A Psychosocial Approach to Understanding the Capacities to Care and Think Critically in Student Mental Health Nurses.

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Abstract

The thesis focuses on mental health nurse motivation and education. Both caring behaviours and critical thinking are essential components of being a capable mental health nurse. By positioning student mental health nurses as psychosocial defended subjects, the research reported here shows theoretically and empirically that caring behaviours and critical thinking dispositions are mutually inclusive and both are influenced by dynamic psychosocial factors.

Using Melanie Klein and other psychodynamic theorists, the research questions generated for the study were: What psychosocial factors influence the desire to be a mental health nurse? And, How do psychosocial factors influence mental health nursing students' pedagogic experiences? These questions were addressed by using a narrative, participatory research methodology to explore with 14 undergraduate student mental health nurses: (1) the relationship between their backgrounds and the psychosocial motives for career choice; and, (2) the influence these motivations had on their capacity to learn compassionate caring behaviours and critical thinking dispositions. They were each interviewed once at the beginning and once towards the end of their final semester of the pre-registration programme (twice each). Data was coproduced using two approaches: a life-grid method for gaining auto-biographical information retrospectively; and a Free Association Narrative Interview (FANI) technique, developed by Hollway and Jefferson (2000).

Narratives analysed through the lens of the psychosocial defended subject revealed that the students had experiences of loss and unmet needs which directed them towards a career in mental health nursing motivated by a desire to heal vulnerable others. Seeking 'reparation' arises as an unconscious defence mechanism against anxieties provoked by prior and present losses and unmet needs. The study also found that the student mental health nurses shared pedagogical situations both in classrooms and in practice which generated common unconscious defence mechanisms, specifically: splitting, systematicity, compliance and reparation. In this way, the study offers a unique insight into the anxieties and defences experienced during a three-year mental health nurse undergraduate programme, revealing how unconscious defence mechanisms *both* enable *and* constrain caring behaviours and critical thinking dispositions, as well as affecting the well-being of the students.

There are implications and recommendations for mental health nurse education, policy and research. If society wants both caring and critical mental health nurses (and other health and

care workers likely to be motivated in similar ways), we need to acknowledge the emotional content and psychosocial characteristics of becoming and practicing as a professional. How mental health nurses are educated can contain and or fuel their anxieties and enable or constrain their capacity to mobilise defences which are productive of caring and thinking critically.

Moreover, the same considerations can be brought to bear on workplace culture and possibilities for supporting resilience in other healthcare practitioners. The wider contribution of the study is to offer an alternative way of thinking about issues related to producing a healthy, caring and competent NHS workforce. The findings engage with the current 'crisis of care' whereby it is argued that high profile cases of patient neglect are contributing to an erosion of public confidence and trust in health care provision and professionals. There are many accounts of detached, de-personalised and defensive behaviour on the part of care staff. From a psychosocial perspective, affect cannot be ignored: 'caring' involves a cluster of complex processes, difficult to define and open to interpretation: being a caring nurse involves (conscious and unconscious) moral, relational and practical dimensions; it is interwoven, intersubjective and expressed in practical situations. Flourishing as caring and thinking people and professionals involves the interplay between individual psyche and social structures and systems.

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Chapter One

Introduction, Overview and Structure of Thesis

Introduction

The research reported in this thesis had a dual and inter-related focus: first, the relationship between mental health nursing students' backgrounds and motives for career choice, and secondly, the influence of background, career motivation and educational experience on mental health nurses' compassionate caring behaviours and critical thinking dispositions. This introductory chapter is divided into four parts. I begin by establishing my position in the research both as a mental health nurse educator and as a professional interested in psychosocial theory. Secondly, I connect contemporary nursing education in England with what has been characterised as a 'crisis of care' in the nursing profession. Thirdly, I propose the use of psychosocial ideas as a way of addressing the challenge of educating nurses (in my study mental health nurses) to be both caring and critical thinking; I am interested in bringing the latter to bear on the former. I end by offering a summary of all subsequent chapters.

Positionality and Rationale for this Study

Throughout my childhood and adolescence, I became aware that some people became mentally poorly and were put into hospitals (asylums) to be looked after. My Mum was a nurse and she helped look after the mentally ill and I would often visit her at work, going to the swimming pool and hospital functions like Easter egg hunts, summer galas and Christmas parties. It was only during my teens (during a prolonged house move, that culminated in moving into hospital accommodation for six months) that I realised the stigma attached to mental illness as the children at school teased me for living with 'mad people' adding that I needed to be careful as madness was catching. Such teasing, poor academic achievement at school/college and my Mum's advice not to become a nurse put me off the idea of a career in nursing and so I went backpacking around the world.

It was only on my return to the UK, and getting job in a nursing home, did I reconsider the idea of becoming a nurse. I undertook my nurse education in 1993 under the Project 2000 curriculum (introduced in 1987 with the move from hospital-based apprenticeship model into higher education). Designed to transform student nurses into 'knowledgeable doers', I spent

50% of my time at university and 50% in the practice setting. This Nursing and Midwifery Council (NMC) approved course provided me with the knowledge and skills deemed necessary to meet the requirements to register as a mental health nurse and I became a Community Psychiatric Nurse (CPN) in 1996.

I soon realised that my education had provided me with understanding of the medical model of mental illness, which helped with medicine management, however, the psychological therapies within the humanistic school of thought (Carl Rogers, for example) were often limited to behavioural communication techniques. Furthermore, the socially constructed elements of mental well-being were lacking. As I worked in the community in which I lived I soon became acutely aware that over half of the people on my caseload had been abused (in some form) during childhood and I had little in my eclectic tool kit to help individuals come to terms with their past and so found it increasingly difficult to manage the emotional pain of others and at the same time manage my feelings. I accessed psychodynamic psychotherapy modules and was introduced to Melanie Klein, Donald Winnicott and Eric Berne. These provided me with some insights into the hidden dimensions of mental health and helped me to understand therapeutic relationships from an unconscious level.

Continuing with my professional development I commenced a Master's degree in Gender theory and found feminism (in particular Elaine Showalter, Jane Ussher, Phyllis Chesler and Judith Butler) and the notion of discourse analysis, language and power particularly helpful in terms of increasing my understanding between mental ill-health and its social causes and the social constructed notions of *normality*. During the same time, I accessed a psychodynamically trained clinical supervisor to help deal with my own emotional difficulties. This, coupled with the courses, helped me to contain my own anxieties, see the wider picture and provide better therapeutic support for those with not only childhood traumas but a number of different mental health problems.

Despite these efforts, administrative restrictions of 12-week input with individual patients limited the therapeutic outcomes for many. Frustrated with my lack of professional autonomy, I took up a post as lecturer practitioner as I wanted to share some of my knowledge with undergraduate students to help them to deal with the realities of mental health nursing. Bridging the theory practice gap for just over three years, I became a full-time lecturer in 2003.

One of my roles when starting this PhD in 2009 was as a module convenor for the final year of the three-year undergraduate programme. The assessment for this element of the course was based around a reflective account using a critical incident analysis model based on a brief encounter with a patient within practice. Students could choose any incident from practice, e.g. administering medication, any form of communication that went well or not, or any element of care that the student felt warranted further investigation. While supporting students through this process many appeared to me to be detached. They provided depersonalised accounts of patients and were defensive about their actions when recounting working with others, including patients, staff and peers. Not only were they seemingly detached and unaware of the influence their input might be having on individuals and their families, they were also unable to critically analyse the incident. For example, they could describe what they had done, for instance, give an intra muscular injection of slow release medication (referred to as depot injections), but when considering why a person might refuse to have this form of treatment, they would refer to a lack of insight on the part of the person and would not have considered the multiple reasons why someone might object to this type of treatment. Such reasons included, for example, the effect on the person's life, the negative side effects, or considering alternative ways of managing the situations. The focus on meeting the assessment criteria or competencies in a 'tick box' fashion, left little time to think critically or consider the care needs of patients.

As a mental health nurse working in education, I have a professional investment and direct role in nurturing future mental health nurses. I have observed high levels of anxiety and stress among student nurses throughout the three-year course. The fact that the professional education process can be a stressful experience is well documented (Beck and Srivastava, 1991; Timmins and Kaliszer, 2002; Sharma and Kaur, 2011). Financial constraint and academic concern are often cited by students as being the most stressful areas of their educational journey. Relationships with both academic and clinical staff have also been highlighted as causing some degree of anxiety (Timmins and Kaliszer, 2002). It is suggested that the transition from student to registered nurse is a significant stressor (Kramer, 1974; Jasper, 1996; McLeod-Clark et al, 1996; Baillie, 1999; Whitehead and Holmes, 2011).

Having noticed the anxieties of students and being interested in psychosocial theory the focus of my study centred around the students' responses/defences to their anxieties and the influence this has on their pedagogic experiences and outcomes in terms of capacities to care and to think critically. I focus upon care because nursing is described as a caring profession.

However, as I show within the next section, there are concerns that the art of caring has been lost within contemporary nurse education and practice. Ironically, this loss is attributed by many to the shift towards evidence-based practice. Students now have an array of knowledge (from a variety of schools) that they can use for application to practice, yet my observation is that students are not thinking critically about the care they provide. I am therefore focussing on the capacities to care in conjunction with critical thinking skills and disposition because both are considered necessary to prepare nurses to deal with the array of health and social care situations that they will encounter and are viewed as an alternative to routine and 'formula-driven' practice.

Having established my position and rationale for this study I now provide the contextual background that my interest for this research developed.

Background and Context

Nursing and its education in the UK have a long history of ongoing change and transformation. These include organisational and legislative reforms, often in response to highly political publicised reports of failures in NHS policy and practice. The most recent of these is the Francis Report (Francis, 2010; 2013, p.3). This report attributed a series of what was described as 'avoidable' patient deaths at Staffordshire Hospital and 'appalling suffering of many patients' to how groups of NHS health care staff had systemically become detached, cruel and disengaged from their responsibilities. The report identified a number of contributing factors to the poor quality of care provision. These include a target driven management culture of fear; secrecy and bullying; poor leadership, poor staffing levels and a lack of compassion portrayed by healthcare staff. Despite the report highlighting systematic failings right across the organisation, much of this criticism fell on the nursing profession. This criticism contributed to what might be described as 'moral panic' amongst professionals, the public and within the media about the quality of nursing care in the UK (Cooke, 2015).

The crux of these findings was the widespread systematic occurrences of what has been referred to as 'inhumane care' by nurses (Kapur, 2014, p.16). In a response to the Francis Report, the Royal College of Nursing (RCN, 2013) argued that the extremes found at Stafford are not the norm and that high-quality nursing care still exists. The RCN (2013, p.3) further posits that that 'the NHS often sets up good people to do bad things; through constant change, chronic understaffing and unrelenting pressure, staff have kindness and compassion eroded

from them.' It remains unclear to what extent healthcare failings relate to institutional factors (such as culture or staffing levels), or to a lack of the virtue of care or clinical judgement/decisions in individual practitioners.

Amid these concerns, nurse education and the quality of its product has come under the spotlight within the media, nursing practice and in academia (Patterson, 2011). Some critics blame the current 'care crisis' specifically on the transfer from diploma to degree-level nurse education, with its emphasis on technical and clinical expertise (Darbyshire and Mckenna, 2013). It has been suggested that in striving for professionalism, competence and evidence-based practice, the caring side of nursing has been lost (Corbin, 2008). Some nurse commentators are questioning what has happened to relational care (Young, 2004; McIlfatrick, 2004), with nurses being portrayed as 'over qualified yet undertrained'; 'Too posh to wash' (Beer, 2013, p.3) or 'too clever to care' (Gillett, 2012, p.297). The notion 'that an educated nurse is not a caring nurse' is prevalent (Gillet, 2012, p.301).

Acknowledging such concerns, the RCN commissioned Lord Willis to lead an independent inquiry into *Nurse Education in England* (Willis, 2012). Willis concluded that there was no link between university-based education and poor-quality care provision. The report did, however, offer a number of recommendations for nursing recruitment, reiterating the importance of moving to higher education and the need for nurses to have both caring and intellectual capacities.

Nursing is essentially concerned with the care of vulnerable fellow human beings. Focussing on the practice of care within the context of power and domination, feminist political scientist Joan Tronto (Tronto, 1993) applies the ethics of care beyond the interpersonal to the wider social sphere. In line with Tronto's ideas, good care entails: care acts and the skilled execution of these while expressing an attitude of caring. From this perspective nursing is perceived as the integration of expert activity (knowledge and skills) and caring (virtue). Nurse education must therefore not only provide nurses with the knowledge and skills required, but also create a pedagogical context in which a caring attitude can be taught and cultivated (Vanlaere and Gastmans, 2007).

Despite the recognition that both caring and intellectual capacities are viewed as necessary to provide high quality healthcare in a variety of rapidly changing environments, I found only one study in Turkey that explored the trajectory of both during undergraduate nurse education (Karadag Arli et al, 2017). The content, processes and outcomes of nurse education have

been investigated from various qualitative and quantitative perspectives. However, this body of research neglects the critical companionship of care and intellect, by and large it also neglects the elements of individual development, motives for career choice and how these might influence student responses to education and social behaviours. My study aimed to address these lacunae by using a psychosocial approach.

A Psychosocial Approach to Mental Health Nurse Education

The primary purpose of this thesis was to develop a psychosocial framework from which to explore previously neglected dimensions of research about choosing a career as a mental health nurse, nurse education and the influence these have on both the caring and critical thinking capacities in students in a research-led university in the UK. Applying the concept of the psychosocial defended subject, was designed to challenge dualistic thinking about care and intellect, the individual and the social by 'conceptualizing human subjects as, simultaneously, the products of their own unique psychic world and a shared social world' (Gadd and Jefferson, 2007, p.4). Concepts from Kleinian theory enabled an exploration of the unconscious and irrational aspects of experience, which are most pertinent with regards to the relationships between individual development, motives for career choice and how these might influence student responses to education and their capacities to care and think critically. This psychosocial approach revealed a wide array of dimensions within the social, including the understandings, significance of meaning and experiences of participants, and the way that social process, institutions, teaching and learning relationships work.

Almost 60 years have passed since Isabel Menzies-Lyth's (1960) classic study which described socially-sustained systems of defence, occurring as a response by British hospital nurses to the anxieties evoked by their work. Menzies-Lyth used psychoanalytical principles (mostly based on the work of Klein and Bion) and applied them to a large institution.[1] Her study revealed that both individuals and groups acted together within the systems in the hospital to contain the unconscious anxieties of the nurses. These included a fear of dependency, anxieties around the intimacy of nursing care and being unable to 'fix' everyone's ills. While defending an individual nurse against the anxieties of work (for instance, in caring for the dying), the social mechanisms used often undermined the therapeutic aims of the institution which were to provide care to the patients. Menzies-Lyth's

[1] Five different hospitals on one site.

theorising was helpful in terms of exploring how organisations develop defences and how they could be deployed to reduce work-related anxiety through depersonalisation of care, avoidance of responsibility and a slavish attention to routines and rituals (Menzies-Lyth, 1960).

Her work also identified that nursing is not just about the clinical dimensions of care delivery but there are also social and emotional processes at work in the interactions with patients which can affect the way nurses (and other healthcare professionals) and patients think, feel and behave (Fabricius, 1999). Scholars following this approach to research have demonstrated how groups, organisations and countries unconsciously create structures and cultures to defend against anxiety (Froggett, 2002; Hirschhorn, 2000; Hinshelwood and Skogstad, 2000; Long, 2015). For example, Froggett (2002), drew on Melanie Klein's work to conceptualise the foundation of the welfare state in post-war Britain as a reparative drive aimed at readdressing the destruction of the previous years. Similarly, Obholzer (1994, p.171) describes the NHS as a collective unconscious system aimed at protecting the public from the anxieties provoked by our awareness of illness and mortality and is perhaps more accurately described as a 'keep death at bay service'. He argues that to lose sight of the 'anxiety-containing' functions that this service provides increases confusion and contributes to the view that the NHS is not 'good enough' at preventing illness or death.

Both Menzies-Lyth's study and the Francis inquiry were carried out in 'general' hospitals rather than within mental health settings. However, Menzies believed that her findings could be extrapolated to the nursing profession as a whole. In the UK, entry into pre-registration nurse education is specific to four general branches or fields of nursing: these are adult; mental health; learning disability and child branches which subsequently lead to nurse registration in one of these areas. This branched approach is based on the notion that students require specialist knowledge and skills to work with particular health care needs and the different roles that nurses perform in a variety of settings.

Menzies-Lyth's study took place in the boundaries and hierarchical settings of the 1950s. Much has changed in the UK since then. Deindustrialisation has led to vast numbers of employees no longer working within wide-scale manufacturing provision, but, instead are working in service, knowledge or information technology industries. Economic structures have changed focussing on profit and 'value for money' within private and public organisations. Control through hierarchies have been replaced by systems of networks or

devolved autonomy, with discipline being imposed through rewards or sanctions. Such changes have been described as a move from government to governance under new public management (Clarke et al., 2000; Du Gay, 2007). That is, control is achieved less through direct instruction or command and more by increasing systems of surveillance, accountability and regulation.

