson and Leiter (1986) as the inability of individuals to give of themselves psychologically. However, there have been many changes and developments in nursing practice and the education of nursing students since Smiths' study. Not least among these changes has been the move away from hospital based vocational training to education in HEI'S. Any conclusions drawn from the study must therefore be done with caution.

A later phenomenological study by Staden (2001) used semi-structured interviews to explore experiences of level two (enrolled) nurses, studying to transition to level one (registered) nursing registration. Although the study was small and the training of enrolled nurses no longer exists in the UK, it provided initial insight into how nursing students might view and manage their lived ECEs in practice. Participants referred to using ‘right’ expressions or the ‘false front’ or ‘blocking’ out feelings, as the image of professional carer. Staden (2001) concluded that these were either ways of surface acting or deep acting as outlined by Hochschild (1983). However, given that students in the study would have had different educational preparation than students undertaking a BSc nursing degree, the findings, and any comparison with experiences of nursing students in HEI should again be used with caution. Thus, a rationale for this study, is to explore such issues in a contemporary context among students from the BSc adult nursing degree programme.

In the paper referred to earlier, Huynh et al. (2008) aiming to analyse the concept of EL, synthesised data from literature, including some previously referred to, such as Smith (1992), McQueen (2004), Bolton (2005) and McCreight (2005). Based on the findings of the review, Huynh et al. (2008) conclude, that when encountering experiences such as patients’ emotional distress, nurses adopt personal strategies of either surface and/or deep acting.

Although the review included papers relating to other disciplines of healthcare practice, the authors conclude that surface acting had negative implications for nurses and their relationships with patients. However, as earlier work by Grandey (2000, p.95) cautions, “the specific mechanisms in understanding the relation of emotional labor with stress outcomes have been unclear” and there may be other influences which impact on individuals’ emotional responses. Nonetheless, there is more recent evidence to support the conclusions offered by Huynh et al. (2008).

For example, Yoon and Kim (2013) used an occupational stress scale self-report questionnaire, to measure levels and sources of job-related stress among Korean nurses. Their study evaluated the association of job-related stress symptoms with EL, using an adaptation of Emotional Labor Scales (ELS) developed by Brotheridge and Lee (2003) as a measure of EL, surface acting, and deep acting. Yoon and Kim (2013) report a correlation between surface acting and depressive symptoms and burnout to be significantly higher among those who used a surface level approach to EL. However, how they define EL is not clear. In addition, while the study population focused on nurses, it was confined to those working in hospitals and thus might not reflect a wider range of HSC settings, influences and ECEs that nurses and nursing students encounter.

A study by Schmidt and Diestel (2014) also examined the impact of surface and deep acting on a sample of 195 nurses employed across a range of HSC settings in Germany (one hospital and three nursing homes). A questionnaire based on a German version of Brotheridge and Lee's (2003) Emotional Labour Scale was used to assess reported surface and deep acting strategies. Schmidt and Diestel (2014) also used a German translation of the Maslach Burnout Inventory (Maslach et al. 1986) as a measure of self-report of burnout, emotional exhaustion, and depersonalisation. Their study then examined such adverse effects against reported surface and deep acting as cognitive control strategies. The authors concluded that nurses were more vulnerable to adverse impacts of EL and dimensions of burnout, such as absenteeism, emotional exhaustion, and depressive symptoms. However, Schmidt and Diestel (2014) acknowledge that the findings were based upon self-reports and that the cross-sectional design of the study prevented causal inferences. Furthermore, they considered that other factors, such as increased workload might have been considered, recommending that future research in this area should consider the event-related or situation-based context.

Celebioglu et al. (2010) also undertook a study using a two-part questionnaire, the first of which included closed-ended questions regarding participants' demographics. The second section included questions that aimed to reveal the

behaviours and emotional reactions of 380, Turkish, 2nd, 3rd and 4th year nursing students in relation to violent experiences in practice. The authors excluded 1st year students as (unlike 1st year students in UK programmes) the 1st students were not exposed to experiences in practice. Thus, the programme differs in this aspect, but also in cultural context and number of years of study, from UK nursing undergraduate programmes. Nonetheless, it has relevance to the aims of my study, as it provides insight into nursing students' reporting of navigation of ECEs. Celebioglu et al. (2010) highlight that 53.3% of participants' reported experiences of confrontation with violence. Over 90% of these experiences included what the authors refer to as, 'verbal violence' from patients and relatives, while 'physical violence' and 'sexual violence' were reported respectively as experienced by 4.2% of such participants. Participants report a range of emotions aroused in response to such experiences. For example, 84% report feelings of anger, while 81% report feelings of anxiety and 60% felt disappointment. However, there were also reported behaviours which indicated how participants responded and managed such ECEs. In their evaluation of students' reactions, Celebioglu et al. (2010, p. 690) found that most students (66%), "did not show any reaction", but continued carrying out their responsibility of taking care of the patient. However, 16.8 % of the participants transferred the care to a colleague and (15%) said, 'I thought of

dropping out', while 8% did not go into practice in response to being subject to violence. Celebioglu et al. (2010) concluded that students' communication skills with aggressive patients and family are not well-developed and that failure to give an 'appropriate reaction' can lead to exacerbation of anger felt by patients and relatives. The authors also conclude that the emotions felt by the students were exacerbated as a result of not being able to express their own feelings. What the authors consider to be 'appropriate reactions' is not clarified, but they highlight that students had difficulties in managing emotions in such situations and suggest that they should be encouraged to learn strategies to respond. However, which strategies students should learn is also not made clear in the study. Despite this lack of clarity, the study raises questions for me as to what strategies nursing students utilise in relation to ECEs and whether there are particular influences which affect how they learn to navigate ECEs. While the context of this study by Celebioglu et al. (2010) differs to the UK, it highlights that violence can be a significant ECE in the work of nurses. Reports in the UK by HSJ (2018) found 56,435 reported violent attacks against NHS staff in 2016-2017. In NI, the Department of Health (2018) report that there were 6138 attacks directed at nurses. Therefore, these issues establish a necessary rationale for undertaking this study, in order to elicit greater understanding of strategies that nursing students in my own HEI might

use when encountering ECEs such as violence. I endeavour thus, to explore nursing students' ECEs and to understand how they are influenced by organisational or professional expectations as to how they should display or express emotions in practice. Considering this, I also want to explore literature to gain an understanding of factors which might influence nursing students in their management of ECEs. The use of questionnaires in the studies by Celebioglu et al. (2010); Yoon & Kim (2013) and Schmidt & Diestel (2014) while allowing for such findings, also limit understanding of the depth and context of the lived experiences of participants. Thus, a study that explores the lived experiences of nursing dealing with ECEs in practice is warranted.

The use of semi-structured interviews along with reflective journals was utilised by Cecil and Glas (2015) in Australia to examine perceptions of emotional protection and regulation among five participating nurses. Cecil and Glas (2015, p.380) concluded that the nurses who participated consistently used a "professional face", as a means of emotional protection and that such a professional face was embedded in professional identity. The authors suggest that this produced a dissonance with notions of nurses being caring and compassionate. This appears to reflect Hochschild's notion of surface acting and echoes with some of the findings by Staden (2001) and arguments made by McQueen (2004) and Littlejohn (2012) that nurses use a professional face

when experiencing negative emotions. Cecil and Glas (2015) highlight that participants became aware of this dissonance through self-reflection and self-awareness. This knowledge of self was an issue which I highlighted in Chapter One, as important in developing the interpersonal relationship aspects of nursing practice and an area in which I seek greater understanding. However, as Cecil and Glas (2015) advise, their findings are not intended to be generalised. Despite this and the different geographical context of the study, where undergraduate nurse training differs from my own area, it provided me with some insight into dissonance that might be experienced by nursing students when dealing with ECEs. I thus want to research further, whether nursing students in my own area of practice meet expectations that they provide a professional face and mask their true feelings. Or that they might experience contradictory messages regarding emotional expression and how they should deal with such issues.

In an interpretative phenomenological (IP) study, Jack and Wibberley (2014) acknowledge that the provision of emotional support to patients can be emotionally challenging for nursing students. The authors explored the meaning of emotion work for nursing students from a HEI in the UK. This is a significant study, in that its aims share a similarity to my own and their findings resonate with the notion of emotions being suppressed or hidden, which I

highlight as a concern. The use of an IP approach allowed participants to give deep description of their lived experiences. Using unstructured interviews with nine participants, Jack and Wibberley (2014, p.902) found that participants experienced feeling such as “anxiety, grief and emotional loss of self”. Central to the study findings, the authors highlight that participants experienced a tension between personal feelings and “feelings of acting the professional” (p.903). The study found that students did not have a strategy to deal with “the emotional nature of nursing” (p.905). Jack and Wibberley (2014) also found that some students tried to make sense of their experience by talking to others, but sometimes it was difficult to find someone with whom they could share their thoughts and emotions. The authors conclude that there is a need by educators for continued monitoring of student well-being in practice including the emotional as well as the physical. It was not evident why a purposive sampling restricting the age group of participants was used by Jack and Wibberley (2014) and as the authors acknowledge the inclusion of older students may have provided different perspectives. Nonetheless, as the authors suggest there is a need for further research into these issues within other locations and HEI settings. Thus, an important consideration for my undertaking this study is to greater understanding of the strategies used by students in my own area of practice in dealing with ECEs.

To summarise this section, these findings and the methodological approaches used are significant to me, as I seek to explicate to what extent and in what context, nursing students across range of perspectives in my own HEI might share similar experiences to those found by Jack and Wibberley (2014) or Cecil and Glas (2015). The study by Celebioglu et al. (2010) also challenges me to consider other strategies that nursing students may utilise in relation to ECEs. In the next section, I examine some literature which discuss other strategies such as avoidance and distancing from ECEs.

2:5.1. Emotional detachment, distancing, and avoidance from ECEs.

Hochschild (1983) suggested that surface acting led to detachment not only from one's true emotions, but also from those of others. She suggested that emotions such as fear, anxiety distress or frustration can lead some individuals to separate themselves from the sources of such feelings. This forms an important conceptual frame in relation to my own study, as I want to explore whether and in what circumstances nursing students might separate themselves from ECEs. I seek greater clarity as to the experiences of nursing students' engagement or disengagement while in practice. Some studies such as those by Gibbons, Dempster & Moutray (2011); Bailey, Murphy and Porock (2011); Chapman and Clucas (2014) and Van der Wath and Du Toit (2015) found that avoidance was used as a coping strategy in dealing with ECEs.

In their study, Gibbons et al. (2011) used a questionnaire to examine the relationship between sources of stress, different types of coping and psychological well-being. Participants were 171 nursing students in the final year of their programme in a HEI in NI. The authors found that 'avoidance coping' was one of the strategies evidenced in the findings. They also concluded that avoidance coping was a strong predictor of less healthy well-being and had a strong adverse effect even when used infrequently. Gibbons et al. (2011) also found that the more frequently avoidance was used, the lower satisfaction with the course and career. The study is of particular interest to my study, as it involves students from my own geographical context and the aims share some similarities, in that it sought to examine participants' strategies in coping with stressful situations. However, the use of questionnaires limited understanding of the depth and context of the lived experiences of participants. Furthermore, participants were drawn from the final year only, whereas I wish to understand the experiences of students across the range of the programme.

Chapman and Clucas (2014) used semi-structured interviews with a purposive sample of eight, 3rd year nursing students, aiming to explore the students' understanding of respect in encounters with patients during placements. The reason given for specific selection of 3rd year students was to ensure that

participants had been exposed to a range of experiences. The aims of their study differ from my own, in that, Chapman and Clucas (2014) did not specifically focusing on ECEs. However, some of the findings do relate to participants' reactions to emotionally challenging situations which are the focus of my study. Chapman and Clucas (2014, p.477) found that some "participants' examples of the nurse's role seemed to be quite rule-based and idealistic" and "that student nurses are expected to be professional at all times, maintaining a calm outer appearance". This resonates with the concept of a professional face as discussed earlier in the papers by Staden (2001); McQueen (2004) and Littlejohn (2012) and Cecil and Glas (2015). Chapman and Clucas (2014, p.478) conclude that the consequence of this was that sometimes student nurses had to separate their own emotions from their professional behaviours. In order to gain control of their feelings, students did so, by "behaving robotically", or "walking away from" or disengaging with emotionally difficult situations.

While the Chapman and Clucas (2014) study is closer to my own context as a UK study, as the authors acknowledge their findings might not generalise to nursing students attending other HEI's in the UK. Therefore, in relation to my study, I need to elicit understanding as to how nursing students in my own HEI navigate emotionally challenging situations such as conflict. Indeed, among

several factors that Chapman and Clucas (2014) suggest is a need for research on the ECEs of nursing students and conflicting emotional demands in HSC settings. The use of semi-structured interviews by Chapman and Clucas (2014) suggests that this may also be one method in which to explore such issues.

In their study, Bailey, Murphy and Porock (2011) used both observations and interviews with ten healthcare staff (including one nursing student), six patients and seven relatives in a UK Emergency Department (ED) to examine the emotional impact of caring for dying patients. Among the experiences of patients and relatives who recalled poor care, was the lack of close nurse/patient relationships and an avoidance of involvement by some nurses. While this study involved only one nursing student and no specific issue relating to students were raised, nonetheless as Bailey et al. (2011, p.3368) argue, it is “essential for nurses to develop the ability to manage the boundaries of intimacy and distance”. The authors suggest that some participants were unable to manage emotional aspects of their work and distanced themselves from dying patients as a coping mechanism and protection for themselves from ECEs such as grief. However, there was an acknowledgment that in the ED, the environment and nature of emergency presentations may have contained development of relationships of therapeutic intimacy between nurses and patients. Bailey et al. (2011) highlight that while

a number of initiatives have been set out in the UK to improve training and support for healthcare professionals, caring for the dying and the bereaved, they do not address the emotional aspects of practice. Therefore, an important consideration for my study is to seek a deeper understanding of nursing students' experiences of the management of boundaries of intimacy and distance in relation to ECEs in practice. In particular exploring nursing students' experiences of preparation for the management of such boundaries.

As these studies by Bailey et al. (2011) and Chapman and Clucas (2014) highlight, uncertainty as to how to balance their emotions, led some participants to emotionally disengage. Evidence of such disengagement is borne out in other studies by King-Okoye and Arber (2014) and Terry and Carrol (2008).

King-Okoye and Arber (2014, p.447) in a UK phenomenological study of 2nd and 3rd year nursing students' experiences in dealing with patients' with cancer, found that some students felt "fearful, lost and abandoned". Participants reported the experience of caring for patients with cancer as emotionally distressing. In response to such experiences participants describe using, "distancing strategies", such as avoiding contact with patients who were upset or crying. King-Okoye and Arber (2014) also highlight that some participants expressed frustration at lack of preparation for such experiences. The study

authors stress the importance of education and preparation for the emotional labour aspects of nursing. In addressing this issue, a necessary aspect of this study will be to examine nursing students' experiences of preparation for ECEs.

The King-Okoye and Arber (2014) study focused on those who had cared for patients with cancer. However, ECEs may occur in other areas of nursing students' practice, which are also important to explore. King-Okoye and Arber (2014) did not include 1st year students. In relation to my own study this was of concern, as students in 1st year are often learning to deal with their own emotions and caring for dying patients and the bereaved can be an aspect of students' experiences in placement. Thus, in my study I want to know how students from all years of the programme learn to navigate their own fears and emotions when encountering diverse ECEs in varied settings.

Terry and Carrol (2008) highlight the importance of acknowledging that students in 1st year can be exposed to experiences of death and caring for the dying. Their study used a self-report questionnaire and focus groups to investigate the preparation for and experiences of death, among three cohorts of 1st year nursing students. Some of the findings resonate with those of King-Okoye and Arber (2014), in that participants used avoidance as a strategy when facing ECEs such as death and dying. Terry and Carrol (2008) report that fears of dealing with death led some to avoidance behaviours and one student

to avoid a dying patient for several days. The authors also found that, "abandonment of relatives regularly occurred" (p, 762) due to "a culture of busyness" (p, 764). Terry and Carrol (2008) caution that students may conclude that showing no emotions or avoiding relatives is appropriate professional behaviour. In relation to my study, this is something which requires exploration. In particular the understanding and expectations of professional behaviours among nursing students' from my HEI when encountering ECEs.

In their study, Terry & Carrol (2008) used a self-report questionnaire, but this has led me to consider literature that provided more in-depth understanding of students' experiences gained using other methods such as interviews.

In a hermeneutic phenomenological study, Msiska et al. (2014, p.1248) used "conversational interviews" to examine learning experiences of 30 participating undergraduate nurses in HSC in Malawi. The authors found that although this was not the focus of their study, emotions such as fear arose among participants in dealing with patients with HIV. Msiska et al. (2014) found that among participants, such feelings led to deliberate avoiding of caring for such patients and "a sense of legitimate emotional detachment" as a means of self-protection. Despite cultural differences that may exist and that the programme is of four years duration, rather than three, such as the BSc programme in my own HEI, Msiska et al's. (2014) study has relevance to my

own, in that it highlights that students may have a range of fears in relation to practice. It also suggests that avoidance might be one strategy used by students when encountering perceived or real ECEs.

While the Msiska et al. (2014) study did not include 1st and 2nd year students, the participants reported having their fears within the early years of their studies. This reinforces my earlier consideration from the review of King-Okoye and Arber (2014) about the importance of including students from across the nursing programme including 1st year. Msiska et al. (2014, p .1248) report one participant as saying that “after some years of training I realised that it was ok”. While this only related to one participant it is significant for my study, as I want to understand how and from where the students may gain any such ‘legitimatisation’ of emotional detachment or engagement. The authors contend that, the emotional disengagement was not necessarily a failure in compassion, but that consideration should be given to the contextual circumstances and of lack of knowledge and experience of caring for such patients. This is an important question that I seek to examine in my study is, how and in what way, personal and professional experiences and training, influence nursing students caring for patients when ECEs give rise to emotions such as fear.

One study by Heggestad et al. (2018) examined the ability of 1st year nursing students in Norway to empathise with patients. In a hermeneutic phenomenological study, they used semi-structured interviews with eleven students who were in their first practice placements in nursing homes. Heggestad et al's. (2018) justification for a hermeneutic phenomenological approach is, that it allowed for understanding of the subjective experiences of informants. While the study did not specifically aim to gain knowledge of students' emotional experiences, it revealed that participants were faced with situations which evoked a range of emotions. Heggestad et al. (2018, p.790) report that participants struggled with balancing their emotions, "to laying feelings aside or not be too emotional if they were to remain professional". In addition, participants reported experiences of indifference and distancing among nurses and/or nursing assistants. While this study is in a different cultural and social context to my own area of practice, it remains relevant to my own, as I aim to gain knowledge of how nursing students learn to navigate ECEs in the early part of their programme. While the participant's experiences relate only to nursing homes similar to studies discussed earlier, it also highlights lack of clarity between engagement with patients' pain and suffering and a professional distance. As Heggestad et al. (2018, p.793) suggest, students "need guidance on how to balance their feelings in a professional way". While

Heggestad et al's study provides insight into 1st year experiences in nursing homes, there remain gaps in knowledge about other types of practice placements, particularly in my own context. Therefore, it is necessary for this study to be conducted in order to add knowledge of students experience in similar settings, but also in other types of practice.

A phenomenological study by Garrinno et al. (2017) used semi-structured interviews to explore the lived experiences of a purposive sample of 20 nursing students in Italy, caring for dying patients and their families. The authors report that 18 participants were in 3rd year of the undergraduate programme. Garrinno et al. (2017, p.129) found that among participants there was a fear of "coming into contact with the dying person". Among the main coping strategies used by participants, were avoidance and detachment. The authors highlight that students struggled with finding a balance with "being with" the dying person and attending to their own emotions. These are consistent with tensions found in the findings as reported earlier by Terry and Carroll (2008) and other research with qualified nurses working with dying patients. For example, Hopkinson et al. (2005, p.131) highlight how nurses caring for dying patients, emphasised the "potential harm of becoming emotionally involved and it was seen necessary to exercise control over involvement, in order to sustain personal well-being and continuing ability to care over the longer

term". These are similar to finding by Ingebretsen and Sagbakken (2016) who explored the emotional challenges of ten nurses, caring for the dying in hospices in Denmark and a study by Funk et al. (2017), of 13 Canadian nurses and 12 healthcare workers caring for the dying. These studies found that some participants adopted an emotionally detached approach to try and prevent feelings of grief from occurring when working with dying patients and their families.

While the focus of the Garrino et al. (2017) study was specifically on participants' experiences of death, it has relevance to my study, as dealing with death and dying is often an ECEs in nursing practice. Nursing education in Italy is similar to the programme in my own HEI, in that it is a three-year Bachelor's degree. However, in the Garrino et al. (2017) study, participants were confined to 3rd year students on the programme, who as the authors suggest were given specific training and support around end-of-life care. It may have been that students nearing the end of the 3-year programme have developed different strategies for dealing with ECEs, than those in 1st or2nd years of the programme. As the authors acknowledge, nearly half of the participants had experience working in palliative care and this may not be reflective of experiences of those in the earlier years of the programme. Nonetheless, the

paper provides valuable insight into strategies that nursing students might use when faced with ECEs, such as dealing with death and dying.

In a grounded theory study using in-depth interviews with 19 nursing students from all years of a nursing programme in an HEI in England, Curtis (2014) explored participants’ experiences of socialisation in compassionate practice. While the author did not specifically set out to explore ECEs, participants expressed uncertainty of the emotional requirements for compassionate practice and to what extent they should be involved emotionally. This uncertainty led students reporting managing feelings of vulnerability, by balancing their intentions away from engagement in compassionate practice. Curtis reports that participants in some instances, suggested that they had been taught by registered nurses and nurse teachers, and their own family to retain an emotional detachment.

Similar to finding in other studies discussed earlier, such as Jack and Wibberley (2014) and Cecil and Glas (2015), Curtis (2014) also reported participants masking of their true feelings, enabling them to carry on when engaging with ECEs. The study by Curtis (2014) also found participants were influenced by the practice of registered nurses and saw ‘hardiness’ as a strategy to survive difficult ECEs that could be deemed as detrimental to their own well-being.

Curtis (2014) concludes that there is a need for further research into how student nurses make sense of emotional requirements for compassionate practice. This study relates to the aims of my own, in that it highlights continued areas of uncertainty around emotional engagement/non-engagement. Curtis (2014, p.213) also highlights how the use of a grounded theory methodology allows researchers to derive “meaning from shared experiences and communication with others in their environments”.

Consequently, I deem it important to obtain a greater understanding of the contextual circumstances of ECEs and to what extent nursing students engage with their own emotions and those that they care for, when encountering ECEs in practice. A necessary aspect of my study is to gain a more complete understanding of nursing students’ lived experience that may be articulated by HSC teams or individual professionals, as to how nursing students should engage with ECEs in practice.

Overall, this section has identified literature and provided some evidence found within the literature, that surface acting or avoiding displays of emotions can have negative effects on the individual. The findings of the studies examined suggest that nursing students encounter uncertainty as to when and how they should engage and disengage with ECEs. Some of the literature reviewed suggests that as a result, some students avoid or disengage from

patients, relatives or ECEs. In relation to my own study, questions remain as to whether nursing students from my own HEI adapt and utilise similar strategies when encountering ECEs in practice. In considering Schmidt and Diestels' (2014) recommendations for future research, it is important for my study to understand more about the context where surface acting and/or deep acting may occur. Therefore, I further explore literature to gain an understanding of factors which might influence nursing students in their management of ECEs. In the next section, I examine literature on how social, organisational, and professional norms may impact upon nursing practice and expectations of nurses and the strategies that they adopt in dealing with ECEs.

2:6. Social, organisational, and professional display rules and expressions of emotions.

In this section, I examine evidence that explores the influence of social, organisational, and professional norms, rules and learned conventions on individuals' management of ECEs. In doing so, I anticipate that this will help me to consider influences within HSC teams or organisations and how they impact on nursing students' navigation of ECEs.

Cornwell and Firth-Cozens (2009) undertook a review of the literature and examined views and comments arising from a series of workshops on compassion and related concepts. The authors claim that there is a traditional

expectation that nurses, and healthcare professionals are taught to hide feelings and to be emotionally detached from patients. This resonates with the findings of Curtis (2014) as highlighted earlier. As an educator this is not part of my own engagement with or advice to nursing students. However, as highlighted in Chapter One, my own experiences of such expectations, lead me to consider that these may be within experiences of others and in different HSC contexts. Therefore, in undertaking this study, I want to gain a greater comprehension of influences or social norms which shape nursing students' responses to and navigation of ECEs in practice. In doing so, I anticipate that this will provide a lens to consider to what extent such influences are experienced by nursing students my own HEI and area of practice.

Theodosius (2006, p.896) used participant observations, audio diaries and semi-structured interviews to explore EL among nurses. The authors developed Hochschild's theory to argue that emotion management is "learnt through socialization, which reflects the social and cultural factors of the society". This view is shared by Van Kleef et al. (2016, p.1) who claim in an editorial commenting on research of emotions, that emotions are often perceived only as an individual phenomenon. The authors argue that there is a need to recognise how "social and contextual influences (e.g., norms, group membership) shape the experience, regulation, and expression of emotions".

Mesquita & Boigner (2014) acknowledging the individual aspects of emotions, developed a model in which emotions are seen as emerging from the interactions and relationships in which they take place. They contend that emotional expressions and displays represent various ways of being in relation to one's environment or require a social embedding. In addressing these claims, it is important that this study investigates the influences of social or cultural display rules on nursing students' expression and regulation of emotions within practice placements. Thus, an important consideration in the context of this literature review and my study, is to seek a greater understanding of nursing students' emotional responses to ECEs within differing social situations in practice.

In early studies by Feldstein and Gemma (1995) and Bolton (2000), there is some evidence of nurses and healthcare professionals being taught to hide feelings and to be emotionally detached from patients. Feldstein and Gemma (1995) examined EL of nurses working with cancer patients, while Bolton (2000) examined EL of nurses in gynaecology wards. Both studies found that nurses were encouraged not to show feelings of grief as part of professional practice, as this was deemed to affect their ability to care for patients. Bolton (2000, p. 583) suggests that nursing students learn not to show, or to "mask" feelings in "a community that has created its own traffic rules of interaction",

yet at the same time insisting upon emotional involvement as part of the caring role. The authors suggest that nurses working in such units had to deal with such contradictions each day. Any conclusions drawn from these studies must be taken with caution given the time elapsed since they were undertaken. However, they do challenge me to explore further, more recent literature in relation to influences or expectations of nurses and nursing students' ECEs. Some recent studies by Diefendorff, Grandey and Dahling (2011) and Cheng et al. (2013) have examined team display norms in relation to the emotion aspects of nurses' work.

Diefendorff et al. (2011) in a study in the USA, examined the effect of shared norms and display rules on nurses' emotional regulation strategies. Display rules, the authors contend, are shared norms in the expression of emotions. The study used a questionnaire to elicit answers from 929 participating nurses from two urban hospitals. The authors found that nurses working in the same units, shared the same emotional display rules, but there were differences across units, in how emotions were expressed. Diefendorff et al. (2011) found that where there were high levels of emotional display norms within teams with high positive affectivity, individual nurses were less likely to engage in surface acting and more likely to make efforts to feel empathy. While Diefendorff et al. (2011) did not specifically define the term positive affectivity,

it is defined by Watson and Naragon (2009) as the “disposition to experience positive emotional states” such as cheerfulness. Diefendorff et al. (2011) found that conversely, where there were low levels of unit displays and low affectivity, nurses were more likely to adopt surface acting approaches. However, as the authors acknowledge, a limitation of their study was that it explored individual participants’ display rules and not the work team as a whole.

Cheng et al. (2013) also undertook a quantitative study using questionnaires, with 201 registered nurses in Australia, with the aim of examining relationships between EL, ‘team climate’ and burnout. While the authors do not define the term ‘team climate’, they suggest that the higher quality of teamwork acts as a buffer against negative aspects of emotion work. They also found that surface acting impacted on individual nurses’ wellbeing and performance. The study reported that hiding and faking emotions was a common strategy for dealing with EL. However, while the study reported that 53% of participants were over 43 years of age, there was no discussion on how age may have affected the participants’ responses. Similar to the Diefendorff et al. (2011) study, the measurement was of individual responses and self-report rather than analysis of the teams as units. The authors also report that a strong ‘team climate’ was a useful resource for many nurses to replenish when emotional resources were

exhausted. However, the use of questionnaires may not have allowed provide a deeper understanding of lived ECEs what specific aspects of the team were supportive.

A phenomenological study in Israel by Arieli (2013, p.192) set out to understand how nursing students navigate “emotional work” in HSC placements. The study used semi-structured interviews to explore the lived experiences of 20 nursing students in the 3rd year of their programme who were in hospital placements. Similar to other studies discussed earlier, Arieli (2013) found that students navigated between expressing emotions and distancing themselves as strategies to cope with ECEs of suffering and death. The authors also report that students valued the importance of interaction and support from other students in their teams. This study shares a similarity to the aims of my study and the methods used allowed for in-depth explorations of participants’ experience. However, it was set in a different cultural context and confined to 3rd year students on placement in hospitals and may not reflect experiences in non-hospital contexts. Indeed, among the recommendations for further research, was the need for exploration of the unit climate and emotional work in other cultural and diverse settings. In my own study the use of such an approach may help me to gain a deeper understanding of the ECEs of students from all years in the BSc programme in my own HEI. Specifically, it

may help me to examine students' experiences of the influence of teams in the diversity of placements. My purpose then, is to seek insight of contextual situations or where nursing students' conversations with mentors or others may have impacted on how they navigate ECEs.

To summarise this section, while the findings of the studies examined have identified some issues relating to the questions of my study, the settings in these studies differ in the type of healthcare systems. As discussed earlier when reviewing Brotheridge & Grandey (2002), there may be different cultural, social and expectations regarding emotional expressions than in NI. While the findings of these studies are important in relation to my own, at present little is known about the experiences of nursing students in NI, in regard to expectations of emotional displays and expressions in practice. Through this study, I aim to explore further nursing students' experiences of different emotional display norms and expectations in placement settings and teams. I want to know more about the influences of teams on nursing students' responses to ECEs and what aspects of units and teams that nursing students may find to be supportive.

As some such as Bailey et al. (2011) suggest, inability to manage EL and ECEs may have negative implications and that if nurses are not supported, they are "at risk of developing ineffective and potentially harmful coping mechanisms".

One recommendation by Garrinno et al. (2017, p.132) was the need to provide further support and training for nursing students with “the opportunity to explore their difficulties in a supportive atmosphere”. This is of significance to me as I want to ascertain the support offered and accessed by students’ in my area of practice. In the next section, I examine some studies which relate to the sources of nursing students’ support in relation to ECEs in HSC practice.

2:7. Sources and types of student support.

One recommendation from the study by Terry and Carrol (2008) discussed earlier, was the need to explore how nursing students are supported. In this section, I examine literature which focuses on student preparation and support for ECEs in practice.

Smith and Gray (2001, a, and 2001, b) undertook a follow up qualitative study of early work by Smith (1992) to explore nurses’ views of support in relation to EL. In the 2001 study, the authors used a variety of methods in data collection, such as a questionnaire on emotional labour, focus groups, seminars and meetings with mentors and students. They also used participant observation during nursing students’ classes. However, one of the main sources of data collection was semi-structured interviews with 16 pre-registration nurses and qualified staff from both hospital and primary care settings.

Smith and Gray (2001a and 2001b) found that unlike the earlier study by Smith (1992), where ward sisters and charges nurses provided support, it was mentors and link lecturers who were more likely to provide support regarding ECEs. In the context of the aims of my own study, this would suggest that existing formal support roles would be able to support nursing students in relation to ECEs. However, there have been many changes to nurse education since these studies and therefore a need to investigate from where and in what ways, nursing students receive support regarding ECEs. In relation to my study, I want to gain greater insight into nursing students' perception and utilisation of current support roles, especially regarding ECEs in NI.

In the study discussed earlier by Curtis (2014) there was also evidence that despite being aware of available formal support from mentors and personal tutors, students did not always avail of such support in relation to ECEs, but instead often availed of support from family and peers. Curtis (2014, p.217) suggests that this may have been due to a perception of support to be available, "only on demand rather than a formalised expectation". Therefore, I want to find evidence as to the experiences of students from my own HEI of both formal and informal support from family, friends, and peers.

Horsburgh and Ross (2013) studied experiences of 42 newly qualified nurses in Scotland. While participants were qualified nurses, it has relevance in that it

relates to experiences of those who had recently been students. The authors found that participants expressed feelings of “being thrown in at the deep end” (p, 1127) and “thrown to the wolves” (p, 1128). The study used focus groups as a means of data collection and as the authors acknowledge, this may have been a limitation in that individuals within such groups may be more vocal than others. The lived experiences of individual participants may not therefore be reflected in the findings. The authors suggest that support depended on willingness of individuals with whom the nurses had worked rather than being from structured organised support. Participants also reported different levels of support, with some reporting weekly clinical supervision where they were able to talk about feelings, while others report that no one asked about how they were feeling. While this study relates to the aims of my own, as to expectations of and types of support offered and accessed by nurses, the different roles between students and registered nurses may preclude any clear conclusions. Thus, in my study I seek a greater knowledge of nursing students lived experiences of support in dealing with ECEs in practice.

The study referred to earlier, undertaken by Weurlander et al. (2018) explored the ECEs of 49, 2nd year nursing students and 65, 3rd year medical students. This firstly involved a questionnaire with open ended questions asking students to

write about ECEs in practice and how they dealt with such experiences. Weurlander et al. (2018) then conducted semi-structured interviews with three of the medical and two of the nursing students to try and gain more in-depth understanding of their ECEs. The study found that participants experienced a range of ECEs, including severe suffering of patients and death, but also upsetting unprofessional behaviours from healthcare staff. This study resonates with my own experiences and concerns raised in Chapter One and with some of the findings of studies discussed earlier. Like, Cecil and Glas (2015) and Jack & Wibberley (2014), Weurlander et al. (2018) found that participants struggled to balance closeness and distance with patients when affected by ECEs and felt unprepared to deal with ECEs. Jack & Wibberley (2014) in conclusion of their study, emphasise the importance of effective support mechanisms to enable students to deal with struggles of ECEs. However, Weurlander et al. (2018) found in their study that while, “some students had supervisors that they could turn to for support; others were left alone to handle their experiences” (p. 79). While the Weurlander et al. (2018) study included medical students and only nursing students from the 2nd year of their programme. The authors argue that their experiences of emotional challenges are similar for medical and nursing students. Weurlander et al. (2018) concluded that when they needed to talk about their experiences, the

majority of participants talked to people, that felt they could trust to confide in, such as peers.

Some of these findings resonate with those from a study by Jack et al. (2018) who report on a subset of data combined from quantitative findings from a survey, with qualitative data from interviews with nursing students from a pre-registration programme in the Northwest of England. The study aimed to identify contributing factors to students' decisions to stay or leave commissioned healthcare programmes. The students who completed the survey (n=1,425) were invited to participate in a follow-up interview. From those students that volunteered, 22 were selected via a stratified sampling method. Jack et al. (2018) found that among the themes that emerged were experiences of being unsupported or of being left to seek out their own learning. A necessary component of this research therefore is to enhance my knowledge as to whom nursing students seek support form in relation to ECEs. One of the recommendations of Weurlander et al. (2018) that students should be trained in dealing with ECEs is of particular interest to me and I want to examine literature which might reveal more about nursing students' experiences of training and preparation for ECEs.

Van der Wath and Du Toit (2015) report on a study that they undertook with 2nd year nursing students in South Africa. They aimed to explore students'

experiences of an experiential learning intervention designed to prepare students for palliative and end of life-care. The authors report that 62 students participated in writing reflections on their experience of learning of end-of-life care. Van der Wath and du Toit (2015, p.5) found that most participants reported that the learning opportunities triggered their “intrapersonal experiences of loss and bereavement”. The learning opportunities appear to relate to specific learning materials around death and bereavement introduced within the classroom context, as opposed to lived experiences in practice. A limitation of the study was that participants’ reflections were on their own personal experiences of loss and bereavement relating to family or friends, rather than such experiences in practice and this is acknowledged by the authors of the study. Nonetheless, as Van der Wath and du Toit (2015, p.5) report that some participants indicated that it helped them to talk more openly about death. However, some reported that as a consequence of this they felt guilty for getting emotionally involved and would as a consequence “try to be as objective as possible”. This suggests a lack of clarity between emotional involvement and professional distance as reported in earlier studies such as Chapman and Clucas (2014) and Jack & Wibberley (2014). How such balances are shaped and influenced in relation to nursing students with limited experience in practice, warrants further exploration. I therefore seek greater

clarity on such experiences, so that ultimately in my role as a nurse educator, I might facilitate students in exploring their own ECEs.

Kinman and Leggeter (2016) undertook a study using an online five-point Likert scale questionnaire, among 351 nursing students in an undergraduate programme in a HEI in England. While the use of a questionnaire precluded individual narratives around the nature and depth of emotional support, the study found evidence “that a strong and supportive team culture can help nurses manage the emotional demands” (p.7). The authors conclude that participants who were able to draw on emotions support and “opportunities for venting” emotions were less likely to be emotionally exhausted. It was unclear as to whether this included students from all fields of the undergraduate nursing programme. The inclusion of students from mental health and children’s nursing may have had bearings on the findings, as such students would have different preparation than those from the adult field who are the focus of my study. Kinman and Leggeter (2016, p.8) suggest providing “opportunities for venting of emotions within trusting and non-judgmental relationships”, for students. However, they highlight barriers, such as anti-social hours and busy organisational demands. They also found that some participants reported difficulties of leaving work emotions behind at the end of a shift. This latter is of particular interest to me, as many students on the

undergraduate nursing programme, often have moved from home, or undertake placements for periods away from their usual home and network of family and friends. Thus, it is important to gain a clearer understanding of nursing students' navigation of ECEs both within and outside the practice context.