The rise of new public management and its 'new professionalism', with the influence of neoliberal market ideologies and practices, has shifted traditional nursing practices based on professional authority to one which is aimed at being more responsive to public needs. Arguably, current healthcare policies are formalising new egalitarian relationships between the public and professionals 'with greater consideration given to consumers of health care rather than the providers' (Dunn et al., 1996, p.45). The public are being seen as 'increasingly assertive' since they are better informed and are taking increasing responsibility for their health care needs. They are, however, at the same time becoming 'increasingly reliant' on health professionals' expertise (McIlfatrick, 2004, p.81). This suggests there is a change in the existing social contract between professionals and the patients.

In light of these changes, it is timely to revisit Menzies-Lyth's work and consider the anxieties that student nurses experience, the defences they employ and the impact this has on their developing intellectual caring capacities. Menzies-Lyth's work has been criticised for focussing too much on interpersonal factors and the hierarchical form of authority typical of the 1950s. Failure to recognise the wider social forces has been used to explain the reasons why interventions aimed to addressing unconscious defences on a local level have been short-lived and often fail (Boxer, 2015; Lucey, 2015; Bain, 1998). It is important to pay equal attention to the social processes that comprise the psychosocial and the manner in which the psychic and the social are already mutually implicated. I aim to offer fresh insight into how psychosocial influences shape how nurses are prepared for practice.

Given the dearth of available research, my professional background, teaching observations combined with my interest in psychosocial theories led me to the research questions:

- What psychosocial factors influence the desire to be a mental health nurse?
- How psychosocial factors influence mental health nursing students' pedagogic experiences?

I provide further detail about how these questions were formulated against the background of literature and theory in Chapters Two and Three. The following section provides a concise summary of all subsequent chapters.

Summary of Chapters

Chapter Two introduces the key psychoanalytical ideas that have been previously applied to nursing and organisations and are drawn together to use as a theoretical framework for this psychosocial research. This chapter is divided into three sections: first I provide a brief historical overview of the work of Sigmund Freud (1856-1939) before focusing on Melanie Klein's (1882-1960) object relation concepts of splitting, introjection, projection, projective identification and reparation, together with ideas from Bion (1961) about containment. Second, I draw on these concepts and show how they have been applied to wider professional systems to gain insights into the seemingly irrational processes of individuals, groups and organisations. Finally, I show how these concepts are applied within this study.

Chapter Three explores literatures relating to both nurse education and nurse professional socialisation. As already argued earlier, nurses need to possess both caring and intellectual capacities. Despite the abundant research on caring in the nursing profession, little research brings together the professional caring behaviours and critical thinking dispositions of student nurses. I found only one study that explored the trajectory of both during undergraduate nurse education (Karadag Arli, et al., 2017). So, in this chapter, I first clarify the concept of care within nursing and its application to this thesis and then discuss literature that considers the influence of pre-registration nurse education on caring behaviours. Secondly, I examine what is known about the influence of nurse education on developing critical thinking skills and dispositions. I finish this part by reviewing the one study that explored both care and critical thinking before concluding with the rationale for a psychosocial approach to examine both dispositions and capacities simultaneously.

Chapter Four discusses research methodology. This chapter is divided into three sub-sections dealing with the features of a psychosocial ontology, the selection of a methodological approach which is congruent with narrative methodology based on co-constructed life grids and Free Association Narrative Interviews (FANI) used within this study.

Chapter Five describes the study design and methods of data generation. It first presents a timeline outlining the sequence of events carried out within this study. Second, I provide information about the context of my research. Third, I explain how I selected and gained access to the 14 third year mental health nursing students who were my research participants and who I then introduce by way of short vignettes. Fourth, I discuss the two methods I used to generate data: the life grid method and two interviews with each participant using the Free Association Narrative Interview (FANI) approach (28 interviews in total). I include a discussion of what I learned from six pilot interviews and explain the principles I pursued in conducting the main interviews. Fifth, I explain the ethical conduct of the research. In the penultimate section, I discuss how I analysed the data; and, finally, the limitations of the approach are set out.

Chapter Six is the first of two empirical chapters that focuses on the connection between motives for career choice and the influence this and pedagogical experiences has on the students' capacities to care and think critically. This chapter is divided into three subsections. First, I develop the concepts of mourning and reparation (introduced in Chapter Two) to frame the chapter's argument that becoming a mental health nurse is influenced by past life experiences of loss and unmet needs. Second, I give an overview of the students' experiences of loss and unmet needs and link them to the choice to become a mental health nurse. Third, I explore the relationship between reparation and becoming a mental health nurse: I consider how elements of both true and manic reparation appear in the students' narratives and how they influence their capacity to care and think about patients.

Chapter Seven is the second empirical chapter. Continuing to position individuals as psychosocial defended subjects, I first discuss Klein's notion of 'Epistemophilic instinct'. I then show how the group as a whole experienced a number of shared situations that were anxiety provoking, which generated common defence mechanisms, namely: splitting, systematicity, compliance and reparation. I show that the capacities to care and think critically depend upon how these defences are employed.

Chapter Eight is the concluding chapter and is divided into four subsections. First, I recapitulate the purpose and findings of this study. Second, I critically examine the contributions to knowledge. Third, I offer a brief autobiographical account of my own

learning. Finally, I explore the implications of the findings and make suggestions in relation to education, policy and future research.

Chapter Two

Psychosocial Concepts and their Applications to Mental Health Nursing and this Study

Introduction

This chapter introduces the key psychoanalytical ideas that have been previously applied to nursing and organisations and are drawn together to use as a theoretical framework for this psychosocial research. I aim to show how important it is to mental health nurse education and practice to take into consideration the interplay between the individual (psyche) and the social. The chapter is divided into three sections: first I provide a brief historical overview of the work of Sigmund Freud (1856-1939) before focusing on Melanie Klein's (1882-1960) object relation concepts of splitting, introjection, projection, projective identification and reparation, together with ideas from Bion (1961) about containment. Second, I draw on these concepts and show how they have been applied to wider professional systems to gain insights into the seemingly irrational processes of individuals, groups and organisations. Finally, I show how these concepts are applied within this study.

Background to Psychosocial Approaches

The term *psychosocial* in its broadest sense is from the words psychological (mind) and social (relationships) and was first used by Erik Erikson (1963) in his theory of psychosocial stages of human development. His ideas were influenced by Freud's theories of personality and childhood development and he emphasised the role of culture and society in psychological conflicts that take place throughout life[2].

Freud is considered the founding father of this school of thought. Originally trained as a neurologist, he developed his ideas while working with psychologically disturbed patients using psychoanalysis. Over time psychoanalysis has been reviewed, modified and developed. It is perhaps best known as a method of treatment but its other major contributions can be found in its theories of human behaviour and mental development. It has also been

[2] At this time, the expression psychosocial was also used to distinguish from a different school of thought, namely social psychology which was aimed at explaining social patterns of behaviours *within* individuals (Williams, 2011).

conceptualised as a set of psychological and psychotherapeutic theories and techniques (Gay, 1995), that are based on the following Freudian (1920) assumptions, that:

- A person's development is determined by early childhood events;
- Any event that is too painful for the conscious mind to deal with is repressed, deposited in the hidden unconscious mind, this then continues to influence human attitudes, mannerisms, thoughts and experiences;
- Attempts to bring these experiences into conscious awareness lead to (psychological) resistance in the form of defence mechanisms (for example, splitting, projection and reparation, which will be discussed in more detail in Chapters Five, Six and Seven);
- Conflicts between the conscious and unconscious can lead to emotional disturbances and mental disorders, for example, anxiety, depression and psychosis; and,
- Liberation from the hidden effects of the unconscious can be achieved by bringing this material into conscious awareness through therapeutic intervention, for example, through free association.

Since I am using these tenets to underpin my research, it is important to acknowledge that Freud's ideas have been subject to criticism, controversy and much debate. Feminists have attacked his ideas and theories for being misogynistic, patriarchal and biologically deterministic (Firestone, 1979; Figes, 1970; Greer, 1970; Horney, 1927; Millet, 1970), although there have been some interesting feminist studies that have applied psychoanalytic theories and practices in a number of different ways (see, for example, Butler, 1997; Chodorow, 1989; Irigray, 2004; Kristeva, 2001; Mitchell, 1974). Neurologists disagree with Freud's ideas, and claim that our mental state is more to do with electrical impulses and chemical stimulation[3]. Others also disagree, for example, biochemists claim that an imbalance of neurotransmitters like serotonin influence mood and that this can lead to emotional disturbances like depression (Young and Leyton, 2002; Dryden, 2015). Further criticism of Freud's work has been aimed at methodological rigidity, lack of theoretical rigour and the ambiguous data produced with a largely homogenous sample group.

Freud's notions that our thoughts and behaviours are influenced by unconscious psychosexual forces (that we are unaware of); that our personality is developed in early

[3] Evidence of this has been shown through Positron Emission Tomography (PET) scans (Papez, 1995; Newman and Newman, 2011).

childhood, and the problems with resistance (among other things) did not make his theories or approach to therapy popular. Indeed, Adler (2006) identified Freud as the most debunked doctor and some describe his notions and techniques as having as much scientific basis as that of witchdoctors (Torrey, 1986) and his school of thought being a pseudo-science (Cioffi, 2005; Eysenck and Eysenck, 1985; Kihlstrom, 2013; MacDonald, 1998).

While many of Freud's ideas are considered out of date, so are many of the criticisms (Westen, 1998). Much has changed within psychoanalysis since Freud's death in 1939, with expanded focus on the individual within the social environment. There now exists empirical evidence to support a number of Freud's propositions, for example, that enduring elements of personality can be found in childhood (Costa, and McCrae, 1994; Deal et al., 2005; Klein, 1959; Mischel et al., 2004; Rothbart et al., 2000); that early experiences play an important role in personality development and are particularly important in shaping the way people form social relationships (Bowlby, 1979; Bott Spillius et al., 2011; Klein, 1959; Nangle et al., 2003; Simpson and Courtney, 2002); and that much of mental life is unconscious (Bargh, 1997; Bargh and Chartrand, 1999; Ferguson and Bargh, 2004; Hassin et al., 2007; Solms, 1997; Westen, 1999).

Further theories and studies have grown out of Freud's legacy with different schools of thought emerging, for example, Klein (1882-1960); Erikson (1902-1994); Anna Freud (1895-1982) and Bollas (1995), while others have developed new theories out of opposition to his ideas, such as, Fromm (1992), Reich (1897-1957) and Horney (1885-1952). Freud was the first to identify different parts of the mind and introduce the concept of a talking cure, although not popular at the time, some of his ideas are now more widely accepted and have been used in a variety of different ways to inform new psychosocial theories and approaches to practice and research.

In the following section, I begin with acknowledging the origins of the unconscious mind in Freud's work, however, it is mostly Melanie Klein's[4] (1882-1960) theory of the paranoid-schizoid position and depressive position and the anxieties and defences contained within them, namely, splitting, projective identification and reparation within object-relation theory

[4] Melanie Klein was a pioneering child psychoanalyst from central Europe. She is known for devising therapeutic techniques for children and viewed play as a means of emotional communication. Observing troubled children with toys Klein interpreted the meaning of play. She was particularly interested in infants' early relationships with their caregivers (usually the (m)other) and the early processes that built up a person's inner emotional world. A divorced woman with two children, limited academic qualifications in a profession that was dominated by male physicians she became an innovative, controversial and powerful member of the British Psychoanalytic Society and co-founder of Object-Relation theory.

that are utilised. Wilfrid Bion's (1961) account of the container-contained, learning from experience and reverie (Bion, 1962) are also introduced because they describe the conditions which allow nurses and nurse educators to develop thinking and caring capacities and offer strategies for improving emotional support for students, academics and nurses.

The concept of the 'unconscious mind' was developed by Freud (1920) who described different aspects of the mind: conscious (all the thoughts and feelings that we are aware of), pre-conscious (beneath this and contains things that we might become aware of, for example, our dreams) and unconscious (below the preconscious mind and is not directly accessible to us). He was not locating physical parts of the mind, but rather, offering metaphors that describe and explain mental (psychic) life. According to his theories, the mind is not a thing, but a process, whereby the unconscious is governed by innate (primary) forces and the conscious mind by learnt (secondary) processes. The conscious mind is logical, in touch with reality, understands the concept of time and defers gratification. The unconscious mind is not constrained by reality and is driven by irrational/emotional processes and the principle of pleasure. For Freud, most mental life is unconscious, including cognitive, affective and motivational processes. The ongoing unconscious influence is dynamic, purposeful and highly influential on our drives, feelings, f/phantasies[5] and behaviours. From this perspective, the unconscious is moving, ever changing and at times turbulent, which is considered a 'normal' part of psychological development and functioning, as the world we live in is ever changing and we need to adjust and respond accordingly (Howard, 2011).

Freud developed psychoanalysis using the techniques of free association, dream and symbolic interpretation while working (mostly) with adults. Klein (1882-1960) on the other hand developed her original theoretical contributions to psychoanalysis through her clinical observations of young disturbed children and adults. Klein's (1988) ideas shifted the focus of psychoanalysis from organically based psychosexual stages of development to the role of early childhood phantasies in the formation of interpersonal relationships. She conceptualised the unconscious inner world, present in all of us, as consisting of characters personifying different parts of self or aspects of the external world. Humans, she argues, are motivated by the need to form relationships and these are at the centre of psychological development. Her focus on 'the nature and quality of emotional relationships' is known as the 'object relations

[5] 'Ph' is used to denote unconscious phantasy and 'f' is used to represent conscious fantasy (Klein, 1929).

approach,' providing a way to explore the meaning of human behaviour as it is affected by the changing predominance of different states of mind (Waddell, 2002, p. xviii).

Klein (1988) identified two states of mind or 'positions' in the first six months of an infant's life: The 'paranoid-schizoid position' and the 'depressive position'[6]. In the first three months, before language, the senses and the psyche are fully developed, infants experience anxieties arising from the trauma of birth and dependency needs and are felt as sensations either inside or outside of the body. She used the expression paranoid-schizoid to refer to the earliest characteristic (persecutory) anxieties, internal/external relations and primitive defences of splitting (schizoid), projection and introjection used during this time frame. This position, is seen as a temporary protective state for the infant, who is not yet able to process complex thought or to differentiate between the self, the object and part-objects[7]. This is a normal state of development that occurs early in life and as a state of mind can reoccur throughout life.

Initially, infants cannot distinguish between self and another and believe that the source of good and bad feelings come from within. The world of the infant is initially experienced as physical sensations through the body, what goes into to it (inside) and out of it (outside). Klein (1946) believes that in order to cope with these good and bad feelings the infant learns to separate or split them and locate bad feelings to an external object (projection) and keep good feelings on the inside (introjection). For example, if the infant is feeling hungry, they may imagine (phantasise) that a bad object is inside them causing this feeling, the infant wants to get rid of the bad feeling/object, so puts (projects) the bad object onto an external object or replaces the bad object with a previously identified good object (introjection). Bits of the infant are split off and put in different places, some are kept by taking them inside self (introjected) or kept close by putting them in others (projective identification[8]) or are got rid of by putting them onto objects in the external world (projection). Projective identification in its broadest sense is the way in which we transfer our thoughts, feelings and emotions *into*

[6] These expressions can be confused with the psychiatric diagnostic categories of paranoid schizophrenia and depression (see ICD10, WHO, 2016). However, this was not what Klein was referring to, rather she was describing different anxieties and their responses during *normal* development.

[7] Objects from this perspective are not inanimate but are usually people, parts of or symbols of others, such objects are always relational, the most influential being between the infant and primary carer (usually, but not always the (m)other).

[8] Projection and projective identification are terms often used interchangeably, covering phenomenon that are not easily distinguished (Hinshelwood, 1991). Klein (1946) identified a difference: projection is getting rid of parts of the self *onto* the object and projective identification is doing the same but the split part goes *inside* the object and in doing so affects the object in some way (Klein, 1946). Bion's (1961) container-contained model expands on this concept and considers projective identification as not only a defence mechanism but as a means of communication as well. I will return to this concept again in Chapters Five, Six and Seven.

someone else and has the implications for the way we think and feel about others, it also influences how we make others feel.

Splitting, projection, introjection and projective identification are a normal part of the developmental process for they assist the infant to overcome anxieties and help with the development of autonomy. These are described as primitive defence mechanisms whereby, unconscious phantasies and mental representations, symbols or images of emotions and objects are used to test reality as well as defend/escape from it. The idea of an internal world from a Kleinian perspective denotes a:

> '[W]orld of unconscious phantasy made up of the self and other internal objects such as people, things, ideas and values that matter to us. […] It is the world of inner phantasy relationships that provides a template for our interactions with the outside world, is itself, shaped by these and is the wellspring of our psychic well-being and of creativity itself' (Fakhry Davids, 2002, p.67).

From this perspective, phantasies do not necessarily reflect reality, (during this position, the infant's world is wholly phantastic) rather they are intersubjectively constructed by limited mental and physical abilities and their interaction with the outside world. Phantasies interact reciprocally with experience to form the developing intellectual and emotional characteristics of the individual. Later relationships are likely to be a continuation of early ones as the infant's primary caregiver promotes a model or template of relationships, this leads the infant to expect others to do the same in later relationships.

Gradually, as the infant develops symbol formation, with enough good experiences internalised they are able to tolerate periods of separation and delayed gratification. That is, with a good inner object safe on the inside, the infant is able to tolerate absences of the external object. With increasing awareness of the self and the other as whole, different and separate, the infant starts to realise that good and bad coexist within one whole object; deep feelings of guilt (remorse) are evoked as recollections of projecting bad things into and onto good objects occur. Thus, the infant has to learn to tolerate that experiences such as love and hate co-exist side by side. This marks the transition from the paranoid-schizoid position to the depressive position, whereby the infant has to face up to a number of painful realisations in order to develop a reparative capacity (Klein, 1935).

Bion (1962) went further in suggesting that there is an ongoing equilibrium between the two positions, building on Klein's thoughts about projective identification he introduced the

notion of Container-Contained model. He outlined the way the infant's ego is overwhelmed by raw psychic experiences that are unavailable for thought. The (m)other[9] takes in these raw experiences before empathising and thinking about the infant's state of mind. This he described as the (m)other's capacity for reverie. He believed that projective identification was not only a defence mechanism but also a form of communication and at the heart of the thinking process.

In order for this process to work, the (m)other needs to be able to be affected by the communication from the infant without being overwhelmed by it. The role of the (m)other is to act as a receiver or container for the child's projections, emotions and absorb and then change these bad persecutory feelings into some kind of meaning and then return the feelings in a way that the child is able to understand. Usually, the (m)other does this until the infant develops the ability to do this alone.

Klein's work has been criticised for focussing too much on terrifying phantasies (see Winnicott, 1988, for example), although this element of her work has been used to explain racial hatred and war (see Clarke, 1999 and Segal, 1988); sexism and homophobia (Gough, 2004). However, Bion's work tended to emphasise environmental and intersubjective experiences of the child, with less reliance on biological reductionism and an emphasis on social psychodynamics of interpersonal communication, which is the way that communication is mediated between self, groups and organisations.

Bion's (1962) stance on working with groups shows how:

> '[A]ny group, organisation and society, needs and evolves a structure of tasks, roles, procedures, rules, ascribed status (what Bion referred to as the 'group culture'), in order to contain the anxiety of the unknown and the responses which, unconsciously, are mobilised to defend against that unknown' (Armstrong, 1995, p.3).

Within groups, Bion (1962) believed that there were a number of powerful unconscious strategies of defences constituting what he described as a 'group mentality'. Object-relation theorists tend to use the concept 'containing' rather than controlling or managing anxiety. As controlling or managing usually denotes some form of defence mechanism being used, for

[9] I will refer to (m)other when relating to the role of primary carers of infants, in doing so I acknowledge that this may be a male, and so (m)other includes those other than birth (m)others, of any gender, who take up a role of (m)other (Irigray, 2004; Muzio, 1993).

example, splitting or reparation; whereas containment is about holding on to the emotions, the idea being that if our anxieties were contained effectively by our parents in childhood our anxieties become reasonably contained in adulthood. Such containment allows the individual to work through their emotions, analyse them and are the foundation for further development (de Raeve et al., 2009).

Bion (1962) suggests that through the process of containment the child is allowed to develop its capacity to manage difficult experiences through accessing support from its (m)other. This process is essential to learning. Bion (1962) posited further that in order for the (m)other to be able to provide containment, she herself must feel a sense of emotional security (which might be provided by a family member, for example). This concept seems immediately transferable to many human relationships and to teaching and learning in particular.

Bion (1961) refers to containment as the ability of the (m)other to hold on to and process the infants' unconscious anxiety and feelings. The term is also applied to describe holding on to one's feelings and responding affectively to them in terms of what they communicate (Clarke and Hoggett, 2009). For Bion (1961) from birth we all have experiences (good and bad) which threaten to overwhelm the ability for containment. Anxiety is one important aspect of human experience. There are also others, for example, hope, resentment, love, hate, envy and so on. All of these emotions can overwhelm us at times and from this perspective we defend ourselves not only from anxiety, but any experience that we find overwhelming. However, being 'defended' or using defence mechanisms is not pejorative, rather it is an observation of how individuals and groups manage their unconscious feelings that are provoked by the experience of living (Bibby, 2011). This is not to imply that we are all walking around feeling extremely anxious, fearful of any life-threatening event but that we are continually managing our conscious as well as unconscious lives.

For Bion (1961) the concept, projective identification, is perhaps best conceptualised as a mode of unconscious communication of emotion. Projective-identification processes, are usually viewed as a dynamic between two people, occurring in all relational contexts, not just within a therapy room. For example, if a student is failing to meet one or more of their learning outcomes, they will be experiencing a range of conflicting emotions. Some of these will be conscious, but the fear of failure, of not being 'good enough', and the accompanying feelings of guilt and shame, are likely to provoke deeply held unconscious feelings, stemming from infancy and childhood, that are intolerable for a student to bear.

Adult relationships are thus understood from two interconnected levels: the current interaction that is occurring in the here and now between two or more people; and the symbolic relationship, which are represented in the unconscious and often brought (unconsciously) into the relationship by those involved (Bomba, 2011). In our everyday life, we frequently transfer emotions, attitudes, phantasies, anxieties, and expectations related to childhood objects onto current objects in our lives. For example, student nurses, like teachers, mentors and patients bring expectations, fears and problems conveyed from their past life to all new relationships. Nurses and teachers are commonly recipients of projections, as patients and students are at times dependent on nurses and teachers for looking after them and helping them to learn.

In relation to this study, I draw upon Klein's two states of mind or positions (paranoid-schizoid and depressive) as well as Bion's container-contained model. This is because the concept of identification describes a developmental process that starts in early life and involves the internalisation of primary carers; this contributes to the development of self as well as the capacity to care. Bion uses the metaphor container-contained to picture this emotional experience of care and being cared for, to describe the experiential foundation for the child's ability to think. This experience is considered to be a prototype for human interaction. Nurse education is not just about professional development; it is also about self/personal development; this is of particular importance in mental health nursing when professional practice involves the use of self as a way of developing effective therapeutic relationships.

Implicit in the role of the nurse, is the capacity to empathise and contain patient suffering (Evans, 2015). This requires the process of taking in the patient's state of mind and projections through observation of the patient's emotional and physical states (Fabricius, 1991). The capacity to move between empathic identification of patient suffering and 'objective professionalism' is essential for developing and maintaining mature therapeutic relationships (Evans, 2015, p.197). This involves the nurse taking in and containing the patient's feelings without being overwhelmed by them. That is, nurses contain patients' emotional states in the same way as Bion described the (m)other does for their baby. However, this is not a simple task and can lead to an unbalanced symbolic equation in which the nurse can no longer distinguish his or her own internal damaged objects from the patient being cared for. In order to develop and maintain a balanced approach, nursing staff need settings and structures that help them contain the anxieties and pain involved in their work.

It is this Kleinian theory that underpins the concept of the 'defended subject', a term first coined by Hollway and Jefferson (2000) in their work on gender, anxiety and the fear of crime. They use the expression to encapsulate Klein's theories about the way we protect ourselves from anxieties. I have borrowed extensively from this work as I have employed similar methodological techniques for coproducing data for my study and will be revisiting their work in Chapters Three and Four. For now, however I want to explore the concept of the psychosocial and ways in which psychoanalytical theory has been applied to nursing before considering the applications to this study.

Psychosocial Concepts and their Application to Nursing

According to Tilley (2005) an adequate narrative history of psychodynamic nursing has not been fully researched or described, although there are a number of nursing scholars that have started this process (see Griffiths and Leach, 1998; Winship, 1995; Wright, 1996). Psychosocial nursing is not new and has been embedded in mental health nursing since the 1940s with the work of Altschul, Peplau and Skellern, their work being commonly referred to as 'the first wave of psychodynamic nursing both in the UK and USA' (Winship et al., 2009, p.506). Perhaps the best known of these is Peplau (1952) who with the shift from Freud's psychobiological perspective used a Kleinian psychodynamic informed approach to nursing and likened the early dynamics of the initial stage in the nurse patient relationship to that of early feeding experiences of infants and purported that patients perceive the nurse as a surrogate (m)other. She developed the ideas of 'therapeutic community' and 'milieu therapy'.

Peplau (1952) an American nurse, developed her interpersonal relations theory to show that the nurse patient relationship is the foundation to all nursing practice, her ideas about roles and therapeutic relationships helped to revolutionise the scholarly work of nurses, contribute to mental health law reform in the United States (US) and lead to improved treatments for individuals with behaviour and personality disorders (O'Toole and Welt, 1989; Tomey and Alligood, 2006). Focussing on shared experiences she showed how nurses could facilitate learning through observation, description, formulation, interpretation, validation, and intervention. For example, as the nurse listens to a patient, it is possible to develop a general impression of the person's situation. The nurse then checks this impression by asking the person for accuracy. The result may be experiential learning, improved coping strategies, and personal growth for both parties. Throughout Peplau's career she continued to recognise the

importance of the interpersonal process arguing that the nurse was the 'true agent of change rather than the mechanism of the therapy' (Winship, 1995, p295). Although it is worth noting that Peplau believed that nurses should undertake additional professional psychotherapy training rather than simply applying psychodynamic theories to every day practice.

Peplau's ideas were influential in terms of theory in the USA and have been developed further by Shirley Smoyak (2008a; 2008b; 2009) and Suzanne Lego (1999), (both of whom were students and colleagues of Peplau) influencing the philosophical approaches to post graduate training (Forchuk and Reynolds, 2001). Yet, Barker (1999) suggests that the level of implementation in practice was limited in the USA and only marginally known in the UK; with the influence of psychoanalytical ideas being greatest within 'therapeutic communities' in which nurses with a particular interest in psychoanalytical ideas worked. Most notably Annie Altschul at Cassel Hospital and Eileen Skellern at Henderson hospital. Despite such ideas not being well known such therapeutic communities still exit today at both Cassel and Henderson hospitals. For example, the therapeutic community at Cassel nurses work alongside patients in their day to day living, helping them to preserve their social identities and pre-admission responsibilities. This social model focuses on individuals' development within families, and their relationships with their nearest and dearest (Chettiar, 2012).

Wright (1996) draws attention to the interactions between different nurses who worked at the above hospitals and recognises the intergenerational influence of nurses like Peplau, Altschul and Skellern have had on him and other nurses, but more significantly he identifies the cultures in which they worked, trained and developed their ideas. Mental health and ill health within such cultures are not viewed in terms of psychiatric classification, but within a psychosocial framework exploring personal and interpersonal relationships that individuals and families reveal in their relationships with self and others. Viewed in this way it is possible to understand the psychosocial influences on mental ill health and how life experiences like for example, poverty, violence and abuse influences people's relational expectations, their ability to trust others and expectations of care. The onus is on patient involvement and social inclusion treating patients as individuals rather than as medical cases. The notion that mental illness is influenced by a number of social factors was further influenced by social construction theory (Bateson and Ruesch, 1951; Sills, 1994). Key to this approach to care is the concept of the therapeutic 'use of self' and what was called psychosocial nursing (Barnes et al., 1998).

There are a number of published articles about psychosocial nursing (Waddell, 1955; Barnes, 1968; Haque, 1987; Denford and Griffiths, 1993; Flynn, 1993; McCaffrey, 1998; Simpson, 1994; Irwin, 1995; Griffiths and Pringle, 1997). Menzies-Lyth's (1960) seminal work applied psychoanalytical thinking to health and social care institutions, providing fresh insight into the work of nurses within a teaching hospital. More recent studies using similar approaches have also been found for example, Hinshelwood and Skogstad (2000), Hirschhorn (2000), Goldie (2008) and Obholzer and Roberts (2006). What universally connects and distinguishes this approach to nursing (Tilley, 2005), teaching and organisations is the importance given to the intrapsychic and interpersonal experiences, the environment in which that work occurs and the potential for therapeutic change for nurses and patients. Important is the understanding of human emotional development and the ongoing interplay between the unconscious and conscious mind and the effect this has on us and our relationships throughout life (Rayner, 1986; Waddell, 1998).

These studies have provided a wealth of insight and deep understanding of the often-complex interactions, relationships and practices involved in everyday, ordinary occurrences in different social settings. The focus upon experiences and individual feelings and emotions within the social context are key aspects of psychosocial approaches (Lewis, 2010). Taking into account unconscious, psychodynamic and social elements of life (Roseneil, 2006), it brings together the personal, political, and social simultaneously in new ways (Woodward, 2015). The processes in which these different elements are connected can be thought of as psychosocial and are employed in this study to develop new ways of understanding mental health nursing and its education. In order to explore how this was achieved I first draw on Menzies-Lyth's work before going on to identify the key theoretical concept of the psychosocial defended subject and explain how it has been applied and used to inform this research.

Menzies-Lyth (1960) and Social Systems as a Defence Against Anxiety

Menzies-Lyth (1917-2008) was a British psychoanalyst and is best known for using the work of Klein and Bion in her application of psychoanalytic principles to groups and organisations. Her classic study was an investigation into the high rates of nursing staff turnover and low

rates of student completion in a teaching hospital[10]. She observed nursing as dirty, intimate and emotional work that evoked high levels of 'tension, distress and anxiety' (Menzies-Lyth, 1960, p.339). She noted that it was difficult to understand how nurses could tolerate the intense anxiety and given the high sickness rates among staff and that a third of students failed to complete their training suggests that many individuals could not work in such an environment. She argued that working with patients' suffering (physical and mental) and the intimate relations involved in care provision aroused primitive desires and fears in nurses that resemble the infant phantasies identified by Klein (1929). In order to reduce these extreme levels of anxiety, nurses used socially constructed defence mechanisms such as: splitting up the nurse-patient relationship by task distribution, depersonalisation, detachment from feelings, ritualistic task performance, no direct lines of responsibility, as delegation of responsibility is transferred up the hierarchy, underestimation of individual ability and avoidance of change. All of these led to nurses being in 'constant state of impending crisis', 'fear of failure' and 'no sense of satisfaction' (Menzies-Lyth, 1988, p.65).

These examples illustrate that by establishing rigid hierarchies, roles and routinised work the hospital was able to disperse anxiety and responsibility from the individual nurses to the organisational system as a whole. These social defences operated by either eliminating the situations that are anxiety provoking or insulating individuals from the consequences of their actions. Menzies-Lyth (1988) also found that the nursing service was in denial of the emotional challenges involved in their work and were therefore unable to support students and nurses. She further observed that the organisational defences did little to alleviate the anxieties of nurses, rather, the mechanisms often undermined the primary task and therapeutic goals (care of patients) and created a set of secondary anxieties and effects. An example would be the need for nurses to follow routines as well as meet the care needs of individuals.

Menzies-Lyth (1988) found a key origin of anxiety for students and nurses was evoked by close intimate nurse-patient relationships, the closer the relationship the more likely the nurse was to experience anxiety when a patient left the hospital or when they died. So, lists of tasks were created to reduce intimate contact with patients. Nurse A, for example, would measure blood pressures for all of the patients on the ward, while, Nurse B administers the medication for all the patients. Allocation of tasks along these lines reduces nurse patient contact and

[10] At this time, student nurses spent all but six months of their three years of undergraduate training working full-time in wards and departments as employees, while learning and practicing nursing skills.

helps to avoid intimate relationships from developing. Given that all of the tasks are aimed at monitoring, maintaining or improving individual health, it is difficult to see how using this approach might undermine care or create further concern.

However, from an operational viewpoint the *way* the work was organised made it difficult to make quick and effective decisions often necessary when caring for ill people. The nursing service was 'cumbersome and inflexible' (1988, p.65), which can be problematic when the total care needs of the different wards and individuals varied considerably, often, at short notice. Factors like patient turnover, individual need and shortages of staff often required flexible autonomous decision making, however, each strictly prescribed task becomes perceived as a matter of life and death and so it is not possible to eliminate any task in spite of increasing, changing and/or urgent demands. For example, a nurse is told to administer some sleep medication, at a certain time to help a patient who had been sleeping badly. In the meantime, the patient had fallen into a deep natural sleep; obeying orders, the nurse woke the patient to give the medicine. Concern becomes about getting the tasks completed rather than meeting the care needs for each individual and appears to inhibit thinking within the nursing profession.

Dartington (1994, p.101) argues that 'contemporary nursing is dogged by a negative expectation that nurses should not think'. Indeed, nurses are often valued for their capacity to be passive at work and is an example of 'stoic idealism' that pervades hospital cultures, not only for nurses and other healthcare professions but for patients too. Menzies-Lyth (1988) highlighted many 'thoughtless nursing rituals' are institutional defences aimed at protecting the nurse from the emotional aspects of care work. Studying other organisations (for example, a day nursery and a fire brigade) she concluded that:

> 'Unfortunately, I have come to a depressing conclusion that institutions have a natural tendency to become bad models for identification; and the bigger the institution, the more likely this is' (Menzies-Lyth, 1988, p.42).

She went further by arguing that a 'pathological organisation, attracts pathological individuals' (Winship, 2006) reiterating that the NHS was a bad object of identification (cited in Winship, 2006). This notion is reflected in Fabricius' (1991, 1999) work who argues that the nursing profession itself is unwell and likens it to depression[11], when depressed a person

[11] Fabricius stresses that she is talking about the nursing profession as if it were an individual patient and not about individual nurses or groups of nurses.

feels worthless and undervalued by both others and self. This condition she argues is internal and so cannot be corrected by external factors, in the case of nursing an injection of resources for example. It is only when the individual takes responsibility for their feelings, given time to mourn loses and recognising personal autonomy can any change occur within the individual and in doing so can lead to changes in the external environment. So, she argues for 'psychological work to be done by the profession as a whole' (1991, p.204). She adds that nursing lowering of self-esteem has occurred in parallel to the advancement of medicine.