McCloughen and Foster (2017) studied the challenging interpersonal clinical experiences of a purposeful sample of 12 nursing and 8 pharmacy students in an Australian HEI. In two phases of a mixed methods study, the authors used semi-structured interviews exploring the experiences and strategies used by participants to manage such experiences. Participants reported a range of unpredicted and ECEs, including lack of support, staff who were rude or unfriendly and generally unsupportive. McCloughen and Foster (2017) identified that the most common coping mechanism was to conform to, what participants believed to be expectations of them as students, i.e., to be subservient and obedient to staff. There were some similarities to the findings of Staden (2001); Chapman and Clucas (2014) and Cecil and Glas (2015) regarding use of a professional face in relation to ECEs. McCloughen and Foster (2017) found that students concealed their true emotions by putting their "game face on". This strategy, McCloughen and Foster (2017, p.2704) highlight as a "professional persona that did not reveal their internal emotional

turmoil". This suggest that individuals maintained a boundary between the personal self and the professional self, in order to prevent themselves from becoming overpowered. The authors also report that participants used, "additional relational approaches" to get assistance and emotional support, but the nature and context of this support is not clarified. However, the authors suggest that there is a need to develop effective strategies to facilitate the educational preparation of staff and students in dealing with such ECEs. McCloughen and Foster (2017) suggest that such strategies, should involve development of reflections, conflict management effective-coping and skills that enhance empathy. The study is set in a different cultural context and participants included pharmacy students and are drawn from students in both Masters and BSc programmes. Therefore, caution should be used in any comparison with the BSc undergraduate nursing programme in my own context. Nonetheless the study provides insight into some strategies that students might use in navigating ECEs. I therefore want to elicit greater insight into the experiences of support available and utilised by nursing students in my own area of practice.

2.6. Summary of the literature review.

In conducting this review, the aim was to critically examine literature for insights into lived experiences of nursing students in relation to ECEs. In

particular, I wanted to explore information which will help to provide answers the questions raised in Chapter One. Some evidence from this review of the literature has helped to partiality answer some of the questions but has not fully closed the gaps in understanding some aspects of nursing student's ECEs. There is still a lot to be learned by conducting research that will add to this knowledge base. The literature around EL suggests that individuals can suffer from burn-out and emotional exhaustion from both surface and or deep acted emotional performances. While there has been research in the literature regarding nurses' ECEs and management of emotions, this has largely focused on registered nurses. While some research has focused on nursing students there remains gaps in the knowledge. Particularly regarding how nursing students are prepared, as to what emotional expressions are acceptable within professional practice or how they should navigate ECEs. Some of the studies have been limited to questionnaires and these have not provided a deeper understanding of lived experiences. While there was some evidence of strategies that nursing students use in navigating ECEs, these were often in different social, cultural, or geographical contexts to my own or relating to students at specific stages of nursing programmes. Other studies were confined to a specific focus, such as placements in hospitals. There has been no evidence in the literature that I examined that would answer the questions

that were outlined in the aims of this study and in particular to my own HEI context. The specific understanding of how nursing students in my own area of practice in NI, navigate ECEs needs further clarification. Therefore, I seek in my study to provide further insight into how nursing students from my own HEI navigate emotional challenging experiences. In the next Chapter, 3, I provide detailed discussion and evaluation of the theoretical and methodological approaches and research design underpinning data collection, to answer these research questions and to meet the aims of this study.

Chapter Three. Theoretical and methodological perspectives and research design.

3:1.1 Introduction.

This chapter provides an explanation of the theoretical and methodological perspectives and study design, which I adopted in seeking to answer the research questions discussed and explained in Chapter One and confirmed in Chapter Two. I first explain and justify the theoretical and conceptual underpinnings and rationale for choosing a qualitative and interpretive phenomenological (IP) approach to the study. The chapter then explains and rationalises the study design and data collection methods to address the study questions. This is followed by discussion and explanation on related ethical, legal, and professional considerations, regarding research with human participants, which in this study involves nursing students. An overview of the approach to analysis of the data is also given, with explanation of how emerging themes are identified and selected. Freeman et al. (2007) suggest documentation of all such procedures as a key strategy to ensure quality in qualitative research.

In this chapter, I first highlight my own theoretical position, as this shapes the methodological approach to the study. In the next section, I discuss the rationale for adopting a qualitative approach, followed by explanation of the theoretical framework which underpins and shapes the methodological

approach to the study. The chapter concludes with a summary of the main methods to ensure rigour and validity.

3:1.2. Theoretical framework and rationale for adopting a qualitative approach.

Parahoo (2006); Robson (2011) and Green (2014) emphasise the importance of explaining the theory underpinning the research and of establishing a theoretical or conceptual framework to guide its organisation and design. In this following section, I explain how the study is framed and provide justification for my approach to the data collection and analysis. My ontological perspective in relation to this study, is one in which I see reality as comprising complexity within individual experiences and social interactions. This understanding confirms my epistemological stance, which seeks knowledge of the social world of myself and my students, through interpretation of lived experiences. As discussed in previous chapters, I aim to understand how undergraduate nursing students navigate emotionally challenging experiences (ECEs) in practice. In particular, I seek to explore individual nursing students' interpretation of their emotional responses to their social situatedness, or as Van Veen and Sleggers (2006, p.91) refer to as the "situational demands". In doing so, I consider the advice of Schutz and DeCuir (2002) who argue the importance of investigating the meaning of emotional experiences to those involved, as well as their social context. As the study questions are concerned

with nursing students' lived ECEs and the meaning-making that they give to such experiences, I consider that the study is best positioned within a qualitative research paradigm.

Zembylas (2007, p.62) outlines several theoretical approaches to such investigations, including interpretative qualitative research in "exploring the meanings of emotional experiences". Robson (2011) and Snape & Spencer (2008) argue that in qualitative research, value is placed on the researchers' interpretation of the social world and understanding of peoples' lived experiences. Mackey (2005, p.179) argues that an interpretative qualitative approach is more likely to reveal depth and diversity as it, "aims for understanding rather than explanation of human phenomenon". A number of other authors such as Smith, Flowers, and Larkin (2009); Burns and Grove (2011); Miner-Romanoff (2012) and Creswell (2013) argue that interpretative qualitative research can provide researchers with a means to explore and enable descriptions of lived experiences, giving them meaning in depth, quality, and complexity. In an interpretative qualitative approach, the aim is to capture what participants say, feel or do as a consequence of their experience or interpretation of their world. These arguments are consistent with the research questions and purpose of this study, as they allow me to explore what nursing students feel and do in relation to ECEs in practice.

O’ Connor (2008) suggests that because emotions are bound up with individual experiences, researchers need to take an idiographic approach where research goals focus on the individual rather than generalising individual results to a wider population. Larkin, Watts, and Clifton, (2006, p.120) suggest that the term idiographic is associated with the study of individuals, but also includes “the study of any specific situation or event”. As individual nursing students are likely to encounter specific emotionally challenging situations or events in practice, an idiographic approach is thus relevant to the aims of this study. However, as Smith and Osborn (2008) suggest, while experiences may be unique to the individual, they may involve some similarities or contradictions, such as with the ECEs of others. Through this study, I seek to obtain greater understanding of nursing students ECEs in practice and insight into individual meanings, similarities, or contradictions in such experiences. Gendron and Feldman (2009) suggest that there are different theoretical perspectives into the study of emotions. This is reflected in the literature with different disciplines taking a particular focus, ranging from those such as, Damansio and Carvalho (2013) who seek to elicit knowledge of the biological or cognitive psychological nature of emotions, to those who focus on social perspectives such as language, behaviours, and social constructs of emotional expression. For example, as highlighted in Chapter Two, Hochschild (1983) researched the

experiences of flight attendants and how they managed public displays of emotions within organisations on a day-to-day basis. Fineman (1993) focused on distinguishing feelings from emotions to explain how emotions shape and are shaped by social arrangements, rules, and language. More recently, Van Veen and Sleggers (2006) sought to understand the significance of various emotions for the individual in professional settings. Other examples include, Scherer, Clark-Polner and Mortillaro (2011) who sought to examine cultural differences in emotion, and Holland (2007) and Linnenbrink-Garcia & Pekrun (2011) who examined the link between emotions, knowledge, and academic achievement. In this study, the focus is more in keeping with that of Hochschild (1983) and Van Veen and Sleggers (2006) in that, I look for greater understanding of nursing students' ECEs in practice and their responses to such experiences. Developing this knowledge requires me as a researcher to explore nursing students' emotions around lived ECEs.

In keeping with the aims of the study and in order to provide answers to the research questions, I considered a range of epistemological approaches such as Discourse Analysis (DA), Narrative Analysis (NA), Ethnography and Grounded Theory (GT), before selecting an Interpretive Phenomenology (IP) epistemological theoretical framework. I give a brief overview of each before

justifying my choice of IP and why it may help to answer this study questions more effectively than the others.

DA is a widely used research method based upon examination of language as a means of providing data and sense making (Robson, 2011). From a DA perspective language is viewed as both creating social phenomena and being representative of social phenomena (Morgan, 2010). DA involves looking beyond the literal meaning of language, understanding the context in which social interaction takes place. In doing so DA aims to shed light on the creation and maintenance of social norms, the construction of personal and group identities and the negotiation of social and political interaction (Starks & Trinidad 2007; Shaw and Bailey 2009). In relation to my own study, such an approach may allow me to gain understanding of the social context of nursing students' ECEs through reading of textual narratives provided by participants. However, as DA is focuses on language used, other aspects surrounding nursing students' ECEs, such as facial emotional expressions may not be fully revealed. Therefore, I sought other approaches which may enable a fuller understanding of the nursing students' lived ECEs and their response to such experiences.

Aragao (2011) suggests that emotions can be researched through a narrative approach which allows individuals to tell their experience and stories and can

help understanding of other lives within social, cultural, and historical contexts. I thus, considered NA as it also is concerned with meaning-making and may help to reveal how nursing students make sense of the complexity of their lived ECEs. However, as Ritchie and Lewis (2008) and Padgett (2016) suggest, while NA is concerned with narrative and meaning, it is also concerned with the structure of the dialogue of the stories. In my study, I want to uncover the sense-making of ECEs in participants' narrative, without being constrained by a focus on the structure of the dialogue of stories. As Smith, Flowers, and Larkin (2009) suggest narrative is only one way of meaning-making and so I examined other approaches such as, ethnography, grounded theory, and phenomenology.

Reeves, Kuper, and Hodges (2008) suggests that an ethnographic approach aims to provide insights into people's views and actions through detailed observations and interviews. Hammersley (2006) sees ethnography as a specific form of enquiry aiming to understand the perspectives and practices of people by observing what they do and say in particular cultural/social contexts and settings. Maltby et al. (2010) see such a method as observing the effect of a phenomenon on an individual. In this study, I wish to understand the perspectives of nursing students in the context of their lived ECEs and therefore considered an observational approach of nursing students during

such experiences. However, as Robson (2011) highlights the use of observations such as in an ethnographic study present potential difficulties. These include the issue, as to what extent the observer (such as myself), affects the situation under observation. Thus, an important consideration for my study is how I as an observer affects the ECEs and nursing students' expressions and navigation of such ECES. There is the potential that students may adapt their expressions and responses, in order to fit perceived acceptable display rules before me in my role as lecturer. A further consideration is that ECEs cannot be predicted and therefore it would be unrealistic that I, as a researcher, could be present to observe such experiences. However, even if such situations were predictable, my presence might be intrusive or indeed impact upon the experience. For these reasons I want to consider other approaches to the study of ECEs.

Engward (2013, p.337) suggests that GT provides a methodology allowing researchers to develop an understanding of social phenomena "by looking at what people experience, what problems are present and how individuals go about resolving these issues". In keeping with the aims of my own study, I considered that a GT approach may allow me to develop such an understanding of nursing students' ECEs. However, as Wimpenny & Gass (2000) argue from a GT perspectives, the questions that are asked influence

the direction of subsequent data collection and further questions asked.GT seeks to develop an explanatory theory of social processes by studying in the environments in which they take place (Glaser & Strauss, 1967; Starks and Brown-Trinidad, 2007). Noble and Mitchell, (2016) suggest that GT is concerned with generation of theory which is ‘grounded’ in data that is collected, analysed, and used to uncover such things as social relationships and behaviours of groups, known as social processes. Willig (2017) and Bryant (2017) suggest that the most common outcome from a GT study is that it draws on convergences within a sample to support wider conceptual clarity, or a conceptual framework, intended to fully explain and predict something. In terms of the aims and focus of my study, I am not seeking to develop conceptual clarity or a conceptual framework. While GT is also concerned with the meanings which experiences hold for the participants. IP by contrast is concerned with giving a more detailed and nuanced account of the lived personal experiences of a smaller sample (Smith et al.2009), which I consider to be more in keeping with the aims of this study. I consider therefore, that an IP approach would provide me with greater focus on nursing students’ lived experience of ECEs, as opposed to attempting to produce a conceptual framework. While IP recognises that emotions are not necessarily transparently available from verbal reports such as in DA, it allows the

researcher to engage with and be able to say something about the sense and meaning making involved (Smith et al. 2009). In addition to these reasons, some previous studies identified in the literature review, with similar aims to my own study, have successfully applied an IP epistemological theoretical framework. Therefore, in keeping with the aims and in order to provide answers to the research questions, this studied is underpinned by an Interpretive Phenomenology (IP) epistemological theoretical framework (Smith et al.2009). A fuller explanation of phenomenology, particularly IP and its relationship to the aims of this study is developed in the next section.

3:2. An overview of Phenomenology and justification for an Interpretive Phenomenological approach to this study.

In this section I provide an overview and explanation of phenomenology and its relationship and relevance to the aims of this study. This is followed by a more detailed explanation of interpretative phenomenology, also known as hermeneutic (Larkin and Thompson, 2011) and the justification for its use in this study.

In keeping with an inductive qualitative paradigm, this study is underpinned by phenomenology, which can be seen both as a theoretical framework and as a methodology (Mackey, 2005; Tuohy, 2013). Langdridge (2007) refers to phenomenology as the study of human perceptions of their lived experience.

Koenig-Lewis and Palmer (2008) and Scharalda and Leonard (2010) suggest that topics concerning people's lived experiences are best suited for phenomenological research. Starks & Brown Trinidad (2007) and Noon (2018) suggest that phenomenology attempts to undercover hidden meaning and common features in understanding individual experiences. Speziale and Carpenter (2011, p.88) also see phenomenological inquiry as an effective approach in eliciting understanding of a topic being explored, involving searching for meaning and awareness of peoples' experiences of "being in the world".

In relation to my own professional practice, phenomenology is a recognised approach for investigating experiences in health research (Pringle, Hendry & McLafferty, 2011). Mackey (2005) highlights that phenomenology has provided an epistemological perspective to nursing knowledge and increasingly as a methodological approach to nursing research. As this study concerns nursing students' ECEs, phenomenology is a relevant theoretical framework and methodology to my own study, as I seek to understand how nursing students make sense of and engage with their lived realities of ECEs in practice. However, as Mackey (2005): Davidsen (2013) and Neubauer, Witkop & Varpio (2019) highlight that there are different kinds of phenomenology, each rooted in different schools of philosophy. Neubauer et al. (2019) highlight two broad

varieties of phenomenology: transcendental (descriptive) and hermeneutic. The latter is often referred to as interpretive phenomenology (Larkin and Thompson, 2011). I will discuss descriptive phenomenology briefly, before justifying why IP is more suited to answering the questions of this study.

Descriptive phenomenology, sometimes known as Husserlian, arises from the work of the German philosopher, Edmund Husserl (1859 to 1939) who held the belief, that all experiences share a universal commonality. Thus, the purpose of descriptive phenomenological research is for a universal meaning (Lopez and Willis, 2004). Christensen, Welch, and Barr (2017, p.115) suggest that "the philosophical underpinnings of Husserlian phenomenology are that of the lived, human experience". Husserl held the view, that in order to gain a true description of the lived experiences of others, the researcher is required to transcend their own world by suspension of their own beliefs and attitudes.

As Smith et al. (2009) and Sloan and Bowe (2014) suggest this means that there is an objectification of human experiences, and that the observer can transcend the phenomenon. Tuohy et al. (2013, p.18) suggest that descriptive phenomenology is concerned more on the general characteristic of the phenomenon, thus "extraneous factors such as religious or cultural thoughts and beliefs, that can influence how phenomena are understood, should be put aside". Christensen et al. (2017, p.117) summarises this as "bracketing the

natural attitude to transcend subjective experience, theories, and suppositions in order to observe and describe the phenomena”.

Neubauer et al. (2019) however argues that phenomenology has developed from a discipline focusing on thorough descriptions towards greater emphasis on interpretation being inherent in experience. Matua & Van Der Mal (2015, p.22) also suggest that phenomenology has “transitioned from descriptive phenomenology, which emphasises the 'pure' description of people's experiences, to the 'interpretation' of such experiences” in IP.

IP or hermeneutic phenomenology arises out of the work of Martin Heidegger (1889-1976) a student of Husserl’s phenomenological research (Woodard, 2003; Overgaard, 2004). IP recognises the uniqueness of each person’s experience and acknowledges that there is no singular truth or reality about lived experiences, but that everyone is different and perceives the world uniquely (Creswell, 2003). Heidegger took a different view from Husserl, arguing that the observer of a phenomenon is part of the existence of the phenomena and thus cannot be removed from it (Mackay, 2005; Larkin et al. 2006; Langdridge, 2007; Sloan & Bowe, 2014; Pietkiewicz and Smith, 2014; Horrigan-Kelly, Millar & Dowling, 2016).

From an Interpretive (Heideggerian) perspective, human existence involves being in the world and thus cannot be separated from the world (Delancey, 2006). Reid, Flowers & Larkin (2005) and Smith, Flowers & Larkin (2009) stress how IP is concerned with examining individuals' lived experiences and how they make meaning and sense of our world, while accepting that these experiences are lived in a shared context. Smith (2004) highlights that in hermeneutic traditions of phenomenology there is recognition of the central role played by the researcher and therefore does not advocate the use of bracketing.

Larkin and Thompson (2012, p.101) argue that IP allows researchers to 'give voice' to and make sense of lived experiences. Thus, the researcher forms a part of the interpretation of the experience or phenomenon. Smith and Osborn (2008) describe the art of such interpretation as a double hermeneutic, in that while interpreting the phenomenon under investigation, researchers are trying to see the world through the eyes of the participant but are shaped by their own experiences and world view. Smith et al. (2009) suggest that the aim of hermeneutic (interpretative) phenomenology is to uncover meaning in a shared context. Shaw (2010) & Chapman and Clucas (2014) also suggest that a fundamental principle of IP research, is that includes an inductive, idiographic approach allowing for an insider perspective.

This is an important consideration in relation to this study, as my world view is shaped and developed by my experiences of nursing education and practice. Spichiger, Wallhagan, and Benner (20005, p.303) suggest that “nursing as a caring practice”, is illustrated through IP research. Lopez and Willis (2004) suggest that it is consistent with nursing philosophy and art as it allows for understanding of uniqueness of subjective individual human experiences. For example, Wilson (2014) undertook an IP study into nurse mentors’ experiences in practice. The authors suggest that IP could be used to answer similar research questions about nurses’ experiences. As such, I am undertaking the study with an insider perspective and as Mackey (2005, p.182) suggests, undertaking the research not just as a recorder but “with prior awareness, attention and anticipation”.

IP according to the Heideggerian perspective embraces the idea that researchers such as myself, becomes part of the research process with some pre-understanding. In this study of nursing students’ ECEs, I recognise that I bring to the research process my own lived experiences of ECEs from working myself as nurse and a nurse educator. Adopting an IP approach allows my own background and experiences to interact with the research. As Hennink, Hutter and Bailey (2011) argue that IP researchers must consider how their social

background, assumptions, positioning and behaviour impact on the research process. (I will return to further discussion on reflexivity later in this chapter).

Ivey (2013) argues that IP is an appropriate framework and suitable methodology as it allows, investigators to identify a phenomenon or lived experience. The deeper exploration that is often possible with an IP approach can add distinctive insights and explanatory value to research. Thus, IP is conducive to the aims of this study, in that it may help me to explore and gain greater insight into the significance of various ECEs for individual nursing students that arise in practice.

As Smith and Osborn (2008) argue, IP allows for a more detailed and nuanced account of lived personal experiences. It may also help to examine in more depth and detail phenomena that are not easily quantifiable, such as in this study, on how nursing students navigate ECEs and learn to display (or not) their own emotional reactions. Schutz and De Cuir (2002) refer to such an approach as emotional inter-subjectivity arising from the work of Denzin (1984) which can allow for the exploration of actual shared experiences of feelings. Van Veen and Sleggers (2006) argues that an IP approach focuses on how individuals manage their emotions in response to their social situatedness. This is of significance to the proposed study; in that I seek to understand how nursing students interpret and manage their ECEs in practice.

An IP approach is therefore appropriate as it will allow me to explore unique ECEs through the discovery of shared experiences and perceptions among participants and myself as researcher.

Wimpenny and Gass, (2000) stress the importance of enabling participants' renditions and interpretations of their experiences. As Robson (2011) argues using an inductive approach in qualitative research is usually used as a means to understand. In this study it is integral with IP and allows participants to describe and share their interpretation of ECEs in practice. While being attentive to such description IP also allows for recognition of my own lived experiences, in which to interpret and analyse participants' recounts of experiences. A further advantage is that such an approach allows for the emergence of unanticipated findings (Barker, Pistrang & Elliott, 2002).

To conclude, in this section the rationale and justification for IP into the study of nursing students' perceptions of their lived ECEs in practice has been demonstrated. The next section will consider the approach to data collection that is informed by IP and enables exploration of the research questions.

3:3. My methods used in the collection of data.

In this section, the rationale and justification for data collection methods will be presented. This will include the approach to inclusion and selection of

participants, followed by an explanation of the use of semi-structured interviews.

3.3.1. Participants.

In keeping with IP, to explore shared meanings and lived experiences, I seek to recruit participants from the adult undergraduate nursing programme in my HEI in NI who have lived ECEs. Ezzy (2002); Speziale and Carpenter (2011) and Benoot, Hannes and Bilsen. (2016) suggest that when seeking insight and in-depth understanding about a phenomenon, researchers should seek participants who have lived the experience. Larkin and Thompson (2011) and Pietkiewicz & Smith (2014) argue that in IP, potential participants are selected on the basis that that they can offer a valuable perspective on the phenomenon by having experience of it. This is in keeping with the aims of my study, as I want to explore the significance of various ECEs for individual nursing students and to examine how they navigate ECEs and learn to display (or not) their own emotional reactions. The study therefore aims to recruit participants from the adult field of the BSc nursing programme, who have completed at least one practice placement. In doing so, I want to recruit participants with a range of lived experiences. This includes those with minimal practice experience such as 1st year nursing students, as well those in 2nd and final year of the programme who are more likely to have a broader range and

diversity of practice placement experiences. I anticipate that inclusion of students from a range of phases of the programme, will help me to gain a range of perspectives and may help to reveal insights into commonalities and individual ECEs and responses to such experiences. As highlighted in Chapter One, students on the programme undertake periods of theoretical study at the HEI, followed by periods of supervised practice in HSC settings. In these various practice placements, it is reasonable to expect that they are likely to have been exposed to a range of ECEs. Thus, they are a convenient and relevant population to the aims of this study having been within at least one placement. They are also likely to share some similar experiences of teaching and learning in preparation for professional practice on the programme within the same HEI in NI.

Fossey et al. (2002) suggest that in qualitative research, researchers use a small number of participants because of the in-depth nature of the study and the analysis of data required. Smith and Osborn (2008) recommend that in keeping with IP, to have a small number who have experienced the phenomenon, in order to illuminate particular research questions and to develop a full and interesting interpretation of the data. As Creswell (2013, p.76) argues “a phenomenological study describes the common meaning for several individuals of their lived experiences of a concept or phenomenon”.

Larkin, Watts, and Clifton (2006) argue that in an IP study, accounts produced by a comparatively small number of participants allow for a highly intensive and detailed analysis. Larkin and Thompson (2011) argue that the number of participants will vary according to the aims, level, and context of the study. Edwards and Holland (2013) suggest that rather than the number of participants being representative in qualitative research, it is the range of meanings that should determine numbers of participants. Anderson (2010) suggests that a small number of participants is necessary in qualitative approaches to understanding complex educational issues because of the detailed work that this requires. Smith and Osborn (2008) suggest a minimum of six participants are needed to perform an interpretative study. Creswell (2013) suggest a sample of ten participants to provide meanings to a phenomenon, while Coyle (2014) suggests between one and twelve participants. In this study the aim is to obtain depth of data rather than breadth and thus in keeping with guidance as above, I aim to recruit between six and twelve students from across the adult nursing programme, so as to gain a range of perspectives of lived ECEs in practice.

Miller and Bell (2012) highlight the importance of researchers recognising the power relationships that are produced and underpin data gathering. Allmark et al. (2009) highlight a difficulty in power relations in dual roles in research, such

as in my role as lecturer and researcher and students also as participants. As I am also a lecturer involved in teaching and assessment of the BSc undergraduate adult nursing programme, I want to minimise any perceptions of a power imbalance or coercion due to my role and participants' roles as students. In order to do so, students for whom I have personal tutor role and who may wish to participate, are advised not to do so, in order as to minimise any conflict of interest with the roles of researcher and personal tutor. Furthermore, as I normally have direct responsibility for the teaching and assessment of students in tutorial groups within the 2nd year of the programme, students from these groups are asked not to participate. I did consider that as I already have a relationship with these students this might facilitate greater sharing of ECEs, however I do not wish to blur the boundaries between my role as researcher with that of providing pastoral and teaching support to students. Table 3 gives an overview of the inclusion and exclusion criteria for recruitment of participants.

Table 3: Inclusion and exclusion criteria for recruitment of participants.	
Inclusion criteria	**Exclusion criteria**
Nursing students from the adult nursing programme who have completed at least one HSC placement	Nursing students from other fields of the programme (i.e., mental health nursing students)
	students for whom I have personal tutor role

	students for whom I have direct responsibility for teaching in tutorial groups in the 2ND year of the programme

Potential participants were contacted via student class representatives. The representatives were asked to send an email to their respective class groups across the BSc adult nursing programme, outlining the purpose and nature of the study, including the participant information leaflet (Appendix A). My telephone numbers and related emails addresses were included, and potential participants invited to contact me as the investigator to clarify any aspects of the study. Students who were interested in participating contacted me directly by email in response to the request. Contact was made with those who responded, inviting them to an initial meeting with myself to explain further the study and to arrange times and dates for set up of interviews. In the next section I explain the rationale for the choice of interviews for the collection of data.

3:3:2. Interviews as data collection.

Creswell (2013) and Sloan & Bowe (2014) see interviews as the primary means of data collection in phenomenological research. Atkinson and Coffey (2002) argue that interviews can provide a window into experiences and their meaning to the interviewee and to throw light onto the context of the social world that the individual experiences. Reid et al. (2005) and Pollit and Beck (2010) suggest that interviews allow for in-depth self-disclosure and personal

discussion of lived experiences. Sturdy (2003) and Baxter & Babbie (2013) suggest that interviews enable learning about meanings of emotions and experiences that cannot be observed.

There are three types of interviews, ranging across a continuum of structured, semi-structured and unstructured. Maltby et al. (2010) highlight that within structured interviews, there are standard pre-set closed questions which are asked to all participants, with limited room for deviation. Whereas unstructured interviews are more conversational and may or may not contain pre-set questions. DeJonckheere and Vaughn (2019) advise that semi-structured interviews allow for more dialogue between researcher and participant, and follow-up questions, probes, and comments. Willig and Stainton Rogers (2017) suggest that in IP research semi-structured interviews are more typically used. In keeping with such advice, I considered that structured interviews were less in keeping with IP, as they would involve me as researcher predefining or hypothesising possible experiences and participants' expression and disclosure of their experiences. Smith and Osborn (2008) argue that semi-structured interviews provide the researcher and participant greater flexibility and thus can gain rich data of the phenomenon being researched. Larkin et al. (2006) and PietKiewicz & Smith (2014) highlight that in IP participants accounts are typically captured using semi-structured interviews.

Jamshed (2014) argues that the flexibility of this approach, compared to structured interviews, allows for elaboration of information that is important to participants, but may not have previously been thought of as pertinent. Grove, McEnroe, and Shen (2008) suggest that it allows the researcher to remain open to the perspective of the participants.

As the purpose of this research is to obtain a rich description of nursing students' ECEs and their emotional responses, the methods used are in-depth semi-structured interviews with nursing students from the BSc undergraduate adult nursing programme who participated in the study.

In keeping with the advice of Smith and Osborn (2008) I formulated a schedule of questions prior to the interview (Appendix B). This invites participants to discuss their ECEs in practice and their navigation of such experiences during and after the event. However, these questions are used merely as a guide to the interviews, as it is the participant's responses which lead the direction of the interviews. As Noon (2018) suggests exploring related but unanticipated topics allows uncovering of phenomena that might not have been previously considered. Willig (2017) Seidman (2006) and Maltby et al, (2010) and Speziale & Carpenter (2011) highlight the importance of open-ended questions in phenomenological research in facilitating participants to share and discuss their opinions, views, and experiences of a phenomena in detail, whereas

closed-ended questions may inhibit fuller expressions of opinions and emotions.

As suggested by Morse and Field (1996) so as to reduce the potential for crucial data being lost, two specific questions are asked at the end of the interview:

- Is there anything you would like to ask me?
- Is there anything else I should have asked you?

To pilot the interview approach, the schedule of questions was distributed along with the participant information leaflet (see Appendix A) to three colleagues and one student (not a participant). These were asked for comments on clarity and any suggestions for changes. As Seidman (2006) argues, such a piloting allows for modification of any questions that are poorly worded or lack clarity and will improve the validity of the process. I was also aware of the potentially sensitive nature of the questions around ECEs and asked the colleagues and student if they had any concerns. They were of the opinion that questions were clear in meaning and no concerns were raised, and no changes were recommended. However, I noted within my own reflections and as Pietkiewicz and Smith (2014) advise, to try to be alert and sensitive to verbal, nonverbal, and behavioural clues which may be signs of

participants' distress which might occur when asking questions. Given that interviews can often be intrusive and the topics in these interviews are around ECEs, I am sensitive that I may need to stop the interviews if participant become unduly distressed.

To try to moderate the power imbalance between myself as researcher and participants and in keeping with IP, I sought to share examples of personal experiences and to be as open as possible about the purpose and process of the study and to build a relaxing context in which to undertake the interviews. As Taylor & Rupp (2005) and Few, Stephens & Rouse-Arnett (2003) suggest, levelling power can occur through self-disclosure during the interview process, whereby, the researcher invokes examples of their own experiences when participants seem uncomfortable with such self-disclosures. In keeping with IP, the researcher's purpose is to reciprocate the vulnerability and level the power between participant and researcher and be able to emphasise with the participant's narrative to express understanding. However, Anyan (2013) suggests that the quantity and quality of information shared with the researcher depends in part on the relationship that develops between the researcher and participants' co-operation may be influenced by power imbalance.

Karnieli-Miller, Strier & Pessach (2009) suggest that relationships in qualitative research are not fully defined, and there is no correct or optimal relationship, but the researcher must try to elicit as much as possible participants' stories, experiences, and wealth of knowledge of the research topic. While interviewers, such as myself, may possess information about the study, it is the interviewee who possesses the knowledge and experience for the study (Karnieli-Miller et al, 2009). Ryan, Coughlan & Cronin, (2007) suggest that it is for the interviewer to encourage the interviewee to reveal and discuss their lived experiences. As Creswell (2013) suggests as the researcher, I sought to listen carefully to the participants' views and interpret the findings based on their background and individual lived experiences, by asking interviewees to clarify or to contextualise, and using prompts to elicit further information.

I tried to be as informal as possible, dressing casually and listening emphatically to participants by showing an interest in the topics being discussed, by asking questions and paraphrasing what has been said. Kirsch (2005) mentions how friendliness can delineate boundaries and expectations within the research relationship. They argue that during collection of data, the interviewer should aim to create a welcoming, non-threatening environment in which interviewees are willing to share personal experiences and beliefs. It was in light of these recommendations that I selected to undertake the measures

as outlined above. In the next section I discuss some of the approaches I use in setting up the interviews

3:3.3. Setting up the interviews.

In setting up the interviews, I want participants to be comfortable and at ease. I thus set out to minimise any possible inconvenience and to build a relationship of trust between myself and the interviewees. As Spezialae and Carpenter (2011) suggest, in interviews there must be a relationship of trust between researcher and participant. I considered it important therefore that participants had an opportunity to meet with me and to ask questions or discuss any concerns prior to interviews.

As indicated earlier, those individuals who responded to the request to participate in the study, were invited to an individual initial meeting at a time, day, and place of their choice. The dates, times and locations selected by participants were during 9am to 5pm and in relaxed public seated refreshment areas of the HEI or in a nearby coffee shop. As I wanted to help participants to relax and to reduce formality, all were invited to partake of simple refreshments, such as tea or coffee. Three participants accepted this invitation by selecting a coffee. Gelinas, Largent, Cohen, et al. (2018) argue that reimbursement of out-of-pocket expenses incurred by research participants is acceptable as “participants should not have to pay for making a contribution to

the social good of research." In keeping with this, participants were offered reimbursement of travel expenses, but all declined.

The aim of the initial meeting was to allow participants to get to know me and why I want to undertake the study. So, they were relaxed, informal and lasted approximately 30 minutes. As PietKiewicz and Smith (2014) advise, such actions allow researchers, such as myself, an opportunity to build a relationship of trust. Participants were given the schedule of interview questions and invited to read and to ask for any clarifications before signing a consent form (See Appendix C) and agreeing to be interviewed at a later date, time, and convenient location which they deemed least formal and comfortable. Elwood & Martin (2000) suggest that the choice of interview location can provide participants more control, resulting in better rapport and richer data. As one interview was to take place outside of HEI premises, this was undertaken in accordance with Kingston University and my own employers, Health and Safety Policy and Guidance on Lone Working/Working in Isolation.

The interview was conducted at the second meeting and all interviews were undertaken by myself. This was for practical reasons, but also as Wengraf (2004) highlights ensures consistency and enhances validity and reliability. Interviews lasted between approximately 35 minutes and 1 hour and were

recorded using a digital recording device. Patton (2002) suggests that this can reduce a known limitation of any recall error. I also considered such recording allows for checking for possible errors in or necessary clarification of transcriptions.

3:4. Ethical considerations.

Burns and Grove (2011) suggest that consideration of ethical issues is central to the research process. The British Educational Research Association (BERA) guidelines for educational research (2018) outline that researchers should respect the rights and dignity of participants in their research. Section 17 of the Declaration of Helsinki amended in 2015 states, "that every research project involving human subjects should be preceded by a careful assessment of the predictable risks in comparison with foreseeable benefits to the subjects or others" (WMA, 2015). In keeping with these guidelines in the following sections, I outline the ethical considerations and assessment of the rights and dignity of participants in my study.

3:4.1. Gaining Research access.

Approval to conduct the study was sought and application made to the Faculty of Health Social Care and Education, Research Ethics Committee (FREC) at Kingston University (See Appendix D, a). A favourable view has been given by the FREC following amendments to the initial study proposal (See Appendix D,

b). Further application was made to the School of Nursing and Midwifery (SNAM), Research Ethics Committee (REC) in the HEI wherein the collection of research data is to be undertaken. Following this a waiver was received from the Chair of the SNAM, REC to undertake the study (See Appendix D, c).

BERA (2018) highlight the importance of obtaining informed consent of participants and informing them of what will happen to their data. Voluntary participation and consent were obtained through completion of a consent form agreeing to partake in the study. As highlighted earlier an information leaflet provided explanation of what participation might entail, such as the time involved; rights of participants, such as the right to decline to offer any particular information requested by myself as the researcher. Pollit and Beck (2010) emphasise the importance of reassuring potential participants that participation (or not) will not be used against them in any way. The information sheet advises potential participants that they have the right to decline to take part in the study or to withdraw at any time until commencement of data analysis and should this occur, it would not impact on their studies or student activities at the HEI. The aim of providing such details is as recommended by BERA (2018) to help to ensure that participants understand the research purpose and their part in it. Pollit and Beck (2010) suggest that this can minimise any potential psychological harm, although no

harm is anticipated in this study. Allmark et al. (2009) in a literature review, highlight that a potential for interviews to harm participants emotionally is noted in some papers, although this is often set against potential therapeutic benefit. There is a potential that participants may experience some discomfort or aroused feelings of discontent (Beauvais et al, 2011) and as the specific purpose of this study is to examine nursing students' lived ECEs, this is a real possibility. However, Rossetto (2014) found some evidence that the research interview process in itself has therapeutic value allowing for a healing making function for participants. Although this is not the purpose of my own study it may be that the interview process itself can allow participants to find a therapeutic value in recounting ECEs. However, I am mindful of a caution by Allmark et al. (2009) against the researcher being tempted to switch from research to therapy when conducting interviews. With this in mind at the meetings prior to interviews participants were given information and contact details regarding university and local counselling services and advised that they may stop the interviews at any time. Prior to the interviews, I rechecked that participants were still happy to give their consent that they had agreed to in signing the consent form at the initial meeting.

Barbour (2008) stresses that researchers must be able to demonstrate how confidentiality of data can be ensured. Contained within the information sheet

and prior to consent being taken, participants were assured that all information would be handled in confidence, except where the participant or someone else are at risk of harm or there is a disclosure of illegal activity requiring confidentiality to be broken.

Only I (the researcher) and a professional transcriber have access to the original data from the interviews. However, the transcriber signed a confidentiality agreement and agreed to return all audio recording and related documentation received after typing up all the information from the interviews (See Appendix E).

Anonymity refers to the safest way of shielding confidentiality (Polit and Beck, 2010). To maintain anonymity of participants, I provided them with pseudonyms. These I selected for no other reason than that they were easy for me to recall and to remind me of each individual participant. These pseudonyms are given alongside extracted quotations throughout the findings and written reports in the study. I also anonymised names of individuals or places that may have been given during interviews. Storage of data complies with the General Data Protection Regulation (GDPR) (2018) and it precursor the Data Protection Act (1998); The Human Rights Act (1998) and Kingston University's Data Protection guidelines. As suggested by Welman, Kruger and Mitchell (2005), I aim to ensure that any identifying information is safely

secured. Passwords are in place to ensure that information in the form of computerised data is not accessed by anyone other than myself. All recording equipment and written data from interviews are kept in a locked filing cabinet in a locked room that only I have access to. Polit and Beck (2010) advise that setting up these procedures helps to prevent any accidental breach of confidentiality. At the end of this study, all data from the study will be archived securely in accordance with Kingston University, Guide to Good

Research practice (2019).

3.5. Data analysis.

This section provides an explanation of the approach to analysis of the data obtained through the participants' interviews and my own reflections and notes during the study. As I have justified a phenomenological approach to the study of nursing students' perceptions of their lived ECEs in HSC practice, I apply Interpretative Phenomenology Analysis (IPA) to the analysis of the data. Rodham, Fox, and Doran (2015) and Noon (2018) highlight how IPA has been developed by Smith (1996) as a distinctive approach to conducting research and is informed by phenomenology and hermeneutics. Smith and Osborn (2003, p.53) emphasises that IPA is consistent with its origins in phenomenology and in particular interpretative (hermeneutic) phenomenology.

Studies based in IPA focus on examining how individuals make meaning of their life experiences and this is typically paired with the researcher's own interpretation. Pietkiewicz and Smith (2014) highlight that the analytical process in IPA is often described in terms of a double hermeneutic or dual interpretation process. Firstly, participants make meaning of their lived experiences, and the researcher then makes comprehensible the participant's experience and how they make sense of the subject's personal world by translating it. This means that the IPA study is a dynamic process with the active role of the researcher who enters into a reflective process of interpretation (Reid, Flowers, and Larkin, 2005).

Interpretative phenomenological analysis (IPA) is an example of an analytical tool that can be applied to phenomenological research. Lyons and Coyle (2007) suggest that IPA aims to provide a detailed exploration of the participants lived experiences. Larkin, Watts, and Clifton (2006) suggest that the aim of IPA is to try to understand the participants' world, focusing on their experiences of a specific event, process, or relationships. As a method of analysis, IPA aims to reveal the depth of each individual's experience and how they make sense of such experiences (Cassidy, Reynolds, Naylor & DeSouza 2011). Smith and Osborn (2003) and Smith (2004) argue that IPA is not meant to be a prescriptive methodology and that the process of analysis is individualised,

aiming to interpret the experience of participants for depth and nuance. In relation to this the study, using this approach, I seek to uncover and interpret common meanings within the lived ECEs of nursing students in practice.

3.5.1. Application of Interpretative phenomenological analysis.

Smith and Osborn (2008) & Pietkiewicz and Smith (2014) argue that IPA is dependent on an ideography, which means the analysis of every single case and individual perspective before producing any general statements. In keeping with this, I began by examining individual cases before examining all cases as a whole. Weed (2005) suggests that this movement from individual to groups of cases, represents the synthesis element of IPA. In doing so, I follow Miner-Romannoff (2012) recommendations of the cyclical process of IPA as the researcher inquiring, listening, searching, comparing, and verifying. Miner-Romannoff (2012, p.2) suggest that this allows for an in-depth understanding of participant experiences in any "social, cultural, emotional and psychological aspects".

Gnisci, Bakeman & Quera (2008) and Syzjka, (2012) suggest that interpretivist analysis often begins with inductive enquiry, moving from specific observations to seeking to detect patterns and regularities, or indications of similar emerging themes that can be explored and finally developing some general conclusions or overarching themes. As Atieno (2009) argues, in using inductive

reasoning, the researcher does not try to establish pre-conceived ideas about what information is needed about the subject being researched but allows salient issues to emerge. Similarly, Shaw (2010, p.196) advises, themes are borne out of, “close reading, careful consideration and systematic interpretation”.

As Dahlberg, Drew, and Nystrom (2008) suggest an initial examination and re-examination of interview data as whole was performed in order to gain a deeper understanding. In keeping with recommendations by Van Manen (2001) and Smith et al. (2008), I read individual transcripts several times while listening to the recordings in order to create greater familiarity. Larkin and Thompson (2012, p.104) suggest analysing each individual case allowing themes to emerge by “detailed line by line commentary on the data”, including my own emotional responses to the participant. While doing so I highlighted recurring words and noted in the margins of the transcript any expressions, phrases concepts, or differences that appear to be significant or which provided me with insight into the participant’s ECEs. (See Appendix F for examples of notated transcripts). As suggested by Ayres, Kavanaugh and Knafl (2003) I sought to identify words or commonly reported phrases within an individual narrative. Listening to the recordings allows me to go beyond

description to note any nuances in the interviews such as intonation of language (Noon, 2018).

As Pietkiewicz and Smith (2014, p12) suggest in the next stage I drew together highlighted statements and the notes in the margins of the participants' experience into emergent themes. I then grouped these themes together, "according to conceptual similarities". For example, Table 4, illustrates how the themes from the analysis of participant Stella's transcript are clustered and grouped. These were then documented into tables formatting emerging subordinate and superordinate themes and reflecting my interpretation of each of the participants' ECEs (See for example, Table 5).

Table 4: Emerging themes from analysis of participant Stella's transcript.

Participants words	**My Comment/ notes**	**Emerging theme**
"a lot of small situations that has happened which has affected me emotionally"	Various experiences which were emotionally challenging.	Emotional challenging experiences.
I felt a bit stupid and that I didn't really know a lot I felt enormous pressure and I was kind of being questioned on things that wouldn't have been… I believe suitable to ask someone who was only in university for 6 weeks previous. It affected me emotionally, it made me feel like 'Am I smart enough to do this? .. it knocked my confidence	Feeling stupid Enormous pressure Assumptions that she should know more. Unrealistic expectations Doubts abilities Feeing inadequate	Assumptions around knowledge and ability.
I was away from my children for that length of time as well and that put a lot of pressure on me emotionally. I felt very sad and very lonely. I felt a bit isolated, maybe, in that first placement and I feel that that affected a lot of things. It affected probably how I was learning as well because I felt so detached from peers and family.	Feeling alone sad and isolated. Detached from peers and family.	Away from support network.

I always had to put on like almost a happy face every day.	? putting on a brave face. Suppressing true feelings.	Strategies in dealing with ECE

Table 5: Sub-ordinate and Superordinate themes from analysis of Stella's transcript.

Sub-ordinate themes	**Superordinate themes.**
Unprofessional culture and behaviour.	Professional culture and practice.
Aggression and Hostile staff	
Uncaring mentors	
Loneliness, away from family and support network Vulnerable	Emotionally challenging experience Lack of support network
Hiding true feelings Surviving	strategies
Knowledge seeking Lack of knowledge	Assumptions around prior knowledge

Comparison of text across individual stories allow me to find commonalities within and across the participants' stories. Larkin and Thompson (2011) suggest that themes generated from each interview are to be compared for commonalties, convergence, or differences with all other transcripts. Richie and Lewis (2003) propose that this involves identifying common and emergent themes, in order to begin to address the questions that are the focus of the research. Further refinement of the themes was undertaken, and where themes were judged as similar, they were combined to make a larger data group.

This allowed for the categorisation of sub-ordinate and super-ordinate themes across the data. Common superordinate themes are organised consistent with which question of the study aims they relate to. However, as Larkin and Thompson (2011, p.104) stress it is important to consider “data that do not fit the prevailing patterns”. Unexpected, unique, and significant themes which do not relate specifically to the questions set out in the aims of the study, are also clustered into specific sub-ordinate themes.

Larkin and Thompson (2011) suggest a diagrammatic representation can enable to have an overview of the analysis. As there is a large amount of data relating to each theme, a large framework table in word format was developed, in which related comments from each cluster are verbatim transcribed onto separate sections.

The next phase involved referring back to the collated data extracts of each theme and organising them into a coherent and internally consistent account. As recommended by Noon (2018) a final table of superordinate themes and sub-ordinate themes was produced. From a more in-depth IPA and cross analysis of all transcripts, subordinate and super-ordinate themes were merged for the data as a whole and presented in Table 7, in Chapter Four. Super-ordinate theme 1, relates to the strategies participants used in navigation of ECEs. Super-ordinate theme 2, relates to how participants were

prepared for ECEs and theme 3, relates to how they were supported during and after such experiences. The interpretation of the data from these is presented in Chapter Four including examples of the verbatim transcripts from each theme. Rigour is ensured by drawing conclusions which were kept close to the content of the comments, by discussing the development of the themes and by presentation of comments (data) alongside interpretation of data in the findings.

3:6:1. Reflexivity and myself as researcher and instrument in data collection.

The importance of giving consideration the potential influence of the researcher on the study in qualitative research is emphasised by McManus Holroyd (2007) and Robson (2011). An important consideration in relation to this study, is that participants' expression of emotions may be affected in order to fit perceived acceptable display rules before me in my role as lecturer. As highlighted earlier I have tried to minimise power imbalances. However, in this study I also recognise that in researching the students' ECEs, I bring to the process my own lived ECEs as a nurse and a nurse lecturer and acknowledge that these have implications for the study. IPA sees the value of the researcher's subjectivity as the means of data collection and analysis and requires the researcher's subjectivity to be explicitly identified (Hennink et al. (2011). I consider it impossible to remove myself from such experience.

Therefore, in adopting an IP approach, I allow my own background and experiences to interact with the research. Vicary, Young, and Hicks (2017, p.552) highlight a debate around "putting aside of preconceptions to engage in the sense making". Reid et al. (2005, p.22) that "IPA researchers are aware that interviews are not 'neutral' means of data collection". Some suggest that with this in mind, steps should be taken throughout the research process to "bracket" prior assumptions and experiences (Tufford and Newmann, 2012). Chan, Fung, & Chien (2013) describe bracketing as a method that requires researchers to put aside their own beliefs and prior knowledge about the phenomenon. However, the notion of bracketing has been challenged by writers such as LeVasseur (2003); McConnell-Henry, Chapman, and Francis (2009); Humble and Cross (2010) and Chan, Fung, & Chien (2013) as being inconsistent with IPA, as the researcher is the instrument of data collection and that it is not possible for humans to be totally objective. Sloan and Bowe (2014, p.1294) suggest from an IPA perspective "it is not possible to bracket off the way one identifies the essence of a phenomenon". IPA embraces the idea that in the researcher becomes part of the process with some pre-understanding.

Based on these arguments and in relation to my ontological perspective as a researcher in this study, I am shaped and influenced by my own thoughts,

beliefs, and culture that I cannot entirely transcend. Furthermore, as each participant's lived ECEs and perceptions of them are unique to that individual, I seek to understand their experience and perspectives and that will be influenced by my own beliefs, thoughts, and culture. Weed (2008) and Cassidy et al. (2011) highlight a double hermeneutic in IP, while the lived experiences of participants are sought this cannot be fully achieved and therefore the researcher must be located in the research dialogue in order to gain an insider perspective. In IPA, both the researcher and participants interpretations are important (Pietkiewicz and Smith 2014).

Callejo-Perez (2008) and Larkin & Thompson (2011) highlight that it is impossible to have value free research and thus it is important to understand the relationship between the research participants and researcher's point of view through a process of constant searching and reflection. Van Manen (2017) argues that the researcher needs to pay attention to the words used and to be aware of their own subjective interpretations. Sloan and Bowe (2014) suggest that the researcher's conscious reflection on a situation or experience can help in the interpretation of meaning. Langdridge (2007) outlines this as a process of reflexivity.

As such, I aim to use a process of reflexivity to enable me to identify and acknowledge the limitations of the research: its location, participants, process,

context, data, and its analysis (Ploeg, 1999; Anderson 2010). It is therefore important that I engage critically and reflexively within this research (Jones, 2006; Anderson, 2010) allowing the consideration of perspectives that relate to my personal interest and 'curiosity' (Stenhouse 1981, p.14).

To help ensure reflexivity, I use a diary recording reflections on how my own experiences may have shaped the collection, generation, and analysis of data. Larkin and Thompson (2011) emphasise that the use of diaries can facilitate understanding between the researcher's interpretation and the participants' accounts of their experiences. The use of a reflective diary enables my reflection on my own emotions and thoughts during and after the interviews Dahlberg et al. (2008) highlight the need for reflection at all stages of the research process in order to restrain and limit any bias. During and at the end of the interview and subsequently I kept detailed notes, which included observations of non-verbal communication. These data were read alongside the verbatim transcripts at the initial stage of analysis. I endeavoured to be mindful that knowledge of findings in early interviews may have subsequent influences and interpretation of later interviews. In interpretation of data and through careful re-reading of data, I sought to become aware of and manage these influences. For example, while waiting for a participant I recorded in my

reflective diary the “need to ask more specifically around previous preparation or experience that helped to navigate emotional experience”.

Reflexivity is deemed as important and as allowing researcher to become aware of what they are seeing and helping to clarify their beliefs and how they came to know (Watt, 2007). Pring (2000) argues that in order to understand the limitations of educational research we need to analyse the social situatedness and the interpretation of social rules and individual values.

Hennink et al. (2011) argue, that through reflexivity, researchers can reflect on how their social background, assumptions, positioning and behaviour impact on the research process. In doing so the researcher must account for their own world view, as the researcher is a thinking individual in communication with the world and thus brings some level of interpretation and understanding to the research theme.

Holloway and Biley (2011) highlight the danger that the meaning that the researcher interprets from the participant may differ. Care will also be taken to understand “deviant” or “negative” views and to actively look for opinions and thoughts that run contrary to my own opinions. Anderson (2010) highlights the need to consider ‘‘fair dealing,’’ i.e., whether a wide range of different perspectives are incorporated. With respect to such fair dealing, I will give attention to not over emphasising the views of any one of the participants as if

they represented the sole truth. Thus, as Shenton (2004) advises I have tried to give “thick description” to allow others to have a proper understanding and make comparisons to their own context.

3:7. Chapter conclusions.

In conclusion, in this chapter I set out to explore the methodological choices for this study which would enable greater understanding of nursing students’ navigation of ECEs in practice. In doing so I have proposed a qualitative interpretive paradigm for this research. The study design was then explained, and the Interpretive Phenomenological approach was explored to demonstrate how this informs and is appropriate to the generation and analysis of the data. I have further justified why semi-structured interviews as methods of data collection are appropriate for exploring how nursing students in this study navigate lived ECEs. Discussion has also been given to the important ethical issues which require consideration throughout all stages of the study.

In the next Chapter, Four, the findings of the study are first explained and discussed. I anticipate that the narratives will reveal nursing students’ ECEs and provide insight into how nursing students learn to navigate these in practice placements. The participants' narratives will be a starting point from which to better understand nursing students' experiences of ECEs and aspects requiring

attention in nursing education in my own area of practice and more broadly in the profession of nursing.

Chapter Four. Findings arising from the data.

4:1. Introduction to the chapter.

This chapter outlines the findings in answer to the questions set out in Chapter One and which were established following the review of literature in Chapter Two as to:

- How do undergraduate nursing students adapt to and respond to emotionally challenging experiences (ECEs) in Health and social care (HSC) practice?
- What particular strategies or approaches do undergraduate nursing students adopt to maintain their own emotional well-being while engaging (or not) in the ECEs of practice?
- What are undergraduate nursing students' lived experiences of influences, which inform and shape the development of their responses to ECEs in practice?
- What are undergraduate nursing students' lived experiences of both formal and informal preparation and support offered, available or utilised (if any), regarding ECEs in practice?

In this chapter, I present my interpretation of the lived ECEs of undergraduate students from the BSc nursing programme in my HEI, who participated in the study. The data is derived from transcripts of interviews with these participants

and from my notes and reflective diary. In presenting and discussing the findings, I aim to ensure that they are in keeping with interpretive phenomenological analysis (IPA) principles as outlined by Pietkiewicz and Smith (2012). Central to these principles is to give voice to participants' unique experiences while acknowledging commonalities and convergence of themes. The main super-ordinate themes that emerge from the data include: -

- strategies used by undergraduate nursing students in navigating ECEs in practice.
- support sought, offered, and utilised in relation to ECEs.
- preparation prior to and for ECEs.

These form some of the headings in this chapter which also include examination of sub-ordinate themes arising under each super-ordinate theme.

The data is rich with diverse, views and opinions of participants, but for the purposes of this study, I focus on data relevant to the research questions. In keeping with IPA and as Sloan and Bowe (2013) advise, for the purpose of this study, I try to interpret participants' accounts of their lived experiences, rather than opinions that may be expressed but which do not relate to lived ECEs.

I first provide a brief demographic profile of participants and while the focus of this study is not on the nature of ECEs, some examples using quotations from

individual transcripts of ECEs are given in order to contextualise participants' navigations of such experiences. I then outline some examples of strategies used by participants in response to ECEs, before discussing their experiences of prior preparation for ECEs. This is followed by examples regarding participants' strategies, utilisation of support (if at all) and facilitators and/or barriers in accessing sources of support. On occasions I insert words within the following bracket format [ ] in order to provide contextual clarification. Ellipsis (…) are also used to indicate omission of unnecessary words within quotations without interference with the meaning. I also underline some words as exemplars revealing emotions experienced by individual participants.

4:1.1. Profile of participants and context of interviews

Twelve participants (2 males and 10 females) from approximately 450 of the undergraduate (adult field) of nursing students self-selected to participate in the study. Table 6 provides a brief profile of participants who were from various years in the programme. As reported in Chapter Three, the names are pseudonyms.

Table 6: Profile of participants.

Pseudonym	Age	Year of study
Kate	41	1st year
Chloe	25	2nd year

Rosie	30	2nd year
Sally	22	1st year
Antony	22	3rd year
Stella	27	1st year
Linda	28	2nd year
Samantha	40	2nd year
Adam	30	2nd year
Tara	26	3rd year
Holly	48	2nd year
Maria	22	2nd year

4.1.2. An overview of emerging themes.

The process of IPA as discussed in Chapter Three, was applied to recordings and transcripts and annotations of interviews. From this, initial insight into each participants' experiences was gained and analysis of these identified sub-ordinate and later the super-ordinate themes for each participant. From a more in-depth IPA, cross analysis of all transcripts and process of refinement, subordinate and super-ordinate themes were merged for the data as a whole. The super-ordinate themes are outlined in **Table 7,** alongside their sub-ordinate themes.

Table 7. Subordinate and Superordinate themes.	
Sub-ordinate theme	**Super-ordinate theme**
Answer seeking. Seeking early exposure Self-reflection and reflection Surviving Releasing/venting emotions Laying feelings aside-non displays The impact the team climate on displays Distraction and avoidance Distancing versus engagement	Strategies and coping behaviours in navigating ECEs
The impact of the team climate on support seeking. Perceptions of how others were reacting to the ECE. Mentors support and lack of support Support from other professionals Link Lecturer & Personal tutor support- conflicting and contrasting of roles. - Lack of relationship and contacts Alternative support -Year Leads -Reflections in tutorials Supportive versus disciplinary Support from other students. Coping alone Friends and Family Barriers to accessing support- Fear of breaching confidentiality. Geographical locations away from usual network	Variations in the support sought, offered, and utilised during and after ECEs
Preparation for death and dying. Informal and opportunistic learning Preparation for specialist nursing areas Formal preparation and advice • Lectures • Tutorials Previous experiences assumptions. Informal advice of other students and healthcare assistants	Preparation for and prior to the ECEs

4:2. Emotionally challenging experiences, exemplars, and commonalities.

In this section, I outline examples of ECEs that participants encountered in practice, in order to provide context to the super-ordinate and sub-ordinate themes. In doing so, I endeavour to include commonalities and acknowledge the uniqueness of each participant's ECEs. Quotations from participants' transcripts are selected to exemplify the content and complexity of themes, thus revealing my interpretation of participants lived ECEs while in placements. While I wish to acknowledge the uniqueness of each participant's experience, a full account of each participant's lived account is not possible within the remit of this Ed.D study, but examples from a range of participants are included as appropriate.

In undertaking this study, the initial impetus has been driven by my own lived emotional experiences of the death of patients and I had anticipated that this would be a significant emotional experience for participants in this study. Indeed, as anticipated care of the dying and death were prominent among the ECEs of participants. For example, Rosie, recalls,

> *my 3rd placement in first year (…) my first death.*

Maria shares a similar memory,

> *(...) that first woman I had dying (...) that would probably be the most significant thing that has impacted me.*

Reflecting on my own assumptions, I found that while there are other recounts of experiences of death and aftercare of deceased patients and their relatives, a range of other ECEs in a variety of HSC settings are also articulated as significant. Exposure to aggression, violence, revelations of sexual abuse of minors, perceived lack of care, inability to provide care and hostile or unwelcoming HSC practice environments were among some of the ECEs recounted as significant. Some of these such as Antony's recollection resonate with my own experiences as a young student nurse of feeling overworked and unwelcome. Antony recalls a first-year experience in a hospital ward where he felt unwelcome, overworked, and experienced discord within the nursing team and which he considered both physically and emotionally challenging,

> *(...) a really hostile environment (…) [the nursing staff] were almost against each other (…) I was (…) made to do the dirty work (…) although [the nursing staff] were short staffed, they didn't want student nurses.*

Other participants articulate experiences of what they deem unprofessional practice which aroused emotional challenges. For example, Stella expresses disappointment and emotional upset in her experiences with some nurses and healthcare staff during her first placement in a hospital.

I honestly believed that every nurse (…) would be living by the code [NMC professional code of conduct (2018)] (…) that naivety was causing me <u>emotional pain</u> (…) some of the staff were being really unprofessional in how they would speak to me and (…) patients.

I reflected in my diary how some of the narratives of participants challenged my own views and perceptions of day-to-day professional nursing practice. During some of the interviews I sensed emotions such as anger and distress arising in myself when some participants' recounted their lived experiences. I believe that being aware of these emotions allowed me a more empathetic understanding of the experiences of participants. For example, I recollected my own emotions in my experience of being away from family and friends in my first-year nursing placements as Stella shared her experience. She became visibility upset tearful when recalling how as a single mother she had been missing her children while on a placement geographically far from home. However, I found myself taking a sharp intake of breath when she recalls the following experience when she shared her feelings of loneliness and separation with a member of practice staff during this placement.

the auxiliary nurse said to me if you [Stella] ever get pregnant again (…) this has stuck in my mind because I found it so <u>harrowing</u> (…) she said, 'I would scrape it, bag it, and bin it'. I felt so <u>horrendously upset</u> (…) she was laughing whenever she said it. It didn't feel like a nice friendly

> *environment, it didn't feel like there was a good culture there (…) It didn't feel very professional.*

Later she describes when a nurse on the same placement used derogatory remarks and gestures about a patient.

> *Another older nurse referred to a patient as being 'a big wuss' and saying that 'he's in there crying over a diabetic ulcer on his leg and it's nothing to cry over'. She [the older nurse] started to make hand signals referring to a really bad name (…) about (…) a man that was in pain (…) I <u>felt disgusted</u> by the lack of compassion, the lack of just basic kindness.*

After the initial preparatory meeting with Kate, I noted in my reflective diary that while she seemed willing to participate in the study, I had reservations regarding her willingness's to open up to me about her ECEs and her own emotions. This was borne out in the later interview when I noted my own emotional frustration in that she appeared hesitant at first to speak about ECEs or to share her own emotions. However, I was also aware that this was my first interview and that I myself was nervous and perhaps that this impacted on her initial willingness to share her own emotions. Her initial responses were one which she highlighted the experience of caring for a patient who had been given a diagnosis of a terminal illness. When asked about her own feelings, in her response I perceived that she wanted to emphasize to me her role in providing a good standard of care, the feelings of other rather than the impact

of the experience on herself. Even when I probed further by asking questions like “*did you feel like a sense of a little sadness?”, “How did that affect you then personally? How did you deal with that or how did you… what feelings did that bring up for you?* , I sensed both in here replies and her body language that she was reluctant to discuss her own emotions with me. I noted that while she smiled and nodded, she often looked down or away from making eye contact when asked about her own ECEs. However, I considered that her reluctance to do so was perhaps based upon her uncertainty as to how freely she thought she could speak. This is reflected in the following extract where she also reports experiencing perceived unprofessional behaviours but appears to seek permission from me as she questions what she might be *‘allowed to say’.*

> *(...) some of them have compassion fatigue (…) less patient centred care to the degree that should be expected of a nurse. If I’m allowed to say that? [Laughs] (…) my mentor (…) would use bad language (…) about a patient who (…) she thought that he was eh ‘milking it’.*

However, as the interview progressed, I found myself summarising and reiterating previous comments and questions. This approach seemed to draw out more rich descriptions and I observed that Kate appeared to relax and to make more direct eye contact with me. Later she shares her own feelings following an encounter with a senior nurse,

she had shouted at me in front of patients and staff, so it was very demeaning, so I was flattened.

Kates initial reticence to share her own emotional reactions contrasts with my impression of Samantha and her willingness to share her own emotions in reaction to the ECE. I sensed that she was keen to share her experience as she required no prompting but quickly recalls her fears during an episode in a mental health setting when a patient became violent, and staff and police intervention was required. Amid the commotion another patient threw a glass and became aggressive toward Samantha. She willingly shares her own emotions in the following extract,

I was really scared (…) I thought she [the patient] is going to hurt me (...) I was scared to go back (...) I went back but I was frightened.

In some participants' ECEs there was also a physical stress response. Tara recalls that following a hostile encounter with a healthcare assistant (HCA),

my breathing (…) was getting (…) overwhelmed (…) I had to keep switching my brain off and saying 'stop it' like don't be dwelling on it (…) I was like hyperventilating.

Some participants report that the ECEs continued to impact on them outside of the practice setting. Samantha explains how she,

thought about it [the ECE] all night (…) to the point where it was actually upsetting me.

Linda also highlighted how she carried her emotions with her after leaving the HSC,

> *I cried in the car (…) I couldn't go home and walk into my house with my children and be in that same position emotionally.*

Samantha reports,

> *it [the violent experience] still upsets me that I was afraid.*

I was able to observe some of this impact myself during the interviews when as participants told their stories, I was aware of facial expressions or attempts to suppress expressions of emotions. Others such as Holly became tearful during the interview, recalling her distress when in first year she encountered a patient whom she knew from her personal circumstances who was unable to move or communicate.

> *she recognised me and she started to cry (…) I then started to cry. I got emotional (…) I was distressed (...) really sad.*

I noted that Adam struggled to hold back expressions of emotions when recalling an ECE in first year. This seems to be reflected in how he reports his emotions during the interview,

> *I actually feel myself, like thinking back on it now getting a bit emotional.*

During interviews when participants such as Holly, Stella, and Samantha, became tearful and upset recalling ECEs, I was mindful of my duty of care, and I

checked with them if they wanted to stop. In two interviews, participants indicated a need to stop. Following brief interludes and after composing themselves, both participants indicated that they wished to continue.

Inability to provide care or to communicate with patients who were unable to communicate, was another significant ECE, leading to feelings of helplessness. Feelings of guilt and frustration also arose among participants who felt unable to provide care that they would have liked, because of other demands or a lack of knowledge or skills. Adam describes his struggles in a first-year placement in being unable to understand a patient with dementia for whom he was caring,

> *he was trying to say something to me (…) I tried different various methods to try and understand (…) I just saw tears trickle down his face. I was like aw no, this guy is trying to tell me something important (…) and he can't verbalise it and that's where <u>I struggled</u>.*

Sally shared her frustration at inability to provide care or to communicate with a young woman with a rare condition affecting brain and physical development,

> *sometimes I believe that she was <u>very distressed</u> and that made me <u>feel helpless</u>.*

Antony, reports feeling overwhelmed physically, cognitively, and emotionally when tasked with caring for a patient with dementia for long periods,

> *she would have constantly been screaming out for help and she was really paranoid, and she would need one-on-one supervision (…) I was super nervous, just watching (…) [the patient] (…). It was really emotionally tolling on myself (...) really draining (…) finishing with that like your head is melted (…) I was exhausted and mentally drained.*

Samantha reports feelings of fear arising from lack of knowledge of mental illness, even though at the time it was her first year in the programme.

> *I felt really scared because I didn't know (…) how to handle someone who is really unwell mentally.*

Even though Stella's ECE occurred at an early stage in her programme, she also assumes that she should have greater knowledge to challenge unprofessional care and describes her feelings at not challenging unprofessional behaviours,

> *I felt guilty that I didn't stand up as a young, aspiring professional (…) and say, 'You can't say things like that' (…). That probably would have helped with the guilty feelings and the bad feeling that I had within that environment (…) probably would have helped my ability to cope.*

While I noted in my reflections that participant Rosie tried to hold back from any physical or facial expression of emotions during the interview, she also became tearful when telling of her feelings of inadequacy in not having knowledge to deal with a patient who was feeling upset. This Rosie reports, led her to feeling further emotionally upset when later the patient died. Along with feelings such as guilt, she retrospectively assumes that she should have

had the knowledge and skills to know what to do beyond that of a first-year student in caring for a dying patient.

> *I didn't realise that he was dying. So, when he had said to me he was feeling bad like that <u>made me feel bad</u> because I didn't do anything [crying] (…) like someone dying you know (…) it's quite a big thing so [crying] (…) I still feel guilty.*

Tara recalls an experience in 2nd year which led her to feel guilty in struggling to provide a standard of care and feelings arising around her inability to be assertive and to challenge others.

It was eating up at me inside (…) I <u>felt guilty</u> because I knew that the woman needed catheterised (…) I kept being told to do other jobs (...) in (…) my head I knew (…) but d<u>idn't feel assertive</u> enough to say actually this needs done now.

Antony expresses frustration at his lack of knowledge regarding an experience of the death of a patient in first year,

> *I felt almost <u>overwhelmed</u> (…) there was very little that I was able to do, (…) <u>and sad</u> mostly.*

Such experiences aroused feelings of uncertainty or inadequacy and led participants to doubt if nursing was a suitable career for them and their ability to continue on the programme.

Holly, finding that she was unprepared to deal with the situation reports her sadness and doubts about her ability to continue on the programme,

> *it's heart breaking you know. It did make me doubt whether I could even do this. You know, it's still… it breaks my heart (…) and it did make me sort of think, have I made a big error here*

Samantha also expressed her doubts following and ECE,

> *I thought 'Am I cut out to be a nurse?' because I didn't handle that well*

In conclusion of this section, it is not the aim of this research, to detail accounts of each aspect of participants' ECEs in HSC. In the above section some extracts are selected to exemplify a range of experiences which were emotionally challenging, but also to highlight some commonalities. Significant ECEs include caring for dying patients and their relatives and aftercare of the deceased. There is also evidence that several participants were emotionally challenged by their inability to communicate with patients. Some participants describe ECEs of violence and aggression including hostile situations and unprofessional behaviours from other health practitioners.

In the findings there is also evidence that the lived ECEs of participants include dealing with issues regarding sexual, mental, physical abuse of children which elicited a range of emotions such as anxiety, fear, sadness, and helplessness.

Some participants report feeling ‘abandoned’, by mentors and other formal support sources. In the next section I provide some exemplars in relation to the superordinate theme regarding strategies used by participants in navigating such ECEs.

4:3. Strategies used by participants in navigation of ECEs.

In this section I report on strategies utilised by participants in response to ECEs and provide quotations as evidence to support the various sub-ordinate themes that emerged in the findings. These include suppression and non-displays of emotions; answer seeking and seeking early exposure and dialogue with a knowledgeable other; and detachment and avoidance of ECEs.

4.3.1. Answer seeking, early exposure and dialogue with a knowledgeable other.

Among the findings there was a perception that participants’ emotional reactions related to lack of knowledge or experience and a typical response to diminishing the ECEs was to develop their knowledge about particular conditions or situations. The focus is often on gaining cognitive understanding rather than participants’ understanding of their own emotional responses. For example, Sally reports,

> *I started to ask google and ask my parents, do people with Rett’s syndrome understand what’s going on (…) to try and question the*

> *condition (…) to find out more information about it (…) because I couldn't really understand it.*

While interviewing Adam, the first male participant in my study, I felt a little apprehensive at first that he might not want to want to reveal much about his own emotions around ECEs. I noted in my diary prior to the interview that *'big boys don't cry might be the dominant experience of the interview*' and that I might therefore have to probe and question more than in other interviews. However, while the interview itself was shorter than previous ones, I felt that Adam shared a lot of rich material regarding his ECEs and how he himself felt in relation to them. Despite this sharing there is some contradiction in his responses when he expressed the view that it is better to suppress emotion. He mentioned that he did not like digging into his emotions and thought that talking sometimes made thing worse. I noted that his eyes filled with tears as he struggled to find words to express his frustration and feelings of failure at being unable to communicate with a patient with dementia. His strategy in response, to such feelings is to find answers and develop his knowledge around the patient's condition. Adam also reports seeking answers from different sources such as an HCA

> *I was wanting to know from other people (…) 'Is there anything that you can do, people (…) I can speak to, to try and understand how to communicate with this man (…) looking at his care plans and stuff like*

that (...) I tried to look up stuff about dementia (...) to have a better understanding of how to communicate with someone like that (…) because I felt that I was failing as a person.

In interviews with some participants, I sensed that they considered that early experiences would ease or diminish future impacts of ECEs. For example, Maria reporting on her first placement experience shows an eagerness to be exposed at an early stage to caring for dying and deceased patients in order to.

In my very first placement (…) care of the elderly (…) patients who passed away, being (…) first year I was not involved (…) I wanted to be involved, I want to be exposed to this so that it doesn't shock me when I am actually responsible and have to deal with it.

Rosie suggests that by gaining more experiences she will have less of a focus on her own emotions in dealing with ECEs such as death and dying. During the interview she openly shed tears when recalling her ECE. However, despite this openness in showing her own emotions her words suggests that she considers that to be a professional there is a need to suppress one's own emotions.

I feel like the more clinical practice I get (…) rather than me focussing on like my emotional side of a death, I'll be able to focus on the more professional, how to make it better for the person.

In this section I have outlined how some participants were driven by emotions such as frustration, failure, and guilt to seek answers and develop their knowledge and experience as strategies in navigating ECEs. In the next section I

provide findings relating to participants suppression of emotions which suggest that this was often used as a strategy in navigation of ECEs.

4.3.2. Suppression and non-displays of emotions as a strategy in navigation of ECEs.

In participants narratives there was lack of clarity as to whether or not it was acceptable to portray emotions. Among the findings, some participants considered it unprofessional to show emotions or that nurses should have feelings such as fear. For example, Sally emphasises that,

> *it's not appropriate to show your feelings at that time, you bring those feelings home in your head*

I interpreted that in suggesting that feelings should be taken home, she makes a distinction between the professional and personal life and that the emotional aspects of her work belong in the personal rather than the professional arena.

I found this view of one's personal emotions of not belonging in the professional arena, to be reflected by Samantha who expresses her struggle to live up to her own understanding of acceptable professional behaviours.

> *The fact that as nurses you have to be unafraid (…) able to handle anything, don't you? (…) and* <u>*I felt a great pressure*</u> *that I wasn't handling that*.

However, while she appears very definitive in her view that nurses should not show emotions, with use *of 'the fact'*, there is an element of uncertainty, as

she qualifies her statement with a question to me, the researcher with *'don't you?'*.

Non-display of emotions as a strategy and as expected professional behaviour is also evidenced in the interview with Holly, who when asked how she dealt with her emotions in regard to ECEs disclosed that she,

> *Just packaged them back up again and shoved them back up on the shelf (…) my emotions shouldn't really come into play (…) nobody who's sick wants to see a nurse crying (…) do you know what I mean? It's like she's crying it must be really bad.*

Holly's strategy appears to converge with her experience of a mentor's professional reactions and behaviours, portraying a professional image without emotional displays. But this sometimes contrasts with her own reports of having expressed emotions in response to other ECEs and other experiences of her mentor in which emotional responses appear to have been portrayed.

> *she has a very hard professional side (…) the same lady I saw (…) having an emotional response to other situations, so I do think (…) this is what she felt she had to say as a mentor and for me.*

When I asked Antony if anyone had said to him that he should not cry or whether he would or had expressed emotions at work, his answers suggest an assumption that non-displays of emotions are a professional norm.