So, what does attract someone to become a mental health nurse? Roberts (1994, p.110) argues that 'the profession we choose to work in; the patients we want to work with; and the environments we work in are often as a result of unresolved conflicts from our past'. Career choice can be based on idealism, however, ideals often have an unconscious determinant, being able to 'cure' mental illness, for example, or rather in today's words, 'recovery' from mental illness. The extent to which certain environments and settings attract people with similar internal needs and a comparable inclination to use similar defences what Bion (1961) calls valency. Gives rise to collective defences (as identified by Menzies-Lyth (1959) in her seminal study) which can hinder task performance.

Despite Menzies-Lyth's wide theoretical acclaim, in practice, the institutional structures were resistive of any psychoanalytical modification (Ellwood, 1995). She further identified that both the nursing system in the hospital that she worked in and more widely in the UK, continued to function in the same way often to the detriment to patients and staff (Bain, 1998). According to Bain (1998), little has changed within heath care provision in the UK in the last 60 years, this is because of a much wider (domain) system of defences that provides a general expression of an overall structure, that is, it is not just about one institution but a system of systems. The nursing service illustrates the problems associated with social settings, the anxieties these evoke and the challenges facing social change. Nonetheless some changes were implemented in the hospital that Menzies was investigating. For example, student courses were planned in advance to enable a more realistic view of both learning and staffing needs.

Significant changes have been made to nurse education since Menzies-Lyth's study. Nursing students are no longer NHS or hospital employees, rather they are full-time university students spending 50% of their time in university and the other 50 % in practice. No longer a part of the work force, students have supernumerary status with emphasis on learning rather

than practice. Despite these (and other) changes, for my purposes, many of her findings are still relevant to nurse education today. Her study reveals that nursing is not only about the clinical dimensions of care delivery but is also an ongoing complex emotional interaction between individuals, groups and organisations, all of which affect how nurses, students and patients feel and behave (Fabricius, 1999). Yet the use of the theoretical underpinnings used by Menzies-Lyth is not generally assumed in nurse education or practice, and, there is still no support for containing the extreme anxieties she identified (Tutton and Langstaff, 2015).

Such changes, however have according to Fabricius (1991; 1999) contributed to a vicious cycle of idealising 'intellect' while simultaneously denigrating 'care'. Since the move to higher education the 'knowledgeable doer' has become the *ideal* nurse, but in emphasising both knowledge and doing she argues that 'being with and for' patients has now become 'entirely neglected' (Fabricius, 1991, p.101). The Francis report (2013) highlighted the way that a group of nursing staff in a hospital had systematically become detached, disengaged and at times, cruel to patients. In my view, it is timely to revisit Menzies-Lyth's work and consider the anxieties that student nurses experience, the defences they learn to use and the impact this has on their developing care and critical thinking capacities. It is of crucial importance to examine critically the quality of interactions with students, nurses and patients; through this process it is possible to link individual and group behaviours within clinical and university settings.

My reading of Menzies-Lyth has helped to inform this study in a number of ways, first, it allowed me to conceptualise the socially constructed environments in which this study takes place (i.e. a School of Nursing and Midwifery, in a research-intensive university, the NHS and other health care organisations) as I explore student learning and their social interactions. Second, it highlights the role the unconscious mind plays in constructing our social reality and that we are constituted with defences (individual and social), that is, we are 'defended subjects', and finally that we are psychosocial, in that, individual interpretation and involvement (conscious and unconscious) shapes our understanding of the world and experiences of the external world influence and shapes our individual experience.

Menzies-Lyth's work also illustrates that nursing provokes high levels of emotion and at the time of her study, nursing services were in denial of this and so were unable to teach students or provide support to contain their anxiety. Within my teaching observations student nurses often express anxiety and confusion about highly emotive encounters with staff, patients and

peers. Some students are reluctant to share their experiences, others openly communicate personal accounts similar to those of their patients, voicing uncertainty and angst over their feared inability to be helpful, and will often report, for example, concerns about their own thoughts, sleep loss, disrupted family relationships, and mental and physical exhaustion.

Little attempt in the past was made to help the individual nurse or student to confront the anxiety provoking experiences and to develop the capacity to tolerate and deal with their angst more effectively. Menzies-Lyth later reflected that her study had emphasised primitive anxieties and their defences without adequately considering what could be done to support staff in tolerating their emotions within the broader structural and management context (Lawlor and Webb, 2009). Although, she did suggest that emotions should be dealt with directly in order to contain them rather than to be avoided or ignored.

In this study, I aim to examine mental health student nurses' anxieties and their defences within the structural and management context of higher education and clinical practice, this enabled me to consider ways in which it is possible to teach and support students to tolerate their anxieties. This aspect of emotional support for students and nurses has largely been ignored within nursing developments and is a focal part of this study. The purpose being to consider what can be done to help contain students' anxieties I will return to define this approach more clearly in Chapter Eight under implication for nurse education.

The ways in which we all experience and defend against anxieties are more complex than my account of Menzies-Lyth's work implies. She viewed nurses' anxieties as arising from the primary task of nursing, namely to care for patients. Hoggett (2015) however, argues that there is no such thing as a primary task of nurses, as the task of the team or organisation is always problematic, contested and socially constructed. He argues that Menzies-Lyth underplayed the role of society in constructing the psychic meaning of nursing tasks, which was mediated through a set of gendered institutions, which were relevant to the nursing profession in the 1950s. A psychosocial perspective is not just about the individual or the social but draws upon both 'the overlapping space, the space in between, the space of the hyphen[12]' (Hoggett, 2015, p.51) in order to develop a clearer view of the ways in which

[12] There is debate within the literature about whether to include a hyphen between psychosocial. For some (see Frosh and Baraitser, 2008) the hyphen signifies both the irreducibility of the psychological to the social (and vice versa), that is, the impossibility of there being the one without the other. In contrast, Hollway and Jefferson (2000) argues that the critique is not best advanced by the dissolving of boundaries and the blurring of differences. The retention of the hyphen insists upon the difference, a difference that can never be overcome, yet

personal development and socially constructed environments influence feelings and behaviours of individuals and groups.

Using a psychosocial approach places a great deal of emphasis on making a thorough, carefully observed, theoretically informed assessment of individuals, their relationships and their historical sociocultural environment. This can offer a fresh insight into how individuals act and relate to one another, while appreciating that 'we all bring feelings and behaviours to situations and that situations provoke feelings and behaviours in people' (Howe, 2002, p.177). Research from this perspective creates representations of individual and social life with diversity, depth and dynamics that might otherwise be difficult to access. In this way, my study moves beyond the traditional binary notions of, for example, subject and object and rational versus irrational behaviour in organisations, learning and social interaction, to reveal how the inner and outer lives of student nurses are connected and interdependent with others in a socially constructed environment. I now explore the concept of the psychosocial defended subject to understand more fully how it underpins my approach to this research.

The Psychosocial Defended Subject

As already identified at the beginning of this chapter the term psychosocial in its broadest sense is from the words psychological (mind) and social (relationships) and research, such as this, is about exploring interactions between individual psychological development and the social environment. Gadd (2000) combined the terms psychosocial and defended subject to explore the notions that the internal (psychic) and external (social) are inexorably linked. Thus, the psychosocial concept identifies that as individuals or as defended subjects we tend to invest in certain discursive positions (for example, career choice) in order to protect vulnerable parts of self (Gadd, 2004a, Ashley, 2009). Sagan (2007, p.51) describes how there is sometimes a need felt (often unconsciously) by subjects to keep their anxiety levels down and so are not always able to 'tell it like it is'. The notion of the defended subject combines the psychic with the social as personal identity is a constant interplay between the inner world and the environment. That is, the choices we make regarding which profession we go into, which group of people we work with and what setting we work in are deeply influenced by our past experiences and the need to come to terms with unresolved past issues.

one which continually invites engagement and exploration. I therefore use the expression psychosocial to denote this viewpoint.

Taking a psychosocial approach, this study is about the interplay between individual biographies (unconscious and conscious), subjectivities and the historical as well as contemporary social relationships. Klein (1940, 1950) proposed that defences against anxiety are intersubjective, that is, they come into play in different interactions and in this sense, are relational and developed through social relationships, thus it is not just about the individual but the person and the social. Hollway and Jefferson (2000) describe psychosocial as being a combination of an individual's unique biography and the manner in which it has been unconsciously defended (psycho) and three shared social/external experiences: first, such defences are affected by discourses (language, systems, and meanings are products of the social world); second, unconscious defences are intersubjective in that they are affected by others; and third, real events in the external social world are discursively and defensively appropriated.

From a psychosocial defended point of view, it is the drive to make reparation, partly conscious but mainly unconscious that is the bedrock to all creative, productive and caring activities. This drive has its roots within our experiences of early care givers, as during the first months of life, the infant splits perceptions of the good nurturing (m)other or the bad depriving (m)other. With maturation comes an awareness that the (m)other is a single person, and that both feelings of good and bad exist in the one person. This realisation brings forth feelings of remorse and guilt (for having directed bad thoughts/phantasies towards the good (m)other) and the desire to repair any damage that may have been caused. Normally, reparative activities keep the infants' anxieties at bay, when the guilt is too strong, however, reparative activity can be inhibited, with the child and later the adult, remaining or returning to earlier defence mechanisms of splitting the good and bad. Usually, by repeatedly discovering that the (m)other was able to survive the bad feelings/thoughts, the infant is able to learn to trust that love and hate can coexist and reparative activities are successful. But when the external reality fails to disprove the child's anxiety, through for example, ongoing ill health, death or the loss of an early care giver then depressive anxieties (guilt and remorse) become too great, resulting instead in more primitive paranoid, manic and obsessional defences.

According to Roberts (1994) two features distinguish care work from most other work, the first is that reparative activities are carried out towards other human beings, which closely resembles our early care experiences, when individuals may be unconsciously still working through. Secondly, is that the carer/helper is themselves instrumental to improving the

situation to benefit the other. This is particularly the case within mental health nursing, whereby the therapeutic relationship and personal attributes of the nurse are considered crucial to the recovery[13], well-being and change in those we work with. By becoming a mental health nurse, individuals unconsciously offer themselves as having enough internal goodness to repair the damage in others and provides a way of expressing this reparation in a socially acceptable way. This is often the source of individual, organisational and social ideals of nurses, it is also the source of much anxiety.

Student nurses often enter into mental health nursing because they want to help people to recover from their mental illness, helping individuals to recover can provide a great deal of job satisfaction as reparation is successful. All too often however, within current healthcare services nurses and other health and social care professionals are often deprived of the ability to make reparation, through unrelenting demands with increased numbers of patients with limited resources often lead to a variety of disappointments. This is reflected within the language and expressions like the 'revolving door patient,' 'treatment resistant patients,' further problems through addictions with drugs and alcohol, hopelessness and self-destructive behaviours, often mean that people do not recover and reparation is not afforded. In caring for patients with mental health problems that feel frustrated, angry, hopeless, frightened and are dependent, may lead nurses to feel resentment and self-denigration.

Klein's theories provide some insight into the often-hidden relationship dynamics that go on for mental health student nurses and how these may influence pedagogic experiences and abilities to relate to others and social environments. This psychosocial study aims to offer an inclusive approach by exploring the dynamic relationships between the individual and the social and how both combined influence student nurses' anxieties and the defences they employ and how the social systems sustain the defences employed and create further anxieties.

[13] What constitutes 'recovery', or a recovery model, is a matter of ongoing debate both in theory and in practice. In general, professional clinical models tend to focus on improvement in particular symptoms and functions, and on the role of treatments, while consumer/survivor models tend to put more emphasis on peer support, empowerment and real-world personal experience (Bellack, 2006; Pratt et al., 2002; Secker et al., 2002)

Conclusion

In summary, therefore, this chapter has considered a number of key psychoanalytical principles, which I apply to my research:

- A person's development is determined by early childhood events;
- Human attitudes, mannerisms, thoughts and experiences are influenced by unconscious irrational drives;
- Attempts to bring these drives into conscious awareness lead to (psychological) resistance in the form of defence mechanisms (for example, splitting, projection and transference);
- Conflicts between the conscious and unconscious can lead to emotional disturbances and mental disorders, for example, anxiety depression and psychosis.

The expression 'psychosocial defended subject' is used to encapsulate the key Kleinian principles. This expression recognises that the research encounter contains a variety of affect e.g. fear, excitement, expectation. It is these affects which may be a product of the relationship, that is, co-produced or brought in by one of the individuals involved within this research. Such different facets of affect are what coproduce the psychosocial defended subject; this can be myself as a registered mental health nurse/educator/researcher, in addition to the students and the social environments in which we work.

Positioning individuals as psychosocial defended subjects is particularly useful in this instance as it explores the way in which the capacities to care (Klein, 1937), learn and think (Bion, 1962) are developed. The concept of the psychosocial defended subject is used to critically examine the relationship between mental health nursing students' backgrounds and motives for career choice, as well as the influence of what background, career motivation and educational experience have on mental health nurses' developing compassionate caring behaviours and critical thinking dispositions. I will return to the concept in Chapters Four, Five, Six and Seven as it has been used to inform data production, and analysis; and, has implications for mental health nurse education, mental health nurse practice, policy and research.

This psychosocial approach considers early life experiences as playing an important role in personality development and are of particular relevance in shaping the way people form adult social relationships. The relationships that are being considered in this study involve individual student biographies and motives for career choice, the connection between their

inner and outer worlds, interactions with other individuals, for example, patients, peers, mentors and academic staff, as well as organisations, for example, the NHS, Universities and other institutions involved in mental health nurse education.

Mental health nursing and its education still tends to deny: the emotional challenges involved when working with patient suffering; the intimate caring nurse patient relationships; and, the pedagogic processes involved when learning how to deal with these. This is what my thesis is about. Research into the motives for choosing mental health nursing as a career is rare, what there is tends to disembody the individual, ignoring past life experiences. The psychosocial approach provides a way to make sense of what influences the choice to become a mental health nurse and how such influences affect behaviours, feelings and relationships. Likewise, the influences of the socially-constructed systems in which mental health nurses work are rarely considered when exploring caring and critically thinking behaviours within individuals. Exploring *both* the individual *and* the social offers fresh insights into the complex influences of anxieties and the (individual and collective) defences employed. Having a better understanding of our emotion within these relationships can be used to inform mental health nurse practice, education and policy (see Chapter Eight).

Despite studies into mental health nursing being rare, there is existing literature on career choice and the helping professions, these are explored further in the following chapter.

Chapter Three

Choosing Mental Health Nursing as a Career and Influences of Nurse Education on Students' Capacities to Care and Think Critically. Review of Literatures

Introduction

Literatures dealing with two main areas are critically evaluated in this chapter. First, since I propose that being a mental health nurse has psychosocial influences, I needed to consider what is already known about choosing mental health nursing as a career. In this chapter, I offer a critical summary of existing literature about career choice applied to nursing, and more broadly, the motives for altruistic helping behaviours in mental health professionals. Secondly, I assess professional socialisation studies and literature on nurse education's influence on students' capacity to care and think. To frame the review of these two sets of literature, I start below by providing a critical synopsis of the contested concepts of mental health and illness and understandings of the role of the mental health nurse. These operational definitions and understandings are then used throughout the thesis, including this chapter.

Part One: Defining Mental Health, Mental Illness and Understanding the Role of the Mental Health Nurse

In this part of the chapter, I explore the concepts of mental health and mental illness and the roles of the mental health nurse so that I can clarify their socially constructed meaning, which has varied over time, and within and between cultures and social contexts.

The Concepts of Mental Health and Mental Illness

It is estimated that one in four people in Britain, will be affected at some point in their life time with a mental health problem (Department of Health (DoH), 2011). Yet what comprises a 'problem' is not always clear. Generally, the concept of 'health' is ambiguous; open to interpretation; and related to the other complex and difficult concepts, illness and disease. The World Health Organisation (WHO. 2017) defines mental health as:

> '[A] state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community' (WHO., 2017, p.1).

Nevertheless, no single, universally accepted definition of mental health exists (Videbeck, 2009). Although, according to Tilbury (2002) most attempts at definitions appear to include three elements: the idea of a mature self; self-management in social relationships; and the ability to carry out social roles (see Hershenson and Power, 1987; Jahoda, 1958; Maslow, 1954; Vaillant, 1970).

Whether physical or mental, health is rarely measured and is often viewed as an absence of disease. Healthcare services have historically been dominated by the biomedical model which focus on such biological factors as genes, viruses or somatic abnormalities (Engel, 1977). In this content, it is easy to ignore mental health until problems arise, yet, from my perspective, mental health is necessary for wellbeing, interpersonal relationships, thinking, communication skills, learning, emotional growth, resilience and self-esteem. Yet, it is important to acknowledge that what constitutes mental health varies across historical time and cultures.