> *I assumed (…) that you should be (…) I wouldn't physically manifest any signs(…) I feel that it's almost my role to, not be hardened (…) to be strong (…) not that it's expected or looked down upon if you cry (…) it's almost like a societal thing (…) you're not supposed to act that way (…) as a student nurse you feel that you have to be hardened and not show any emotion to almost fit in (…) show that you're not just new to it (…) I felt like I kind of had to be solid.*

Chloe also explains how she presented herself in practice and with relatives of deceased patients. She relates that,

> *on the ward I would be very, what looks like cold hearted, wouldn't show a lot of emotion (…) quite closed off (…) quite stony-faced [laughs](…) I don't like showing emotion (…) I didn't want to break down in front of [the relatives] and them holding me up.*

I noted that Linda also shared assumptions of an expectation of professional non-displays. When I asked why she did not disclose with her mentor her own emotions around the ECE, she replies

> *I didn't want them [colleagues] to think badly of me as a student nurse (…) they sort of expect you to be professional and be able to deal with death and difficult situations without being emotional (…) it's just that sort of stiff upper lip attitude sometimes with nurses.*

The sources of such discourses are not always identified, but among participants there was reference to having to learn to deal with ECEs in professional nursing practice. Tara recalls being told by a mentor,

when you do become a nurse you really do need to be better equipped at dealing with these things.

Antony recalls discussion in classroom among students, some of whom had previously been HCAs, which echoes with his earlier suggestion of non-displays of emotions as an expected professional norm. However, in this next quotation I noted that the sources of such a discourse were his fellow students.

student nurses in my class, they had experienced deaths (…) would say 'Aw if you get caught up about it then nursing is not for you' (…) I don't think anyone really like challenged it or disagreed (…) I wasn't sure (…)[these other students](…) said there's a lot of deaths that you need to get used to (…) if you don't, if you're constantly displaying emotion or crying then nursing is not for you.

I found that some participants experienced contrasting discourses regarding emotional displays. For example, Holly tells,

the other deputy sister actually took me into the tearoom (…) and said 'It's ok to get emotional' that she would be more worried if I wasn't upset.

However, I noted by the frowns and nodding of her head from side-to-side, her confusion and frustration as she recalls being later reprimanded by her mentor on the same placement regarding her expression of emotions and reactions in the same ECE incident,

My mentor told me (…) that it wasn't acceptable and told me off.

Linda also received advice from a senior nurse about the acceptability of and need to express emotions.

> *She says, ' it's good to talk about it, you can't hold everything in (…) you'll just end up a mess and burnt out (…) 'this is a job and people will expect us to(…) be able to cope with dying, but if you need to cry sometimes, sometimes it's just better to cry' (…) I thought that by her acknowledging that it was alright to cry that yeah actually sometimes it is alright to cry.*

However, she also experiences contrasting advice from a ward sister,

> *she was very sort of stiff upper lip and 'You'll see lots of hard things (…) but you just have to get on with it'*

Other participants reveal examples of self-imposed non-displays of emotions as a strategy in navigating ECEs. Sometimes this was a conscious decision as a strategy of self-preservation or of 'survival' in hostile or unfriendly HSC environments. Recalling the unhappy and lonely experience in a placement in first year (highlighted earlier), Stella describes how she made a conscious decision to smile despite this being contrary to her own feelings,

> *I always had to put on like almost a happy face every day (…) I did do it quite well, but inside (…) I felt a bit sad (…) that was enough to get through them 6 weeks that was good work (…).*
>
> *I made a conscious decision that I wasn't going to let my mood affect anyone (…) am I going to go (…) and meet these patients and not smile*

at them and not make them feel happy or make them feel a wee bit at ease?.

Other participants undertook not to express or to disclose emotions as they considered that this would be evidence of weakness, thus implying that nurses should portray a hardened professional persona. For example, Samantha, despite having anxieties about violence in regard to a mental health placement in first year, describes her hesitance to disclose such anxieties because of how she might be perceived.

> *I didn't want them to think I was a complete wimp (…) to think 'This student is such a plonker, that (…) you come into a mental health setting and you're afraid, wise up' and I didn't want them to feel that I was prejudiced.*

Linda also suggests that expressions of emotions might be considered as weakness,

> *I didn't think it was appropriate for me to cry in front of doctors and OTs (…) I felt like they might judge me as being weak.*

In summarising this section, I interpreted that participants had contrasting experiences and views regarding expression of emotions in professional practice in response to ECEs. For some the uncertainty led them to be influenced by what they heard and witnessed from others who were perceived to have more experience. Such influences led some participants to avoid or

detach themselves from ECEs. In the next section I examine further findings as evidence of such detachment and avoidance of ECEs.

4.3:3. Detachment and avoidance of potentially emotionally challenging experiences.

Some participants struggled to find a balance as to when they should engage or disengage from ECEs. There is evidence in the findings that on occasions participants detached themselves or used avoidance of patients, relatives, or situations as a strategy in dealing with ECEs. For example, Katie highlights her uncertainty of professional behaviour as a struggle between emotionally engaging with patients and withdrawing from them,

> *(…) a balance between professionalism and having a whole heart for your patient, perhaps withdrawing slightly from your desire to give them exactly what they need to give them that ear and the workload and professionalism that you need to carry out all the other tasks.*

Antony considers that there are circumstances when it was appropriate to engage with emotions, but also views that there is an expectation to detach from patients and/or relatives.

> *I think it's perfectly ok to sit down with a patient or a family member and express emotion, because when you meet a patient, you get to know them and although you're supposed to (…) detach yourself, you don't get too close, but you still make an emotional connection.*

However, he adds,

I think particularly with learning disability nursing and mental health that there is a level that you can get too close for the patients' sake, they're emotionally vulnerable.

In the quotations above I interpreted these as Anthony's opinions rather than his actual lived experience. As I noted earlier at the outset of this chapter that it was the participants actual lived ECEs rather than opinions that may be expressed that I sought. However, the quotation below highlights important lived experience of the influence on such opinions. Anthony clarifies that his views are based upon influences from what his fellow students have shared rather than his own experience,

Particularly with learning disability nursing and mental health (…) I haven't had a mental health placement myself yet, but other people in my class have talked about service users or patients (…) there is a level that you can get too close.

In response to perceived hostile experiences some participants reported withdrawing themselves from the situation. For example, Tara, reports how she withdrew from a hostile and emotionally upsetting confrontation with an HCA.

I just got up and removed myself went into the toilet, couldn't stop crying.

Holly recounts how the ECE with a patient in second placement, led her to withdraw contact from the patient.

> *I didn't go back into the bay (…) I couldn't go in there for a couple of days.*

I considered that Rosie's ECE remained a deeply emotional issue for her as she often paused to dry her tears during the interview. She recalls her struggle as to whether she could engage with relatives of a patient who had died. In this instance she distanced herself but expresses remorse at doing so.

> *I remember thinking about it for like a good hour after, just thinking about him (…) his family came and they were standing [crying](…) I seen his son standing outside the door and like it went through my head (…) should I go over or like should I not? And I chose not to, but I also regret not going over.*

Overall, this section provides some examples that when participants were uncertain or unprepared as to how to navigate ECEs some selected to avoid patients or situations as a means of preventing further exposure to such challenges.

4.4. Planning, preparation, and preparedness for ECEs.

An important aspect of the aims of this study was to seek greater insight into nursing students lived experiences of their preparation and preparedness for ECEs. I noted in my reflections the need therefore to ask specifically about

previous preparation or experiences that might have helped participants in their navigation of ECEs. One sub-ordinate theme that emerges from the data relates to the expectations and consideration of participants' preparedness and abilities to engage with potentially ECEs. In some of these experiences learning was unplanned and opportunistic, i.e., participants were invited to witness or partake in an event or experience by other professionals or HCAs. From participants reports there is evidence to suggest assumptions by mentors, other professionals, and students themselves that prior or early exposure to experiences such as death and dying would better prepare participants for future ECEs. Maria explains how in first year she wanted to be involved in caring for a dying patient.

> *I wanted to be involved, I want to be exposed to this so that it doesn't shock me when I am actually responsible and have to deal with it*

Samantha reports,

> *it's always sort of said 'You're going to come across all these situations, and you know, you have to learn how to handle them'.*

Adam also highlights how he wanted to have early exposure to potentially ECEs experience at an early stage in first year

> *dealing with cardiac arrest and stuff like that (…) all the big things (…) I felt like they were important to me, I was able to experience them.*

Among the reports there was evidence of participants experiencing occasions, when they were encouraged by HSC staff to engage in activities as part of their learning and to get involved in procedures or situations which were complex or unusual, but also emotionally challenging. In several such experiences, participants were exposed to what both they and I considered extremely ECEs which they had not anticipated or had little or no preparation. Even among those who had previous experience of patient deaths, participants still felt unprepared for aspects of caring for the deceased, traditionally referred to as "last offices". As Antony highlights,

> *despite the fact that I had patients before that had died and relatives, it's still always a shock.*

Rosie also highlights an experience on a medical ward in first year where she,

> *'thought I was in here to help you toilet him', so they were obviously doing the last offices and they offered do you want to help with it but I was kind of in shock (…) they maybe didn't realise that that was like my first death or anything.*

Antony recalls how following the death of a patient that he had cared for, he was unprepared when asked by other nurses to join his mentor who was dealing with cardiac resuscitation of another patient.

she passed away. I was working on the ward beside but when the crash trolley came in, I was told if I wanted to come in and watch and then she died there.

Linda, with previous experiences as an HCA, reports on her experience as a first-year nursing student on second placement, being asked to help with aftercare of a deceased patient.

I've never been in the room when someone has passed away and I've never had to perform last offices(...) I had said 'Well I haven't ever done it before so I don't feel I would know what to do' (…)I was thrown in at the deep end (…) I don't feel like it is the right thing for me to have done (...) she just said to me, do you want to go with the care assistant (…) you can perform last offices and get him [the patient] ready for the coroner.

Linda suggests she would like more preparation to include a reflection along with practical skills for death and dying.

If we had done a reflection, I would have talked about it (…) I don't feel like the university prepares students going out for death and dying (…) before (…) first placement that topic should be broached and they should say 'this is last offices and this is what you do (…) to prepare you (…) I have had two placements and nobody has talked about that. I don't feel like they're preparing students properly for that.

However, this is not a view shared by other participants who identify that they had experienced preparation in the HEI on how to deal with subjects such as death and mental health.

Chloe recalls how her mentor prepared her to care for the death of a patient

> *she sort of prepared me a wee bit and I was like 'right ok'*

Rosie shares her experience of preparation for death and dying,

> *in first year, we talked about a lot of death and this year we've talked about it in lectures as well how to deal with it.*

In the interview with participant Maria, I noted that even when she spoke of her own ECEs she avoided direct eye contact with me and often physically shifted her head to look away. My impression was that she did not wish to show any emotion during the interview. There is some ambivalence in her reports on her experiences and expectations of preparation on subjects such as death and dying,

> *we have had an awful lot of lectures on death and dying (…)it is good that [the university] have tried to prepare us (…)but lectures only do so much, you need some sort of practical (…)It is a very sensitive topic(…) and it can be quite controversial(…) by the end I(…)I didn't want to hear about death and dying anymore (…) it's not something you learn in a lecture, it's just real life.*

Some participants assumed that they themselves should have known what to do despite having had limited knowledge or experience. For example, as Holly highlights her own assumption that because she is older that she has knowledge and ability beyond her status as a first-year student.

I thought 'I'm a first year nursing student' (...) I know that I'm old and I should be able to handle all this and I suppose people look at me my age and think 'You're a first year nursing student but you're an adult, you shouldn't be getting upset like this.

In recalling the earlier highlighted ECE, Samantha expresses feelings of guilt and assumes that she should have known how to deal with the situation despite having limited preparation or previous experiences for the situation,

I felt bad (…) I should have known (…) been able to handle that myself. I shouldn't have been <u>scared.</u> I should have went (…) don't need to be afraid'.

Some participants refer to lack of information and preparation in relation to specialised placements, confiding that this left them in a position where they felt overwhelmed and unsupported when encountering ECEs.

Sally recalls experiences of a specialist learning disability HSC placement,

it just really shocked me (…) you don't think when you hear of learning disability that it can really be that extreme (…) there was challenging behaviour and I <u>didn't feel prepared</u>. (…) I just didn't feel like we had enough experience to deal with challenging behaviour so I would have panicked.

Sally also shares her experience of lack of preparation,

if my mentor had of took me aside and gave me some information (…) insight into (…) some of the patients' conditions (…) I felt with very little

knowledge on learning disabilities (…) if I maybe had of been told (…) that this person can understand to this level or this person can't understand at all (…) that might have helped me be able to cope with it better.

Linda recounts a first-year placement in a specialist children's unit caring for children who had been sexually abused, was unplanned with little consideration of her ability to deal with the ECE,

other than being told it was looked after children, I didn't realise the severity of what I was walking into (…) my first placement (…) [her mentor] sent me out to clinics and one (…) a child development clinic (...) that was all the information I was given (…) without even any warning, they started into talking about all the children (…) and all the history of sexual, mental, physical abuse (…) I wasn't prepared for that.

The following excerpt helps to convey the anxiety that Samantha recalls prior to her placement. While acknowledging having preparation for mental health settings, some of her apprehension seems to emanate from experiencing conflicting messages specifically about potential experiences of violence in mental health settings.

two (…) mental health lecturers. One (…) asked, 'What are you worried about?' I said, (…) violence and aggression. He said (…) very reasonable. The other lecturer, who became my link lecturer said, 'No, that's a prejudice' (…) you will never come across violence (...) He made me feel like (…) it would be abnormal (…) one of them was great and he was like 'yeah I can understand why you feel like that but(…) the other(…) I felt

> *like he thought I was pre-judging people and that I was stupid for even saying that, he appeared annoyed with me.*

In summary of this section, I found that there is evidence that the unpredictable nature of the practice environments can create ECEs for participating nursing students. While there are some contrasting experiences regarding preparation for death and dying, there is evidence among participants' experiences that they considered that they had insufficient knowledge and preparation to dealing with ECEs. Some participants report being distressed and overwhelmed in dealing with new ECEs. In this next section I examine the participants' experiences of support sought, offered, and utilised in relation to such experiences.

4.5. Support sought, offered, and utilised in navigating emotionally challenging experiences.

In this section I outline some of my findings regarding support that nursing students sought or received around ECEs in placements. Among the findings there was evidence of participants experiencing support in relation to ECEs from a range of sources including mentors.

Linda reports on her mentor's reaction after Linda disclosed that she was feeling uncomfortable in being asked to perform last offices,

> *she was quite supportive of the fact that I didn't feel comfortable*

Tara experienced support from a nurse when she (Tara) was emotionally upset following a hostile encounter with an HCA,

> *one of the nurses had come around and went and sat down beside me and went '(…) are you ok?'*

Maria also describes positive experiences of support received from mentors,

> *I've had some honestly fantastic mentors (...) they often would check in with me like 'Is everything ok? Are you ok?'.*

Antony shared his experience of his mentor checking on how he was feeling following the death of a patient,

> *my mentor was good (…) She took me aside and was asking me what I felt about it and was I ok*

Samantha communicated how nursing staff were supportive in relation to the violent ECE in a mental health setting highlighted earlier in this chapter,

> *Very supportive (…) one guy (…) was excellent (…) he said to me 'Are you ok? We'll talk about this the next time you're on shift. I'm really sorry you've witnessed all this today (…) on the next shift one of the staff said 'We heard what an awful day you witnessed yesterday, are you ok? Do you want to talk about that?'.*

Chloe shares her experience of other support received following the death of a patient,

The sister (...) said to me how I was getting on (…) and that I'd experienced death (...) 'you know you can come and talk to us there's no issue with anything like that'. She just asked how I was feeling now and was I ok.

However, other participants report limited support offered or received from mentors and other staff. Katie describes her feelings of being abandoned in her first HSC placement, which included experience of caring for a dying patient.

I felt abandoned, left to my own devices and told to go and learn the basics with the healthcare assistants (…) I felt very much neglected, I wasn't looked after as a human being.

For Rosie the opportunity,

to have even talked it through at the time would have been helpful.

4.5.1. The participants experience of support from personal tutors.

As I recounted in Chapter One, the experience of the death of a patient had been raised by a student to me in my role as Personal Tutor (PT) and had been an impetus for undertaking this study. The participants' experiences of the role PT in providing support and advice around ECEs was one that I was particularly interested in. When asked about support from PT, participants report different experiences of the support received of those undertaking this role.

Holly's facial expression and raised tone of voice revealed her continued anger regarding the role of the PT. She reports that her PT took on a reprimanding role when she [Holly] shared in a written reflection of the ECE in which she had become upset and tearful when caring for a patient whom she knew,

> *my personal tutor basically ripped it to shred (…) said that I hadn't taken ownership for my actions (…) whether I felt what I had done was professional or otherwise.*

Stella shares an experience of contact with her PT which led her [Stella] to view her PT mainly in a reprimanding role, rather than someone who would provide pastoral support.

> *The personal tutor doesn't seem to be in contact (…) the impression that a lot of us get (…) if you're in trouble or you're causing trouble you are going to see your personal tutor (…) if you're well behaved and you're a good student you are not.*

Tara joked and laughed during the interview when telling her experience of her PT. Despite specifically requesting to meet her PT also experiences a lack of support,

> *I don't think I've ever had support from my personal tutor (…) me and another student wanted to meet [the PT] (…) [the PT] emailed us back to say 'you don't need to see me '(…) they didn't see us even though we asked to see them.*

Linda highlights her experience of a limited interactive relationship and a lack of support from her PT,

> *I didn't talk about it with them (…) there's such a limited interaction with them I don't think I know them well enough.*

Sally also reports a lack of relationship and communication with her PT.

> *I wouldn't say the relationship was bad, but I don't think it's good (…) There's not a lot of communication.*

4.5.2. Participants experience of support from Link Lecturers.

Participants report varied experiences in relation to support from link lecturers (LL). Sarah reveals contrasting experiences of support from LL's over a six-week period in two different placements in her first year,

> *my first 3 weeks placement (…) my link lecturer came out (…) the way she acted (…) comforted me(…)Whereas in the 2nd, 3 weeks it didn't really feel like I had anyone (…) I didn't hear boo from my link lecturer, so I felt slightly isolated.*

Linda contrasts her experience of lack of contact from her LL with other students' experiences,

> *I had no contact with my link lecturer (…) in my first placement (…) other (…) students (…) their link lecturers all came out to see them (…) I got an email (…) when you only get an email and you can't put a face to the name, I don't think there's that sort of support.*

The importance of a personal relationship between students and those in supporting roles is highlighted in the extract from Rosie who shares her experiences of support from her LL,

> *I got a visit on that placement, but I didn't really get to talk to them for that long. However, would I have opened up? I don't know.*

Katie explains how her reluctance to access support from the LL was shaped by an early experience in which the same LL took on a reprimanding role, which Katie viewed as supporting the mentor rather than providing support to her,

> *the link lecturer (…) I got an instinct that she had a relationship with my mentor (…) she had relayed on how my mentor had felt and asked me did I understand where I had went wrong and of course you know I said yes (…) that basically was the long and the short of the conversation so I didn't feel it would have been any use at all.*

Samantha tearfully shared with me how her experience with a lecturer in preparation for mental health placement (highlighted earlier) later impacted on her feeling unable to approach that same lecturer who was in a LL role.

> *my mental health link lecturer and if you've any problems (…) you're supposed to go to him and the reason I went to [Year Lead] was because he was the link lecturer who gave the lecture and said 'You won't come across any (…) when he gave the lecture, he was almost angry.*

Instead, she sought answers on how to deal with the ECE from her academic year lead at the HEI,

I emailed [year lead] (…) 'Can you help me handle this? I don't know what to do. How do I act? How do I deal with <u>these feelings inside me of fear</u>'?

Sally suggests that because a relationship had already been established with the year lead, she felt more able to discuss fears about challenging behaviours of clients in learning disability placement

my year lead, rather than a link lecturer because obviously like my tutorial teacher, I see her every week and you have that closer bond(...)It was very warm, it was concerned.

4.5.3. Participants experiences of support from other students in relation to ECEs.

While some participants recall support from other students during or close to the time of ECEs, others report a reluctance to share their experiences with other students. Samantha articulates her experience of support from a fellow student after the violent ECE in a mental health setting,

The second year student (…) a mental health nurse (...) 'Ok we're going to make you a cup of tea, sit you down' because I was shaking (…) He said 'It's ok(…)to feel vulnerable (…)to feel scared, this is not normal and it's ok to be frightened(…) he was really good, he was like, ' bring yourself down from being so frightened and go home tonight and try and unwind from this'.

Linda recollects that her only experience of support was from another student,

Another student had come in (…) briefly we discussed it (…) but other than that I didn't really talk about it. I didn't feel like I could go home and talk about it with anybody.

I noted an underlying sense of anger and disappointment as Antony raised his voice a little when he reports that the only person, he felt able to talk to regarding the ECE in caring for a patient with dementia was,

another student nurse, a third year (…) she was good. She would have been the only person I could talk to.

Sharing of experiences with other students was often undertaken both formally and informally in the context of tutorial groups when the students return to the HEI following placements.

Tara appeared upbeat when she highlights how,

we all reflect, we all tell our stories when we come back and I'm pretty sure it always happens in tutorials.

Sarah also reports,

when we all came back (…) we all reflected on our practices and what was good and what was bad.

Linda explains that because others were sharing their experiences in tutorials this enabled her to share her own,

I was able to talk within my tutorial group about how I felt, I was a bit emotional (…) talking about it within the confines of a room that I knew

it wasn't going to go any further it did help (…) the reflections help and knowing that it's a safe place to talk(…) if you said to me to get up in front of your whole year group and tell us about your experience (…) I wouldn't feel comfortable (…) in a small group and everybody is sharing their experiences and the fact somebody (…)shared their experience (…) that they had shown emotion, it sort of validated me showing emotion.

Stella's experiences led her to view sharing in tutorials as being positive,

We probably would all benefit from more of those reflective sessions because in a way it's just like throwing out all the emotional baggage (…) the best thing to cope with all this is talking about it and letting it out and being able to express it instead of being afraid to say anything.

However, willingness to share ECEs varied, and some participants appear to self-censor as to what they could or not should share with others.

Despite being quite open with me in the interview, Samantha explains a reluctance to share her ECEs with friends,

I actually have a group of really good friends in university, but we don't really talk about emotions (…) about anything too deep.

Maria also recalls her reluctance to share her experience of a patient's death in a tutorial,

After practice we would usually have (…) informal discussion where you could choose to bring up things (…) it wouldn't be something I was jumping to bring up. When someone else was saying 'It was really good I

> *got to see this' and then I go 'Oh one of my patients disclosed that they were ready to die'*

Holly, however, has a differing experience of feeling compelled to disclose within a tutorial group, I noted that amidst her tears and from her facial expression and slightly raised tone of voice during the interview that she remained quite angry about the experience of sharing within the tutorial.

> *we had to share about the reflective piece (…) after our first placement. Nobody else was willing to share theirs, so I read mine out and the message that I was getting (…) be a wee bit harder on yourself (…)*
>
> *I'm not entirely sure that there is a need for people to lay themselves bare over every emotional response (…)I don't feel that the support mechanisms are set up (…) that you are not left with all this emotional baggage(...) I was expected to really dig deep as to what it was that initiated that response [crying](…) if you want me to go that deep you need to set up something there as a safety net to help me deal with stuff that maybe I'm not aware of yet. Maybe it's ok if you're dealing with youngsters, who are still living with their mummy's and daddy's and have that support mechanism (…)I did feel it was a bit of a slap in the teeth that I felt that I hadn't done enough with my response (…)I do feel that there is this constant push to 'what have you learned from this and how are you going to change as a person?' and I'm not entirely sure that I came into nursing to change me as a person.*

Holly's comments suggest that her experiences of sharing her reflections on the ECE in a tutorial was not supportive, but she also suggests that some students may have support from family.

4.5.2. Family and friends as sources of support.

Participants shared different experiences of support from friends and family. Maria explains that she used family as a support network in dealing with ECEs,

> *My granny, I would phone her quite a lot (…) I think she found it quite heavy (…) I actually find it really quite helpful because if something annoys me, I can phone and talk to someone about it. It does make things easier (…) nice to have a support network (…) when I rang my family it wasn't that I was upset, it was more that I am trying to process this and think how I can deal with this in the future.*

Antony recalls,

> *going home and talking to my parents about it because some of the stuff that the patient was talking about was really deep and depressing.*

Samantha explains how she shared her experience with her husband.

> *I went home and I told my husband (…) about the situation (…) and how scared I felt.*

Tara also highlights how she sought support from her parents.

> *I told mummy and daddy (…) if I'm going to talk about something like that it's going to be with my family.*

Stella recalls the impact of being away from family on her first placement,

> *I live a good 2½ hours away (…) I got somewhere to stay (…) I was away from my children (…) that put a lot of pressure on me emotionally. I felt very sad and very lonely (…) isolated (…) detached from peers and family (...) I didn't feel like there was anybody I could really talk to (…) didn't have any friends in the city (…) friends that I had made in university, they were mammies (…) with children (…) they didn't have time to meet up.*

Linda despite being able to travel home didn't feel that she could share with her family. She expressed,

> *I didn't feel like I could go home and talk about it with anybody.*

4.5.4. Barriers and facilitators to accessing support or sharing experiences.

Some participants were aware of support networks available to them but didn't see the need to utilise them. Maria recalls,

> *I probably could have looked for support if I felt like I needed to (…) it depends on what you've previously experienced in life as to how you feel.*

Tara highlights some difficulty in sharing emotions,

> *from day one (the university) (…) said if anyone has any problems speak to your mentor, to the sister, or speak to us. Which seems like such a simple thing but it's not.*

Her reasons included,

> *not wanting to be a complainer*.

Chloe despite seeing her mentor in a positive light and experiencing sadness at the death a patient does not want to be a burden.

the mentor is lovely but (…) we were so busy, I probably felt that I would be taking time out of her day for her to sit down and talk to me, but I know she probably wouldn't have seen it as that.

Antony reports that because of the experience of the placement as hostile

I didn't get along well with them (…) they didn't ask me how I was getting on but if they would have, I don't think I would have felt comfortable talking to them.

One barrier to seeking support appeared to be a misunderstanding of the nature and extent of confidentiality. The following extract from Sally highlights a perceived barrier to sharing emotions.

Not that I would break confidentiality, but you just feel like what if I say too much (…) in nursing everything is so confidential(...) you can't really tell anyone how you feel (...) because it's confidential.

Stella when asked whether she had spoken to anyone about her ECE replied,

I didn't (…) because everything is confidential (…) you can't really talk about (…) anyone as far as I'm aware.

In my findings there were examples of how participants experience of social and behaviours norms within healthcare teams, impacted upon their [students'] own reactions to ECEs.

Antony compares contrasting experiences that he had of nursing teams' responses to death. Commenting on one experience involving death he recalls,

> *in that hospital setting the staff were a lot better at talking to each other (…) would (…) amongst each other ask if they were ok and talk about it.*

Whereas in relation to a later experience of death in a different HSC context he describes,

> *the way the nurses handle it, they obviously were very experienced (…) almost a bit hardened and emotionally resilient (…) not that they wouldn't have cared (…) they were easier at switching off. Once the family had gone home, they didn't talk about it (…). It kind of was, not brushed aside (…) everyone moved on to other work (…) It wasn't talked about (…) not even between the other nurses.*

Antony's own navigation of ECEs is shaped by how he sees others behaving,

> *I was thinking about it quite a lot(…) I'm sure if I had of talked to one of the nurses that they would have been open to talking about it(…) because no one else was(…) I didn't initiate any conversation about it (…) I would have liked the nurses, not necessarily to come to me to talk about it but them to be more open about it (…) even between themselves(…) even in the break room or just take another member of staff aside to make sure that they're ok.*

Maria reporting on her first experience of death in HSC acknowledges that while the nurses appeared *'quite emotional and upset'* that no one talked to her about the event.

I knew what had happened (…) when they put her into the side room and put the little card up, I kind of got confirmation (…) no one actually really told me.

Rosie had a similar experience where there was no discussion or sharing among staff regarding the death of a patient,

I don't know what they thought about it, but they never mentioned it to me. I think it was probably a bigger deal to me because I hadn't ever seen someone who had died.

Linda however was enabled to express her feelings whenever other nurses first raised discussion around the death of a patient.

we performed last offices and we were waiting on the coroner coming to take the body (…) one of the nurses had broached the conversation (…) because she expressed her opinion that then allowed me to voice how I felt.

Despite her inner emotions, the hostile HSC environment which Stella experienced was a factor in not disclosing her emotions to others. She highlights her reluctance to share her feelings of isolation while in this placement.

I did talk about some things (…) but I didn't really talk about being alone or being isolated, I did keep that to myself.

To summarise this section, there was evidence from participants of positive experiences of support offered and received from mentors and other nursing and healthcare staff in relation to ECEs. However, there was also evidence that while participants were aware of support networks and systems available, they [participants] did not always utilise these. Among reasons given include perceptions of how others were reacting to the ECE, lack of rapport with the individuals undertaking the support role, and perceptions of those in such roles as disciplinary rather than supportive. This is also echoed in the use of reflective sessions which encouraged sharing of ECEs. While some found these to be helpful, others were reluctant to share their experiences. Among the reasons outlined were that reflective sessions were reprimanding rather than supportive. There was evidence of use of informal networks such as family and friends. However, there were also barriers to the use of such networks, such as being on placements which distanced the student from their usual networks, fear of breaching confidentiality and not wanting to burden on family members.

4:5. Chapter conclusions.

The findings outlined in this chapter have contributed to answer the aims and questions of the study. The super-ordinate themes that emerged from the rich data include:

- Strategies used by participants in navigation of ECEs.
- Participants’ experiences of planning, preparation, and preparedness for ECEs.in practice.
- Support sought, offered, and utilised in navigating ECEs.

These themes describe the essence and my interpretation of participants’ lived ECEs in practice. In the next chapter, I discuss these themes and their meaning in the context of what is already known in wider literature around navigation of ECEs. In doing so, I formulate and provide new knowledge and understanding as to how participating nursing students from my own HEI navigate ECEs.

Chapter 5: Discussion.

5:1. Introduction to the chapter.

This chapter provides discussion of the findings, which are grouped under three super-ordinate themes arising from my analysis and interpretation of the data as presented in Chapter Four. The super-ordinate themes are: -

- strategies used by nursing students in navigating emotionally challenging experiences (ECE) in practice.
- support sought, offered, and utilised in relation to ECEs.
- nursing students' experience of preparation for ECEs.

In this chapter, Chapter Five, these, and the sub-ordinate themes are discussed in the context of related literature and the aims and study questions as set out earlier. The chapter also includes summary of the main findings.

5:2. Nursing students' emotionally challenging experiences in placements.

As outlined previously, the overall aim of this study is to gain greater understanding of nursing students' navigation of ECEs in practice. As anticipated, caring for dying patients and their relatives and aftercare of the deceased are significant ECEs for participants. However, there is evidence that participants experience a range of other ECEs. Similar to the findings of Curtis (2014) and Heggestad et al. (2018), in my study there is significant evidence of several participants being emotionally challenged by the suffering and illness

of patients whom they encounter and cared for. Several participants' ECEs include inability to communicate or to provide an expected standard of care, leadings to feelings of failure, frustration, and inadequacy. There were also several examples, where participants describe being overwhelmed and ill-prepared for exposure to aggressive and hostile situations. These include ECEs, such as being subjected to hostility, verbal aggression, and unprofessional behaviours from health practitioners. Such experiences share some commonalities with the findings of Weurlander et al. (2018) who report in their study, that participants were exposed to unprofessional behaviours by nurses and other healthcare staff, which left participants with feelings of guilt, anxiety, and unease.

While many participants in my study report positive experiences of support from mentors and other healthcare staff, others recount ECEs, such as aggression arising from registered nurses or healthcare assistants (HCA). Several participants report their emotional upset at being reprimanded by both practice and HEI staff for having shown or sharing personal emotions about ECEs in practice. These include experiences of being reprimanded by mentors, senior nurses, lecturers, personal tutors, and tutorial leads. One participant encountered a particularly violent and frightening ECE in a 'taster', mental health placement. Her experience was preceded by being reprimanded

by a lecturer, when she (the student) asked about the possibility of violence in such placements and being told that she was unlikely to encounter violence. The ECE of another participant in a 'taster' experience, included dealing with issues regarding sexual, mental, and physical abuse of children. The experience elicited a range of emotions such as anxiety, fear, sadness, and helplessness for the participant. Such experiences during placements have been reported by Bakker et al. (2019) as among factors leading to dropout by nursing students from nursing programmes. Hamshire, Willgoss, and Wibberley (2013) and Hamshire et al. (2019) in a two-part survey of factors influencing attrition rates by healthcare students, found that difficulties associated with placements were among the main factors. Some 1st year participants in my study indicated that ECEs led to uncertainty about their ability to continue on the programme and whether nursing was a suitable career for them. In examining the data and from notes in my reflective diary, I noted that many participants in 2nd and 3rd year of the programme, reported ECEs as occurring in 1st year practice placements. This might suggest that ECEs impacted on students in earlier practice placements and that students had not developed strategies in which to navigate or seek support in relation to such ECEs. However, there was also evidence that some participants in the early part of the programme, were able to share their feelings and vulnerability, by accessing support from others

including mentors, fellow students, and others from the HEI. Participants' access to support and the support offered, utilised, and received in relation to ECEs are discussed later in this chapter, but I first discuss in the next section, strategies used by participants in navigating ECEs.

5.3. Strategies used by nursing students in navigating ECEs in practice.

Similar to Dewar and Cook (2014) and Wilson (2017) I have argued for more explicit recognition of how nurses connect emotionally with ECEs in practice. One of the main questions of this study, therefore, is to understand how nursing students navigate ECEs. In this study, there is evidence that participants wanted to engage with ECEs, despite feelings of fear or uncertainty that such ECEs evoked. However, I also found evidence of struggles and tensions among all participants, with knowing how, and to what extent they should engage with ECEs. Such a tension resonates with findings of others as discussed in Chapter Two, such as Terry and Carroll (2008); Cadge and Hammonds, (2012); Jack and Wibberley (2014); Curtis (2014) and Garrinno et al. (2017). In the next sub-section, I discuss how frustrations and feelings of inadequacy, led participants to seeking information from different sources and greater knowledge of conditions and early exposure as strategies in mitigating ECEs.

5:3:1. Knowledge and answer seeking and early experience as strategies in mitigating ECEs.

One sub-ordinate theme that emerges, is that of knowledge and answer seeking as a means to mitigate the impact of ECEs. For some participants there is a perception that ECEs relate to their lack of knowledge and experience of specific patient groups, illnesses, or conditions. Such participants describe feeling out of control, especially when meeting with ECEs or patients' conditions for which they (participants) had no prior preparations, knowledge, or experience. Such ECEs arise especially when dealing with patients who have conditions affecting their ability to communicate or with whom participants struggled to communicate with. Such struggles are often viewed by participants as a reflection on their own abilities, leading to feelings of guilt, frustration, and inadequacy. Other participants experience frustration at being unable to provide a standard of care, or address the patients' needs to a standard that they (participants) desired. Such findings share some consistency with those of Hilliard and O Neill (2010) and Kornhaber and Wilson (2011) who found that nurses encountered feelings of distress, powerlessness, and guilt when unable to assist patients and to effectively provide care. In this study, such feelings sometimes are an impetus for seeking to learn. A frequent strategy in response to such ECEs, is to try to gain greater knowledge, develop communication and psychomotor skills and understanding of conditions.

Participants sometimes engage in cognitive approaches, such as trying to find more information about conditions affecting patients, so as to be able to communicate and engage with patients as a strategy to try minimising the impact of the ECEs. These findings resonate with McCloughen and Foster (2017) who found that students engage in such cognitive strategies as a way to manage ECEs. My findings also echo with the work of Heggestad et al. (2018) who reported that participants in their study (1st year nursing students), believed that they could handle demanding situations by gaining more knowledge. There is also evidence in my findings of a perception among participants that early exposure to ECEs, would make it easier to deal with similar future ECEs.

In Chapter One, I argued that there is a dominating focus in nurse education on cognitive and technical skills in preparation of nursing students, with emotional and relationship elements being seen as secondary. This is borne out in this study with evidence of participants seeking to develop theoretical cognitive knowledge as a means of dealing with the emotional impact of ECEs. As highlighted in previous chapters, a concern to me at the outset of the study was, what awareness and understanding nursing students have of their own emotional responses in extending themselves to care in ECEs. While knowledge seeking is a strategy used, there is limited evidence of participants

seeking to develop self-knowledge or recognition of their own emotional needs when encountering stressful interpersonal relational aspects of practice or navigating the complexities of ECEs. Although some participant's experiences led them to reflect informally, by thinking alone on the ECEs either or talking with family members, there is limited evidence of participants seeking knowledge of self and how ECEs impact on themselves. Wilson & Carryer (2008) and Cricco-Lizza (2014) argue a fundamental aspect of nursing practice and nurses' knowledge and understanding is the ability to recognise and manage emotions in themselves and others. My study shows that nursing students do not adequately consider their own emotional needs as part of nursing professional development. This therefore remains a concern, in that, failure to recognise and address the emotional reactions may have detrimental implications for nursing practice and for nursing students themselves. Some authors such as Vahey, et al. (2004) and Elliot (2017) caution that inability to manage and deal with stressful emotional experiences can lead to fatigue and burnout. While in this study, I did not specifically aim to study negative impacts of ECEs, there is evidence that such experiences continued to impact on several participants after the event, such as crying in the car when driving home, or sharing their upset with a partner, relative or friend. For some

participants, the ECEs continued to be a source of distress many months and even years later, as manifested during the interviews for the study.

While there is evidence that participants sought to engage with ECEs, I also found that for some there was uncertainty, as to what extent they should give of themselves and engage with patients suffering, and when it might be important to disengage. Kinman and Leggeter (2016, p.89) stress that while it is important to understand how nurses make empathic connections, it is also important to understand how they "construct emotional boundaries when interacting with patient and their families and the implications for their well-being". In the next section, I discuss other strategies that participants use as boundaries in navigating ECEs, including avoidance, distancing, non-engagement, and disengagement.

5:3.2. Avoidance, distancing, non-engagement, and disengagement from ECEs.

As highlighted in Chapter Four, another sub-ordinate theme that emerges in the findings, is that some participants in dealing with ECEs, used avoidance of patients, relatives or potentially ECEs as a strategy. This sometimes manifests in the participant removing themselves from the situation or avoiding interaction with the patient or relatives or the situation. These findings resonate with those of King-Okoye (2014) who found that nursing students

used strategies of avoidance and distancing from patients with cancer. Similarly, Terry and Carrol (2008) in a study of 1st year nursing students found that fear of dealing with death, had led one student to avoid a dying patient for several days. In my study there is also evidence of some participants, avoiding relatives of deceased patients or patients in ECEs for periods of time. Brunero, Lamont and Coates (2010) argue that a reason for nurses' disengagement from emotional aspects of practice, is that there is a fear that healthcare professionals who lose their "objectivity" may risk becoming overwhelmed by emotional aspects of care. Similar to my own findings and to those of Terry and Carrol (2008), Cricco-Lizza (2014) in a study of neonatal nurses found that among coping strategies used by some, was withdrawing from emotional pain and avoidance of the emotional demands of the job.

The findings of my study also resonate with those of a study by Michaelsen (2011) of registered nurses caring for older patients. Michaelsen (2011) found that participants used avoidance and emotional distancing as a survival tactic against potential negative impacts of dealing with so called 'difficult patients'. In my study there was evidence of such a strategy being used by several participants to avoid or 'survive' difficult ECEs. Michaelsen (2011) highlights, that in their study this avoidance strategy or emotional distance, meant for some participants that they were not always able to recognise patients' needs

and in one case this led to serious physical symptoms being overlooked. However, while my study did find evidence of avoidance, it did not seek to examine the impact of avoidance strategies on patients and there was no evidence found of negative implications for patients.

The findings from my study share a similarity with those of Hammonds and Cadge (2013) who reporting on a qualitative study among intensive care nurses, found emotional distancing was used by some as a buffer against stress. My study also found evidence that while participants continued to provide physical aspects of care, they sometimes maintained an emotional distance as a strategy to buffer from stress associated with their work. Emotional distancing in such situations did not always necessarily involve distancing from interaction or the provision of physical aspects of care provision. Participants report continuing to provide care while trying to maintain an emotional distance, for example, by being busy rather than taking time to reflect on and process what is occurring in relation to themselves or the ECEs. In my study there was evidence that several students, while continuing to provide direct care in ECEs, avoided eye contact or engagement with patients and/or relatives.

These latter findings resonate with those of Stayt (2009) and Hilliard and O Neill (2010) who found that such a strategy did not necessarily limit

interactions with patients. Stayt (2009) also explored EL of nurses caring for patients and their relatives in intensive care units, found participants frequently described the creation of a space between themselves and the families as a strategy for self-preservation. Such strategies involved attending to physical tasks with the patient as a means of distancing from relatives' emotional demands. My findings also resonate with the work of Hayward and Tuckey (2011) who in examining experiences of nurses' emotion regulation found a strategy where the nurse chooses to cognitively engage with patients and families but not at an emotional level.

In this present study, participants describe being advised by others to detach themselves from engagement or not to fully engage with ECEs as a means of protecting themselves. The sources of such advice vary from fellow nursing students to healthcare assistants (HCA) and some mentors. As I recorded in my notes after the interview had finished, one participant reported, that other students had told them '*to toughen up'.* In relation to advice given from other nursing students, such advice was often based upon previous experiences working as HCA. There is also strong evidence in this study which resonates with the findings of Chapman and Clucas (2014) that students do not always learn professional behaviours from other nurses but are significantly influenced by HCAs.

Previous experiences such as working as HCA appears to be a factor affecting how some individuals dealt with ECEs. Such participants often drew on their own experiences of ECEs while working as HCA, to advise others on how to navigate such issues. There was some evidence in this study that participants looked to their peers who had experience working as HCA for advice, as to how they should deal with ECEs. Some of the reported advice received appears to suggest that the approach should be one of keeping a distance and not getting too emotionally close to patients.

However, several participants report struggling to find a balance as to the level needed to detach themselves from patients suffering, while still making an emotional connection. Jack & Wibberley (2014) highlight such, as a balance between being human and being professional. Such a struggle is also echoed by Hammonds and Cadge (2013) who reported that among participants in their study (37 intensive care nurses), there was continual negotiation of emotional boundaries, which, for some, involved placing strict boundaries around emotional experiences, seen as mandated by professional nursing practice. The findings of my study indicate that this is an ongoing significant issue among nursing students, who often struggle to find a balance between detachment and engagement with ECEs. Faced with such uncertainties, the default position for professional behaviour often adopted by participants, is to

avoid emotional engagement and to suppress emotional displays. In the next section, I discuss findings as evidence of suppression and non-displays of emotions in professional nursing practice.

5:3:3. Suppression of or non-displays in relation to ECEs as an expected professional norm.

The findings of this investigation provide strong evidence that there is lack of clarity and uncertainty as to whether it is acceptable to portray emotions. Participants report many struggles to balance their feelings with perceptions of how they should act as professionals. When unsure participants frame their responses to ECEs in the context of perceived or stated professional expectations, or to follow the example of other professionals. Among many participants there is an assumption that non-displays of emotions are a professional expected norm in dealing with ECEs. There is also a perception that expressions of emotions would be considered by other healthcare professionals as unprofessional, or that participants would be considered as '*just the wee student'.* There is evidence of a reluctance to express emotions for fear of being judged by colleagues, even when working in a supportive nursing team. Terms used by participants to describe their responses include, *'packaged'* feelings, *'adopting an air'*, *'put on a brave face'*, *'being stony faced'*, '*being closed off'* or to '*bottle things up'.* Such terms echo with those found by Curtis (2014) who found that students adopted a hardiness persona. The

findings in my study also have some resonance with those of Weurlander et al. (2018) and Jack & Wibberley (2014) who also report that nursing students struggled in balancing a professional attitude with their emotional expressions. In my study some participants see this as putting their caring duties before their own emotional needs. However, others see suppression of their emotions as means of self-preservation or 'surviving' ECEs. The findings echo with those of Cecil and Glas (2015. p, 380) who found that nurses in their study described putting on a 'professional face' as a means of emotional protection and that such a "professional face was embedded in professional identity".

Diefendorff and Gosserand (2003, p.952) suggest that suppression of emotions is an emotion regulation strategy and may involve, "expressing positive emotions, such as cheerfulness and avoiding the expression of negative emotions". In earlier discussion in Chapter Two, surface acting has been found in many studies, to be a response to ECEs. There is strong evidence in the findings of this study, of surface acting being adopted as a strategy through suppression or hiding true emotions. For example, participants in my study report put on an outward smile or avoiding outward expressions of what might be perceived as negative emotions. These are used as a strategy to *'survive'* or endure what such participants experience as hostile or difficult ECEs. There is also evidence of participants being consciously motivated not to allow their

true personal feelings to impact upon the care that they provide to patients or relatives. Among such findings are reports of putting on a hardened persona or putting on a smile, despite feelings underneath of loneliness, emotional exhaustion, and sadness. As a consequence, participants sometimes felt emotionally overwhelmed and mentally drained or as one participant described the latter using a NI colloquial term, *'my head was melted'.*

Grandey (2000) and Brotheridge and Grandey (2002) argue that such methods of responding to ECE, require a level of effort by the individual and inauthenticity of showing expressions discrepant from one's true emotions may have negative implications for individuals, such as stress. Jack and Wibberley (2014) suggest that if there is a restriction from ones' authentic being there is a risk of emotional numbness. I did not specifically seek to investigate the impact of participants suppression of their emotions or emotional expressions, however, an important aspect of the aims of this study is to understand particular strategies or approaches that nursing students adopt to maintain their own emotional well-being while engaging (or not) in the ECEs of practice. This includes the participants' experiences of access to and utilisation of support, which I discuss in the next section.

5:4. Support sought, offered, utilised, and received.

In this section, I discuss the findings in relation to participants experiences of support sought offered, utilised, and received by participants in relation to ECEs. In their quantitative study of 3rd year nursing students, Gibbons et al. (2011) found that among various coping strategies used by students when experiencing the suffering of patients, or caring for the dying, was to seek emotional support from others. Smith and Gray (2001) in their study exploring nurses' views of support in relation to their emotional labour, found that it was mentors and link lecturers (LL) who were more likely to provide support regarding EL. In the context of the aims of my own study, this would suggest that existing roles of LL and mentor would be able to support nursing students in navigation of ECEs. However, in my study this is not always borne out and there are variations in participants' experiences of support sought, offered, and utilised.

Hammond and Cadge (2013) stress that it is important to understand EL strategies used outside of the work environment as well as within. I found that in response to ECEs, participants utilise both formal and informal support within placements, but also after and outside of such settings, including in the HEI. In many instances, participants recount how they received both instrumental and emotional support in such circumstances. Semmer et al. (2008) and Morelli et al. (2015), examined literature around support, and

highlight that support is often conceptualised into two distinct forms: instrumental support and emotional support. The former involving debriefing and practical advice on how to carry out a role and emotional support as facilitating discussion and expression of feelings (e.g., making someone feel cared for or comforted).

Among the findings of this study there are a range of experiences of support in relation to ECEs, which include to varying degrees both instrumental and emotional support. Several participants report their experiences of seeking and being offered advice from others, such as mentors on what course of action, the participant should take when meeting ECEs. Several participants report how they had been taken aside by their mentors or other nurses to be comforted and/or debriefed following ECEs, while others report talking through ECEs with colleagues, friends, and family. On many occasions where instrumental support was given this frequently related to advice on what strategies the students should adopt when facing ECEs.

While there is evidence of suppression of emotions as an expected norm, there is also evidence that participants often experience situations where they were encouraged to vent and express their emotions. Similar to findings by Jack and Wibberley (2014), in this study I found participants tried to make sense of their emotional experiences by talking to others. However, this was sometimes

hampered by factors, such as whether or not the participants felt at ease and comfortable with those in support roles. There were also differences among participants in regard to their sharing of ECEs with fellow students, family, and friends. As Jack and Wibberley (2014) suggest, finding others to share experiences can be difficult.

5:4.1. Barriers to support seeking

There is evidence from the data, that there are barriers to nursing students seeking and accessing support. These include the HSC placement location impacting on participants' normal support networks, perceptions of professionals in support roles as reprimanding rather than supportive and a lack of rapport with individuals in such roles. Among participants' reports, there are examples of uncertainty as to how much information about ECEs they could share with others. Sometimes participants stress being unable to disclose their true feelings or share or seek support regarding ECEs with family, friends of even colleagues, because of the participants understanding of confidentiality. This often left such participants trying alone to process their ECEs and their own emotions.

For some the placement locations, impacted on their normal support networks, particularly when they have moved from home to undertake the programme or undertake placements for periods away from their usual home.

Some participants report how this often led to feelings of isolation and lack of opportunities to discuss ECEs. The formal support structure offered or available by the HEI and or the HSC practice could be considered as especially important in such circumstances. In the next section I discuss participants' experiences of support from those in HSC practice.

5.4.2. Support from mentors and registered nurses.

Some of the experiences of participants in this study, have been highlighted in other literature as important when considering how to provide support for students during practice. Participants in this study report a range of experiences in relation to formal support and attitude of mentors in relation to emotional support. Similar to the findings by Curtis (2014) there was evidence that despite being aware of available formal support from mentors, students did not always avail of such support in relation to ECEs. As Jack & Wibberley (2014) and Bennett & McGowan (2014) highlight, the quality of mentorship and preparation and support of mentors for the demands of the role are important. As Ousey (2009) and Pearcey and Elliott (2004) suggest, mentors play a significantly important role of in terms of student's development of knowledge and skills and professional socialisation. Several participants report that they received offers of support from mentors and overall, their experiences of mentors were perceived as supportive, with some describing

the support received as '*excellent*.' However, despite experiences of support being offered or available from mentors and other staff, some participants often did not reveal to others how they were really feeling and often reported that they were *'okay',* even when carrying an emotional issue with them. In several instances this was because the participants saw their mentors as busy and did not want to be seen as a nuisance or to interrupt the provision of care. However, among the findings there was evidence that the opportunity to just talk things through with someone, such as their mentor, was experienced as being helpful, particularly at times of ECEs. However, similar to findings by King-Okoye and Arber (2014) and Weurlander et al. (2018) several participants report feeling 'abandoned' by mentors. Some participants reflect upon their experience of being mentored, as not always positive and report their view, that they, could have been better supported. In such instances participants questioned why the mentors were undertaking such a role. For some participants, the ECEs occurred in unfriendly placements where mentors themselves and register nurses were perceived as hostile to students and where the participants felt unable to share or disclose their emotions.

As highlighted in the literature review, the social-cultural context of ECEs was important. Kinman and Leggetter (2016) highlighted the need for opportunities for 'emotional venting', which they suggest are expressions of emotion sharing

to help nursing students' deal with ECEs in HSC practice. In my finding there are examples of how the culture within healthcare teams impact upon the students' own reactions to ECEs. The findings indicate that the 'team climate' and the social context encircling the participants, influence how participants respond to ECEs. There is strong evidence that participants' expression of emotions was validated by how other professional such as mentors shared their emotion and discussed the ECEs. Participants' own emotional responses or 'emotional venting', is often impacted upon by how other professionals discuss or display their own emotions. For example, participants' willingness to talk about ECEs, such as the death of a patient were influenced by the behaviours and reactions of members of the healthcare teams in the practice area. Participants report differing experiences of 'emotional venting', varied across differing placements. These findings have a similarity with those of Williamson et al. (2011) who argue that a crucial aspect in forming students' placement learning experiences is the attitudes and behaviour of ward staff and mentors.

Levett-Jones et al. (2007) who explored nursing students' experience of belongingness while on clinical placements, emphasise the importance of maintaining and developing an effective learning environment for students. Their study identified that the provision of consistent, quality mentorship was

important to help alleviate students' feelings of alienation, stress, and anxiety. However, from my exploration of the findings in this study, there is evidence of several participants struggling 'to just get through', or 'survive' placements which they experience as hostile and unwelcoming. These contribute and sometimes exacerbate feelings of isolation, alienation and increase stress and anxiety among participants. Van Rhynn and Gonstana (2004) found in their study that participants' stress was increased by what they experienced as non-supportive staff in HSC situations. Barratt (2018) also highlights that the manner in which colleagues work together is fundamental to establishing a supportive workplace culture and feeling supported in the workplace is important for emotional resilience. However, there was evidence from my study that some participants experienced being left alone and unsupported, especially in relation to ECEs, such as dealing with patients with dementia. In the next section I examine participants' experiences of other supporting roles such as personal tutor and link lecturer.

5:4.3. Experiences of support from personal tutor, link lecturers and others.

An earlier study by O'Donnell (2011) in my own HEI, which set out to identify the reasons for voluntary attrition in pre-registration nursing students, found that a significant number of participants reported that they were more likely to seek support and advice from peers rather than personal tutors (PT). While

there is some limited evidence from my study that participants sought support from peers, there are variations in participants' experience of access, utilisation and offer of support from their PT and link lecturers (LL). Some of which suggests a lack of clarity in how such roles were perceived and experienced. Some of the evidence suggests, that participants experience ambiguities in the roles, between being guardians of professional practice and the provision of pastoral support. While some participants report being 'very well' supported by the PT and/or LL, there was evidence of perceptions of such roles as being admonishing or reprimanding for errors or wrongdoing rather than supportive. In addition, requests by some participants for contact with their PT were sometimes dismissed if not related to the student progression. Similar to finding by MacIntosh (2015) there is a lack of clarity in regard to the role of nurse lecturers in relation to students' clinical practice. In this study, participants report that instead of accessing support from the LL or PT, they instead sought or were given support from those that they had a social relationship with, such as their tutorial or year lead at the HEI. Frequently, support utilised in relation to ECEs, was not confined only to those in formal support roles but was sought and provided by others with whom participants felt close to, such as family and friends and to a lesser extent peers. This resonates with Engster (2005) who emphasises the importance of a sense of

kinship in caring and that people turn to others with whom there is closes proximity or social relationships. While I highlighted earlier some barriers to support seeking, such as perceptions of confidentiality, there is also evidence that some participants' experiences led them to seek informal support around ECEs with a trusted peer, friend, or family member when they went home or when they left the HSC environment.

5.4.4. Peer support and shared reflections among peers.

O 'Donnell (2009), Curtis (2014) and Weurlander et al. (2018) found in their studies that participants reported that they were more likely to seek support and related advice from peers. However, this is not always evident in the findings of this study. There are mixed reports by participants regarding discussing ECEs or support seeking with peers. Some participants recall support received from other students during or close to the time of ECEs. While some indicate that they would share their ECEs with immediate group of friends or colleagues, others report a reluctance to share experiences with other students, even those who are friends. Where sharing of experiences with other students occurs, this is often undertaken in both informal and formal reflections in the context of tutorial groups when the students return to the HEI following placement.

Authors such as Kinsman and Letter (2016) and Weurlander et al. (2018) emphasise the importance of trust and non-judgemental relationships and mutual support in peer venting of emotions. They acknowledge that it is not easy to develop such relationships but suggest guided reflection as one approach. There is already evidence in published literature as to the benefits of reflection and reflective writing within tutorial groups especially in relation to students' own emotions (Gill, 2014; Raut & Gupta 2019). In this study, the evidence indicates that some of this type of reflection was initiated informally by students themselves or by tutorial leads. However, there is a diversity of experiences of such organised reflections. While many participants found these reflective sessions to be beneficial, others experienced such reflections as an admonishment by tutorial leads for errors or shortcomings in the student's professional practice, rather than a supportive exercise around ECEs. Such experiences of tutor expectations resonate with the work of Bold (2008) who in a study of peer support groups, found that students often engaged in reflection in terms of what they thought tutors expected.

To conclude this section, I have demonstrated that participants experience support from various informal and formal sources. Overall, such experiences of such support are positive, however there is evidence that participants did not always seek or access support from existing formal support roles. Some

reasons given are based upon importance of a personal relationship of rapport and trust between participants and those in such supporting roles. Such findings in my study and findings by Bold (2008); O 'Donnell (2009); Jack and Wibberley (2014) and Jack, Hamshire and Chambers (2017) emphasise the importance of a personal relationship of rapport and trust between students and those in such supporting roles. Several participants recall reflective sessions as positive experiences and some indicate that they would like more reflective sessions as part of preparation for practice. However, others found such reflection sessions as being used to reprimand. In the next section, I discuss the findings in terms of participants' experiences of planning, preparation, and preparedness for emotionally challenging experiences in HSC.

5:5. Preparation and preparedness for ECEs in HSC practice.

An important aim of this study is to gain greater insight into nursing students' lived experiences of their preparation and preparedness for ECEs. The findings have resonance with previous literature and analysis asserts that participants in this study, do not feel adequately prepared for what Dwyer & Hunter-Revell (2015) refer to as the 'emotional toll' of practice. An aspect that emerges in relation to preparation and preparedness for ECEs, is that there are assumptions made by participant themselves or others, that nursing students either have knowledge to deal with ECEs or need to be involved in such

situations as part of their learning. As I highlighted in Chapter Two, Gardner (1993) viewed emotional competence as including the ability to have self-awareness and recognition of one's own feelings and to take account of these in social situations. The findings of this study demonstrate that emotional competence in dealing with ECEs, is often assumed by others or indeed by participants themselves. Allan et al. (2015) argue that there is a social context to learning and that all forms of knowledge are tied to the settings where things occur. There are reports in the data that on occasions, participants were encouraged to engage in ECEs activities as part of their learning and to get involved in procedures or situations which were complex, unusual, or specialised. In a number of these experiences, participants report exposure to ECEs for which they felt they had little or no preparation. Several participants refer to the lack of information offered by mentors and other healthcare professionals, particularly in relation to placements which are specialised. Some suggest that it would have been helpful for mentors to take them aside and explain what was wrong with patients with complex conditions and some of the challenges which to expect. Participants regarded such information as crucial in preparing for ECEs and confided that lack of appropriate information left them in a position where they felt overwhelmed and unsupported. There is also evidence that participants felt unprepared for ECEs which occurred in

‘taster’ placements in other fields of nursing practice, such as mental health, children or learning disability. These taster experiences occur in the first year of the programme, but ECEs in such early placements were reported by participants from across all years of the programme. This suggests that such placements have particular ECEs for students for which they may require more preparation.

There is evidence that participants experienced preparation in the HEI, in the form of lectures and discussions in tutorials on subjects such as death and dying, prior to their first practice placements. However, some consider that these were insufficient for the practical aspects of caring for the deceased, which many had found emotionally challenging.
Another aspect in the findings suggest that there was a perception that prior or early exposure to ECEs such as death and dying, would better prepare students to navigate such ECEs in future. There is evidence from the data that such assumptions were often made by the participants themselves. However, there is also evidence among those who had previous experience of death of patients that they still felt unprepared for aspects of caring for the deceased, often referred to as “last offices”.

In some participants’ experiences they were invited to witness or partake in ECEs by other professionals, who had limited or no prior assessment or

involvement with the student learning needs or ability to deal with such ECEs. In the absence of mentors, the decisions as to when and what student should be involved in as part of their learning was often initiated by other nurses, healthcare professionals, HCAs, or the student themselves. These findings resonate with earlier findings of Chapman & Clucas (2014) and O'Driscoll, Allan & Smith (2010) who suggested that HCAs have taken informal responsibility for aspects of nursing students' learning.

To conclude this section, there is evidence in the finding of mixed experiences of preparation for ECEs among participants. Among participants' experiences there are reports of lectures on topics such as death and dying and mental health. However, despite such reports, many participants felt unprepared for the ECEs that they would encounter in placements, particularly 'taster' and specialised placements. Among some participants' experiences there is evidence that decisions to involve them in ECEs were often ad hoc or opportunistic and not instigated by mentors and those with responsibility for the students' learning.

5.6. Chapter conclusions.

This current study has added to the understanding of lived emotionally challenging experiences of nursing students in practice. From the themes summarised in Table 6, Chapter Four and discussed in the previous sections,

there is strong evidence of students adopting strategies such as surface acting, avoidance, and disengagement from ECEs. However, there is strong evidence demonstrating that participants in the study want to engage and care for patients despite sometimes facing difficult ECEs. The evidence resonates with the work of McCloughen and Foster (2017) and of Heggestad et al. (2018) as highlighted earlier, of participants seeking to minimise the effect of ECEs, by knowledge seeking or early exposure to such ECEs. As highlighted in Chapter Two, Mesquita & Boigner (2014) argue that emotional expressions and displays are impacted by the context of interactions and relationships in which they take place. In this study, when uncertain as to the extent that they should engage, participants often take the lead or advice from those whom they deem to have more experience. Similar to the finding of Curtis (2014) there is strong evidence that participants' navigation of ECEs was shaped by how those in nursing leadership roles behaved and advised. My findings also share resemblance with those of Jack, Hamshire and Chambers (2017) who examined factors influencing nursing students' decisions to remain or leave their programme. In their study, Jack et al. (2017) found that the influence of role models in both practice and the HEI was a recurring theme among the experience of participants. In a later study exploring nursing students' perceptions of unfairness experienced in placements, Jack (2018) found that

there was agreement that a supportive mentor was essential to guide learning during placement. In my study in the absence of support or guidance from mentors or others in leadership roles as to how to navigate ECEs, participants often selected their own interpretation of a professional norm by showing no reactions. There were also several examples, where participants experienced being advised by and took cues from HCA or other students with HCA, experiences, as how to respond to ECEs. This often led to the adoption of strategies of avoidance, distancing or suppression of the participants own emotional reactions. These findings resonate with those of King-Okoye (2014), Terry and Carrol (2008) as discussed earlier. In my study there similar to the findings of Curtis (2014) was also evidence of some participants using as a strategy, the suppression of emotions to enable them to ‘survive’ ECEs. There is evidence that such experiences and strategies left participants to retain upsetting emotions after the ECEs and outside of the HSC placement. There was also evidence that many participants felt unprepared and unsupported for ECEs. The findings also suggest that there is a need to prepare nursing students in advance of ECEs of placement, particularly, ‘taster placements’ in other fields of nursing practice. These taster experiences often occur in the first year of the programme and have particular ECEs for students. The finding of the

study indicate that more preparation is required specifically for such placements.

This preparation might include teaching and learning strategies that facilitate reflections on ECEs, how students might recognise their own responses, the implications for practice and sources of support.

As highlighted in Chapter One, in NI, there are several support systems and roles in place to support students prior to, during and after placements. However, the findings suggest that the nature, quality, and access of such support varies in relation to ECEs. Participants highlight barriers in accessing such support in both from HEI and from practice, such as not wanting to be a seen as a burden, but particularly around the nature and extent of confidentiality, and lack of rapport or relationship with those undertaking support roles. Participants' experiences and perceptions of the function of these roles and how they are performed has an important impact on students' access of support. The findings provide strong evidence of these roles sometimes being experienced as reprimanding for perceived errors of failures in practice, rather than of pastoral support. This study indicates that there is a need for demarcation between pastoral support and disciplinary aspects in LL and PT roles, so that students do not get confused about whether they are being supported or being assessed or disciplined.

In the next Chapter, the contribution of new knowledge, limitations of the research are discussed. The implications and recommendations for the future preparation, education, and support of nursing students for ECEs in HSC are discussed.

Chapter 6. Conclusions and implications and recommendation for nursing education and future research.

In this chapter, I outline how this study contributes new knowledge to my own area of practice in nurse education and to the wider nursing community involved in the education and support of nursing students. In addition, the specific skills that might be developed to help nursing students deal with ECEs and support systems that might best help them to navigate ECEs will be considered. The limitations of the study are also discussed. The chapter highlights recommendations for the development of nurse education programmes and future research in this area.

6.1. Contribution to new knowledge.

Timmins (2005) emphasises that the findings of research should endeavour to contribute to nursing practice, knowledge generation and ultimately patient care. Therefore, it is important that I draw out the implications of this study for nurse educators and those responsible for nurse education.

This study is undertaken in the context of nurse education in a Higher Education Institution (HEI) in NI. To the best of my knowledge there are no studies which specifically explore nursing students' navigation of lived of emotionally challenging experiences (ECEs) in Health and Social care (HSC) practice in NI. As such the lived experiences of participants and my interpretations provide a unique contribution to the body of nursing

knowledge around ECEs from a NI perspective. I do not therefore set out to generalise the findings to other UK or international nurse education programmes. Nonetheless, a number of conclusions can be drawn from the study that others may consider in their own context.

In this study, I found evidence that nursing students in NI, face many ECEs in practice environments, which affect their personal and professional behaviours and learning processes. The study has shown something of the complexity of attempts to balance concern for and engagement with patients and ECEs, with nursing students' knowledge and care for themselves. The study also adds to knowledge of how nursing students navigate ECEs, by providing a deeper understanding of some of the strategies, preparation and support that participants were offered and utilised prior to, within and following placements.

Participants' experiences of social and behaviours norms within healthcare teams and among their peers, impacted upon the students navigation of ECEs. Participants sometimes were unclear as to whether or not it was acceptable to portray emotions. When uncertain and without support and advice of mentors or others in leaderships roles, as to how to navigate ECEs, participants often make their own decision. This is sometimes evidenced by participants suppressing their own emotions in order to portray what they consider to be

professional behaviours. Other participants when uncertain as to how to navigate ECEs, selected to avoid patients, relatives, or situations as a strategy.

Among strategies used by participants in navigating ECEs is seeking cognitive understanding or around patients' conditions. There is also evidence to suggest students sought early exposure to experiences, procedures or situations which were complex or unusual, but also emotionally challenging. However, while knowledge seeking is a strategy, there is limited evidence of participants' self-knowledge or recognition of their own emotional needs in navigating the complexities of ECEs in practice.

Some participants refer to lack of information and preparation in relation to specialised and 'taster placements', confiding that this left them in a position where they felt overwhelmed and unsupported when encountering ECEs. Other participants report limited support offered or received from mentors and other staff. However, there is also evidence of students experiencing support in relation to ECEs from a range of sources including mentors. Participants report varied experiences in relation to support from those undertaking link lecturer and personal tutors (PT). While students are aware that there are particular roles to support their practice education, they are unclear about the role of these sources in support around ECEs. In many cases there is a tension over whether they will be supported or reprimanded. This is

often due to experiences of lack of clear demarcation of the function of such roles between pastoral care and admonishment. The PT or LL is often perceived in a reprimanding role when in trouble, rather than someone who would provide pastoral support. The importance of a personal trusting relationship between students and those in supporting roles is highlighted. Some participants recall support from other students during or close to the time of ECEs, while others report a reluctance to share their experiences with other students. Participants shared different experiences of support from friends and family. While there was evidence of use of informal networks such as family and friends, there were also barriers to the use of such networks, such as being on placements which distanced the student from their usual networks. Other barriers include poor rapport with individual performing support roles and misunderstanding and lack of clarity around the nature and extent of confidentiality. Overall, the study highlights, not only diverse ECEs that nursing students encounter, but also the difficulties that currently exists in both the HEI and practice towards meeting the needs of nursing students to navigate such challenges. There is also clear evidence that students find reflective sessions to be helpful in venting emotions around ECEs, but not when such session are used as exercises to reprimand.

6.2. Study Limitations.

While this study provided greater clarity and insight into participating nursing students' lived ECEs in HSC, certain limitations are acknowledged. While 12 participants self-selected to take part in the study, and these were a convenient and relevant population allowing for in-depth focus on their experiences, it is not intended to generalise to other settings. Nonetheless others may also learn from this study, both in relation to the methods used and/or the findings. The research was also undertaken in a specific context in one HEI in NI and while some of the findings may be compared to other research, the context of the study differs in the geographical and institutional social and cultural norms, especially in relation to ECEs.

When discussing their responses and how they navigated ECEs there is a possibility that participants might have under-reported what they themselves considered as unprofessional or inappropriate behaviours or emotional responses. Conversely it is possible that they presented an idealised, version of their professional behaviour. Thus, there is a possibility that the reported experiences do not necessarily reflect individuals actual ECEs. However, as I indicated in Chapter Three, I undertook a number of measures prior to and during the interviews to minimise the power relationship and to make participants at ease and relaxed. As the participants stories are rich and often evoked emotions during interviews, this gives confidence that the students felt

comfortable and that the participant shared real ECEs. Indeed, one participant emailed a few days after the interview with the following words, *"thank you for giving me the opportunity to share the experience it was actually very therapeutic, and I felt like you got what I was saying without making me feel ashamed".*

The selection procedures employed for recruiting those who took part in this study were dependent upon participants self-selecting and giving their consent. It could be argued that this influenced the makeup of the study population with participants who have a strong desire to express a viewpoint or experience. Thus, the views expressed by participants in this study, may not be reflective of the experiences of the wider nursing student population from the HEI. However, the demographic characteristics of the sample more or less compare to the wider nursing student population in my HEI which is predominately female and from the Northern Ireland population.

6.3. Recommendations for nurse education.

The findings compliment the literature which acknowledges the need for interventions to better prepare students for the ECEs of practice that they are likely to encounter. This view is echoed by Jack & Wibberley (2014) and Kinman & Leggetter (2016) who highlight the need to strengthen in the curriculum, the knowledge and awareness of emotional work of nursing

practice I argue from the finding of this study, that if nursing students are to understand, engage support and give best care to patients and their relatives, students need to be facilitated in exploring their own ECEs in a safe space. While students may have been supported in developing cognitive knowledge or technical skills, there is strong evidence that many students are psychologically unprepared to face the potential range of ECEs in practice. More attention needs specifically to be paid to the impact that ECEs have on nursing students, both in terms of their professional practice, but also on how ECEs affect them personally. This requires interventions that prepare students to gain a greater knowledge of self and their emotions and how these are affected by ECEs. As Gohm, Corser and Dalsky (2005) suggest the development of skills, such as perceiving of emotions in oneself (self-insight) and of others should lead to feelings of situational control and to reduce stress. My study suggests that if participants are supported to enable their understanding of the nature and impact of ECEs, they may feel more empowered to regain a sense of control over their situation. From the evidence in my study, there is a need to include in nursing education interventions to enhance nursing students' ability to decrease negative effects of ECEs and enhance self-care.

As the findings suggest there remains a lack of adequate preparation and support for the ECEs and as Schmidt and Diesel (2014) this needs to be

addressed in the training and education interventions. Through the provision of education on the multi-dimensional impact of ECEs, the focus in current practice could be balanced away from attending merely to cognitive knowledge and technical skills, to include greater focus on self-knowledge and relational aspects of care and also in developing their own skills of resilience and self-care. The Royal College of Nursing (RCN) also stress the need to ensure that “the complex competences related to caring, interpersonal interactions and decision-making elements are assessed and acknowledged” (RCN, 2017, p.3). At the time of writing, in the UK opportunities to implement specific training to support nursing students’ abilities around ECEs arise with the development of the NMC (2019) “Future Nurse, Future Midwife”. undergraduate curricula. Nurse educators are in a key position to prepare nursing students in the early stages of their career for ECEs that students are likely to encounter in placements. For example, there is large body of evidence in wider literature which recognises the significance of psychological trauma and how ECEs can impact on individuals. For example, Cudmore (1996) and more recently Lavoie, Talbot and Mathieu (2011) highlight how nurses working in critical care and emergency departments, regularly face traumatic events and are at risk of developing Post-Traumatic Stress Disorder.Trauma informed care is an emerging concept that acknowledges the lasting effects of trauma

(Stokes et al, 2017). However, training on Trauma Informed Care is lacking in most nursing school curricula. With implementation of new 'Future Nurse, Future midwife' curricula, there is an opportunity to introduce training which considers the impact of secondary and vicarious trauma arising from ECEs. There is also an opportunity to introduce initiatives and supportive strategies which focus on the wellbeing of undergraduate nursing students. Support can be developed in various ways such as through peer support initiatives. Basson, and Rothmann (2018) highlight the need to recognise the important role family and peers play in the emotional and mental wellbeing of students. The concept of Peer-assisted leaning (PAL) has been explored within the field of nurse education across a range of learning environments. Carey et al. (2018) argue that while PAL in undergraduate nursing education has resulted in enhancements in student's skills of communication, critical thinking, and self-confidence particularly in theoretical settings. However, there appears to have been minimal exploration of PAL in the context of the clinical practice and this is an area which needs to be developed in relation to students' ECE.

Mead, Hilton, and Curtis (2001) propose that Peer support is a system of giving and receiving help respectfully in a mutual agreement and involves offering understanding and care to peers empathetically through sharing emotional experiences. In my study there was evidence that participants often were able

to reflect on their ECEs with members of their peer community. Mead, Hilton, and Curtis (2001) propose that this is easier to practice with peers than others, such as professional counsellors, because people find affiliation with individuals they feel are similar to them.

Overall, in the finding there was strong evidence that many students found reflective sessions to be beneficial in dealing with ECEs. Reflective practice has become part of the discourse in nursing education. Cecil and Glass (2015), McCloughen and Foster (2017) and Barratt (2018) also call for education providers to ensure that students reflect on their practice and to include in the curricula opportunities for reflection and self-reflexiveness. However, as Jack & Wibberley (2014) suggest nursing students need to be given time to access advice and support around ECEs. In my HEI currently there are organised reflective sessions for nursing students returning from placement in 1st year. However, I argue that such sessions should be given a greater focus and embedded in the timetable across all years of the programme. Such supported reflective sessions or regular debriefing meetings can provide nursing students with opportunities to communicate openly and vent their fears and concerns, especially in relation areas of practice where they may be exposed to particularly ECEs (Vanlaere and Gastmans 2007). Such reflective sessions may provide students with what Allan (2017) refers to as liminal spaces, where they

are able to reformulate knowledge of themselves and ECEs into new contexts and progress towards professional practice. However, has highlighted in the findings some participant experienced reflections sessions as being used to reprimand or admonish them. To overcome this and to be effective, there must be a clear differentiation between individuals' reflection on their own emotional experiences and reflection which tries to look for causes of errors or which admonish students. Thus, to ensure that reflection is used as a means of helping students deal with the emotional aspects of their role, rather than one where they will be reprimanded, the role of reflection and training for nurse educators needs also to be explored. As Ruth-Saad (2003) contends that before fostering reflective process in students, nurse educators need to believe in the value of reflective practice and set time aside for their own reflection on their practice as role models for students.

While the focus of nurse education is on the provision of care and support to patients and their relatives, nurses need also to be enabled to provide both instrumental and emotional support to their colleagues. Nurse educators can also provide nursing student's nurses with both instrumental and emotional supportive preparation by use of their own knowledge and experiences around potential ECEs that may occur in some specialist HSC situations. Thus, enabling

students to how to deal with their own emotions or plan their learning about ECEs, in such a way to make them less stressful.

The findings in this study also support the suggestions by Allen, Holland, and Reynolds (2015, p.386) that more work needs to be done in practice placements to create “welcoming, considerate and courteous workplaces”.

It is envisaged that such implementations may help eliminate or reduce lack of discussion among healthcare professionals around ECEs in practice that participants experienced. In this study there is evidence that how mentors and other healthcare professionals behave in relation to ECEs, had a strong influence on students’ navigation and responses to ECEs. The recent introduction of new NMC (2019) ‘Standards for student supervision and assessment (SSSA) in UK HEI undergraduate nursing programmes effectively removes the need for students to work 40% of the time with a mentor. Instead, all NMC registered nurses, midwives and nursing associates and other registered health and social care professionals can supervise students and serve as role models for safe and effective practice. This change increases the range of professionals who may contribute to students learning. However, given that some of the experiences among participants in this study involved feelings of abandonment, hostility and conflicting experience and advice regarding ECEs, there needs therefore to be ongoing review and examination

of support of students in navigation of ECEs. This could start with some practice training that explores registered nurses and HSC professionals' own navigation of ECEs. In placing more attention on ECEs and illuminating the complexities of the phenomenon, this may encourage nurses to recognise the need to address the psychosocial issues inherent in their everyday nursing practice.