While mental health is ill-defined, mental illness is similarly problematic. It has been defined as 'collectively all diagnosable mental disorders' or 'health conditions that are characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning' (United States Surgeon General, 1999, p.5). The Diagnostic and Statistical Manual of Mental Disorders, 5th. Edition (DSM-V, 2013) is the reference guide that mental health professionals and physicians use to diagnose mental disorders in the US. Similarly, the International Statistical Classification of Diseases and Related Health Problems (ICD -10, 2018), a medical classification list by the WHO was first mandated for use in the UK in 1995. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. It is used by clinicians, researchers, psychiatric drug regulation agencies, insurance companies, pharmaceutical companies, the legal system, and policy makers. By design, the DSM and ICD are primarily concerned with the signs and symptoms of mental disorders, rather than the underlying causes. The lack of a causative or explanatory basis, however, is not specific to the ICD or DSM, but rather reflects a general lack of

pathophysiological understanding of psychiatric disorders (Spitzer, 2005). Similarly, there are those who question the accuracy of the diagnoses, arguing that they reflect an increase in the medicalisation of human living, which may be attributed to 'disease mongering' by psychiatrists and pharmaceutical companies, the power, financial profit and influence of which has been growing dramatically (Healy, 2006). Furthermore, there are those who feel they have been given a label that invites social stigma and discrimination. Diagnoses can become internalized and affect an individual's self-identity, and some psychotherapists have found that the healing process can be inhibited and symptoms can worsen as a result (Honos-Webb and Leitner, 2001).

When exploring diagnoses and definitions it is important to consider the psychosocial context: there is much contention and social stigma surrounding mental illness. The anti-psychiatry movement[14], for example, arose in the 1960s and early 1970s, from contestations about defining and diagnosing mental disorder and was led by, among others, the psychiatrist Thomas Szasz (born 1920, the author of *The Myth of Mental Illness*). He claimed that the diagnostic criteria of mental disorder are vague, socially constructed and a convenient label for the type of thinking and behaviour that society finds unacceptable. This position is like that of the philosopher, historian, and sociologist Michel Foucault (1926–1984), one of the forerunners of the anti-psychiatry movement. According to Foucault, 'madness' is a social construct dating back to the enlightenment, and its 'treatment' is nothing more than a disguised form of punishment for deviating from social norms.

Similarly, the psychiatrists R.D. Laing (1927–1989), Silvano Arieti (1914–1981), and Theodore Lidz (1910–2001) argued that mental disorder is a comprehensible reaction to the impossible demands that families and societies place upon certain sensitive individuals. Laing never denied the existence of mental disorder, but rather regarded it differently from his contemporaries. For Laing, the content of a person's mental illness is masked in an enigmatic language of symbolism that can be interpreted and worked through, rather than simply assumed to be a meaningless marker of distress or disease.

[14] The anti-psychiatry movement was never really a unified movement in any way, more a collection of philosophers and activists who were identifying negative elements of psychiatry.

So ‘mental health’ and ‘mental illness’ are difficult to define precisely and they have long been considered controversial and contested concepts. Descriptions of mental illness are modified over time and what one society considers as appropriate, another may judge as maladaptive or inappropriate. For example, people who are able to carry out their role in society and whose behaviour is deemed appropriate are considered ‘healthy’. Conversely those who are unable to fulfil their roles and behave in inappropriate ways may be viewed as ‘ill’.

Influenced by the psychosocial approach I discussed in the last chapter, I accept the existence of the conditions that psychiatrists call mental illness and the suffering experienced by those with mental health problems. However, I am not so sure that these conditions and distress can all be labelled as ‘illness’. This is because such disorders comprise of a broad range of emotional and behavioural problems, with different signs and symptoms[15] though they are consistently characterised by combinations of people experiencing thoughts, emotions, behaviour and relationships which negatively affect cognition (thought), behaviour, and/or affect (mood) to such an extent that it causes a significant amount of distress and functional impairment for a prolonged period. Moreover, viewing health and illness as correlative terms suggests that health is the opposite from illness, forming extreme poles of a continuum. This binary view ignores the fluidity of both and does not consider the changes in peoples’ life circumstances; their changing abilities to cope; or, the changes in social perspectives about what constitutes normal and abnormal behaviours. For me, what is important are the descriptions of acute distress rather than labels denoting illness. Yet, the terms ‘mental illness’ and ‘mental disorder’ are however, widely used in practice within the UK and while this remains controversial, they also have practical and legal implications. These will be discussed under the next section within the summary of the roles of the mental health nurse.

Understandings of the Role of the Mental Health Nurse

Given the contested concepts of mental health, mental illness and extensive roles of the nurse it is likewise problematic to define mental health nursing. According to the NMC (2008, p. 29):

[15] Listed in DSM V and ICD 10.

> ‘Mental health nurses care for people who experience mental distress. The focus for mental health nurses is to establish a relationship with service users[16] and carers to develop an understanding of how they might cope with their experiences and maximise their potential for recovery. Mental health nurses are expected to understand the context in which mental distress has occurred and possess a repertoire of evidence-informed understanding to develop interpersonal, psychosocial and other skills that underpin an empathic attitude’.

Mental health nurses practice in a variety of settings, with all age groups in mental health hospitals; community teams; general hospitals outpatient clinics; people’s homes; schools; prisons; primary care services; crisis teams; industry; and, drug and alcohol services. The challenge within all these settings is to form therapeutic relationships with individuals and their families. From the perspective I am taking, fundamental to this approach is the concept of the therapeutic ‘use of self’ and what is called ‘psychosocial nursing’ introduced by Hildegard Peplau (Peplau, 1952; Barnes, 1968; Barnes et al., 1998). Peplau’s (1909-1999) interpersonal relations theory led the way towards more humane treatment of patients with behaviour and personality disorders (O’Toole and Welt, 1989; Tomey and Alligood, 2006). Her vision provided the foundation for the profession and established psychiatric/mental health[17] nursing as a separate specialty with its own standards and scope of practice (Sills, 1998). She described the therapeutic use of self as how nurses use their personality, experiences, values, feelings, intelligence, needs, coping skills and perceptions to establish compassionate and effective relationships with patients to help them grow, change and heal. She believed in nurses developing self-awareness to promote the growth in others and to avoid limiting patient choices. Peplau’s concept of the nurse-patient relationship (with tasks and characteristics) is still seen as the foundations for good nursing practice today (see Tidal model, Barker and Buchanan-Barker, 2005; Videbeck, 2009). She also identified a number of

[16] Generally, ‘service user’ means anyone who is a patient or other user of health and/or social services. This term was chosen to eliminate the ‘patient’ label and restore the person to an active role as a user or consumer of services. However, I am aware that some people who fall into this category do not like being referred to as a ‘patient’ or ‘service user’, for whatever reason. Many feel unable to access services that appropriately meet their needs, and so a more accurate description for them might be ‘service eligible’. For the purpose of this thesis I use the expression patient.

[17] The terms psychiatric nurse and mental health nurse are often used interchangeably, although there is much debate about whether these terms are synonymous, the former being allied to the biomedical model and the latter allied to recovery focused approaches to care (see Cutcliffe, Stevenson and Lakeman, 2013). Broadly they both refer to nurses who work with people with mental health issues, to large extent, the title depends on where they have worked (Rogers and Pilgrim, 2001), various public and/or mental health policy positions (Ramshorn and Pearlmutter, 1982), and the fads of passing fashion (Nolan, 1993).

key roles of the mental health nurse: Stranger, Teacher, Resource Person, Counsellor, Surrogate and Leadership.

So, it is accepted that within mental health nursing interpersonal interaction is central to practice (Barker, 2009; Browne et al., 2012; Dziopa and Ahern, 2009; O'Brien, 1999; Peplau, 1952; McGuire et al., 2001; Muller and Poggenpoel, 1996). There is evidence that therapeutic outcomes for patients within a variety of clinical settings and patient populations is strongly associated with the quality of patient/mental health nurse relationship (Barker and Buchanan-Barker, 2005; Castledine, 2004; Fradelos and Staikos, 2013; Henderson, 2001; McCabe and Priebe, 2004; Videbeck, 2009). Yet, the formation of a good or quality interaction between nurses and patients is often elusive and difficult to measure (Welch, 2005; Dziopa and Ahern, 2009; Weissmark and Giacomo, 1995). This elusiveness means that the interpersonal aspects of the therapeutic relationship are vague and, therefore, the opportunity for high level practice, education and research is lost (Dziopa and Ahern, 2009). In addition, some studies have suggested a link between the mental health nursing practice environment and the therapeutic relationship (Bowers et al., 2010; Brennan et al., 2006). The mental health nurse's ability to engage in therapeutic relationships is fundamental to their role, and the psychosocial factors that may influence this capacity should therefore be explored.

Attempts to operationalise the therapeutic relationship can create confusion rather than clarity because the concepts involved escape succinct quantification and mental health nurses may adopt a variety of poorly articulated approaches dependant on their background. According to Hewitt and Coffey (2005) the therapeutic relationship has become a 'waste basket' into which multiple approaches are placed in a non-reflective or strategic manner. The approach is ad hoc, based more on education and clinical experience than an overarching vision of what constitutes a therapeutic relationship. In a review of the mental health nursing literature on the therapeutic relationship, Dziopa and Ahern (2009) confirmed that it is the core of practice. The outcome of their review was the development of nine main behaviours including: conveying understanding and empathy; accepting individuality; providing support; being there/being available; being genuine; promoting equality; demonstrating respect; maintaining clear boundaries; and, having self- awareness. Such behaviours however, require 'mental health' in the mental health nurse, reinforcing the need for a psychosocial approach to this research.

Although an approach to mental health nursing which aligns to psychosocial understandings and values has been promoted, the context in which the nurses work is ambiguous. Several recent politically and economically motivated changes have influenced mental healthcare. They include a move from inpatient care to community-based services, the introduction of the Care Programme Approach in 1991, changes to the Mental Capacity Act (2005) and amendments of the 1983 Mental Health Act in 2007 (Archambeault, 2009). These changes have resulted in a shift towards evidence-based practice and recovery-focused strategies, with the emphasis on collaborative partnership now evident within policy initiatives (see the Chief Nursing Officers Review of Mental Health Nursing, DoH, 2006). With limited resources, mental health policies in many Western countries have been remodelled to focus on providing comprehensive and integrated health and social care services for those people with the most severe illnesses, those deemed to be at greatest risk (to self or others) and most complex problems. This means that all too often there are insufficient staffing levels with much of the time of the nurse being afforded to administration, leading to nurses having too many patients (with high risks and complex needs) in their care to be able to spend much time with individuals. Therapeutic relationships are further problematised when faced with providing care in conjunction with involuntary treatment and detainment under the Mental Health Act (1983, amended 2007).

Forchuk (2001) has likened mental health nursing to a 'house divided'. Not least amongst these divisions is that between the so-called 'therapeutic relationship' and 'biology' camps. The latter (medical model) perpetuates a reductionist, 'scientific' disease model of mental illness is critical of nurses employing interpersonal theories (Gourney, 1995; McCrone, 1996). Amidst the subsequent barrage of claims and counterclaims (Barker and Reynolds, 1995; Dawson, 1997; Barker, 2003), retorts and challenges to each of the other's evidence base (Huxley et al., 2000), nurses, not unremarkably and perhaps akin to the patients under their care, are finding themselves increasingly confused, disillusioned and disempowered (Sullivan, 1998). No longer reliant on a purely biomedical model of understanding, the primary paradigm of contemporary mainstream Western mental health care is said to be the biopsychosocial (BPS) model which incorporates biological, psychological and social factors. This suggests that the body affects the mind and the mind affects the body and that both are influenced by environmental factors resulting in a symbiotic relationship between both body and mind, and subsequently physical and mental health. There is a growing body of empirical literature that suggests patient perceptions of health and threat of disease, as well as barriers

in individuals' social or cultural environment appear to influence the likelihood that they will engage in health-promoting or treatment behaviours, such as medication taking, proper diet or nutrition, and engaging in physical activity (DiMatteo et al., 2007). Increasingly, public health models are now focussing on not only areas of diagnosis, treatment and aetiology of mental illness, but also epidemiology, health promotion, disease prevention, and access to and evaluation of services (Last and Wallace, 1992).

Mental health nurse education does not occur in a vacuum, rather it is influenced by the political climate, philosophical views of mental health and illness as well as the overarching mental health policy framework. Contemporary mental health policy aspires to the development of recovery-focused services (DoH, 2011). The concept of recovery is based on the lived experience of people who have faced mental stress and distress, and who have often also used mental health services. Critically, recovery was devised by people who had this lived experience to emphasise the individual journey to a meaningful life, rather than on treating the signs and symptoms of mental illness (Anthony 1993; Bennett et al., 2013; Gordon and Ellis 2013). Critics of the biopsychosocial model argue that rather than being holistic, it artificially promotes distinctions between the three factors, causes confusion with assessment and educational needs and it has done little to destigmatise mental health (Tavakoli, 2009).

In this part of the chapter I have, first, come to a position on the meaning of mental health and illness that informs this thesis. Nevertheless, I acknowledge that in practice and policy the terms often cause confusion for student nurses in particular, moreover, terminology has practical and legal implications in terms of diagnostic criteria and eligibility of mental health services. I have, secondly, explored the role of the mental health nurse, emphasising the context in which they work. The result of the political and economic climate is that, increasingly, mental health nurses work with those considered most at risk; who are most significantly affected by mental illness; and, who have complex problems. This configuration can make it difficult to form the positive therapeutic relationships still considered to be the cornerstone of mental health nursing practice. As I show below, it is the promise of this relationship that often attracts individuals into a career in mental health (Browne et al., 2012; Clinton and Hazelton, 2000; Muir- Cochrane, 2001; O'Brien 1999, 2001). My interest is in shedding a psychosocial lens on what enhances and constrains individual nurses in their relationships with patients. From this perspective, what motivates someone to become a

mental health nurse is indicative of what will enable and constrain so it is to the substantial literature about this that I turn next.

Mental Health Nursing and Career Choice

This part of the chapter is framed by my, first, critically examining three career choice theories which have been applied to nursing and justify my psychosocial approach, which is a fourth theory. Next, I summarise the nursing literature investigating influences on career choice, most of which focuses on the desire to be a general or adult nurse: little is known about the specific choice to be a mental health nurse (as seen in Appendix 1, 12 papers were found that relate specifically to choosing mental health nursing). I moved to studies on the role of altruism in mental health professionals both to augment the paucity of evidence and because it relates to an exploration from a psychosocial perspective.

Critical Summary of Career Choice Theories

Career choice has been studied since the early 20th century, mainly in the disciplines of organisational and vocational psychology (Gottfredson, 1981; Holland, 1959; Lent et al., 1994; Roe, 1956; Strong, 1927). Once thought to be a static, one-time only decision, career choice is now recognised as a dynamic process that forms over time through a variety of experiences and evaluative processes (Ashforth and Saks, 1995). The most prominent theoretical approaches in the extant career choice literature include: developmental, person-environment fit and social cognitive perspectives. In the following section I provide a synopsis of each highlighting what they contribute to the understanding of career choice within nursing. The limitations I identify provide justifications for taking the psychosocial approach in this study.

Developmental Career Choice Theories

This first theory considers occupational preference to be determined by early life experiences, family interactions and the socialisation processes[18]. There are a number of vocational psychologists who have considered the influence of development on career choice. For the purpose of illustration, here I go into more depth about two particular influential theorists: I

[18] See: Ginzberg et al., (1951); Gottfredson, (1981); Hartung et al., (2005); Roe, (1956; 1980); Super, (1953; 1954;1980;1988).

consider, Super's (1953, 1980, 1988) Theory of Vocational Choice and Gottfredson's (1981, 1996) Theory of Occupational Aspirations: Circumscription and Compromise.

Super's (1953, 1980, 1988) Theory of Vocational Choice was one of the earliest attempts to understanding career choice processes. It emphasises self-concept[19]. Super devised a framework for conceptualising how careers constantly evolve, that is experience changes or recycles occupational preferences and self-concept throughout life. In this theory, individuals express their self-concept in their vocational choices. Evolution occurs as individuals pursue job satisfaction through work roles in which they can express and develop their self-concept. Career self-concept development, therefore, is a lifelong dynamic process involving interactions between personality abilities, interests, experiences and values, in the one hand, and occupational and environmental factors, on the other. For example, if an individual has an ability and interest in listening to others; likes the idea of being able to help people; and, considers themselves a caring person then a career in the helping profession feels appropriate. For Super, the best career choices people make are the ones that provide opportunities to use as many elements of self-concept as possible.

Despite this theory's appeal and its influence in career counselling (Bocknek, 1976; Sharf, 1992), there has been little empirical study to support it (Smart and Peterson, 1997). The theory has been criticised for its emphasis on the individual and its ignoring of social influences as gender, race and class (Price, 2009). Moreover, Super first developed his theory in the 1950s and is no longer considered appropriate because it does not consider the fluidity within modern life, careers and the changes in life role experiences (Flum and Blustein, 2000).

However, Gottfredson (1981, 1996) built on Super's theory by taking account of gender, career prestige and interest in decision-making. He focused on the compromises individuals make when exploring career choice, proposing four stages of cognitive development and career preferences from preschool age to early adulthood. Two key constructs were: 'circumscription', a process of eliminating jobs based on social criteria, such as gender and class; and 'compromise', which involves modifications of career choice due to obstacles. Support for this theory has been mixed, for example, while a 10-year longitudinal study by

[19] The idea or mental image one has of oneself and one's strengths, weaknesses, status, etc.; self-image (dictionary.com, 2016).

Helwig (2001) of children's career aspirations supported Gottfredson's theory, Blanchard and Lichtenberg (2003) experimental study with college students evaluated the conditional priorities hypothesis by placing students in either a minor, moderate, or major compromise condition but found little empirical evidence in support of the circumscription/compromise model.