The evidence suggests that a number of barriers to students seeking support around ECEs need to be addressed. While confidentiality as outlined in the NMC Code (2018) forms an important part of the nursing students' professional practice, greater discussion, and clarity about the extent of confidentiality is needed. While nurses including nursing students, owe a duty of confidentiality to all those who are receiving care, it must be clearer that this does not necessarily preclude students discussing their own emotional responses or seeking support around ECEs.

The students' relationship with personal tutors (PT) and experiences of such roles suggests that there needs to be a clearer demarcation of the pastoral support element of this role, which may enable a basis on which to build a rapport and trusting relationship.

The implementation of purposively placed supportive interventions specifically aimed at addressing nursing students ECEs is also needed. This is particularly

evidenced when students are allocated to placement which means that they are removed from their usual support networks. The use of designated telephone support or availability of pastoral support, which actively seek contact with students, especially at weekends and evenings may be one possible means to supporting students in such circumstances.

As previously highlighted the support of nursing students in practice has been the subject of ongoing debate. While there are a range of existing support mechanisms in place, this study findings would suggest that more work is needed by those concerned with nursing education in supporting students with the emotionally challenging aspects of their learning as well as practical and academic aspects.

6.4. Recommendation for future research.

One of the main areas of future research would be to conduct similar IPA explorations with different participant groups and in specific types of placements. For example, while I did not specifically set out to examine differences in navigation of ECE according to gender, there were hints in the responses by both male participants that their response might have been influenced by stereotypical expectations of male behaviours, i.e., non-expression of emotions. As Gray (2010) suggest that emotional expressions in nursing may be shaped by perceived roles of male and female nurses. It would

be valuable see if there were gender differences in students' navigation of ECEs which was beyond the scope of this research.

There was evidence in this study that students did not always have awareness or knowledge of their own emotions or struggled to attend to their own emotional needs. Future research should consider how to help students deal with their own emotional needs in response to ECEs. Akerjordet and Severinsson (2007) argue that despite differences in theoretical background, there is general agreement that EI "embraces emotional awareness in relation to self and others, in addition to professional efficiency and emotional management" (p. 1408). There is some emerging consensus in the literature suggesting that emotional intelligence (EI) can be developed and that properly developed training in EI can have a positive impact on a participant (Groves, McEnrue and Shen, 2008; Littlejohn, 2012). Allen, Ploeg and Kaasalainen (2012) contend that EI might help to determine an individual's ability to adapt within an environment of emotional interactions with others. These latter claims might have significance for examining the feasibility of EI training for nursing students in dealing with emotional and stressful aspects associated with nursing practice. Nooryan et al. (2011) found some evidence that a training intervention in EI helped to reduce stress among nurses. However, Akerjordet and Severinsson (2007) and Bulmer-Smith et al. (2009) emphasise

that research specifically into EI in relation to undergraduate nursing student is limited. As Beauvais et al. (2012) suggest, research is needed to understand the role of EI in nurse education. While some published articles such as Carragher and Gormley (2016) highlight the importance of embedding EI in healthcare education and practices in the UK and Ireland, to my knowledge there have been no studies into EI or the impact of EI training in nurse education, specifically in NI.

In my study I did not specifically seek to investigate the impact of suppression of their emotions or emotional expressions on participants. However, there is evidence that for some participants, there were lack of opportunities for participants to share how ECEs impacted upon them. The need for opportunities for collective 'emotional venting', is highlighted in the findings of this study as a necessary aspect of emotional support. The use of Schwartz Rounds has been advocated by authors such as Lown and Manning (2010); Davis (2011); Goodrich (2014); Barker and Flanagan (2015) as one way to giving support to the providers of care support. Schwartz rounds are forum where HSC staff from all backgrounds are invited to come together to reflect on the own experiences of clinical aspects of care such as ECE. The aim is to offer staff a safe environment in which to share their stories and offer support to one another. The use of these and research into their uses has been mainly medical

within medical school curricula or with registered nurses. Arising from the findings of this study, I am currently involved with other colleagues in nurse education in exploring the possibilities of establishing such Schwartz rounds for students and staff within our HEI programmes. Their use with nursing students particularly around ECEs within the NI context requires further exploration and research.

There were also some themes within the current study that might valuably be explored at greater depth and complexity. For example, analysing the later stages of the journey, I started to consider how the different approaches to ECEs were related to the amount of time and exposure that participants had to previous ECE such as through work as HCA, as opposed to those who had no or limited experiences, i.e., new to healthcare practice. This may mean comparison between age groups or between length of time in healthcare practice or individuals who have been in receipt of nursing care.

6: 5. Conclusions of chapter and thesis.

In conclusion of this chapter and thesis, this study has explored the lived ECEs, while in HSC placements, of a small group of nursing students from an undergraduate adult nursing BSc programme in NI. The use of an interpretive phenomenological approach allowed for an in-depth understanding of the lived experiences of participants. While there were distinct differences in

individual experiences of each participant, there were many commonalities identified. The narratives demonstrate how students struggled to balance when and how to engage with ECEs and their own emotional displays.

A lot of work has been done in the development of the nursing curriculum, in terms of the cognitive and technical components of nursing practice and education, but more needs to be done in relation to examining the knowledge and skills that nursing students need in relation to navigating ECEs. The findings demonstrate the need to broaden nursing students' knowledge and skills and review support in order to enable their ability to manage the emotional aspects of caring, including how to care for themselves when encountering ECEs. In doing so there is a greater need to develop knowledge of self and one's own emotions and how these are affected by ECEs.

This means having a clearer focus on the preparation of nursing students for ECEs through teaching emotional management techniques and to manage emotion boundaries with patients. This study has added to the understanding of the lived emotionally challenging experiences of nursing. This study provides evidence that the emotional aspects of nursing work need to be made more explicitly incorporated into the practice and in education and training of nurses. Such new knowledge provides the nursing community and particularly those involved in nurse education in NI such as myself, greater insight into the

knowledge and skills that nursing students need to provide care in relation to ECEs. This new knowledge and understanding provides a basis to enable myself and colleagues to provide appropriate preparation and help students to recognise how and when to seek help and access support systems in dealing with ECE. The findings from this study have also highlighted areas where further research is needed, with the ultimate aim of contributing towards improved education and preparation of nursing students in my own HEI and the wider nursing community.

6.6. A post-script on the Covid-19 pandemic and the importance of this study.

During the write up stage of this study, the unprecedented public health emergency of the Covid-19 pandemic has posed many challenges for individuals and societies across the globe. The pandemic has particularly highlighted the importance of support for healthcare workers including nursing students. Like many other across the world and the UK, NI nurses and nursing students face additional emotionally challenging experiences. At the early outset of the pandemic, the Nursing & Midwifery Council worked with government to introduce legislation enabling final year students within six months of registration to go into the NHS in a paid capacity. In my HEI over 320 final year nursing students with less than six months to complete their course, took the opportunity to work to support clinical teams and help with the

Covid-19 crisis. In doing so these students required specify preparation for the challenges of transitioning into such roles. While many innovations in technology enabled many other students to continue their learning from home, it must be remembered that nursing is about caring for people and human aspects of caring for people including touch, forms an integral part of professional practice. However, it is understandable that many nursing students from all years of the programme while wanting to complete their studies, may experience high levels of anxiety in the current situation for in regard to practice placements. The findings of this study highlight the importance of enabling and preparing nursing students to navigate emotionally challenging experiences in practice.

References

Addison, M. (2017) "Overcoming Arlie Hochschild's concepts of the real and false self by drawing Pierre Bourdies concept of habitus", *Emotion, Space and Society, 23, pp.9-15.*

Akerjordet, K., Severinsson, E. (2007) "Emotional Intelligence: a review of the literature with specific focus on empirical and epistemological perspectives". *Journal of Clinical Nursing, 16, pp. 1405-1416.*

Allan, H., Magnusson, C., Horton, K., Evans, K., Ball, E., Curtis, K and Johnson, M (2015) "People, liminal spaces and experience: understanding recontextualisation of knowledge for newly qualified nurses". *Nurse Education Today, 35 (2), pp.78-83.*

Allen, B.C., Holland, P and Reynolds, R. (2015) "The effect of bullying on burnout in nurses: the moderating role of psychological detachment*", Journal of Advanced Nursing, 71(2), pp.381-390.*

Allen, D., Ploeg J., Kaasalainen, S. (2012) "The relationship between emotional intelligence and clinical teaching effectiveness in nursing faculty". *Journal of Professional Nursing, 28(4), pp.:231-240.*

Allmark, P. J., Boote, J., Chambers, E., Clarke, A., McDonell, A., Thompson, A. and Tod, A. (2009) "Ethical issues in the use of in-depth interviews: literature review and discussion". *Research Ethics Review, 5(2), pp.48-54.*

Anderson, C. (2010) "Presenting and Evaluating Qualitative Research", *American Journal of Pharmaceutical Education, 74(8) Article 141.*

Andersson, E. K; Willman. A., Sjosstrom-Strand. A., Borglin, G. (2015) "Registered nurses' descriptions of caring: a phenomenographic interview study, *BMC Nursing, 14(16), pp.1-10.*

Andrews, M., Roberts, D. (2003) "Supporting student nurse learning in practice". *Nurse Education Today, 23, pp.474-481.*

Anyan, F. (2013) "The Influence of Power Shifts in Data Collection and Analysis Stages: A Focus on Qualitative Research Interview", *The Qualitative Report, 18(18), pp.1-9.*

Aragao, R. (2011) "Beliefs and emotions in foreign language learning", *Systems, 39 (3), pp.302-313.*

Arieli, D. (2013) "Emotional work and diversity in clinical placements of nursing students", *Journal of Nursing Scholarship, 45(2), pp.192-201.*

Ashforth, B.E & Humphrey, R.H. (1993) "Emotional Labor in service roles: the influence of identity" *Academy of Management review, 18(1), pp.88-115.*

Atieno, O. (2009) "An analysis of the strengths and limitations of qualitative and quantitative research paradigms", *Problems of Education in the 21st Century, 13, pp.13-18.*

Atkinson, P and Coffey, A. (2002) *"Revisiting the relationship between participant observation and interviewing"* in *J.F Gubrium & J.A Holstein (Eds) Handbook of interview research.* Thousand Oaks, California, Sage, pp.801-814.

Ayres, L., Kavanaugh, K., and Knafl, K (2003) "Within-Case and Across-Case Approaches to Qualitative Data Analysis", *Qualitative Health Research, 13(6), pp.871-883.*

Badolamenti, S., Sili, A., Caruso, R. Fida, R. (2017) "What do we know about the emotional labour in nursing? A narrative review", *British Journal of Nursing, 26(1), pp.50-58.*

Basson, M.J. and Rothmann, S. (2018) "Antecedents of basic psychological need satisfaction of pharmacy students: the role of peers, family, lecturers and workload", *Research in Social & Administrative Pharmacy, 14(4), pp.372-81.*

Available at https://doi.org/10.1016/j.sapharm.2017.04.015 (Accessed 10/06/2021)

Baesslera, F., Zafara ,A.,Schweizerb ,S.,Ciprianidisa ,A.,Sanderc ,A., Preusslerc ,S., Honeckerc,H.,Wolfa, M., Bartolovicd ,M.,Wagnera ,F.L., Kleina S.B., Weidlicha, J., Ditzene ,B., Roesch-Elyd ,D., Nikendeia ,C., Schultza, J.(2019)"Are we preparing future doctors to deal with emotionally challenging situations? Analysis of a medical curriculum", *Patient Education and Counselling, 102, pp.1304–1312.*

Bailey, C., Murphy, R., Porock, D. (2011) "Professional tears: developing emotional intelligence around death and dying in emergency work", *Journal of Clinical Nursing, 20, pp.3364-3372.*

Bakker, I .,Verhaegh, K., Kox , J., van der Beek A., Boot, C., Roelof, P., Franckebe, A.(2019) "Late dropout from nursing education: An interview study of nursing students' experiences and reasons*", Nurse Education in Practice, 39, pp.17-25*

Barbour, R. (2008) *Introducing Qualitative research. A student guide to the craft of doing qualitative research.* Sage, London.

Barker, C., Pistrang, N., Elliott, R. (2002*) Research Methods in Clinical Psychology: An Introduction for Students and Practitioners (2nd Edition).* Chichester: Wiley.

Barker, R., Flanagan, E. (2015) “Schwartz Rounds: what are they and how do they support all staff working in healthcare?” *In Bostock, L(ed) Interprofessional staff supervision in adult health and social care services, Volume 1 Pavilion, pp.67-73.*

Barnett-Page, E., Thomas, J. (2009) “Methods for the synthesis of qualitative research: a critical review”. *BMC Medical Research Methodology, 9(59), pp.:1-14.*

Barratt, C. (2018) “Developing resilience: the role of nurses, healthcare teams and organisations. *Nursing Standard, 33(7), pp.43-49.*

Barroso, J., Gollop, C., Sandelowski, M., Meynell, J., Pearce, P., Collins, L. (2003) “The challenges of searching and retrieving qualitative studies”, *Western Journal of Nursing Research, 25, pp.153-178.*

Bassett, C. (2002) “Nurses’ perception of care and caring” *International Journal of Nursing Practice, 8, pp.8-15.*

Baxter, L. A and Babbie, E. (2003) *The basics of communication research,* Boston, MA Wadsworth.

Beauvais, A., Brady, N., O’Shea, E., Griffin, M. (2011) “Emotional Intelligence and Nursing performance among nursing students”, *Nurse Education Today, 31, pp.396-401.*

Bennett, M and McGowan, B. (2014) “Assessment matters-mentors need support in their role” *British Journal of Nursing, 23, pp.454-458.*

Benoot, C., Hannes K., Bilsen J. (2016) “The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory”. *BMC Medical Research Methodology, 16(21), pp.1-12.*

Best Evidence for Medical and health Professional Education BEME (2021*)*

Available at: https://bemecollaboration.org/LiteratureSearch/(Accessed 26/06/2021).

British Educational Research Association BERA. (2018) *Ethical guidelines for educational research (4th Edition)*, London: British Educational Research Association. Available at: https://www.bera.ac.uk/wp-content/uploads/2018/06/BERA-Ethical-Guidelines-for-Educational-Research_4thEdn_2018.pdf?noredirect=1 (Accessed 10/7/2018).

Blatt, S. J., & Levy, K. N. (2003) “Attachment theory, psychoanalysis, personality development, and psychopathology”. *Psychoanalytic Inquiry,* 23*(1), pp.102–150*.

Boland, A., Cherry, M. and Dickson, R. (2013) *Doing a systematic review*, Thousand Oaks, CA: Sage Publishing.

Boell, S. and Cecez-Kecmanovic, D (2014) "A Hermeneutic Approach for Conducting Literature Reviews and Literature Searches*," Communications of the Association for Information Systems: Vol. 34, Article 12, pp. 257-28.*

Bold, C. (2008) *Peer support groups: fostering a deeper approach to learning through critical reflection on practice, Reflective Practice, 9:3, pp. 257-267.*

Bolton, S. (2000) “Who cares? Offering emotion work as a gift in the nursing labour process”. *Journal of Advanced Nursing, 32(3), pp.580-586.*

Bolton, S.C. (2005) “Emotion Management in the Workplace”. *Management, Work and Organisations*. Palgrave Macmillan.

Bolton, S., Boyd C. (2003) “Trolley Dolly or skilled emotion manager? Moving on from Hochschild’s *Managed Heart*”, *Work, Employment and Society, 17(2), pp289-308.*

Booth, A. (2016) “Searching for qualitative research for inclusion in systematic reviews: a structured methodological review”. *Systematic reviews, 4; 5(1), p.74.*

Borneuf, A., Haigh, C. (2010) “The who and where of clinical skills teaching: A review from the UK perspective”. *Nurse Education Today, 30, pp.197–201.*

Borrego, M., Douglas, E., Amelink, C. (2009) “Quantitative, Qualitative and Mixed Research Methods in Engineering Education”. *Journal of Engineering Education, 98(1), pp.53-66.*

Brion, M and van Veldhoven, M. (2012) “Emotional labour in service work: Psychological flexibility and emotion regulation”, *Human Relations, 65(10), pp.1259-1282*.

Brook, P. (2009) “In critical defence of ‘emotional labour’: refuting Bolton’s critique of Hochschild’s concept”, *Work, Employment and Society, 23(3), pp.531-548.*

Brotheridge, C.M., Grandey, A. (2002) “Emotional labor and burnout: comparing two perspectives of “people work”. *Journal of Vocational Behavior, 60, pp.17-39.*

Brotheridge, C.M., Lee, R.T. (2003) “Development and validation of the emotional labour scale”, *Journal of occupational Psychology, 76 (3), pp.365-379.*

Brunero. S., Lamont, S., Coates, M. (2010) “A view of empathy education in nursing”, *Nursing Inquiry, 17(1), pp.65-74.*

Bryant, A. (2017) *Grounded theory and grounded theorizing: Pragmatism in research practice.* New York: Oxford University Press.

Bulmer-Smith, K., Profetto-McGrath, J., Cummings, G. (2009) “Emotional Intelligence and Nursing: an integrative literature review”*. International Journal of Nursing Studies, 46, pp.1624-1634.*

Burns, N., Grove, S. (2011) *The Practice of Nursing Research: Appraisal, synthesis, and generation of evidence (6th edition),* Saunders, USA.

Burston, P., Stichler J. (2010) “Nursing work environment and nurse caring: relationship among motivational factors”, *Journal of Advance Nursing, 66(8), pp.1819-1831.*

Cadge, W., Hammonds, C. (2012) “Reconsidering detached concern: The case of intensive-care nurses*”, Perspectives in Biology and Medicine, 55(2), pp.266–282.*

Cadman, C., Brewer, A. (2001) “Emotional Intelligence: a virtual pre-requisite for recruitment in nursing”. *Journal of Nursing Management, 9, pp.321-324.*

Callahan, J., McCollum, E. (2002) “Conceptualizations of emotion research in organizational contexts”, *Advances in Developing Human Resources, 4(4), pp.1-21.*

Callejo-Perez, D. (2008) “Teacher Education and Research: Imagining Teacher education between past and future”. *American Educational History Journal, 35(1), pp.19-40.*

Cameron, J., Roxburgh, M., Taylor, J. and Lauder, W (2011) “An integrative literature review of student retention in programmes of nursing and midwifery education: why do students stay?” *Journal of Clinical Nursing, 20(9-10), pp.1372-1382.*

Care Quality Commission Report (2013) *Care Quality Commission Report,* London, The Stationery Office.

Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/246623/0374.pdf (Accessed 4/4/2018)

Carey, Matthew & Chick, Anna & Kent, Bridie & Latour, Jos. (2018) “An exploration of peer-assisted learning in undergraduate nursing students in paediatric clinical settings: An ethnographic study”. *Nurse Education Today. 65(10), p.212-217.*

Carr, G. (2008) “Changes in nurse Education: delivering the curriculum”, *Nurse Education Today, 2, pp.120-127.*

Carragher, J., Gormley, K. (2016) “Leadership and emotional intelligence in nursing and midwifery education and practice: a discussion paper”, *Journal of Advanced Nursing 73(1), pp. 85–96*

Critical Appraisal Skills Programme (2019). CASP Qualitative Research Checklist. Available at: https://casp-uk.net/ (Accessed: 28/6/2020).

Critical Appraisal Skills Programme (2019). CASP Systematic Review Checklist. Available at: https://casp-uk.net/ (Accessed: 28/6/2020)

Cassidy, E., Reynolds, F., Naylor, S., DeSouza, L. (2011) “Using interpretative phenomenological analysis to inform physiotherapy practice: an introduction with reference to the lived experience of cerebellar ataxia*”, Physiotherapy Theory and Practice, 27(4), pp.263-277.*

Cecil, P., Glass, N. (2015) “An exploration of emotional protections and regulation in nurse-patient interactions: the role of the professional face and the emotional mirror*”, Collegian 22, pp.377-385.*

Celebioglu, A., Akpinar, B.R., Kucukoglu, S., Enging, R. (2010) “Violence experience by Turkish Nursing students in clinical settings: their emotions and behaviours”, *Nurse Education Today, 30, pp.687-691.*

Chan, Z. C., Fung, Y., & Chien, W. (2013) “Bracketing in Phenomenology: Only Undertaken in the Data Collection and Analysis Process”. *The Qualitative Report, 18(30), pp.1-9.*

Chapman, H., Clucas, C. (2014) “Student nurses' views on respect towards service users -An interpretative phenomenological study”, *Nurse Education Today, 34, pp.474–479.*

Cheng, C., Bartram, T., Karimi, L., Leggat, S. (2013) “The role of team climate in the management of emotional labour: implications for nurse retention”, *Journal of Advanced Nursing, 69(12), pp.2812-2825.*

Choi, Y.G., Kim, K.S (2015) “A literature review of emotional labor and emotional labor strategies”, *Universal Journal of Management, 3(7), pp.283-290.*

Christensen, M., Welch, A., Barr, J. (2017) “Husserlian Descriptive Phenomenology: A review of intentionality, reduction and the natural attitude”, *Journal of Nursing Education and Practice, 7(8), pp.113-118.*

Cornwell, J., Firth-Cozens, J. (2009) *Enabling compassionate care in acute hospital settings*

The Kings Fund,

Available at: https://www.pointofcarefoundation.org.uk/evidence/enabling-compassionate-care-acute-hospital-settings/ (accessed 6/3/2018).

Coyle, D. (2014) “Phenomenology”. In A. McIntosh-Scott, T. Mason, E. Mason-Whitehead, & D. Coyle (Ed), *Key Concepts in Nursing and Healthcare Research (pp.116-124).* London: Sage.

Coyne, I. (1997) “Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries?” *Journal of Advance Nursing, 26(3), pp.623-30.*

Cudmore, J. (1996) “Preventing post-traumatic stress disorder in accident and emergency nursing. A review of the literature*”, Nursing Critical Care, 1(3), pp.120-6.*

Creswell, J. (2003) *Research design: qualitative, quantitative and mixed methods approaches.* Thousand Oak: CA Sage Publications.

Creswell, J. (2013) *Qualitative inquiry & research design: choosing among the five approaches.* Thousand Oaks, CA: Sage Publications, Inc.

Cricco-Lizza, R. (2014) "The need to nurse the nurse: emotional labor in neonatal intensive care." *Qualitative Health Research, 24(5), p.615-628.*

Crombie, A., Brindley, J., Harris, D., Marks-Moran, D., Thompson, T. M. (2013) "Factors that enhance rates of completion: What makes students stay?" *Nurse Education Today, 33(11), pp.1282-1287.*

Curtis, K. (2014) "Learning the requirements for compassionate practice: student vulnerability and courage". *Nursing Ethics, 21(2), pp.210-23.*

Curtis, K. (2015) "Compassionate care: the student nurse perspective*", Nursing and Residential Care, 17(11), pp.:641-642.*

Dahlberg, K., Drew, N., Nystrom, M. (2008*) Reflective life world research. 2nd edition,* Malmo, Student Literature. Lund, Sweden.

Damansio, A., Carvalho, G.B. (2013) "The nature of feelings: evolutionary and neurobiological origins". *Nature Reviews. Neuroscience, 14, pp.143-52.*

Darbyshire, P and McKenna, L. (2013) "Nursing's Crisis of care: What part does nursing education own?" *Nurse Education Today, 33, pp.305-307.*

Davidsen A.S. (2013) "Phenomenological Approaches in Psychology and Health Sciences". *Qualitative research in psychology, 10(3), pp.318–339.*

Davis, C. (2011). "Forum to help staff deal with day to day stress", *Nurse Management, 199(18), pp.18-21*

DeJonckheere, L and Vaughn, M. (2019) "Semi-structured interviewing in primary care research: a balance of relationship and rigour", *Family Medicine and Community Health, 7, pp.1-8.*

Available at: https://fmch.bmj.com/content/fmch/7/2/e000057.full.pdf (Accessed 14/1/2020)

DeLancey, C. (2006) “Action, the Scientific Worldview, and Being-in-the-World”, in Hubert L. Dreyfus, H and Wrathall, M. (Editors) (2006). *A Companion to Phenomenology and Existentialism,* Blackwell Publishing.

Delgado, C., Upton, D., Ranse, K., Furness, T. (2017) “Nurses’ resilience and the emotional labour of nursing work: an integrative review of empirical literature”, *International Journal of Nursing Studies, 70, pp.71-88.*

Denzin, N. (1984) “On understanding emotion”, San Francisco, Jossey-Bass.

Department of Health. (NI*) Over 6000 nurses attacked at work in 2018.*

Available at: https://www.health-ni.gov.uk/news/over-6000-nurses-attacked-work-2018 (Accessed 24/08/2019

Dewar, B., Cook, F. (2014) “Developing compassion through a relationship centred

appreciative leadership programme”, *Nurse Education Today, 34, pp.1258-1264.*

Diefendorff, J.M., Grandey, A.A., Dahling, J. (2011) “Emotional display rules as work unit norms: A multilevel analysis of emotional labor among nurses”, *Journal of Occupational Health Psychology, 16(2), pp.170-186.*

Dinc, L., Gastmans, C. (2012) “Trust and Trustworthiness in nursing: an argument-based literature review”, *Nursing Inquiry, 19(3), pp.223-237.*

Dwyer, P., Hunter Revell, S. (2015) “Preparing Students for the Emotional Challenges of Nursing: An Integrative Review”, Journal *of Nursing Education, 54(1), pp.7-12.*

Edwards, R., Holland, J. (2013) “What is Qualitative interviewing?” Bloomsbury Academic London. Available at: http://eprints.ncrm.ac.uk/3276/1/complete_proofs.pdf (Accessed 6/3/2017)

Eick, S., Williamson, G. Heath, V. (2012) “A systematic review of placement-related attrition in nurse education”, *International Journal of Nursing Studies, 49(10), pp.1299-1309.*

Ekman, P., Sorenson, E. R., Friesen, W. V. (1969) “Pan-cultural elements in facial displays of emotion”, *Science (New York, N.Y.)164(3875), pp.86-8.*

Elliot, C. (2017) “Emotional Labour: learning from the past, understanding the present”. *British Journal of Nursing, 26(19), pp.1070-1077.*

Elwood, S. A. & Martin, D. G. (2000) "Placing Interviews: Location and Scales of Power in Qualitative Research." *Professional Geographer, 52, pp.649-657.*

Engster, D. (2005) "Rethinking Care theory: the practice of caring and the obligation to care", *Hypatia, 20(3), pp.50-74.*

Engward, H. (2013) "Understanding grounded theory". *Nursing Standard,28 (7):37-41.*

Ezzy, D. (2002) *Qualitative Analysis: Practice and Innovation*. Crow's Nest, NSW: Allen & Unwin.

Feldstein, M.A., Gemma, P.B. (1995) "Oncology nurses and chronic compounded grief". *Cancer Nursing, 18(3), pp.228-236.*

Few, A.L., Stephens, D.P., Rouse-Arnett, M. (2003) "Sister-to-Sister Talk: Transcending Boundaries and Challenges in Qualitative Research with Black Women". *Family Relations, 52(3), pp.205-215.*

Fineman, S. (1993). "Organizations as emotional arenas". In S. Fineman (Ed), *Emotion in organizations* (pp. 9-35). Thousand Oaks, CA, US: Sage Publications, Inc.

Finfgeld-Connett, D. & Johnson, E.D. (2013) "Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews". *Journal of Advanced Nursing, 69(1), pp.194–204.*

Fossey, E., Harvey, C., McDermott, F., Davidson, L. (2002) "Understanding and Evaluating Qualitative Research", *Australian and New Zealand Journal of Psychiatry, 36 (60), pp.717-732.*

Foster, K., McCloughen, A., Delgado, C., Kefalas, C, and Harkness, E. (2015) "Emotional intelligence education in pre-registration nursing programmes: An integrative review". *Nurse Education Today, 35, pp.510–517.*

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, The Stationery Office Limited, UK. Available at: http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf (Accessed 14/10/2017)

Freeman, M., deMarrias, K., Preislle, J., Rouslton, K., St Pierre, E. (2007) “Standards of evidence in Qualitative research: an incitement to discourse”, *Educational Researcher, 36(1), pp.25-32.*

Freshwater, D., Stickley, T. (2004) “The heart of the art: emotional intelligence in nurse education”, *Nursing Inquiry, 11(2):91-98.*

Frowe, I. (2005) “Professional Trust”, *British Journal of Educational Studies, 53(1), pp.34-53.*

Funk, L., Peters, S., Steiber, R. (2017) “The Emotional Labour of personal grief in palliative care: balancing caring and professional identities”, *Qualitative Health Research, 27(4), pp.2211-2221.*

Galdas, P. (2017) “Revisiting Bias in Qualitative Research: Reflections on Its Relationship with Funding and Impact”, *International Journal of Qualitative Methods, 16, pp.1-2.*

Gardner, H. (1993) *Multiple intelligences: Theory into practice*. New York: Basic Books.

Garrinno, L., Contratto, C., Massariello, P., Dimonte, V. (2017) “Caring for dying patients and their families: the lived experiences of nursing students in Italy”, *Journal of Palliative Care, 32(3-4), pp.127-133.*

Gelinas, L., Largent, E., Cohen, G., Kornetsky, S., Bierer, B., Fernandez Lynch, H. (2018) “A Framework for Ethical Payment to Research Participants”, *The New England Journal of Medicine, 378(8), pp.776-771.*

Gendron, M., Barret Feldman, L. (2009) “Reconstructing the Past: A Century of Ideas about Emotion in Psychology” *Emotion Review, 1(4), pp.316-339.*

Gentles, S.J., Charles, C., Nicholas, D.B., Ploeg, J., McKibben, K.A. (2016) “Reviewing the research methods literature: principles and strategies illustrated by a systematic overview of sampling in qualitative research”. *Systematic reviews, 5(172), pp.1-7.*

Gibbons, C., Dempster, M & Moutray, M. (2011) “Stress, coping and satisfaction in nursing students, *Journal of Advanced Nursing, 67(3), pp.621-632.*

Gill, G.S. (2014) “The nature of reflective practice and emotional intelligence in tutorial settings”, *Journal of Education and Learning, 3(1), pp.86-100.*

Glaser, B., Straus, A. (1967) *The discovery of grounded theory: strategies for qualitative research,* New York: Alding De Gruyter.

Gnisci, A., Bakemanand, R., Quera, V. (2008) "Blending Qualitative and Quantitative Analysis in Observing Interaction: Misunderstanding application and proposal"*, International Journal of Multiple Research Approaches, 2, pp.15-30.*

Gohm, C., Corser, G., Dalsky, D. (2005) "Emotional intelligence under stress: Useful, unnecessary, or irrelevant?" *Personality and Individual Differences, 39, pp.1017-1028.*

Goodrich, J. (2014) "Compassionate care and Schwartz Rounds: the nature of the work-acknowledging it is hard", *Nurse Education Today, 34, pp.1185-1187.*

Gooty J., Gavin, M., Ashkanasy, N.M (2009) "Emotions research in OB: The challenges that lie ahead" *Journal of Organizational Behavior, 30, pp. 833–838.*

Grandey, A. (2000) "Emotion regulation in the workplace: a new way to conceptualise emotional labour", *Journal of Occupational Health Psychology, 5(1), pp.95-110.*

Gray, B. (2010) "Emotional labour, gender and professional stereotypes of emotional and physical contact, and personal perspectives on the emotional labour of nursing", *Journal of Gender Studies, 19(4), pp.349–360.*

Gray, M., Smith, L., (2000) "The professional socialization of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study". *Journal of Advanced Nursing, 29, pp.639–647.*

Gray, B., Smith, P. (2009) "Emotional labour and the clinical settings of nursing care: the perspectives of nurses in East London", *Nurse Education in Practice, 9(4), pp.253-261.*

Green, H. (2014) "Use of theoretical and conceptual frameworks in qualitative research*", Nurse Researcher, 21(6), pp.34-38.*

Gross, J.J. (1998) "The Emerging Field of Emotion Regulation: An Integrative Review". *Review of General Psychology, 2(3), pp. 271-299.*

Groves, K., McEnroe, M., Shen, W. (2008) "Developing and measuring the emotional intelligence of leaders". *Journal of Management Development, 27(2), pp.225-250.*

Groundwater-Smith S., Sachs, J. (2002) "The activist professional and the reinstatement of Trust", *Cambridge Journal of Education, 32(3), pp.341-358.*

Hammersley, M. (2006) "Ethnography: problems and prospects", *Ethnography and Education, 1(1), pp.3-14.*

Hammonds, C and Cadge, W. (2013) "Strategies of emotion management: not just on, but off the job". *Nursing Inquiry, 21(2), pp.162-170.*

Hamshire, C., Willgoss, T. G., & Wibberley, C. (2013) "Should I stay, or should I go? A study exploring why healthcare students consider leaving their programme". *Nurse Education Today, 33(8), pp.889–895.*

Hamshire, C., Jack, K., Forsyth, R., Langan, M., Harris, E. (2019) "The wicked problem of healthcare student attrition" *Nursing Inquiry, 26, pp.1-8.*

Hayward, R. M., Tuckey, M. R. (2011) "Emotions in uniform: How nurses regulate emotion at work via emotional boundaries". *Human Relations, 64(11), pp.1501–1523.*

Health Service Journal Report (HSJ). (2018) *Violence against NHS staff: a special report by HSJ and Unison,*

Available from: https://www.hsj.co.uk/workforce/violence-against-nhs-staff-read-the-full-report/7022168.article (Accessed 24/08/2020).

Heggestad, K.A., Nortedt, P., Christiansen, B., Konow-Lund, A. (2018) "Undergraduate nursing students' ability to empathise: a qualitative study", *Nursing Ethics, 25(6), pp.786-795.*

Hegney, D., Plank, A., Parker, V. (2006) "Extrinsic and intrinsic work values: their impact on job satisfaction in nursing*", Journal of Nursing Management, 14(4), pp.271-281.*

Henderson, A. (2001) "Emotional labor and nursing: an under-appreciated aspect of caring work", *Nursing Inquiry, 8(2), pp.130-138.*

Hennink, M., Hutter I., and Bailey, A. (2011) *Qualitative Research Methods,* London; Sage.

Higgs, J. Burn, A., Jones, M. (2001) "Integrating clinical reasoning and evidence-based practice." *AACN Clinical Issues, 12(4), pp.482-490.*

Hochschild, A. (1983) “The managed heart”. University of California, Berkeley.

Holland, J. (2007) “Emotions and research”. *International journal of Social Research Methodology, 10(3), pp.195-209.*

Holloway, I and Biley, F. (2011) “Being a qualitative researcher*”, Qualitative Health Research, 21(7), pp.968-975.*

Hopkinson, J. B., Hallett, C. E., Luker, K. A. (2005) “Everyday death: How do nurses cope with caring for dying people in the hospital?” *International Journal of Nursing Studies, 42, pp.25-133.*

Horrigan-Kelly, M., Millar, M. Dowling, M. (2016) “Understanding the key tenets of Heidegger’s Philosophy for Interpretive phenomenological research”, *International Journal of Qualitative Methods, 15(1), pp.1-8.*

Horsburgh, D., Ross, J. (2013) “Care and Compassion: the experiences of newly qualified staff nurses”, *Journal of Clinical Nursing, 22, pp.1124-1132.*

Horton-Deutsch, S., Sherwood, G. (2008) “Reflection: an educational strategy to develop emotionally-competent nurse leaders”. *Journal of Nursing Management, 16, pp.946-954.*

Humble, F., Cross, W. (2010) “Being different: A phenomenological exploration of a group of veteran psychiatric nurses”. *International Journal of Mental Health Nursing, 19, pp.128-136.*

Hunter B., Deery R. (2005). “Building our knowledge about emotion work in midwifery, combining and comparing findings from two different research studies”. Royal College of Midwives. Evidence Based Midwifery 3(1): 10-15

Hunter, B., Smith, B. (2007). “Emotional Labour-just another buzz word?”. *International Journal of Nursing Studies, 44(6), pp.859-861.*

Huynh, T., Alderson M and Thompson, M. (2008) “Emotional labour underlying caring: an evolutionary concept analysis”, *Journal of Advanced Nursing, 64(2), pp.195-208.*

Ingebretsen, L.P., Sagbakken, M. (2016) “Hospice nurses’ emotional challenges in their encounters with the dying”. *International Journal of Qualitative Studies on Health and Well-being, 11(1), pp.1-13.*

Ivey, J. (2013) “Interpretive Phenomenology”*, Pediatric Nursing, 39(1), p.27.*

Jack, K., Wibberley, C. (2014) “The meaning of emotion work to student nurses: a Heideggerian analysis”. *International Journal of Nursing studies, 51, pp.900-907.*

Jack, K., Hamshire, C., Chambers, A. (2017) "The Influence of Role Models in Undergraduate Nurse Education." *Journal of Clinical Nursing 26, pp. 4707-715.*

Jack, K., Hamshire, C, W., Harris, E., Langan, M. Barret, N., Wibberley, C. (2018) “ ‘My mentor didn’t speak to me for the first four weeks’: Perceived Unfairness experienced by nursing students in clinical practice settings” *Journal of Clinical Nursing,27,pp.929–938*

Jalali, S. and Wohlin, C (2012) “Systematic Literature Studies: Database Searches vs. Backward Snowballing”. *In Proceedings 6th International Symposium on Empirical Software Engineering and Measurement. 12, pp.29-38.*

Available at: https://ieeexplore.ieee.org (Accessed 15/01/ 2021).