Overall, developmental theories of career choice do not explain variances in terms of gender, race and class (Hartung, Porfeli and Vondracek, 2005). Given that 80% of nurses are women (NHS Digital, 2016) with increasing numbers of migrant and ethnic minorities working as registered nurses within the NHS in the UK (Nelson, 2004; England and Henry, 2013) gender, race and class have particular relevance to nursing. Moreover, much of the research found within this review focuses on adolescence and young adulthood rather than early childhood and family interactions (Hartung et al., 2002). My study considered students' individual past experiences across their life span, at the same time as considering the social context of the individual and the interplay between the individual and the social.

Nevertheless, the developmental perspective is relevant to nursing and this study because past experience and self-perception have been shown to influence career choice, attrition, transition and retention (Boychuk-Duchscher and Cowin, 2004; Gould and Fontenla, 2006; McIntosh, 2003). My contribution to knowledge includes a psychosocial understanding of early life experiences (in particular the relationships with parents) and the processes involved in choosing nursing as a career. However, as already discussed in Chapter One, it is important to consider not only the individual but also the context. There is therefore the need to consider developmental experiences of individuals in the 21st century, in relation to contemporary healthcare provision.

Person-Environment Fit Theory

Secondly, stemming from the developmental approach, the person-environment fit theory suggests that career choice is influenced between the fit or congruence with personality and career characteristics. The theory is that career choice behaviour focuses on the interplay between personality and environment and that individuals choose career environments that best fit their attitudes, values, skills and abilities. A key theorist within this area was Holland (1959) who drew on the work of Roe (1956) and Strong (1927) to propose a 'Career

Typology' whereby people choose careers based on reaction to need, satisfaction and environmental demands. Holland's work is used as the basis of several self-directed career search tools (Furnham, 2001) and has been influential in studies on career choice and job satisfaction (Price, 2009). However, the model has been criticised for lacking in validity as a predictor in vocational outcome: Tinsley (2006) and Tsabari, Tziner and Meir (2005) carried out separate meta-analyses of studies using Holland's model and found no statistical correlation between career choice and job satisfaction.

Further criticism of Holland's theory is that he inadequately explains diverse populations and in particular women and ethnic minorities (Lindley, 2005; Tinsley, 2006). The over-emphasis on psychometric testing has also been criticised for not recognising the 'unique phenomenology and the context of the individual being tested' (McIlveen and Patton, 2006, p19). Tinsley (2006) argues that continued expansion of Holland's model is futile, suggesting that other options need to be considered when exploring vocational theory, practice and research. So, a qualitative approach to researching the individual within context is indicated, which is what I undertook in this study.

Social Cognitive Career Theory (SCCT)

Thirdly, SCCT links self-efficacy beliefs, outcome expectations and goals in relation to job preference. It is the most extensively researched theories of career choice and was developed by Lent, Brown and Hackett (1994). SCCT is linked to Bandura's (1986) social cognitive theory and considers career choice as being influenced by personal accomplishments and social learning, whereby individuals choose careers to fit with their expertise and past successes to maintain self-efficacy and increase the likelihood of future success. According to Locke and Latham (2002) personal goals are essential for direction and maintenance of behaviours that help to achieve future rewards. So, from this perspective, if an individual wants to help others is a key motivator for choosing to become a nurse, then being able to help others or make a difference is the intended goal of working.

There has been a substantial amount of empirical evidence that supports self-efficacy and career choice theory (Betz, Klein and Taylor, 1996; Lent et al., 1994; Smith and Fouad, 1999), especially in the areas of science and academia (Lent et al., 2001) The SCCT provides a framework for exploring career choice by recognising the interaction of multiple individual,

social and environmental influences. However, much of the research using SCCT does not explore self-efficacy within real-life situations (Lindley, 2005) and does not allow for the contradictions and ambiguities in people. As with the limitations of the developmental theories, the SCCT was devised during a time of stable industrialisation and does not consider the fast-paced changes and uncertainties of organisations, especially those seen within the healthcare setting (Bright and Pryor, 2005; Meijers, 2002). There have been considerable changes in both the workplace and wider organisations over the past few decades (Rousseau, 1997). Such changes have been found to influence job security, working relationships, job satisfaction, employee turnover and productivity (Millward and Brewerton, 2000).

The three traditional theoretical perspectives identified above offer an understanding of the ways in which career choice can be seen as a multi-faceted complex process including all areas of a person's life (Hall, 1996). Many researchers have attempted to explore the factors that influence the decision to choose nursing as a career. Factors such as aptitudes, interests, resources, limitations, requirements, and opportunities (e.g., Parsons, 1951; Ginzberg et al., 1951; Super, 1953; Swanson, 1996) have all been found to be influential. It is common today to view career choice as an ongoing process that continues throughout a person's life. This perspective of 'life career development' is broad and holistic (Gysbers, Heppner, and Johnson, 1998), and 'encompasses all spheres of activity and all corresponding facets of personal identity' (Hall, 1996, p.7). There is therefore the need to consider all elements of the individual and the environment to understand better the experiences of choosing mental health nursing as a career.

These theories have their limitations and require updating, however there seems to be sufficient evidence to support the need to consider early relationships as these have been found to be influential. Notions of self-concept and self-efficacy are also considered to be important, so there is the need to explore career choice in relation to these concepts, including exploring subjective experiences of career choice. However, subjective experiences cannot be detached from their social, cultural and historical contexts and so need to be viewed within these contexts thus I will now explain how the qualitative psychosocial approach which I adopted is appropriate.

The Psychosocial Perspective and Career Choice Theory

Psychosocial approaches to research are characterised by considering what occurs for individuals within their internal world (e.g. thoughts, feelings, motivations and behaviours) while living in the social world (e.g. interactions between individuals and groups). As discussed in the previous chapter, this approach draws on psychodynamic/analytic theories and so assumes that thoughts, feelings and behaviours occur in both the conscious and unconscious minds and it seeks to understand social, cultural, political influences on individual thoughts, feelings and behaviours. There is a growing curiosity in both psychoanalytically informed theory and practice within the social sciences, often referred to as psychosocial studies, that explores the notion that there are unconscious influences on career choice[20]

So, psychoanalytic theory makes a significant contribution to the theories of life career development by adding the dimension of unconscious vocational choices. Pruyser (1980, p.61) notes that this approach assumes that: '[T]he work that any person undertakes in almost any environment, excepting only the extremes of slavery and imprisonment, is to some extent determined by personal choice, made at several levels of consciousness.' It is these different layers of consciousness that I explored to provide a unique in-depth understanding of the psychosocial influences involved in choosing mental health nursing as a career. Building on the theories identified above I discuss how they play out in the studies found that explore choosing a career in mental health nursing.

What is Known about Choosing a Career in Mental Health Nursing?

A review[21] of theoretical and empirical evidence within nursing literature for recruitment and career choice revealed a wide variety of influencing factors for wanting to become a nurse (Gottfredson, 1981; Lent et al., 1994). The career choice model proposed by Gottfredson (1981) holds that occupational selection is influenced by both the image the individual holds of a particular occupation and the individual's self-concept. The image of nursing has its origin in women's traditional role of domestic caring. In the late 19th century, following

[20] See: Bordin, 1979, 1980; Bratcher, 1982; Clarke, 2006; Gadd, 2006; Kets de Vries, 1995, 1996; Kets de Vries and Associates, 1991; McKelvie and Friedland, 1978; Obholzer and Roberts, 2006; Osipow and Fitzgerald, 1996; Robinson, 2007; Roe, 1956; Pines and Yanai, 2000; Young, 2011.

[21] See Appendix 1 for approach to literature review.

Florence Nightingale's work, choosing to be a nurse began to be portrayed as a calling to a higher being (Brodie, 1994). Nevertheless, for a long time, nursing endured negative images, with nurses being viewed as unintelligent, or portrayed as 'sex kittens' or doctors' handmaidens (Kalisch and Kalisch, 1987). Although modern nursing has been developing as a profession with potential for scholarship and career development requiring intellectual mastery and skilled technical expertise (Brodie, 1994) the very nature of the work, for example, intimate contact with the human body and performance of 'menial' tasks, has a negative influence on the image of nursing which remains to this day (Lawler, 1991). Having had negative images on the one hand, nursing has also traditionally received positive images such as nurses as angels of mercy and mothers on the other (Bridges, 1990). Often referred to in psychosocial literature as 'denigration' and 'idealisation' of nurses (Dartington, 1994).

It is worth noting that there is often a crude demarcation between mental health nurses and general/adult nurses which appears to have existed in the nursing discipline throughout history, and is evidenced in many of the historical reports and associated debates. Additionally, the historical perception of mental nursing being an activity carried out by 'working class' males, and general nursing being an activity carried out by 'middle class' women (see Cutcliffe, 2003; Nolan, 1993; Porter, 2002). I return to this in Chapter Six. Most of the literature found for this study related to general/adult nursing with only 12 studies (see below) that considered the reasons for wanting to become a mental health nurse.

A number of empirical studies have examined the reasons why people choose professional adult nursing as a career (Branscome, 1989, Duffield et al., 2004, French et al., 1994, Kersten et al., 1991, Lynn et al., 2006, Magnussen, 1998, Maurer, 1994, Moores et al., 1982, Murray and Chambers, 1990, Neil and Barclay, 1989, Weiss, 1970, Williamson, 1990, Zysberg and Berry, 2005). These studies have revealed three groups of factors which influence those who are considering nursing as a career: restrictive factors, such as financial conditions of the family (e.g. whether they are the breadwinner or are generating a second income) and family responsibilities; attractive factors, such as holding a positive image of nursing, good experiences of caring for others or of hospitalization, having positive role models of family and friends who are also nurses; and internal motivation factors, for example altruism and the desire to meet personal or emotional needs. Of these factors, altruism is the most frequently motivating influence reported by people who choose nursing as a career.

Many of these variables are difficult to determine and their influence is unpredictable (Patton and McMahon, 2006). Studies on the choice to be a nurse relate to adult nursing and emphasise the extrinsic influences (restrictive and attractive factors) on the decision to enter professional nursing. There are fewer investigations into the internal factors (Mimura, Griffiths and Norman, 2008), despite altruism being the most frequently reason for people choosing nursing as a career. The studies are not concerned with where the altruism comes from, in what way the internal experiences are influenced by social factors or what helping others means to individuals or how such meaning might influence their ability to care for others.

What motivates someone to enter mental health nursing specifically is rarely investigated: my review of available resources yielded only 12 studies (see Appendix 1). Critically reviewing this small literature revealed little about what influences choosing mental health nursing as a career, however, they provided a picture of the wider socio-political context in which mental health nursing and its education, takes place.

Motivations to Become a Mental Health Nurse

Six out of the twelve studies were carried out in Australia[22], although some also referred to the UK[23]; In Australia: Happell (2000) designed a quantitative quasi-experimental study to ascertain changes (pre and post course) in attitudes of undergraduate nursing students towards a career in psychiatric nursing; Happell et al. (2013), conducted a qualitative exploratory study of 15 nursing students based on the work of Stebbins; Happell and Gaskin (2013) carried out a literature review in 2012 of 3 electronic databases to understand the attitudes of undergraduate student nurses towards a career in mental health nursing; McCann, Clark and Lu (2010) conducted a three-year longitudinal study. The research used a repeated measures survey design, with data collected three times from this single cohort of students between 2005 and 2007, in their first, second and third years of study because they wanted to determine whether career preferences changed as students progressed through their studies.

[22] These studies have been undertaken since the loss of any mental health specific courses and the introduction of comprehensive nurse education programmes in the 1990s. This has led to mental health professionals and academics having concerns about the under-representation of mental health within nurse education curricula and the abilities of new graduates to work in this area (Edward et al., 2015). These concerns have led to the recent reintroduction of a 'major' in mental health nursing in some universities in Australia which has provided further opportunity for research in this area.

[23] See Edward et al., 2015, this study compared diploma students in the UK and BSc students in Australia.

Stevens, Browne and Graham (2013) carried out a replicated (Happell's 2000 study) longitudinal study on students completing their undergraduate course in 2009. The other six studies found emanate, one from each country: In Ireland, Wells and McElwee (2000) undertook a literature review on nurse recruitment, although do not highlight the methods used; In New Zealand, Surgenor, Dunn and Horn (2005) using a cross- section design, to investigate the associations between attitudes, demographic variables, mental illness exposure, and career aspirations in 164 nursing students; In South Africa, Jansen and Venter (2015) used a qualitative research design that aimed to explore 27 final year nursing students' career options; In the Netherlands, Hoekstra et al. (2010) conducted a descriptive qualitative study design with semi-structured interviews to gain an understanding of how 120 students perceive mental health care and a career in this discipline, and how these perceptions influence their choice of major; In the USA, Thongpriwan et al., (2015) conducted a quantitative study using a descriptive, online survey to examine students' perceptions of mental health nursing. A total of 229 junior and senior nursing students were recruited from eight nursing colleges in Midwestern US.; and in the United Kingdom, Ferguson (1992) offered an opinion article. Whatever the country, it was found that mental health care is one of the least popular career choices leading to nurse shortages in the field.

Edward et al. (2015) found that prior exposure to mental illness in both UK and Australian participants had an impact on the decision to consider a career in mental health nursing. A 12-item survey was developed for the purpose of this study and was checked for face validity by experienced mental health nurses. Convenience sampling was used and 395 responses were received. In the UK, 54% of participants had previous experience of mental health issues, either personal or professional, and 48% claimed that the main factor in choosing or not choosing a career in mental health nursing was based upon personal experience. Approximately 61% of the Australian cohort had not had previous experience of mental health issues either personally or professionally. However, 24% said personal experience was the major motivating factor for choosing a career in mental health nursing once registered. Given the paucity of studies into this area provides a rationale for this research, likewise in order to explore the different internal, attractive and restrictive factors involved in choosing mental health nursing as a career a psychosocial approach is warranted.

Only Happell et al.'s (2013) qualitative exploratory study of twelve students' reasons for undertaking their degree focused specifically on wanting to work in mental health nursing.

The students were asked about: motivation for choosing mental health nursing; other people's responses to the choice; and, whether taking a module on 'recovery for mental health nursing practice' confirmed or influenced an interest in working in this area. For my purposes, the findings are limited because they emphasise the negative responses of friends and family for majoring in mental health nursing, rather than the reasons for undertaking the degree. Although the authors did give some indication about reasons for choosing mental health: three students identified that they had always wanted to do something in mental health and the taught session had confirmed this interest. However, again the initial reasons for enrolling on the course were not identified or discussed, so despite this paper promising a focus on the reasons for choosing this degree, it is not gone into in any depth.

The other 10 papers found considered reasons for *not* wanting to work in this area. Two interrelated themes emerged from my review of these studies: first, I noted that the findings indicated a lack of knowledge and understanding among the general public about what mental health nurses do, coupled with stereotypical negative perceptions and fear of mental illness[24] ; and, secondly, they found a perception that mental health is 'not real' nursing when compared to adult/general nursing.

The highly limited research about what motivates someone to choose a career in mental health nursing provides a justification for carrying out this present study. Moreover, the literature does not address how complex psychosocial interactions influence the choice to be a mental health nurse. There is however, abundant literature on altruistic helping behaviours within the mental health 'helping professions' (refer to Appendix 1 for how I selected and reviewed this literature). Most notable and relevant for me was the high incidence of the term 'wounded healer' which refers to the propensity of those in helping profession to identify adverse childhood experiences (Barr, 2006). I used the concept of the 'wounded healer' to investigate personal experience in relation to career choice and its relevance to mental health nursing and mental health nursing education.

[24] It appears that the stigma attached to mental illness (Hinshaw, 2007) is, by implication of these studies, associated with choosing (or in this case not choosing) a career in mental health. Goffman (1963, p30) wrote about 'courtesy stigma', to refer to the social stigma that attaches to those who are associated with a stigmatised person or group: the problems faced by the stigmatised person spreads out in waves of diminishing intensity among those who come in contact with the stigmatised person.

Altruism in Mental Health Professionals: The Wounded Healer

Altruism refers to motivation that is 'other-directed' or that aims to increase or benefit another individual's well-being (Mikulincer et al., 2005; Batson et al., 2009). Some argue that altruism supersedes motivations and intentions, and instead manifests as an action or behaviour (Monroe, 2002). Thus, altruism may be considered a motivation for helping behaviour or it may be considered as the behaviour itself.

Overall the literature questions whether 'unselfish' altruism exists especially when working with strangers and whether it is possible to identify and measure the motives or reasons for wanting to help others (Penner, 2002). Of special interest are the psychological factors (some considered innate and others learnt) that account for helping behaviours (Batson et al., 2002; Losoya and Eisenberg, 2001). However, according to Mikulincer et al. (2005) few attempts have been made to link altruism to psychological theories of personality, motivation and social behaviour.

Studies investigate the early life influences on career choices of: psychotherapists (Prodgers, 1991; Rycroft, 1993); doctors (Fitzpatrick et al., 1993; Paris and Frank 1983); social workers (Lackie, 1983); and, mental health professionals working as therapists (Elliot and Guy, 1993; Malan, 1979; Tillet, 2003) [25]. These studies concur that there is a higher prevalence of adverse childhood experiences (trauma and emotional deprivation) for these professionals compared to other non-care-related professionals. Yet, how such early experiences influence adults in terms of psychological distress and career choice is contentious.

Within this literature, the concept of the 'wounded healer' is often used to describe conscious and unconscious factors, derived from personal experiences, that drive human behaviour and contribute to the decision to enter the helping profession[26]. The archetype of the wounded healer, suggests that healing power comes from insight gained from the healer's own injury (Zerubavel and Wright, 2012). 'The wounded healer is someone who works with (heals) others and is informed by their own traumatic or difficult experiences (wounds) in the work that they do' (Vachon, 2010, p.55).

[25] I also found one quantitative study by Phillips (1997) that considered the early experiences of student nurses, compared to a group of students intending to work outside the helping profession.

[26] Barnett (2007); Bradley (2009); Brandon (1999); Cain (2000); Conti-O'Hare (1998); Dunning (2006); Graves (2008); Hall (1996); Jackson (2001); Laskowski and Pellicore (2002); MacCulloch and Shattell (2009); Maeder (1989); Means (2002); Nolte and Dreyer (2010); Richard (2012); Wallace (2012); White (2000).

Studies in counselling, social work and psychiatric nursing, including reflective autobiographical accounts show the decision to enter into the helping profession is shaped by: the wish to repair the hurts and disappointments of early life (Sedgwick 1984; DiCaccavo 2002; MacCulloch and Shotwell, 2009); the desire to resolve personal psychological distress (Guy 1987); the desire to fulfil intimacy needs that were not met in childhood (Dryden and Spurling, 1989); and/or, the desire to extend the caretaking role that was carried out in the family (DiCaccavo, 2002). There are various studies researching the concept of the wounded healer, most notably that by British counsellor and psychotherapist Alison Barr (2006) who studied the significance of psychological wounds on people who decide to train as counsellors or psychotherapists. She used a pluralistic approach to her research, with the quantitative data analysed using descriptive and inferential statistics and the qualitative data analysed using thematic analysis, with a grounded theory approach. This study found that 73.9% of the 253 therapists and counsellors that completed her on-line questionnaire had experienced one or more wounding experience. She also found the causes of the wounds varied considerably ranging from abuse, chaotic family life as a child, mental ill-health (own and others), social or family life as an adult, bereavement, life threatening events and, physical ill-health (own and others).

Conti-O'Hare (2001) offers a rare insight into nursing and believes that individuals are often attracted to certain professions, like nursing, by the desire to ease the suffering of others after enduring or observing painful events in their own lives. She considered the wounded healer as a process, starting with suffering (the wound), followed by growth and recovery. Finally, the person is transformed with the ability to integrate personal experiences into the healing relationship (Conti-O'Hare, 2001). Recovery and transcendence from a wound requires insight and reflection in order to understand the experience and then use this suffering to help others. Conti-O'Hare (2001) identified five elements to this process: recognition, transformation, transcendence, walking wounded, wounded healer. Viewing the wounded healer as a process Conti-O'Hare (2001) developed the theory of the nurse as wounded healer to explore how nurses cope with their daily working lives, including resolving lateral violence (bullying) in the work place; transcending personal pain and suffering in order to build better therapeutic relationships; and building positive working relationships.

So, from this body of literature, individuals choose a career in the helping profession to heal or repair themselves through their clinical work and by doing so become more sensitive to the needs of others and more effective with patients (Paris and Frank, 1983). In summary, 'helping professionals' are motivated by their own 'wounds' which are unmet childhood needs, unresolved conflicts and the desire to put perceived wrongs right. From the psychosocial perspective I am taking in this research and discussed in the previous chapter, childhood difficulties, especially in the areas of attachment, care giving and illness create a predisposition to care for others as a defensive reaction to feelings of anxiety, helplessness or isolation. The desire to care for others is, to some extent, driven by unconscious identification with the patient role, based on projection of our own unmet emotional needs. The meaning of these experiences and degree of influence on the processes of identification and taking on the caring role remains contentious. In the literature there is also a gap in the understanding the links between altruistic helping and psychosocial theories of personality, motivation and social behaviours. This is a key focus within this current study.

I have used the existing literature to come to a view of mental health as containing the idea of a mature self, capable of self-management in social relationships and has the ability to carry out social roles. However generally, nurses and the public tend to consider mental health to be the absence of illness. Mental illness is similarly difficult to define but can interfere with social relations and fulfilling social roles and individuals tend to experience emotional and physical distress. I have proposed that the role of the mental health nurse is conceptualised as someone who provides care for people who experience mental distress and that key to this role is establishing a relationship with patients and carers to develop an understanding of how they might cope with their experiences and maximise their potential for recovery. While there are useful theories about career choice in nursing almost none refers directly to mental health nursing and entirely ignores the complexities which a psychosocial approach intends to illuminate. Exceptionally, literature about altruistic motivations to work, using the concept 'wounded healer' aligns with understanding the complexities of motivation. Nevertheless, a gap remains in terms of the psychosocial factors influencing mental health nursing as a career choice, my first research question aims to explore this gap.

The next part of the chapter turns to literature which concerns the second focus of the research which is how students' motivations to be a mental health nurse can be harnessed to create caring and critical thinking nurses.

Part Two: Professional Socialisation and Nurse Education's Influence on Students' Capacity to Care and Think

Introduction

Given that student nurses learn about being nurses both in practice and in the classroom, this next review explores literatures relating to both nurse education and nurse professional socialisation. As already argued in Chapter One, nurses need to possess both caring and intellectual capacities. Despite the abundant research on caring in the nursing profession, little research brings together the professional caring behaviours and critical thinking dispositions of student nurses. I found only one study that explored the trajectory of both during undergraduate nurse education (Karadag Arli et al., 2017). So, in this section, I first clarify the concept of care within nursing and its application to this thesis and then discuss literature that considers the influence of pre-registration nurse education on caring behaviours. Secondly, I examine what is known about the influence of nurse education on developing critical thinking skills and dispositions. I finish this part by reviewing the one study that explored both care and critical thinking before concluding with the rationale for a psychosocial approach to examine both dispositions and capacities simultaneously.

A Review of Care in Nursing and Nurse Education

Care is a broad term, which should perhaps be broken down into smaller categories, the fact that the word has come to cover such broad and varied definitions is significant in itself and I shall aim to work with the obscurity of meanings rather than trying to put them into neat categories. There is a huge literature on care, yet it is considered central in the field of nursing, with some authors spending their entire careers exploring the concept (Benner and Wrubel, 1989; Morse, 1991; Martinsen, 2006, Watson, 2012; Tronto, 1993). Caring is considered the essence of nursing practice and the foundation of the nursing profession. It is promoted as a crucial component of good-quality health care that meets patients' needs (Marilyn and Hiba, 2014). Yet, as outlined in Chapter One, there is concern that compassion is lacking in nursing and, that, therefore, there is a failure to provide good-quality care (Pearcey, 2010; Beckett, 2013). This is the context of my study.

In the international literature, caring is often described in terms of, or associated with, aspects of the nurse patient/client interactions, such as having a sympathetic presence and person-

centeredness (McCance, McKenna, and Boore, 2001). It is seen as intrinsic to the core of nursing, shaping the nurse's therapeutic drive and is activated when patient-centred care is delivered by developing a therapeutic relationship (Welch, 2005; Granados Gamez, 2009; Canning et al., 2007; Dewar and Mackay, 2010). As an illustration, the most commonly utilised tool for measuring caring, the Caring Behaviours Inventory (CBI), captures four elements; assurance of human presence, knowledge and skill, respectful deference to others and positive connectedness (Wolf, 1986; Wu et al., 2006). These four essentials for caring are related to the features identified by health patients, but it is unclear whether they are the same, as a pan-European study of patients (n = 1659) and nurses (n = 1195) from 34 different hospitals identified many similarities in the descriptors used for caring across the countries but also found some differences too (Papastavrou et al., 2012).

However, the meaning of care varies over time and between cultural contexts (Clouder, 2005; England, 2005). This is clearly illustrated by Morse et al. (1990) who systematically reviewed nursing literature and identified 35 authors' definitions of caring and the main characteristics of their perspective. Using a qualitative approach to content analysis, they revealed five epistemological perspectives on caring: caring as a human trait; caring as a moral imperative; caring as an affect; caring as an interpersonal relationship; and caring as a therapeutic intervention. Two outcomes of caring were identified: caring as the subjective experience and as the physiologic responses in patients. However, despite Morse et al.'s (1990) attempts, confusion still exists in the literature: while care seems to be universally understood, it is difficult to define and communicate (Spandler and Stickley, 2011). The interrelated and conflated use of the terms like caring, compassion and empathy means sometimes means it is hard to know whether the same thing is being discussed (Richardson et al., 2015). Below, I come to a position on caring which will serve for the thesis.

Nursing literature takes two broad perspectives when considering the concept of care, first from a philosophical, and often abstract view ‘the ethics of care’; and, secondly, from a social policy perspective, aimed towards carers and working about the best way to provide care (Hollway, 2006). Because of women’s historical association with caring, feminist literatures have been prolific and have reflected the same two emphases, the first taking the debate about ethics of care and its relation to gender and second looking at caring as an activity. Both approaches tend to work from the premise of women’s subordination and the way caring roles reproduce this. In England, 90% nurses are women, 98% of the midwives are women,

75% supervisors are men, and only 10% of the surgeons are women (Equal Opportunities Committee, 2006). Although it is argued that men choose to become nurses for the same reasons as women do (e.g., caring for people), often they are represented by media as "male nurses" and women as nurses (Meadus, 2000).

The smaller philosophical literature explores the ethics of care. For example, Martinsen (2006) points out that care is a practical, relational and moral phenomenon. Care is practical because it is expressed in actions, often using basic tools such as face cloths, bedpans, toothbrushes or drinking glasses. Care is typically a relational phenomenon because it is expressed in encounters with others. Moreover, it is a fundamental attitude that is conveyed in relationships in the form of sensitivity towards others and recognition of others in the light of their situation. As a moral concept, care is associated with the principle of responsibility for the weak (Martinsen, 2006). The moral, relational and practical dimensions of care are interwoven.

The large literature about care from a social policy perspective provides frameworks for carers (paid and unpaid) for working out how to provide the most appropriate care with the available resources[27]. The philosophical literature offers the concept of 'caring about' while the social policy literature leans towards 'caring for':

> 'Caring about which involves social dispositions that operate at a personal level and assume a relationship between the carer and cared for and caring for which involves the actual practice of caring, specific tasks such as lifting, cleaning and cooking and does not necessarily relate to caring about' (Skeggs, 1997, p.67).

Fisher and Tronto (1990), Skeggs (1997) and Sevenhuijsen (1998) argue that the concepts of caring about and caring for are not as separate or as mutually exclusive as the literature might suggest. This is because the concept of care and its meaning tend to be mutually defined and 'caring about' usually happens in the context of practice and the relationships involved in 'caring for' others.

[27] Benner and Wrubel (1989); Chambers and Ryder (2009); England and Henry (2013); Firth-Cozens and Cornwell (2009); Gilbert (2005)

Combining the notions of caring about and caring for, feminist political scientist Joan Tronto (Tronto, 1993) theoretically applies the ethics of care beyond the interpersonal to the wider social sphere, addressing justice. Tronto (1993, p.3) argues also for 'taking care of.' She further argues that there are five values of caring: 'attentiveness, responsibility, nurturance, compassion and meeting the needs of others.' Developing her argument and offering a practical application she modified, these values to form a model of 'elements' of care, these are: caring about - attentiveness; caring for - responsibility; taking care of - competence; and, care receiving - responsiveness.

Taking all of the above and positioning for the purpose of this study, providing care depends, first, on the ability to recognise others' needs. Secondly, care is a practice, that is crucial for structuring all human relationships and so has moral and relational elements. Finally, knowledge and skills (intellectual capacities) are required to take care of others. This model is helpful because it identifies the different elements involved when taking care of others. Tronto's work also challenges the boundaries between the public and private spheres and questions how care ethics work beyond the interpersonal to large scale political issues.

However, useful as it is, a limitation in Tronto's (1993) thinking is her lack of consideration of the human trait element identified in Morse et al.'s (1990) concept clarification. Similarly, her interpersonal caring model has been criticised by Hollway (2006) for excluding the theorisation of self, and its relational development, on which the capacity to care is founded. She fails to consider the hidden, unconscious dimensions of care, yet argues for the need to use psychosocial understandings of how the conscious and unconscious processes of intersubjectivity are involved in the relational acquisition of the capacities to care. For example, as I will show later, Klein's (1946) notion of reparation, influences the quality of relationships with others throughout life. There is therefore a gap in the nursing education and socialisation literature about how the capacity to care develops and how the relation to another person is achieved. This is where I am positioned in relation to thinking about how to nurture the capacity to care in mental health student nurses. Therefore, I now expand on the psychosocial perspective on the capacity to care.

Using the psychoanalytical concept of identification, Hollway (2006, p.14) makes the point:

> '[P]rocesses that are conscious, unconscious, embodied, affective and cognitive, both primary (unthought) and secondary (thought) processes. Without the psychological capacity to identify with others across the boundary that comes to define one individual from another, compassion and concern would be impossible'.

For Hollway (2006) early dependency experiences of maternal care (good enough or not) lay the foundations from which subjectivity, including capacity to care, originates. The intersubjective care relationship is within our bodily memories and the resource of future care giving and receiving experiences. That is:

> '[C]apacities to care are psychosocial, in the sense that they develop as a part of self-development, which is intersubjective, and that the life histories of individuals during the course of this development are inextricably relational and also derive their meaning from their social setting (structures, cultures, practices and discourses)' (Hollway, 2006, p.17).

Tronto (1993) similarly uses the psychoanalytical concept of identification, throughout her work to explain, how attentiveness and/or recognition are achieved. Primarily theoretical she explored inattentiveness and ignorance in carers and their inability to recognise the difference between their own needs and the needs of others, which she described as 'over-identification'. However, Hollway (2006) uses the concept of identification to describe the developmental processes that involve the internalisation of primary carers during the early years. This is because accurate identification is an on-going dynamic, which can be compromised by defence mechanisms employed to safeguard the person from painful feelings (both conscious and unconscious). Identification is a key concept of my analysis and will be discussed further in Chapters Six and Seven.

A psychosocial approach considers context as well as the individuals and groups. While many of the texts on caring in nursing explore the process of nursing they often do so in isolation from the world in which nurses' work. This is a view similarly held by Crawford et al. (2014, p.3592), who use a narrative literature review of the individual and organisational responses to compassionate practice within healthcare. They found the 'focus is on the individual emotional, attitudinal and cognitive factors' involved in compassionate practice'. Individuals rather than the 'threat culture of production-line, metrics-obsessed modern

healthcare delivery' are blamed for the lack of care (Crawford et al., 2014, p.3592). Yet, such systems have been found to hinder compassionate processing (Gilbert, 2009), the experience of threat can also lead to compassion fatigue and to a deterioration in care (Collins and Long, 2003; Gilbert, 2009). Staff are driven to meet time-related targets (a management practice borrowed from business) which in contemporary health care does not always foster compassionate caring relationships. Compliance with guidelines and standards can lead to superficial routine behaviours and not being engaged fully with the caring relationship.

My study offers a psychosocial lens on care. Therefore, I view caring as a cluster of complex processes, difficult to define and open to interpretation: being a caring nurse involves (conscious and unconscious) moral, relational and practical dimensions; it is interwoven, intersubjective and expressed in practical situations. I turn now to what is known about the pedagogical process that influences students' capacity to care. As caring is essential to the work of professional nurses and nursing is grounded in the ethic of caring, the need to accept caring as a primary value in nursing education is crucial (Tanner, 1990; Sawatzky et al., 2009).

Nurse education and learning to care

Whether care can be taught to undergraduate student nurses in adult educational settings is an ongoing debate, although much of the literature explored relating to teaching and learning about care in nursing is not whether students can learn how to care, but how educators can best measure it and design pedagogical situations that facilitate students to learn to care more effectively. In the UK, the requirement for all nurses to be educated to degree level is recent. As already discussed in Chapter One, this has sparked a debate about whether the move towards higher education has been partly responsible for the decline in the quality of care identified by the Francis Report (Darbyshire and McKenna, 2013). While this debate has been popularised by a number of key stakeholders, the argument revolves around the potential that as nurses become more highly educated, and take on ever more complex technological duties, they increasingly delegate and move away from the relational elements of care delivery.

Several empirical studies, both qualitative and quantitative, reveal that nurses' caring behaviours deteriorate over time. While showing that pre-registration nursing students often

enter the profession with a sense of altruism, it diminishes significantly during the three-year course (Curtis et al., 2012; Lowenstein, 2008; Mackintosh, 2006; Murphy et al., 2009). Scholars argue that the apparent decline in compassion and empathy over the course and the first years of training is because reality takes over from an idealised view of the work, creating dissonance. Students and newly-qualified nurses become distanced from patients; balancing patient needs with the pressures and responsibilities imposed by organisations and professional bodies leads to frustration and burnout which negatively affects the quality of care; and, they focus on managing symptoms, illness or disease rather than relating to the individual (Firth-Cozens and Cornwell, 2009; Murphy et al., 2009; Smith, 1992). Conversely, a recent study within a school of nursing used 39 Practice Assessment Documents (PADs)[28] randomly sampled and analysed across both bachelors and masters programmes, using an appreciative enquiry approach found no evidence to suggest that caring behaviour or attitudes diminish over the course of either programme (Young et al., 2018).