Jamshed, S. (2014) “Qualitative research method-interviewing and observation”, *Journal of Basic and Clinical Pharmacy, 5(4), pp.87-88.*

Jeffrey, D. (2016) “A meta-ethnography of interview-based qualitative research studies on medical students’ views and experiences of empathy”. *Medical Teacher, 38(12), pp.1214-1220.*

Jones, P. (2006) *“Raymond Williams's Sociology of Culture. A Critical Reconstruction”,* Basingstoke: Palgrave.

Jones-Berry, S and Munn, F. (2017) “One in ten nurse sick days down to stress or depression”. *Nursing Standard, 32(5), pp.12-15.*

Jordan, P., Ashkanasy, N and Hartel, C. (2002.) “Emotional Intelligence as a moderator and behavioural reaction to job security”. *Academy of Management Review, 27(3), pp.361-372.*

Karnieli-Miller, O., Strier R., Pessach, L. (2009) “Power Relations in Qualitative Research” *Qualitative Health Research, 19(2), pp.279-289.*

Kellogg, M.B., Barker, M., McCune. N. (2014) “The lived experience of pediatric burn nurses following patient death”. *Pediatric Nursing, 40(6), pp.297-301.*

Keogh Report, NHS England. (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report.* Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx (Accessed 14/1/2020).

King, M., Gardner, D. (2006) “Emotional intelligence and occupational stress among professional staff in New Zealand”, *International Journal of Organizational Analysis, 14 (3), pp.186-203.*

King-Okoye, M, Arber, A. (2014) “It stays with me': the experiences of second- and third-year student nurses when caring for patients with cancer. *European Journal of Cancer Care, 23(4), pp.441-449.*

Kings Fund (2012) Quality of Care Conference, “Transforming the delivery of health and social care”, London.

Available at: https://www.gov.uk/government/speeches/28-november-2012-jeremy-hunt-kings-fund-quality-of-care (accessed, 05/05/2019).

Kingston University, Guide to Good Research practice (2019) Available at: https://www.kingston.ac.uk/research/policies-and-guides/ (Last accessed 24/6/2020)

Kirsch, G. E. (2005) “Friendship, Friendliness, and Feminist Fieldwork*”. Signs, 30, pp.2163-2175.*

Koch, T. (1998) “Story telling: is it really research?” *Journal of Advanced Nursing, 28 (6), pp.1182–1190.*

Koenig-Lewis, N., Palmer, A. (2008) “Experiential values over time-a comparison of measures of satisfaction and emotion”, *Journal of Marketing Management, 24, pp.69-85.*

Kornhaber, R., Wilson, A. (2011) “Enduring feelings of powerlessness: a descriptive phenomenological inquiry”, *Contemporary Nurse, 39(2), pp.172-179.*

Langdridge, D. (2007) *Phenomenological psychology: theory, research, and method.*

Pearson Education Limited, Harlow.

Larkin, M., Thompson, A. (2011) "Interpretative Phenomenological Analysis in Mental Health and Psychotherapy" in D. Harper and A.R. Thompson (Eds). *Research Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*, First Edition. John Wiley & Sons, Ltd.

Larkin, M., Watts, S., Clifton, E. (2006) "Giving voice and making sense in interpretative phenomenological analysis", *Qualitative Research in Psychology, 3, pp.101-120.*

Larkin, M., Shaw, R., Flowers, P. (2019) "Multi-perspectival designs and processes in interpretive phenomenological analysis research*", Qualitative research in Psychology, 16(2), pp.182-198.*

Lavoie, S., LR, Mathieu, L. (2011) "Post-traumatic stress disorder symptoms among emergency nurses: their perspective and a 'tailor-made' solution", *Journal of Advanced Nursing, 67(7), pp.1514-22.*

Le Blanc, P.M., Hox, J.J., Taris, T.W. and Peeters, M.C.W. (2007) "Take Care! The Evaluation of a Team-Based Burnout Intervention Program for Oncology Care Providers". *Journal of Applied Psychology, 92(1), pp.213-227.*

Leigh, J. (2014) "The Role of the Nurse Lecturer Situated within a Practice-Education Partnership". *International Journal of Practice-Based Learning in Health and Social Care, 2(1), pp.122-141.*

LeVasseur, J. (2003) "The Problem of Bracketing in Phenomenology", *Qualitative Health Research, 13(3), pp.408-420.*

Levett-Jones, T., Lathlean, J., McMillan, M & Higgins, I. (2007) "Belongingness: A montage of nursing students' stories of their clinical placement experiences", *Contemporary Nurse, 24(2), pp.162-174.*

Levy, Y., Ellis, T. (2006) "A Systems Approach to Conduct an Effective Literature Review in Support of Information Systems Research", *Informing Science Journal, 9, pp.181-212.*

Lindqvist, H. (2019) "Strategies to cope with emotionally challenging situations in teacher education", *Journal of Education for Teaching, 45(5), pp.540-552.*

Linnenbrink-Garcia, L., Pekrun, R. (2011) “Students’ emotions and academic engagement: Introduction to the special issue”, *Contemporary Educational Psychology, 36, pp.1-3.*

Littlejohn, P. (2012) “The missing link: using emotional intelligence to reduce workplace stress and workplace violence in our nursing and other health care professions”. *Journal of Professional Nursing, 28(6), pp.360-368.*

Long, H., French, D. and Brooks, J. (2020) “Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis”. *Research Methods in Medicine & Health Sciences, 1(1), pp.31-42.*

Lopez, K.A., Willis, D.G. (2004) “Descriptive versus interpretive phenomenology: their contribution to nursing knowledge”, *Qualitative Health Research, 14(5), pp.726-735.*

Lown, B.A., Manning, C.F. (2010) “The Schwartz Center Rounds an evaluation of an interdisciplinary approach to enhancing patient centred communication, teamwork and provider support”, *Academic Medicine, 85, pp.1073-108.*

Lyons, E., Coyle, A. (2007) *Analysing Qualitative Data in Psychology*, Sage London.

MacIntosh, T. (2015) “The link lecturer role; inconsistent and incongruent realities”. *Nurse Education Today, 35(3), pp.8-13.*

Mackey, S. (2005) “Phenomenological nursing research: methodological insights derived from Heidegger’s interpretive phenomenology”. *International Journal of Nursing Studies, 42, pp.179-186.*

Maltby, J., Williams, G., McGarry J., Day, L. (2010) *Research Methods for Nursing and Healthcare. Harrow England*, Pearson Education Limited.

Maslach, C., Jackson, S.E., Leiter, M.P. (1986) *Maslach Burnout Inventory Manual*. Palo Alto, CA: Consulting Psychologists Press, 3.

Mark, A. (2005) “Organizing emotions in health care”, *Journal of Health Organization and Management”, 19, pp.277-289.*

Matua, G., Van Der Wal, D. (2015) “Differentiating between descriptive and interpretative phenomenological research approaches”, *Nurse Researcher, 22(6), pp.22-27.*

McCloughen, A., & Foster, K. (2017) "Nursing and pharmacy students' use of emotionally intelligent behaviours to manage challenging interpersonal situations with staff during clinical placement: *A qualitative study". Journal of Clinical Nursing, 27, pp.2699–2709.*

McConnell-Henry, T. Chapman, Y., Francis, K. (2009) "Husserl and Heidegger, exploring the disparity", *International Journal of Nursing Practice, 15(1), pp.7-15.*

McCreight, S.B. (2005) "Perinatal grief and emotional labour: a study nurse in gynae wards". *International Journal of Nursing Studies, 42, pp.439-448.*

McDougall, R. (2015) "Reviewing literature in bioethics research: Increasing rigour in non-systematic reviews". *Bioethics, 29(7), pp.523-528.*

Mead, S., Hilton, D., and Curtis, L. (2001) "Peer support: a theoretical perspective', *Psychiatric Rehabilitation Journal, 25(2), pp.134-141.*

Available at: https://doi.org/10.1037/h0095032 (Accessed 10/06/2021)

McManus Holroyd, A. (2007) "Interpretative hermeneutic phenomenology: clarifying understanding", *Pacific Journal of Phenomenology, 7(2), pp.1-12.*

McQueen, A. (2004). "Emotional intelligence in nursing work". *Journal of Advanced Nursing, 47(1), pp.101-108.*

McSharry, E., McGloin, H., Frizeel, A., Winters-O" Donnell, L. (2010) "The role of the nurse lecturer in clinical practice in the Republic of Ireland". *Nurse Education in Practice, 10, pp.189-195.*

Meier, J., Beresford, L. (2006) "Preventing Burnout". *Journal of Palliative Medicine, 9(5), pp.1045-1048.*

Menzies L, I. (1959) "The functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital", *Human Relations, 13, pp.95–121.* Reprinted in Menzies Lyth, I. (1988) Containing Anxiety in Institutions, Free Association Books, London.

Mesquita, B., Boigner, M. (2014) "Emotions in Context: A Socio-dynamic Model of Emotions", *Emotion Review, 6(4), pp.298–302.*

Michaelsen, J. (2011) “Emotional distance to so called difficult patients” *Scandinavian Journal of Caring Sciences, 26, pp.90-97.*

Miller, T & Bell, L. (2012) “Consenting to what? Issues of access, gate-keeping and informed consent,” *In Miller T., Birch M., Mauther M and Jessop J. (Eds) Ethics in Qualitative Research*. Sage Publications, London.

Miner-Romanoff, K. (2012) “Interpretative and Critical Phenomenological Crimes studies: a model design,” *The Qualitative report, 17(27), pp.1-32.*

Moher, D., Liberati, A., Tetzlaff, J. and Altman, D (2009) “Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement”. *British Medical Journal, 339(211), pp.2535-2535.*

Morelli, S.A. Lee, I. A., Arnn, M.E., Zaki, J., DeSteno, J. (2015) Emotional and Instrumental Support Provision Interact to Predict Well-Being. *Emotion, 15(4), pp: 484–493*.

Morgan, A. (2010). “Discourse Analysis: An Overview for the Neophyte Researcher”, *Journal of Health and Social Care Improvement, May issue, pp.1-7.*

Morse, J. M. & Field, P. A. (1996) *Nursing research. The application of qualitative approaches (2nd Edition.)*. Cheltenham: Stanley Thornes (Publishers) Ltd.

Neubauer, B.E., Witkop, C.T., Varpio, L. (2019) “How phenomenology can help us learn from the experiences of others”. *Perspectives of Medical Education, 8, pp.90–97.*

Noble, H., Mitchell, G. (2016) “What is grounded theory*”. Evidence Based Nursing, 19(2), pp.34-35.*

Noon, E.J. (2018) “Interpretive Phenomenological Analysis: An Appropriate Methodology for Educational Research*?”, Journal of Perspectives in Applied Academic Practice,6, pp.75-83.*

Nooryan, K., Gasparyan, K., Sharif, F., Zoladl, M. (2011) “The Effect of Teaching Emotional Intelligence (EI) Items on Job Related Stress in Physicians and Nurses Working in ICU Wards in Hospitals, Yerevan, Armenia”, *International Journal of Collaborative Research on Internal Medicine & Public Health,3(10), pp.704-713.*

Nursing and Midwifery Council, NMC. (2008) *Nursing and Midwifery Council: Standards to support learning and assessment in practice,* Nursing and Midwifery Council, London, UK.

Available at: https://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-to-support-learning-assessment.pdf (Accessed 4/9/2016).

Nursing and Midwifery Council, NMC. (2013) NMC *response to the Francis report- 18 July*.

Available at:https://www.nmc.org.uk/globalassets/siteDocuments/Francis-report/NMC-response-to-the-Francis-report-18-July.pdf (Accessed 2/3/2018).

Nursing and Midwifery Council, NMC (2018). *The Code: Professional standards of practice and behaviour for nurse and midwives,* Nursing and Midwifery Council, London, UK.

Available at:https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (Accessed 16/07/2020).

Nursing and Midwifery Council, NMC (2018) *Aims and principles for fitness to practise*, Nursing and Midwifery Council, London, UK.

Available at:https://www.nmc.org.uk/ftp-library/understanding-fitness-to-practise/using-fitness-to-practise/ (Accessed 15/03/2019).

Nursing and Midwifery Council, NMC (2018) *Realising professionalism: Standards for education and training Part 2: Standards for student supervision and assessment* Nursing and Midwifery Council, London, UK. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/standards-for-student-supervision-and-assessment/student-supervision-assessment.pdf (Accessed 26/09/2020).

Nursing and Midwifery Council, NMC (2019) *Future Nurse: Standards of proficiency for registered nurses,* Nursing and Midwifery Council, London, UK.

Available at:https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/ (Accessed 15/03/2019).

Nursing and Midwifery Council, NMC (2019) *Quality assurance framework for nursing, midwifery and nursing associate education*, Nursing and Midwifery Council, London, UK.

Available at:https://www.nmc.org.uk/globalassets/sitedocuments/edandqa/nmc-quality-assurance-framework.pdf (Accessed13/06/2020).

O'Connor, K.E. (2008) "You Choose to Care": Teachers, Emotions and Professional Identity". *Teaching and Teacher Education, 24, pp.117-126.*

O'Donnell, H. (2011) "Expectations and voluntary attrition in nursing students". *Nurse Education in Practice. 11 (1), pp. 54–63.*

O'Driscoll, M.F, Allan H.T, Smith P, A. (2010) "Still looking for leadership-who is responsible for student nurses' learning in practice?", *Nurse Education Today,30(3), pp.212-217.*

Ousey, K. (2009) "Socialization of student nurses-the role of the mentor", *Learning in Health and Social Care, 9(3), pp.175-184.*

Overgaard, S. (2003) "Heidegger's Early Critique of Husserl", *International Journal of Philosophical Studies, 11(2), pp.157-175.*

Padgett, D. (2016) *Qualitative Methods in Social Work Research (3rd Edition*), Sage Sourcebooks for the Human Sciences, New York University, USA.

Parahoo, K. (2006). "Nursing Research: Principles, Process and Issues". (2nd edition). Palgrave Macmillan, Basingstoke.

Patterson, M., Nolan, M., Rick, J., Brown, J., Adams, R., Musson, G. (2011) "From metrics to meaning: culture change and quality in acute care hospital for older people". *Report from the National Institute of Health Research Delivery and Organisation programme.*

Available at: http://www.sdo.nihr.ac.uk/files/project/93-final-report.pdf (Accessed 1/11/2018).

Patton, M. (2002) *Qualitative research and evaluation methods (3rd edition.).* Thousand Oaks, CA: Sage.

Pearcey, P., Elliott, B. (2004) "Student impressions of clinical nursing". *Nurse Education Today, 24(5), pp.382-387.*

Peeters, M. C. W., Montgomery, A. J., Bakker, A. B., & Schaufeli, W. B. (2005) "Balancing Work and Home: How Job and Home Demands Are Related to Burnout". *International Journal of Stress Management, 12(1), pp.43-61.*

Pfun, R., Dawson, P., Francis, R., Rees, B. (2004) "Learning how to handle emotionally challenging situations: the context of effective reflection", *Nurse Education in Practice, 4, pp.107-113.*

Pietkiewicz, I and Smith, J. (2014) "A practical guide to using Interpretive Phenomenological analysis in Qualitative research psychology", *Psychological Journal, 20(1), pp.7-14.*

Pisaniello, S., Windefield, R.H., Defabro, H.P (2012) "The influence of emotional labour and occupational health and wellbeing of South Australian hospital nurses", *Journal of Vocational Behaviour, 80, pp.579-591.*

Ploeg, J. (1999) "Identifying the best research design to fit the question. Part 2: qualitative designs" *Evidence-Based Nursing, 2(2), pp.36-37.*

Polit, D., Beck, C. (2010*) Nursing Research Principles and Methods (7th Edition)*. Lippincott Williams and Wilkins, London.

Price, L., Hastie, L., Duffy, K., Ness, V., McCallum, J. (2011) "Supporting students in clinical practice; Pre- registration nursing students' views on the role of the link lecturer", *Nurse Education Today, 31: 780-784.*

Pring, R. A. (2000) Philosophy of Educational Research. London: Continuum.

Pringle, J., Hendry, C., McLafferty, E. (2011) "Phenomenological approach: challenges and choices" *Nurse Researcher, 118(2), pp.7-18.*

Quality Assurance Agency (2018) *UK Quality Code for Higher Education Part A: Setting and Maintaining Academic Standards PART A*, The Frameworks for Higher Education Qualifications of UK Degree-Awarding Bodies. Available at: https://www.qaa.ac.uk/docs/qaa/quality-code/part-a.pdf?sfvrsn=4f09f781_18 (Accessed 5/03/2019).

Quicke, J. (2006) "Towards a new professionalism for new times: some problems and possibilities", *Teacher Development: An International journal of teachers' professional development, 2(3), pp.323-338.*

Raut, A.V., Gupta, S.S. (2019) “Reflections and peer feedback for augmenting emotional intelligence among undergraduate students”, *Education for Health, 32, pp.3-10.*

Reeves, S. Kuper, A., Hodges, B. (2008) “Qualitative research methodologies: ethnography”, *British Medical Journal, 337: a1020*

Available at: https://www.ncbi.nlm.nih.gov/pubmed/18687725 (Accessed 19/1/2020)

Reid, K., Flowers, P., and Larkin, M. (2005) “Explored Lived experience”, *The Psychologist, 18(1), pp.20-23.*

Rhodes, M., Morris, A., Lazenby, R. (2011) "Nursing at its Best: Competent and Caring", OJIN: *The Online Journal of Issues in Nursing, 16(2), pp.10-23.*

Ritchie, J and Lewis, J. (2008) (Eds) *Qualitative research practice: a guide for social science students and researchers*. London: Sage.

Robson, C. (2011) *Real World Research (3rd Edition)*, John Wiley and Sons. Sussex, UK.

Rodham, K., Fox, F AND Doran, N. (2015) “Exploring analytical trustworthiness and the process of reaching consensus in interpretive phenomenological analysis: lost in transcription,” *International Journal of Social Research Methodology, 18(1), pp.59-71.*

Rossetto, K.R. (2014) “Qualitative research interviews: assessing the therapeutic value and challenges” *Journal of Social and Personal Relationships, 31(4), pp.482-489.*

Royal College of Nursing (RCN) (2013) *Beyond breaking point? A survey report of RCN members on health, wellbeing and stress*, Royal College of Nursing, London. Available at:

https://www.rcn.org.uk/professional-development/publications/pub-004448 (Accessed 14/9/19).

Royal College of Nursing (2017) “Key messages from the RCN’s response to the NMC consultations on: Standards of proficiency for registered nurses; Education framework: standards for education and training; Prescribing and standards for medicines management”, Royal College of Nursing, London. Available at https://www.rcn.org.uk/professional-development/publications/pub-006505 (Accessed 16/12/2017)

Rustin, M. (2003) “Learning about emotions: the Tavistock approach”, *European Journal of Psychotherapy, Counselling and Health, 6 (3), pp.187-208.*

Ruth-Sahd, L (2003) “Reflective Practice: A Critical Analysis of Data-Based Studies and Implications for Nursing Education”, *Journal of Nursing Education, 42(11), pp.488-497*

Ryan, F., Coughlan, M., Cronin, P. (2007) “Step-by-step guide to critiquing research. Part 2: Qualitative research”, *British Journal of Nursing, 16(12), pp.738-44.*

Sargent, A. (2012) “Reframing Caring as discursive practice: a critical review of conceptual analyses of caring in nursing”, *Nursing Inquiry, 19(2), pp.134-143.*

Sawbridge, Y., Hewison, A. (2011) *Time to care. Responding to concerns about poor nursing care,* Health Services Management Centre, University of Birmingham. Available at:https://www.birmingham.ac.uk/Documents/news/Time-to-Care-Final-Report.pdf (Accessed 26/1/2018).

Scharalda, J., Leonard, J. (2010) “Appraising Qualitative Research in Health Education: Guidelines for Public Health Educators”, *Health Promotion Practice, 5, pp.612-617.*

Scherer, K. R., Clark-Polner, E., & Mortillaro, M. (2011) “In the eye of the beholder? Universality and cultural specificity in the expression and perception of emotion”. *International Journal of Psychology, 46(6), pp.401-435.*

Schmidt, K., Diestel, S. (2014) “Are emotional Labour strategies by nurse associated with psychological costs? A cross sectional survey”, *International Journal of Nursing Studies, 51, pp.450-1461.*

Schutz, P., DeCuir J. (2002) “Inquiry on Emotions in Education”, *Educational Psychologist, 37(2), pp.125-134.*

Seidman, I. (2006) Interviewing as qualitative research: a guide for researcher in education and the social sciences (3rd edition) New York, Teachers College Press.

Semmer, N., Elfering, A., Jacobshagen, N., Perrot, T., Beehr, T & Boos, N. (2008) “The Emotional Meaning of Instrumental Social Support”. *International Journal of Stress Management, 15, pp.235-251.*

Sharp, N.L., Bye R.A., Cusick A. (2019) Narrative Analysis. In: Liamputtong P. (Eds) Handbook of Research Methods in Health Social Sciences. Springer, Singapore.

Shaw, R, (2010) “Embedding Reflexivity within Experiential Qualitative Psychology”, *Qualitative Research in Psychology, 7(3), pp.233-24.*

Shaw, S., Bailey, J. (2009) “Discourse analysis: what is it and why is it relevant to family practice”, *Family Practice, 26(5), pp.413-419.*

Shenton, A. (2004) “Strategies for ensuring trustworthiness in Qualitative research Projects”, *Education for Information, 22, pp.63-75*.

Slaski, M and Cartwright, S. (2003) “Emotional Intelligence training and its implication for stress, health and performance”. *Stress and Health, 19, pp.233-239.*

Sloan, A., Bowe, B. (2014) “Phenomenology and hermeneutic phenomenology: the philosophy, the methodologies, and using hermeneutic phenomenology to investigate lectures experiences of curriculum design”, *Quality Quantity, 48, pp.1291-1303.*

Smith, A. J. (1996) “Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology”, *Psychology & Health, 11(2), pp.261-271.*

Smith, J., Flowers, P and Larkin, M. (2009) *Interpretative phenomenological analysis, theory method and research*. Sage London.

Smith, J., Osborn, M. (2008) “Interpretative phenomenological analysis”. *In J. A. Smith (Ed.) (2nd Edition), Qualitative Psychology: A practical guide to research methods.* London, Sage.

Smith, J., Noble, H. (2014) “Bias in research”. *Evidence-Based Nursing, 17(4), pp.100-101.*

Smith, P. (1992) *The Emotional Labour of Nursing: Its Impact on Interpersonal Relations,* Management and the Educational Environment in Nursing, MacMillan, Basingstoke.

Smith, P. (2011) *The Emotional Labour of Nursing Revisited: Can Nurses Still Care?* Palgrave Macmillan.

Smith, P., Gray, B. (2001, a) “Emotional labour of nursing revisited: caring and learning 2000”, *Nurse Education in Practice, 1, pp.42-49.*

Smith, P., Gray, B. (2001, b) “Reassessing the concept of emotional labour in student nurse education: role of link lecturers and mentors in a time of change”, *Nurse Education Today, 21, pp.230-237.*

Snape, D., Spenser, L. (2008) “The Foundations of Qualitative research” in Richie, J and Lewis, J. (Eds). *Qualitative research practice: a guide for social science students and researchers.* London: Sage.

Snyder, H. (2019) “Literature review as a research methodology: An overview and guidelines”, *Journal of Business Research, 104, pp.333-339.*

Speziale, H Carpenter, R. D. (2011) Qualitative *Research in Nursing: Advancing the Humanistic Imperative,* Lippincott Williams & Wilkins.

Spichiger, E., Wallaghen, M., Benner, P. (2005) “Nursing as a caring practice form a phenomenological perspective”, *Scandinavian Journal of Caring Science, 19, pp.303-309.*

Staden, H. (2001) “Alertness to the needs of others; a study of the emotional labour of caring”, *Journal of Advanced Nursing, 27, pp.147-156.*

Starks, H., Brown Trinidad, S. (2007) “Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory”, *Qualitative Health Research, 17(10), pp.1372-1380.*

Stenhouse, L. (1981)'What counts as research?' *British Journal of Educational Studies, 29(2), pp.103-114.*

Stokes, Y., Jacob, J., D., Gifford., W., Squires, J., & Vandyk, A. (2017) “Exploring Nurses' Knowledge and Experiences Related to Trauma-Informed Care”. *Global qualitative nursing research, 4, pp.1-10.*

Sturdy, A. (2003) “Knowing the Unknowable? A discussion of methodological and theoretical issues in emotion research and organizational studies”. *Organisation, 10(1), pp.81-105.*

Sucharew H., Macaluso, M (2019) “Methods for Research Evidence Synthesis: The Scoping Review Approach”. *Journal of Hospital. Medicine, 7, pp.416-418.*

Suri, H. (2011) “Purposeful Sampling in Qualitative Research Synthesis", *Qualitative Research Journal, 11(2), pp.63-75.*

Taylor, V. and Rupp, L. J. (2005) "When the Girls Are Men: Negotiating Gender and Sexual Dynamics in a Study of Drag Queens". *Signs, 30, pp.2115-2142.*

Terry, L., Carrol, J. (2008) "Dealing with death: first encounters for first year nursing students", *British Journal of Nursing, 17(12), pp.760-765.*

The British Psychological Society (2014) *BPS Code of Human Research Ethics*

Available at: https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014 (Accessed 13/8/2018).

The Data Protection Act (1998) Available at: http://www.legislation.gov.uk/ukpga/1998/29/contents#sch1-pt1 (Accessed 20/1/2018)

The General Data Protection Regulation (2018) Available at: https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation (Accessed 14/8/2018).

The Human Rights Act (1998) The National Archives, UK Government.

Available at: http://www.legislation.gov.uk/ukpga/1998/42/contents (Accessed 24/06/2020).

The National Nursing Research Unit (2015) "Partnership working in delivering student nurse mentorship: facilitators and constraints. A complex network of partnerships". *Policy plus evidence, issues and opinions in healthcare Issue 44.*

Available at: https://www.kcl.ac.uk/nursing/research/nnru/policy/Currentissue/Policy--Issue-44-FINAL.pdf (Accessed 5/03/2019).

Theodosius, C. (2006) "Recovering Emotion from Emotion Management*", Sociology, 40(5), pp.893-910.*

Theodosius, C. (2008) *Emotional labour in health care: The unmanaged heart of nursing*. Abingdon, UK: Routledge.

Timmins, F. (2005) "European Nursing Research and its Contribution to Nursing Knowledge Development", *Western Journal of Nursing Research, 27(1), pp.111-113.*

Tufford, L, and Newman, P. (2012) “Bracketing in qualitative research”. *Quality Social Work, 11(1), pp.80-96.*

Tuohy, D., Cooney A, Dowling, M. Murphy, K., Sixmith, J. (2013) “An overview of interpretative phenomenology as a research methodology”. *Interpretative Phenomenology, 20(6), pp.17-20.*

Vahey, D., Aiken, L., Sloan, D., Clarke, S., and Vargas, D. (2004) “Nurse burnout and patient satisfaction”. *Medical Care, 42(2) Supplement, pp.57-64.*

Van der Wath, A.E. & Du Toit, P.H., (2015) ‘Learning end-of-life care within a constructivist model: Undergraduate nursing students’ experiences’, *Curationis, 38(2), pp.1-9.*

Van Kleef, G.A., Cheshin, A., Fischer, A.H and Schneider, I.K. (2016) “Editorial: The Social Nature of Emotions”. *Frontiers in Psychology, 7(896), pp.1-5.*

Vanlaere, L, Gastmans, C. (2007) “Ethics in nursing education: learning to reflect on care practices”, *Nursing Ethics, 14(6), pp.758-766.*

Van Manen, M. (1997) “From Meaning to Method”, *Qualitative Health Research, 7(3), pp.345-369.*

Van Manen, M. (2001) “Professional Practice and ‘Doing Phenomenology”*. In: Toombs S.K. (Eds) Handbook of Phenomenology and Medicine. Philosophy and Medicine, Vol, 68.* Springer, Dordrecht.

Van Manen, M. (2017) “Phenomenology in Its Original Sense*”, Qualitative Health Research, 27(6), pp.810-825.*

Van Rhyn, W and Gontsana, M. (2004) “Experiences by student nurses during clinical placement in psychiatric units in a hospital”, *Curationis, 27(4), pp.18-27.*

Van Veen, K and Sleggers, P. (2006) “How does it feel? Teachers’ emotions in a context of change”. *Journal of Curriculum studies, 38(1), pp.85-111.*

Vicary, S., Young, A., Hicks, S. (2017) “A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis”. *Qualitative Social Work, 16(4), pp.550–565.*

Wallbank, S and Proctor, S. (2013) “Creating a compassionate and caring NHS: A view on the Francis Report”. *Journal of Health Visiting, 1(3), p.136.*

Watson, D and Naragon, D. (2009) “Positive Affectivity: The Disposition to Experience Positive Emotional States”, in Lopez, S.J and C.R. Snyder, C.R. (Eds) *The Oxford Handbook of Positive Psychology (2nd edition).* Oxford University Press.

Watt, D. (2007) “On Becoming a Qualitative Researcher: The Value of Reflexivity”. *The Qualitative Report, 12(1), pp.82-10.*

Weed, M. (2005)"Meta Interpretation: A Method for the Interpretive Synthesis of Qualitative Research, Forum”, *Qualitative Social Research, 6(1), pp.1-21.*

Weed, M. (2008) “A potential method for the interpretative synthesis of qualitative research: Issues in the development of ‘Meta- interpretation’*”. International Journal of Social Research Methodology, 11(1), pp.13-28.*

Welman, J., Kruger, S and Mitchell, B. (2005) *Research Methodology (3rd edition*). Oxford

University Press, Cape Town.

Wengraf, T. (2004) *Qualitative interviewing*. Sage, London.

Wenzel, J., Shaha, M., Klimmek, R. and Krumm, S. (2011) “Working Through Grief and Loss: Oncology Nurses’ Perspectives on Professional Bereavement”. *Oncology Nursing Forum, 38, p.4.*

Weurlander, M., Lonn, A, Seebeger, A., Brobeger, E., Hult, H., Werneson, A. (2018) “How do medical and nursing students experience emotional challenges during clinical placements”, *International Journal of Medical Education, 9, pp.74-82.*

Weurlander, M., Lonn, A, Seebeger, A., Brobeger, E., Hult, H., Werneson, A. (2019) “Emotional challenges of medical students generate feelings of uncertainty”,

Medical Education, 5(10), pp.103-1048.

Whitemore, R., Kaff, K. (2005) “The integrative review: updated methodology”, *Journal of Advanced Nursing, 52(5), pp.546-553*

Williams, J and Stickley, T. (2010) "Empathy and Nurse Education*". Nurse Education Today, 30, pp.752-755.*

Williamson, G., Callaghan, L., Whittlesea, E and Heath, V. (2011) "Improving student support using Placement Development Teams: staff and student perceptions", *Journal of Clinical Nursing, 20, pp.828–836.*

Williamson, G., Whittaker, A. (2014) *Succeeding in literature reviews and Research Project plans for nursing students,* (2nd Edition), Sage Publications, London.

Willig, C and Stainton Rogers, W. (2017) *The Sage Handbook of Qualitative Research in Psychology*, Sage Publications.

Willis, P. (2012) *Quality with compassion: the future of nurse education.* London: [Online] Available from: http://www.williscommission.org.uk/recommendations (Accessed 6/02/2018).

Wilson, A. (2014) "Being a practitioner: an application of Heidegger's phenomenology", *Nurse Researcher, 21(6), pp.28-33.*

Wilson, J. (2017) "The emotional impact of nursing: identifying issues and supporting staff. Sheffield Hallam University Research Archive (SHURA). Available at: http://shura.shu.ac.uk/17305 (Accessed 28/10/2018)

Wilson, S. C., Carryer, J. (2008) "Emotional competence and nursing education: A New Zealand study". Nursing Praxis in New Zealand, 24(1), pp.36-47.

Whittemore, R. and Knafl, K (2005) "The integrative review: updated methodology". *Journal of Advanced Nursing, 52(5), pp.546-553.*

Wimpenny, P., Gass, J. (2000) "Interviewing in phenomenology and grounded theory: is there a difference?" *Journal of Advanced Nursing, 31(6), pp.1485-1492.*

Winchester, C., Salji, M. (2016) "Writing a literature review", *Journal of Clinical Urology, 9(5), pp.308–312.*

Woodard, F. (2003) "Phenomenological contributions to understanding hypnosis: review of the literature*", Psychology Reports, 93, pp.829-847.*

World Medical Association (WMA). (2015) Declaration of Helsinki-ethical principles for medical research involving human subjects. Available at: https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/ (Accessed 21/06/2020).

Yoon, S., L.; Kim, J.H. (2013) "Job-Related Stress, Emotional Labor, and Depressive Symptoms among Korean Nurses", *Journal of Nursing Scholarship, 45(2), pp.169-176.*

Zembylas, M. (2007) "Theory and Methodology in researching emotions in education". *International Journal of Research and Methods in Education, 30(1), pp.57-72.*

Appendices.

Appendix B. Schedule of questions included in the interviews.

The interview questions would invite participants to discuss emotional experiences in a clinical placement, which they deem to be significant and to discuss how they responded. They would be asked for a description of the situation, and how they felt during and after the event and about how coped with the experience

Questions include: -

- Could you share your experience of a difficult, distressing or emotionally challenging event or situation while in HSC practice?
- How did you feel during the experience?
- Did you discuss your feelings with anyone?
- Were you offered guidance or help on how you should deal with the experience either before, during or after the experience?
- How did you deal with the situation?
- Did you feel prepared for the emotional experience that you encountered?
- How were you prepared and by whom?
- Looking back, were there any specific influences on how you expressed your feelings in response to the emotional experience?
- If you came across a similar experience again would you deal with it differently?
- If so, how and why would you do so?

However, these questions are merely a guide to the interview sessions; it is participants' responses which would lead the direction of the interview.

Appendix A. Participant information leaflet explaining the nature and purpose of the study.

Faculty of Health, Social Care and Education
St George's Campus
Cranmer Terrace, London, SW17 0RE

Telephone: (0)20 8725 2247

www.healthcare.ac.uk

Title of study: How might undergraduate nursing students' responses to their emotional experiences in clinical practice be better understood?

Information for participants

You are being invited to take part in this study exploring how nursing students navigate and manage emotional experiences in the clinical setting. Please take time to read the following information and discuss with others if you wish. Please also ask me any questions if you need to (see my contact details below). I am a lecturer in adult nursing within the school of Nursing and Midwifery at Queens University and I am undertaking the study as the final research project for a part-time Education Doctorate (Ed. D) with the School of Education, Kingston University, and London. I am supervised by Professor Keith Grieves.

What is the purpose of the study?

In this proposed study I would aim to examine undergraduate student nurses' emotional experiences in clinical practice and to explore students' perceptions of what they deem acceptable and unacceptable emotional displays and expressions in their professional practice. In particular I seek to understand: -

How undergraduate nursing students adapt to and navigate an environment in which they frequently encounter an array of emotional experiences in clinical practice?

Why have I been invited?

You have been invited to take part because you are a student undertaking the three-year BSc undergraduate adult nursing programme and have undertaken at least one six-week period of supervised practice in a clinical setting. As such you may have been exposed to a range of emotional experiences. In order to explore further how students, adapt and navigate such emotional experiences it would be useful to gain a range of perspectives from you and other students as you progress across through the programme.

As I am a lecturer within the BSc adult nursing programme and in order to reduce any sense that you are being coerced into taking part, I have contacted you via your class representative at the School of Nursing & Midwifery staff student/consultative forum, who is distributing this information leaflet and consent form. I am looking to recruit nine to twelve participants. If more people agree to participate than my hoped for number, I would chose the first 4 from each year who responded. If you are a student for whom I have a personal tutor role I would ask you not to take part as there may a conflict of interest with the roles of researcher and personal tutor.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do wish to take part, please contact me via email at k1170923@kingston.ac.uk or by telephone on 02890975853. If you decide not to take part, this will not affect the relationship you have with the university or your studies within the BSc Nursing programme. If you do take part you are free to withdraw at any time until data analysis has commenced, without giving any reason and

without any detriment to you. If you should withdraw before data analysis has commenced, any information that you have given would not be used in the study and all records will be deleted.

What will happen if I do take part?

You will be given a copy of this information sheet to keep. You would be invited to a face to face meeting with myself initially at a time and location that is convenient, least formal and comfortable to yourself, such as the student union or a local coffee shop. I would be offering to pay for any soft drinks or snacks and would reimburse any travel expenses. It is hoped that this initial meeting would take place towards the end of May or early June 2017 and last approximately 45 minutes. It would allow you to get to know me as a researcher and why I want to undertake the study. You would then be asked to sign the attached consent form agreeing to be interviewed.

If you continue to agree to take part, you would be invited to attend a face to face interview for the study during June/July 2017 at a day, time and place that is convenient and comfortable for you. It is expected that this interview would last approximately 60 minutes. At the outset of the interview you would be asked to provide some basic information about yourself such as the phase and year on the programme. At this interview you would be invited to talk about significant emotional experiences that you encountered in clinical practice and how you responded. You would be asked for a description of the situation, and how you felt during and after the event and about how you coped with the experience. You would also be asked if there were any changes in how you expressed their emotions and if there were any specific influences on how you expressed emotions. However, these questions are merely a guide to the interview sessions; it is your responses which would

lead the direction of the interview. The interview would be audio-recorded so that I have an accurate record of what has been said and as part of the collection of information for the study.

What are the possible benefits of taking part?

There are no immediate benefits. However, it is hoped that information from this study will help to may contribute to a greater understanding of nurses' emotional experiences and how nurses deal with and manage such emotions. Ultimately, I hope that this understanding would help to prepare and supports students for clinical practice.

What are the risks of taking part?

There are no anticipated risks in taking part in this study. However, some people may find talking about their experiences upsetting. If this happens, you can stop the interview and take a break at any time. If you should find it difficult or upsetting to talk about your experience you would be asked if you want to suspend or end the interview at any time. You would be provided with the details of local support and university counselling services that could be contacted if you would like further support.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice in accordance with Kingston University's data management policy. All information will be handled in confidence. Details such as names of participants would be kept confidential throughout the study and within the findings and written reports. Only I (the researcher), my research supervisor and a professional transcriber would have access to the original data from the interview. The transcriber has signed a confidentiality agreement and after typing up all the information from the interviews has agreed to return all audiotapes and related documentation received. (Please see attached confidentiality agreement for more information).

Following transcribing I would send you a paper copy for you to check that it is an accurate reflection of your interview. All recording equipment and typed up versions including paper copies of the interview would be kept in a locked filing cabinet in a locked office. Any electronic information gathered will be securely stored on a password protected computer, and no names or contact details will be attached to the data files. At the end of the study all data will be archived securely for 10 years and then destroyed in accordance with Kingston University Data Retention guidance and Queen's University Belfast, Code of Conduct and Integrity in Research. I may want to use quotes from the interviews in the final research report or in articles about this research. If I should do this, any information (such as names, clinical places) which could be used to identify you or anyone else you have mentioned in the interviews would be removed.

What you say to me in the interview is **confidential.** This means that whatever is shared in the interview and any quotes used in publication would not lead to your identification. An **exception to this would be** where you tell me that you, or someone else, are at risk of harm or danger, there is a disclosure of illegal activity or you give permission for confidentiality to be broken.

What will happen to the results of the study?

I will write up my findings in a dissertation in part fulfilment of my Ed D course of studies. If possible, l will submit the findings to a suitable journal. In publishing this study, you will not be identified in any way.

Who has reviewed this study?

The study has been looked at by an independent group of people called the Faculty of Health, Social Care and Education Research Ethics Committee to protect your safety, rights, and dignity. They have given a favourable opinion. Further application has been made to the chair

of Queens University School of Nursing and Midwifery Research Ethics Committee who also has given a favourable opinion.

What if I have a complaint?

If you wish to complain about any aspect of the research, please contact my supervisor, using the details given below.

Contact Details of Course Supervisor:

Professor Keith Grieves

School of Education, Faculty of Health, Social Care and Education London

Email: K.Grieves@kingston.ac.uk

Telephone: 0208 417 5100

Researcher's Contact Details:

If you have any questions or concerns relating to the research, please contact

Laurence Leonard

School of Nursing and Midwifery

MBC Building

Queens University

Lisburn Rd

Belfast BT9 7LW

Email: k1170923@kingston.ac.uk

Or

l.leonard@qub.ac.uk

Telephone: 028 9097 5853

Appendix C. Consent form agreeing to participation in the study.

Faculty of Health, Social Care and Education
St George's Campus
Cranmer Terrace, London, SW17 0RE
Telephone: (0)20 8725 2247
www.healthcare.ac.uk

CONSENT FORM

Centre Number:

Study Number:

Participant Identification Number for this trial:

Title of Project: How might undergraduate nursing students' responses to their emotional experiences in clinical practice be better understood?

Name of Researcher: Laurence Leonard

Please initial box

1. I confirm that I have read the information sheet dated.................... (version............) for the
   above study. I have had the opportunity to consider the information, ask questions and have
   had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time ☐

without giving any reason, without my studies at the university or legal rights being affected.

3. I agree to take part in the above study by participate in a face to face interviews with the researcher and I agree to the interview being audio recorded. ☐

4. I understand that any information which suggests that I or another person is at risk of harm or involved in illegal activity, may have to be passed on to the relevant authorities. ☐

5. I understand that will not be identifiable in any data published in relation to this study ☐

6. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Person taking consent	Date	Signature

Please return to or for further information, please contact: Laurence Leonard Email.l.leonard@qub.ac.uk

Appendix D,a. Application to the Faculty of Health Social Care and Education, Research Ethics Committee (FREC) at Kingston University.

APPLICATION FORM FOR ETHICAL REVIEW (RE4)

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

SECTION A

Is this an application for a 'block release agreement':	Yes		No	X

If *yes*, please specify the name of the group/cohort and note who will be responsible for ethical oversight of projects in this area (the block release holder); this will usually be the module leader, supervisor or head of subject. This RE4 form should present a project *typical* to this group/cohort.

Project title:

How might undergraduate nursing students' responses to their emotional experiences in clinical practice be better understood?

Name of the lead applicant:

Name (Title / first name / surname):	Laurence Leonard
Position held:	Ed Doctorate student
Department/School/Faculty:	Faculty of Health, Social Care & Education School of Education, Kingston University
Telephone:	07941730512 or 02890975853
Email address:	k1170923@kingston.ac.uk

Name of co-applicants:

Name (Title / first name / surname):	
Position held:	
Department/School/Faculty:	

Telephone:	
Email address:	

Name (Title / first name / surname):	
Position held:	
Department/School/Faculty:	
Telephone:	
Email address:	

Name (Title / first name / surname):	
Position held:	
Department/School/Faculty:	
Telephone:	
Email address:	

Is the project:					
Student research	Yes	X	No	
KU Staff research	Yes		No	X
Research on KU premises	Yes		No	X

If it is STUDENT research:

Student number	K1170923
Course title	Ed Doctorate
Supervisor/DoS	Professor Keith Grieves, School of Education, Kingston University, London

<u>SECTION B</u> ***(Complete this section if another ethics committee has already granted approval for the project.)***

Have you received ethical approval for this project from any other ethics committee?

Yes		No	x

Committee that granted approval	
Date of approval	

Please attach evidence that the project has been fully approved (usually an approval letter). The original application should be retained on file in the Faculty for inspection where necessary.

SECTION C

Provide a brief project description (max. 150 words). This should be written for a lay audience

The proposed study is being undertaken as the final part of an Ed D joint award with Kingston and Roehampton Universities, London. As a registered nurse (RN) and registered nurse teacher my perception of both nursing practice and education is that the focus is often centred on developing a range of clinical skills and/or academic performance. I am concerned that nursing students are unprepared for the emotional aspects of their role and unsure as to what emotional expressions or displays are acceptable within professional practice.

In this proposed study I would aim to gain an in-depth understanding of how BSc undergraduate nursing students adapt to emotional experiences in clinical practice and to explore students' perceptions of what they deem acceptable and unacceptable emotional displays and expressions in their professional practice.

Ultimately, I hope that this might provide insight into how nursing students might be better prepared for and supported in navigating the myriad of emotional experiences in clinical practice.

Estimate duration of the project (months)	14 to 18 months
State the source of funding	Annual tuition fees for the Ed Doctorate are paid by employer, School of Nursing and Midwifery, Queen's University Belfast.

Is it collaborative research?

Yes		No	x

If YES, name of the collaborator institutions:

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Briefly describe the procedures to be used which involve human participants

Sturdy (2003) and Dilley (2004) suggest that interpretivist hermeneutic phenomenological approaches are concerned with seeking lived accounts of knowing emotions as experienced and a way of finding out what others feel and think. Such an approach has relevance to this proposed study in that it may help to explore the significance of various emotions for individual nursing students that arise in caring for patients in the clinical setting. As the purpose of this research is to obtain a rich description of nursing students' emotional experiences and their emotional responses, the methodology used therefore would be an interpretative approach using in-depth

open-ended interviews with a sample of nursing students from across Queens University BSc undergraduate adult nursing programme.

Open-ended interviews would allow participants to discuss their opinions, views and experiences in detail, whereas perhaps a set interview with closed-ended questions may inhibit a fuller expression of opinions and feelings (Siedman 2006). Unstructured interviews allow for follow up with further questions and through probing and paraphrasing a shared construction of meaning can be made. Bryman (2008) argues that the unstructured interviews are more flexible allowing for consideration of the diversity of individual participants, experiences.

These interviews would be based around Seidmans' Phenomenological Interviewing Model (Siedman, 2006) which aims to enable participants to explore and reflect on their experience. The interview questions would invite participants to discuss emotional experiences in a clinical placement, which they deem to be significant and to discuss how they responded. They would be asked for a description of the situation, and how they felt during and after the event and about coping with the experience. (More detail of the nature of these interview questions is provided in the next section on page 7and in the attached interview schedule). These questions are merely a guide to the interview sessions; it is the participant's responses which would lead the direction of the interview. The flexibility of this approach, particularly compared to structured interviews, also allows for the discovery or elaboration of information that is important to participants but may not have previously been thought of as pertinent (Jamshed, 2014) and would allow me as the researcher to remain open to the perspective of the participants.

Summarise the data sources to be used in the project

Within Queens University School of Nursing & Midwifery, where the proposed study would take place, the three-year BSc undergraduate adult nursing programme involves students undertaking 3 phases of learning each year amounting to nine phases overall. Each phase includes a period of theoretical study at University followed by a period of supervised practice in a clinical setting. Students are likely to have been exposed to a range of emotional experiences in those clinical settings. In order to explore further how students, adopt and navigate such emotional experiences, it would be useful to gain a range of perspectives from students across the three year programme and from all phases. The inclusion of students from a range of phases of the programme may help to reveal insights into whether there were any changes in how they expressed their emotions and if there were any specific influences on how they expressed their emotions as they progressed.

The study population would therefore consist of a purposive convenience sample of undergraduate adult nursing students who have completed at least one clinical practice placement in their educational programme, as these are a convenient and relevant population to the aims of this study, having been within a clinical practice setting. They are also a group which relate to my own area of practice as a registered nurse in adult care and lecturer in adult nursing.

Cormack (2000) suggests that in qualitative research, researchers use a small selective sample, because of the in-depth nature of the study and the analysis of data required. This study therefore would aim to recruit nine students to participate (three from each year of the programme), so as to gain a range of perspectives and experiences.

Potential participants would be invited to take part in the research, through the distribution of an information sheet outlining the purpose and nature of the research (Please see attached with this application).Within this information there is an explanation of what participation would entail, such as time involved, rights of the participants, such as the right to decline to offer any particular information

requested by myself, the researcher. My telephone number and related email addresses will be included, and potential participants will be invited to contact me to clarify any aspect of the research

Participation would be voluntary, and consent obtained through completion and signing of a consent form to partake in the study. Participants would also be provided with details regarding complaints on any aspect of the research process.

As I am a lecturer within the BSc adult nursing programme and in order to reduce any sense of being coerced into taking part, I would contact potential participants via the class representatives to the School of Nursing & Midwifery staff student/consultative forum, who would be invited to distribute this information leaflet and consent form via email, to each of their respective class groups across the BSc adult nursing programme.

If more people agree to participate than my hoped for number, I would chose the first responses from each phase of the programme. Students for whom I have personal tutor role, would be asked not to take part as there may a conflict of interest with the roles of researcher and personal tutor.

Polit and Beck (2010) highlight the importance of reassuring potential participants that participation (or not) will be used against them in any way. Participants will be advised that they would have the right to decline to take part in the study or to withdraw at any time until data analysis has commenced, without giving any reason and should this occur it would have no impact on their studies or student activities at the University.

Allmark et al (2009) highlight a difficulty in power relations in dual roles in research such as in my own role as nurse educator and researcher and students also as participants. Anyan (2013) suggests that the quantity and quality of the information shared with the researcher depends in part on the relationship that develops between the researcher and participants' cooperation may be influenced by power imbalance. Such an imbalance may be due to a variety of factors, including the degree of participant's willingness to express themselves on the subject of the research and to help the

researcher and importantly, interview location. Kirsch (2005) mentions how friendliness can delineate such boundaries and expectations within the research relationship. They argue that during the personal collection of data, the interviewer should aim to create a welcoming, non-threatening environment in which the interviewees are willing to share personal experiences and beliefs. Participants would therefore be invited to a face to face initial meeting with myself during June 2017 at a time and location that is convenient, least formal and comfortable to themselves, such as the student union or a local coffee shop. I would offer to pay for any soft drinks or snacks and would reimburse any travel expenses. The first meetings would last approximately 45 minutes and allow participants to get to know me and why I want to undertake the study. It would also allow me as the researcher an opportunity to build a relationship of trust. Participants would be asked to sign a consent form agreeing to be interviewed and to agree a convenient time and place for the interview later in June/July 2017.

As meetings and subsequent interviews are likely to take place outside of University premises, they would be undertaken in accordance with the University Health and Safety Policy and Guidance on Lone Working/Working in Isolation. Interviews are anticipated to last no more than 60 minutes and would be audio-taped and later transcribed using NVvivo8 software (QSR International, Cambridge) which is designed to help organize, analyse and find insights in unstructured qualitative data such as in interviews.

At the outset of the interview participants would be asked to provide some basic demographic information, such as the phase and year on the programme. At this interview participants would be invited to talk about their emotional experiences in clinical practice and how they responded. They would be asked for a description of the situation, and how they felt during and after the event and about how they coped with the experience. They would also be asked if there were any changes in how they expressed their emotions and if there were any specific influences on how they expressed

emotions. However, these questions are merely a guide to the interview sessions; it is the responses which would lead the direction of the interview. (Please see attached interview schedule).

The interview would be audio-recorded so that I have an accurate record of what has been said and as part of the collection of information for the study.

Allmark et al (2009) in reviewing the literature, highlight that a potential for interviews to harm participants emotionally is noted in some papers, although this is often set against potential therapeutic benefit. Although no harm is anticipated in this study, there is a potential that participants may experience some discomfort or aroused feelings of discontent. Rossetto (2014) found some evidence that the research interview process in itself has therapeutic value allowing for a healing meaning-making function for participants. Although this is not the purpose of the research it may be that the interview process itself would allow participants to find a therapeutic value in recounting any emotional experiences. Few et al (2003), suggest that levelling power can also occur through self-disclosure during the interview process whereby, the researcher invokes examples of their own experiences when participants seem uncomfortable with such disclosures or became emotional. However, as Allmark et al (2009) cautions against the researcher being tempted to switch from research to therapy when conducting interviews. Participants would be advised that they may stop the interview or take a break at any time and they would be advised of local support and university counselling services contact details that could be contacted if they would like further support.

It is impossible to have value free research and thus it would be important to understand the relationship between the research participants and my researcher’s point of view through a process of reflection. Dahlberg et al. (2008) highlight the need for reflection at all stages of the research process in order to restrain and limit any bias. Reflexivity is deemed as important and would allow me as researcher to become aware of what I am hearing and seeing and helping to clarify beliefs. Through reflexivity, I can reflect on how my social background, such as my role and positioning may impact on the research process. For example, participants’ expression of emotions may be affected in order to fit

perceived acceptable display rules before me in my role as lecturer. A process of reflexivity would enable me to identify and acknowledge the limitations of the research. It is therefore important that I am able to engage critically and reflexively within this research allowing the consideration of perspectives that relate to my personal interest and 'curiosity'. To help to ensure reflexivity a coding diary would record reflections on how my own experiences may have shaped the collection, generation and analysis of data. Steps are to be taken throughout the research process to "bracket" any prior assumptions and experiences. I would write reflectively at the end of each interview to enhance insight and my understanding and illustrate my own thought and feelings. I would endeavour to be mindful that knowledge of findings in early interviews may subsequently influence interpretation of later interviews. In interpretation of data and through careful re-reading of the data I would seek to become aware of and manage these influences and consider ''fair dealing,'' i.e., whether a wide range of different perspectives are incorporated. With respect to such fair dealing, I would give attention to not over emphasising the views of any one of participants as if they represented the sole truth.

The concept of descriptive validity and interpretative validity arises from the work of Maxwell (1992) who suggests this in terms or checking for factual accuracy of the data. Freeman et al. (2007) see the systematic documentation of all procedures as a key strategy to ensure quality in qualitative research. This would require me to give a "thick description" to allow others to have a proper understanding and make comparisons to their own context. In order to strengthen descriptive validity, the individual participants' transcript would be emailed to them with a recording of their interview for their view as of its accuracy before content analysis. Following analysis, participants would also be invited to review the final version of data analysis for its interpretative validity.

This study is being undertaken part time and therefore would require me to commit my personal time over the following 12 months. However, I have also received a commitment from my employer that I would be allowed 6 weeks block of free time for analysis and write up.

An indicative timetable for undertaking the research is outlined in the table below.

Date	Activity
March 2017	Prepare application for Ethical approval for Submission on the early April 2017 (Include prepare participants invitation letter and consent form
Aril 2017	Submit application for Ethical approval Begin writing literature review Prepare demographic questionnaire Draft interview questions/themes
June 2017	Following approval from ethics committee Invite prospective participants to consent to join the study. Begin schedule of meetings Arrange schedule of interviews Continue Writing literature review
June/July 2017	Complete scheduled interviews Complete writing literature review
July/August 2017	Initial examination of data and highlighting of emerging themes
August 2017	In-depth data analysis
Sept 2017	Writing analysis
Oct to May 2018	Ongoing discussion with supervisors and writing of discussion section
June 2018	Submission of Thesis

Storage, access and disposal of data

Describe what research data will be stored, where, for what period of time, the measures that will be put in place to ensure security of the data, who will have access to the data, and the method and timing of disposal of the data.

I would follow ethical and legal practice and all information would be handled in confidence and would not be shared, **except** where the participant or someone else, are at risk of harm or danger or there is a disclosure of illegal activity requiring confidentiality to be broken.

Only I (the researcher), my research supervisor and a professional transcriber would have access to the original data from the interview. The transcriber has signed a confidentiality agreement and has agreed to return all audiotapes and related documentation received after typing up all the information from the interviews. (Please see attached confidentiality agreement for more information).

Following transcribing of individual interviews, I would send a copy to the respective participant for their records and to check that it is an accurate reflection of their perspective and views.

Details such as names of participants would be kept confidential throughout the study and within the findings and written reports. Storage of data would comply with the Data Protection Act (1998), The Human Rights Act (1998) and the University's Data Protection guidelines and data privacy policy. As suggested by Welman et al. (2005) I would also ensure that any identifying information is safely secured. All recording equipment and typed up versions and written data of the interview would be kept in a locked filing cabinet in a locked room or on a password secure computer that only I would have access to. Setting up these procedures will prevent any accidental breach of confidentiality. I will write up my findings in a dissertation in part fulfillment of my Ed D course of studies. If possible, I will submit the findings to a suitable journal. In publishing this study, I may want to use quotes from the interviews in the final research report or in articles about this research. If I should do this, any information (such as names, clinical places) which could be used to identify participants or anyone that they have mentioned in the interviews would be removed.

At the end of the study, all data resulting from the study would be archived securely for 10 years in accordance with Kingston University, Data Privacy Policy and Queen's University Belfast, Code of Conduct and Integrity in Research.

References.

Allmark, P. J., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A. and Tod, A. (2009). "Ethical issues in the use of in-depth interviews: literature review and discussion". Research ethics review, 5 (2), 48-54.

Anyan, F (2013) "The Influence of Power Shifts in Data Collection and Analysis Stages: A Focus on Qualitative Research Interview", *The Qualitative report Vol18 (18):1-9*

Bryman, A. (2008) Social research methods (3rd Edition) Oxford, Oxford University Press.

Cormack, D. (2000) *The Research Process In Nursing* (4th Edition). Oxford: Blackwell Science

Dilley, P. (2004) "Interviews and the philosophy of Qualitative Research"

The Journal OF Higher Education, Vol 75:127- 132

Few, A.L., Stephens, D.P., Rouse-Arnett, M. (2003). "Sister-to-Sister Talk: Transcending Boundaries and Challenges in Qualitative Research with Black Women". *Family Relations, Vol. 52 (3): 205-215*

Jamshed, S. (2014)"Qualitative research method – interviewing and observation", *Journal of Basic and Clinical Pharmacy, Vol 5 (4) : 87- 88.*

Kirsch, G. E. (2005) "Friendship, Friendliness, and Feminist Fieldwork". Signs, Vol 30, 2163 - 2175.

Polit, D., Beck, C. (2010*) Nursing Research Principles and Methods (7th Edition)*. Lippincott Williams and Wilkins, London.

Rossetto, K.R. (2014) "Qualitative research interviews: assessing the therapeutic value and challenges" *Journal of Social and Personal Relationships, Vol 31(4):482-489*

Seidman, I. (2006) Interviewing as qualitative research: a guide for researcher in education and the social sciences (3rd edition) New York, Teachers College Press.

Sturdy, A. (2003) "Knowing the Unknowable? A discussion of methodological and theoretical issues in emotion research and organizational studies". *Organisation Vol 10(1):81-105*

Wallbank, S and Proctor, S. (2013) "Creating a compassionate and caring NHS: A view on the Francis Report". *Journal of Health Visiting, Vol 1(3):136*

Risk Assessment Questionnaire: Does the proposed research involve any of the following?

		YES	NO
0.	The use of human biological material?		x
1.	Children or young people under 18 years of age?		x
1.a	If YES, have you complied with the requirements of the DBS?		N/A
2.	People with an intellectual or mental impairment, temporary or permanent?		X
3.	People highly dependent on medical care, e.g., emergency care, intensive care, neonatal intensive care, terminally ill, or unconscious?		X
4.	Prisoners, illegal immigrants or financially destitute?		X
5.	Women who are known to be pregnant?		X
6.	Will people from a specific ethnic, cultural or indigenous group be targeted in the proposed research, or is there potential that they may be targeted?		X
7.	Assisted reproductive technology?		X
8.	Human genetic research?		X
9.	Epidemiology research?		X
10.	Stem cell research?		X

11.	Use of environmentally toxic chemicals?		X
12.	Use of ionizing radiation?		X
13.	Ingestion of potentially harmful or harmful dose of foods, fluids or drugs?		X
14.	Contravention of social/cultural boundaries?		X
15.	Involves use of data without prior consent?		X
16.	Involves bodily contact?		X
17.	Compromising professional boundaries between participants and researchers?		X
18.	Deception of participants, concealment or covert observation?		X
19.	Will this research significantly affect the health[1] outcomes or health services of subjects or communities?		X
20.	Is there a significant risk of enduring physical and/or psychological harm/distress to participants?	x	
21.	Does your research raise any issues of personal safety for you or other researchers involved? (especially if taking place outside working hours or off KU premises)	x	
22.	Will the research be conducted without written informed consent being obtained from the participants except where tacit consent is given by completing a questionnaire?		X
23.	Will financial/in kind payments (other than reasonable expenses and compensation for time) be offered to participants? (Indicate in the proposal how much and on what basis)		X
24.	Is there a potential danger to participants in case of accidental unauthorised access to data?		X

SECTION D ***(To be signed by all applicants)***
Declaration to be signed by the applicant(s) and the supervisor (in the case of a student):

[1] Health is defined as not just the physical well-being of the individual but also the social, emotional and cultural well-being of the whole community

- I confirm that the research will be undertaken in accordance with the Kingston University *Guidance and procedures for undertaking research involving human participants.*

- I will undertake to report formally to the relevant Faculty Research Ethics Committee for continuing review approval where required.

- I shall ensure that any changes in approved research protocols or membership of the research team are reported promptly for approval by the relevant Faculty Research Ethics Committee.

- I shall ensure that the research study complies with the law and University policy on Health and Safety.

- I confirm that the research study is compliant with the requirements of the Disclosure and Barring Service where applicable.

- I am satisfied that the research study is compliant with the Data Protection Act 1998, and that necessary arrangements have been, or will be made with regard to the storage and processing of participants' personal information and generally, to ensure confidentiality of such data supplied and generated in the course of the research.
  (Further advice may be sought from the Data Protection Officer, University Secretary's Office)

- I shall ensure that the research is undertaken in accordance with the University's Single Equality Scheme.

- I will ensure that all adverse or unforeseen problems arising from the research project are reported immediately to the Chair of the relevant Faculty Research Ethics Committee.

- I will undertake to provide notification when the study is complete and if it fails to start or is abandoned;

- (For supervisors, *if the applicant is a student)* I have met and advised the student on the ethical aspects of the study design and am satisfied that it complies with the current professional (*where relevant),* departmental and University guidelines. I accept responsibility for the conduct of this research and the maintenance of any consent documents as required by this Committee.

- I understand that failure to provide accurate information can invalidate ethical approval.

Is this an application for fast-track ethical approval?

Yes X		**No**	

(Fast track is **only** available for projects either pre-approved by another ethics committee, or where you have accurately indicated 'No' to every question on the Risk Assessment Questionnaire – above)				

Please sign and date	*Signature*	*Date*
Lead applicant		12/5/2017
Co-applicant		
Co-applicant		
Co-applicant		
Supervisor		

NOTE

If you have answered YES to any of the questions in the Risk Assessment, you should complete a full application for ethical approval and provide the information outlined in the checklist below. Your project proposal should show that there are adequate controls in place to address the issues raised in your Risk Assessment.

If you have answered NO to all of the questions in the Risk Assessment you may submit the form to your Faculty Ethics Administrator as a fast-track application. Please remember to include your participant information sheet(s) and consent form(s).

CHECKLIST ***(Where a full application for ethical approval is required)***

Please complete the checklist and attach it to your full application for ethical approval:

Before submitting this application, please check that you have done the following: *(N/A = not applicable)*	**Applicant**	*Committee use only*

	Yes	No	N/A	Yes	No	N/A
All questions have been answered	**X**					
All applicants have signed the application form	**X**					
The research proposal is attached, if applicable			**n/a**			
Informed Consent Form(s) is attached	**x**					
Participant Information Sheet(s) are attached	**x**					
All letters, advertisements, posters or other recruitment material to be used are attached, if applicable			**n/a**			
All surveys, questionnaires, interview/focus group schedules, data sheets, etc, to be used in collecting data are attached, if applicable	**x**					
Reference list attached, if applicable	**x**					

**GREATER
+TOGETHER**

Kingston and St George's
Faculty of Health, Social Care and Education

Appendix. D, b. Favourable letter received following application to the Faculty of Health Social Care and Education, Research Ethics Committee (FREC) at Kingston University.

Professor Scott Reeves
Kingston and St George's Joint Faculty
Health, Social Care and Education
6th Floor Hunter Wing

Cranmer Terrace
London SW17 0RE

Laurence Leonard

Kingston and St George's Joint Faculty

Health, Social Care and Education

6th Floor Hunter Wing
Cranmer Terrace

London SW17 0RE

05 June 2017

Dear Laurence,

Ethics application: 'How might undergraduate nursing students' responses to their emotional experiences in clinical practice be better understood' FREC 2017-04-004

I am writing to confirm that the Faculty Research Ethics Committee (FREC) considered your proposed study as above at the meeting on 25 April 2017. The Committee requested some minor amendments which have been satisfactorily addressed in the following documents:

- Application form for ethical review, version 3 dated 05/06/2017
- Participant Information Sheet, version 2 dated 11/05/2017

- Consent form, version 2 dated 05/06/2017

The following documents were approved with no changes:

- Interview schedule, version 2 dated 05/06/2017
- Transcription services confidentiality agreement, version 1 dated 12/5/2017

I am now pleased to confirm that this proposal has received a favourable ethical opinion.

I wish you every success with your work on this project.

Yours sincerely,

Professor Scott Reeves

Chair, Faculty Research Ethics Committee

Appendix D, c.) Waiver from the Chair of the SNAM, REC to undertake the study.

The School of Nursing and Midwifery
Queen's University Belfast

Medical Biology Centre
97 Lisburn Road
BELFAST

Northern Ireland
Tel: 028 9097 2233/2061

Fax: nursing@qub.ac.uk 028 9097 2328 www.qub.ac.uk/nur

12 June 2017

Ref: 11. LLeonard.06.17.M7.V1

Laurence Leonard
School of Nursing and Midwifery
Queen's University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast
BT9 7BL

Dear Laurence,

SCHOOL RESEARCH ETHICS COMMITTEE

RE: How might undergraduate nursing students' responses to their emotional experiences in clinical practice be better understood'

Thank you for your recent submission to the School of Nursing and Midwifery Research Ethics
Committee. The committee has noted that ethical approval has already been given by another Ethics Committee. As such, the committee is happy to provide you this letter as proof of exemption which will allow you to proceed with the study.

Yours sincerely

Dr Oliver Perra

Chair, School Research Ethics Committee
School of Nursing & Midwifery

cc File copy

Appendix E. Transcriber confidentiality agreement.

CONFIDENTIALITY AGREEMENT

Transcription Services

How might undergraduate nursing students' responses to their emotional experiences in clinical practice be better understood?

I, ___________ Eimear Ruane-McAteer ___, _________________, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Laurence Leonard related to [How might undergraduate nursing students' responses to their emotional experiences in clinical practice be better understood]. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Laurence Leonard];

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;

4. To return all audiotapes and study-related documents to Laurence Leonard] in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) EIMEAR RUANE-MCATEER

Transcriber's signature

Date 11 May 2017

Appendix F. Examples of notated transcripts.

Participant….

Interviewer: Laurence Leonard

Duration: 38 minutes 24 seconds

2nd year

Chemotherapy Administration unit

60 year old woman

2 experiences of death

P: Yeah I'm at the end of phase 6, my second year.

I: Ok so your last placement really. What I'm looking to find out is, did you come across any emotional experiences anything that you thought was really emotional and I just want to know what happened and how you dealt with it.

DEATH

P: Yeah, the I think where an incident that affected me was in a chemotherapy administration unit and so they would naturally have a lot of mechanisms set up to support families with the loss of a relative, but I think that as a student when one of the patients that I would regularly have seen, I had heard the news that they had died. I don't think that there

THEME SUPPORT

was a lot of support mechanisms set up for the staff themselves and there was a lot of it was on the patients maybe.

P: So it was a 60 year old woman who would have been getting chemotherapy for lymphoma and then she had been getting treatment regularly so it was towards the end of the placement so I would have been treating her throughout the 6 weeks

P: Yeah, under my r . I regularly would have seen her

I: How did you feel about that, going in there?

P: For myself it.was a surprise because when I had went in I had been told that the patient

Feelings UNDERSTAND

died but I wasn't sure how long my mentor had been talking to the family, what they had

I was really a bystander

heard so far and

rrangements they had been talking about so it was hard for myself to

eally a bystander a bystander.

lack of knowledge By-stander

1 Perception of Professional – hardened

Role modelling

Surface acting

Emotional display rules.

P: For me, as a student nurse I feel that a lot of the nurses are so experienced in handling that and as a student nurse you feel that you have to be "hardened" and "not show any emotion" to "almost fit in as a nurse." "To show that you're not just new to it

non-displays "hardening"

I: Ok so to show that you're not just new to it. But how did you feel underneath then?

NB

Discord between feelings + showing.

P: "Underneath" I was very shocked, despite the fact that I had patients before that had died and relatives, it's still always a shock

Previous experiences of death – still a shock.

she passed away, I was working on the ward beside but when the crash trolley came in I was

told if I wanted to come in and watch and then she died there

no preparation for emotional impact

Support

P: For the first one I actually experienced the patient dying right there. I wasn't

there when the family came and they had broken the news or anything. I

staff were a lot bstaff were a lot better at talking to eachother that they would even just amongst eachother ask

if they were ok aif they were ok and talk about it

. openness / discussion about death among staff.

Perception that in some situations staff were better at showing + discuss

3

think in that hospital setting the

implies that caring should not involve showing fe

P: I think if you're caring after a relative of a patient, you should be caring for

them and supporting them, as opposed to the other way around

Assumes

P: Not so much. It was just kind of, I assumed myself really like. It was just that air that you non

Display of Emotions a norm.

should be

I: So you assume

P: Yeah

Reflection - Self

P: I was thinking about it quite a lot and I think I'm sure if I had of talked to one of the nurses that they would have been open to talking about it but it was because no one else was talking about it I didn't initiate any conversation about it

no-one initiated conversation about death.

P: Honestly yeah, I think it did. It took my mind off it. I don't think that was the reason why I went out but it certainly helped

I: You were with these people, did you talk to your mates when you were out about this?

Didn't share with Social network

P: Not about it no.

P: Personally I would have liked the nurses, not necessarily to come to me to talk about it but for them to be more open about it and like even between themselves. Although they're obviously very experienced in dealing with it, it always helps to be able to talk about it. Like even in the break room or just take another member of staff aside to make sure that they're ok

ut ly he

Would have liked someone to raise discussion

I. You mentioned earlier that you had experience of death before that, where was that? Was that before you were a student?

P: Yeah just relatives really

P feel that even though it's still me in the same kind of scenario, I felt a lot more upset, naturally when it was one of my relatives, but I felt like as my position as a

Non-display of emotion

ent nurses in my class, they had experienced deaths and that they

ple of individuals who would say 'Aw if you get caught up about it

u'

Discourse from other students

Socialisiation in how to express - is by fellow students.

P: I think with other student

in expressing between profession + personal.

relative I was allowed to feel more sad rather than…

As personal grief is different

legitamate to have feelings of sadness when it is relatives

7

INFLUENCE of OTHERS

would... there was a couple of

individuals who would then nursing is

not for you'

HCA influence of

P: It would be some of the older nursing students, like mature students that would have worked in healthcare before as maybe healthcare assistants

from HCA And mature Studies

I: So you think more mature students or people who have experience working as healthcare assistants and they were saying…?

care assistants on student

care

P: Yeah so chatting to them they would have said that if you're

working... because this would have been when I was quite inexperienced with

placements,

you're constantly displaying emotion or crying then nursing is not fo you

I: So was it after you had a placement and people were talking about that?

P: No it was before, I think it was quite early on when people were

talking about their different levels of experience within healthcare

eir

INFLUENCE of HCA + mature students on others.

I: So this was just conversation amongst students, ok, and the conversation was about... did

somebody start if off by saying "Oh well what do you do if somebody dies?"?

P: Em I'm not sure how it initiated, how it started off but I think that it was more that they were almost trying to give advice but it wasn't particularly worded very well

: Yeah I think because I had met the relatives before, like they had just been driving their mother in to the unit so I had met them but I hadn't really got to know them and I think if I had done it again I would... I did go and introduce myself but I would really ask them more about themselves and you know brought in what I knew about their mother and stuff rather than...

Need to engage with relatives Would

s not a test or anything,

P: I just think it would have been nice for relatives to hear that, that it's always nice to hear

that the people looking after them don't just see them, their relative, as a number or like just another patient. They did know a lot about them and that it was really holistic care and theygot to know them

P: No, I just remember going home and being like... it was one of the times that I was staying with the patient for about 2 and h hours and I was just, after a long 13 hour shift finishing f with that like your head is melted, you're really...

I: Your head is melted, ok, it's a good expression. So how did your parents know then, or did

they know that your head was melted?

P: I came back and I explained to them that like it was...
I think it was the 3rd long shift in a row and by the end of it I was exhausted and mentally drained

n a Specialising A Patient With Dementia Really Draining.

I: So did your parents pick up on that, that you were...

P: Yeah I remember talking to them and they could tell that I was exhausted

I: So you went to your parents, did you find that helpful?

P: Yeah definitely

Parents support

P: My mentor, she was on annual leave for the last 2 weeks that I was on placement so there

Directing learning

Non-mentor took charge

was an interim nurse almost taken over to do my final assessment which she wouldn't really have supervised me as much

. Did anyone say to you 'How are you?' or anything like that 'How are you feeling?'

P: No, that ward itself. Obviously, I'm not going to name it but I think massively was understaffed and one of the wards beside it had just closed so half of the staff from that had

learning becomes secondary in busy units

P: I think that they really didn't, although they were short staffed, they didn't want student

nurses there and although we did a lot of the work,

P: It was just. she... one of the secondary sisters, she didn't even know my name. Like she kept calling me Aaron or something. It was just like obviously

hostile

P: I was talking to the other student nurse that I was on with about doing it and I was thinking, I was considering putting in a complaint about that vice-sister but I think because I was doing 3 long days a week so I kind of just went in and got in finished and focused on my assignments that I was doing at the time

I: Did you talk to your personal tutor at any time about how you were feeling?

P: Retrospectively I think I should have and now... I should have used a lot more of the university support now you know….. there is the support and if it happened say next shift I would have but back then I wasn t aware as much of the support that there is set up.

USE OF PERSONAL TUTOR + HEI

of the

nt, I know

vasn t NB

them all finished an

long shifts for a short days as possible you know get them mished

and get out of there iere (Switching) and not talk to anyone about it

P: No I wouldn't really. Well with my partner I would talk a bit about it just generally, but I wouldn't really go to any of my friends or partner for. . .

I: If you don't mind me asking why would that be?

P: off, not that I'm forgetting about it or

I like the idea of going home and almost switching

out placement. That's a

not caring about it, I like to keep myself busy and not think about placement.

different life.

Separation of work/home life

DIVIDE PERSONAL + PROFESSIONAL LIFE

P: I think I would personally had went to my personal tutor a lot earlier, and don't think even a member of staff that works there and is getting paid would ever be made to do that

kind of level of work never mind a student

I: You mentioned about your personal tutor, did you go to the personal tutor?

P: No, I didn't. I think now looking back I would have, but at the time I didn't really know of much support and I had a different personal tutor back then

P: I think when I met the family members if I were to be in the same situation now, I would engage more with the family members and talk to them rather than be too afraid of saying maybe the wrong thing, or being afraid that I would come across as too emotional

I: Ok, too emotional, what do you mean by that

P: Well not express emotion, you know