This evidence still leaves open the question of what education can do to shape caring capacities. Although caring is one of the integral aspects of nursing practice and education, it is often implicit, assumed and loosely threaded through the curricula (Schwind et al., 2014). There is increasing literature exploring how to teach care, compassion and empathy. For example, using the framework of transformational learning, one study of 108 nursing schools describes how caring can be taught and how such a training programme can affect change in attitude and care (Herbst et al., 2010). Another reports multi-method action research with nurses, patients and family members to identify action plans for embedding compassionate approaches within an elderly care unit. From the results, being supportive, valuing relationships and reflective practice are pivotal to conveying compassion, all of which the authors concluded could be taught and embedded into nursing registration (Dewar and Mackay, 2010).

Recently, there has been a movement to more intentionally re-introduce the 'art of caring' into the nursing curricula and it is of international concern (Begum and Slavin, 2012; Eskilsson et al., 2015; Khademian and Vizeshafar, 2007; Lee-Hsieh et al., 2007; Schwind et al., 2014; Sitzman, 2007). An example of how caring can be embedded in curriculum is

[28] PADs are designed to support and guide students towards achieving the criteria set out in the Standards for Pre-Registration Nursing Education (NMC, 2010). Assessment criteria are based on Essential skills clusters, progression criteria and standards of competence (NMC, 2010).

Eskilssona et al.'s (2015) qualitative study of supervisors' role in an orthopaedic-dedicated education unit in Sweden (based on 8 interviews phenomenologically analysed). The findings show that a reflective attitude in supervision, a clear structure for daily activities, and that when teaching and supervision strategies emphasise the learner's attitude, experience and embodied understanding (lifeworld-led didactics) can promote a learning and caring environment.

The body of research about the content, processes and outcomes of nurse education, whether qualitative or quantitative, tends to neglect elements of individual development, motives for career choice and how these might influence student responses to education and social behaviours. Caring is a way of being, thinking and doing within relationships with oneself and with others, the task of self-discovery is a co-constructive process that requires creative self-expression and critical thought. For this reason, a psychosocial framework sheds light on previously neglected dimensions of nurse education and the influence this has on caring capacities in students. However, as suggested above, it is not enough to care about others within nursing, there is also the need to provide care to and for others, and this requires the ability to think critically about the care provided.

A Review of Critical Thinking and Nurse Education

The rapid growth of technology and knowledge within healthcare requires nurses to problem solve to make effective clinical decisions. As discussed previously, mental health nurses work with individuals with the most severe mental ill health that involves complex problems: often several options need concurrent assessment to decide the most appropriate course of action. Making the right decision often plays a vital role in safeguarding patients' lives and assisting in their recovery. This is why critical thinking is so crucial in nursing (Ozdelikara et al., 2012). There are many studies that have emphasised the need for critical thinking in nursing and the tertiary sector more generally (Carter et al., 2015). However, there is a gap in our understanding of the relationship between the characteristics of critical thinking as related to caring behaviours and dispositions. In this section, I clarify what is already known about critical thinking in nursing and nurse education before concluding with the rationale for a psychosocial approach to examine both capacities simultaneously.

Research on critical thinking in higher education falls into two broad categories. The first is response to a perceived need for a consistent and precise definition of the term, evident in the view that critical thinking 'is another concept whose value is diminished by terminological disarray' (Gabannesch, 2006, para. 1, see also Black, 2008; Tsui, 2002). This category typically includes investigations into the relationship between students' dispositions, perceptions and learning outcomes (see, for example, Sulaiman et al., 2007; Trigwell, Prosser, and Waterhouse, 1999). The second category relates to pedagogical approaches, which, in turn, are described as either standalone programmes, or contextualised into existing studies or activities. When critical thinking is taught as a standalone course, it is typically within more general academic skills programs (see, for example, Tapper, 2004; Van Gelder, 2000). Investigations are typically undertaken to measure the efficacy of these courses or their transfer of learning to specific disciplines. The standalone option is challenged by criticism of critical thinking as a "free-floating entity" (Moore, 2004, p.5); a contention which has implications for the potential to either teach or test critical thinking out of context. I will discuss both categories in relation to nurse education.

Defining critical thinking

According to Riddell (2007) the definition of critical thinking comes with associated terms, 'critical analysis', 'decision making' and 'clinical reflection' all requiring explanation. In spite of Scheffer and Rubenfeld's (2000 - see below) attempts to explain critical thinking, nursing studies tend to use a variety of different definitions and dispositions (Brunt, 2005; Simpson and Courtney, 2002; Turner, 2005). This perhaps highlights how the concept of critical thinking skills and dispositions are not fixed but change and need to be viewed in context (Chan, 2013). Despite the difficulties defining it, there is a consensus that critical thinking is a desirable outcome of education, particularly in relation to professional and higher education (D'Angelo, 1971; Pardue, 1987, McMillan, 1987) and can be seen within accreditation standards (NMC, 2017) and government policy (Facione et al., 1995). Society as a whole is considered to benefit from critically thinking people, and is considered fundamental to maintaining democracy (Glaser, 1985; Paul, 1984).

Central to this interpretation of critical thinking is a realisation that it is not a method to be learnt, but rather a process, an orientation of the mind and so includes both the cognitive and affective domains of reasoning. The confusion about definition led to the formation of a

critical thinking Delphi Project in 2000 focusing on finding consensus about the meaning of critical thinking within nursing, experts from nine countries and 23 states of the USA were involved. 88% agreed that critical thinking is:

> '[A]n essential component of professional accountability and quality nursing care. Critical thinkers in nursing exhibit these habits of the mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance and reflection. Critical thinking in nursing practice involves the cognitive skills of analysis, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge' (Scheffer and Rubenfeld, 2000, p.7).

Using this approach, critical thinking encompasses both cognitive skills and 'habits of mind' or dispositions considered necessary to manage complex care situations, in an ever-changing environment that calls for increased accountability (Mong-Chue, 2000; Muoni, 2012; Pucer et al., 2014). Here critical thinking is seen as the foundation for self-reliance and professional functioning (Jones and Brown, 1991) and underpins competent nursing practice (Bauwens and Gerhard, 1987; Facione and Facione, 1996; Paul and Heaslip, 1995). Furthermore, it has been identified as improving patients' outcomes by facilitating nurses to use more evidence-based practice rather than 'guesstimating' appropriate action (Profetto-McGarth, 2005; Scheffer and Rubenfeld, 2000). The assessment of professional competencies has occurred parallel with and linked to managerialisation. It has transformed professional education emphasising its performative dimensions (Dominelli, 1996; Froggett and Sapey, 1997; Clarke et al., 2000). Competence measurement has generated increasingly formulaic learning as students struggle to fit the ambiguous experiences of practice and their ambivalent feelings about it into demonstrable skills appropriate to routinised and risk averse settings.

Within this thesis I use Scheffer and Rubenfeld's (2000) definition of critical thinking as it is possible to see how outcomes are measured and enables students to learn how to perform tasks and meet their competencies, however further dimensions are required as students need critical *contextual* awareness *and* an understanding of the intersubjective relations that occur within the practice (and educational) setting. There is the need to recognise that in practice situations both conscious intentions and unconscious projections influence all parts of the system. Because (by definition) the unconscious elements are difficult to realise there is the

need to apply psychoanalytical thinking of the type that has been developed within professional relationship-based practice (Trevithick, 2003, 2012). This can sustain complex, ambivalent reactions to situations which incite manic hope, unreasonable despair, traumatised inaction or overt aggression, and the ongoing experiences of identification and projection to which the student may experience in the course of an ordinary working day. That is, there is also the need to consider the emotional factors that influence and guide intuitive thinking as these are likely to interrupt the thinking or reflective processes. There is the need to consider how emotions might influence judgement or the capacity to learn; there is the need to develop ways of exploring the unconscious, defended dimensions of subjective experience, unavailable to reflective cognition. Some of these shortcomings have been addressed by authors advocating Critical Reflection (for example, Fook et al., 2006) which have sought to combine the insights of reflective practice with the critical promise of social constructionism. I return to this in Chapters Seven and Eight.

Having identified my position on critical thinking I next explore the empirical studies found that consider the influence pedagogic experience has on critical thinking in nursing students.

Pedagogical approaches to critical thinking in nursing students

The NMC (2017) require nursing programmes to measure students' development in critical thinking as a competency. Although as discussed earlier finding a definition is problematic let alone measuring it, much of the research found is quantitative. During the 1970s there was a dominant 'skills' approach, for example, evaluation, deduction and clarification (Brown and Cook, 1971). Critics objected to lists of skills because the studies ignored the question of application (Siegel, 1988; Daly, 1998). Since then, tools have been developed to measure reasoning skills needed for reflective decision-making concerning what to do, for example, the California Critical Thinking Skills Test (CCTST) (Castledine, 2010; Di Vito-Thomas, 2005; Leppa 1997). Since the 1990s, further tools have been developed and used in nursing to measure the relationship between critical thinking and affective dispositions (Colucciello 1997; Lacey, 1986). However, this predominant quantitative approach using pre-test/post-test assessments is criticised for providing limited information about change, ignoring individual variability, including the effects of past experiences (Willet, 1997)

Qualitative studies evaluating critical thinking include Oermann et al.'s (2000) suggestion to ask students to analyse a clinical situation, identify and choose among options available and provide a rationale for the decisions made. Ironside (1999) adopted a qualitative approach to study the acquisition of critical thinking skills in 45 students and faculty members. She asked them to reflect on their teaching and learning experiences to uncover dialogue regarding students' ability to interpret new and changing situations. In 2002-2011, Chan (2013) undertook a systematic review of qualitative studies related to critical thinking in nursing education, of which 13 discussed educational strategies for promoting critical thinking. Between them the strategies mentioned were: questioning (Jenkins, 2011; Myrick, 2002; Raymond and Profetto-McGrath, 2005; Twibell, Ryan and Hermiz, 2005); reflective writing (Callister et al., 2009; Jenkins, 2011; Kaya et al., 2011; Mun, 2010; Raymond and Profetto-McGrath, 2005; Twibell et al., 2005); and, case-based interventions or problem scenarios (Jenkins, 2011; Kaddoura, 2010; Rush et al., 2008; Twibell et al., 2005). Further strategies used within undergraduate programmes were art-based workshops (Casey, 2009) and concept maps (Hicks-Moore and Pastrik, 2006).

Only one study in Chan's (2013) literature review explores the relationship between critical thinking and caring behaviours. Karadag Arli et al. (2017) cross-sectional study of 167 Turkish student nurses enrolled on a four-year nursing course obtained data using a caring nurse-patient interaction scale (CNPI) and the critical thinking disposition inventory (CCTDI). This study found a positive relationship between overall critical thinking disposition and caring behaviours. Students with greater caring behaviours reported more positive critical thinking dispositions (Pai and Eng, 2013). It is possible that caring motivates students to listen to and consider patient demands, which provides a foundation for critical thinking and the provision of high-quality care.

Nevertheless, controversy remains about what critical thinking is and the effectiveness of the tools used to measure it (Adams et al., 1999: Stewart and Dempsey, 2005). It also remains unclear how critical thinking dispositions are developed (Redding, 2001). Despite the assumption that critical thinking can be learnt, there is mixed evidence that nurse education is effective in developing critical thinking skills and disposition in students (Daly, 2001; Hoffman, 2006; Lees et al., 2013). Indeed, like the studies into care and compassion, some of the research suggests that rather than enhancing critical thinking over the three years, students' abilities may decrease during the course (Duchscher, 1999; Facione and Facione,

1996). It is also assumed that critical thinking improves the quality of nursing practice: it is viewed as an alternative to routine and 'formula-driven' way of nurses dealing with the array of health and social care situations that they will encounter (Riddell, 2007).

It is important to note that as nursing attempts to become a research-based profession, ritual and routine has become stigmatized and associated with thoughtless repetition. However, within the world of nursing, ritual and routines affect the delivery of care (Menzies-Lyth, 1959; Procter, 1989; Walsh and Ford, 1989; Annandale, 1996; Allen, 1998). Ritual serves social functions that often go unnoticed because they are embedded in the common-sense, everyday understanding of the world. The persistence of ritual is thought by Parker (1999) to be due to a lack of familiarity with the research. Procter (1989) and Allen (1998) suggest that the routinisation of nursing work assists its management and the audit process. In addition to these reasons, ritual persists because it signifies and communicates meaning (Douglas, 1970). It also serves as a means of transmitting culture from one generation to the next (Helman, 1980). Furthermore, it lessens the emotional impact produced by the intimacy in nursing by re-signifying the situation and it is invisible. Many behaviours become ritualised without their participants knowing (see for example, the change-of-shift handover ritual by Evans et al., 2008).

In the nursing literature, Menzies-Lyth (1959) was amongst the first to recognise the importance of emotional factors such as anxiety in structuring the organisation of nursing work. She proposed that nurses should examine the 'use of primitive psychic defence mechanisms' if the profession intends to mature and develop. Much has changed within nursing since this time, yet the lessons about the emotional aspects of nursing are still being neglected. In this modern healthcare environment, with its complex technology and patient interventions, nurses do require critical thinking skills. Therefore, (as identified above) many studies have emphasised the need for the development of critical thinking in nurses. However, there is a gap in our understanding of the dimensions of critical thinking as related to certain behaviours, especially caring, which is still considered the core of nursing. Only one study found by Karadag Arli et al. (2017) explored the relationship between critical thinking disposition and caring behaviours of nursing students. In their cross-sectional study of 167 nursing students on a four-year nursing course in Eastern Turkey they found a positive relationship between overall critical thinking dispositions and caring behaviours (R = 0.470,

$p < 0.01$). There findings indicate that the development of the intellectual capacities of student nurses as independent critical thinkers, also developed their capacity to care.

Given the psychosocial premise of this study it is perhaps not surprising Karadag Arli et al. (2017) found that as intellectual capacities develop so do caring capacities. From a Kleinian perspective developmental processes starts in early life and involves the internalisation of primary carers, this contributes to the development of self as well as the capacity to care. Likewise, Bion (1961) uses the metaphor container-contained to picture this emotional experience of care and being cared for as the experiential foundation for the child's ability to think. Thus, from this theoretical perspective both capacities are inextricably linked, however both capacities can be seen to be linked within nursing practice, as for example, it is not sufficient for nurses to care about their patients, they also need to think about the most appropriate action to be taken with the resources available to them and the patients they work with in order to provide the most effective care.

This study therefore aims to consider both capacities simultaneously as both can be viewed as a part of the developmental process, they are both relational and necessary in providing the most appropriate care. A psychosocial approach is warranted as given the defence mechanisms identified in the previous chapter, when faced with uncertainty, both caring and thinking capacities can be thwarted, so both need to be viewed in conjunction if better ways to enhance their development can be found to improve mental health nursing practice.

Conclusion

This chapter was divided into two main parts. The first part provides a synopsis of mental health and illness and the role of the mental health nurse, before a critical review of literature about career choice applied to nursing, and more broadly, the motives for altruistic helping behaviours in mental health professionals. The absence of research into the motives for choosing mental health nursing as a career, provides a rationale for this study. Career choice is seen as a lifelong dynamic process involving interacting personal and environmental factors. A psychosocial approach to explore career choice is thus indicated. In the second part I evaluate literature about professional socialisation and nurse education's influence on students' capacity to care and think critically. The concepts of care and critical thinking are ambiguous, complex, open to interpretation and difficult to evaluate in nurse education, yet

both are considered necessary for competent compassionate mental health nursing within contemporary healthcare provision. Thus, this study uniquely considers both capacities concurrently within the context of mental health nurse education from a psychosocial perspective.

The psychosocial framework from which I explore previously neglected dimensions of research about choosing a career as a mental health nurse, nurse education and the influence these have on both the caring and critical thinking capacities is provided in the following chapter.

Chapter Four

Aligning Methodological Approach with a Psychosocial Ontology

Introduction

In chapter two I established that the psychosocial defended subject (underpinned by key psychoanalytical ideas) forms the ontological basis for this research. This is the first chapter dealing with how I designed and carried out my research. The chapter is divided into three sub-sections dealing with the features of a psychosocial ontology, the selection of a methodological approach which is congruent with narrative methodology based on co-constructed life grids and Free Association Narrative Interviews (FANI) used within this study. The next chapter will focus on the concrete details of the research.

Paradigms are belief systems or theories that guide the way researchers approach problems, or establish a set of practices. They are characterised through their ontology (assumptions about what constitutes reality), epistemology (assumptions about how we know what we know) and methodology (assumptions about how we find out about it). These characteristics in turn create a holistic view of how knowledge is viewed; our relation to this knowledge and the methodological strategies used to discover it (Guba, 1990). The following, three sub-sections cover my assumptions, views and approaches within this study.

Features of a Psychosocial Ontology

A psychosocial ontology shaped the research methodology I have pursued. From a psychosocial perspective, reality is an intersubjective and relational process; it is complex, dynamic and constructed internally through the reciprocity of people interacting. Moreover, we make sense of our experiences of ourselves and each other within wider social systems (Crotty, 2003; Cousin, 2009). Klein's (1940) proposal, discussed in Chapter Two, identifies that reality interacts with unconscious phantasy and vice versa, so that our unconscious influences our understanding of reality and perceptions of self and others. These characteristics apply also to the research environment and the data this generates. For research purposes, reality is intersubjective and understood through different interactions and so it is relational and developed within social relationships. This means, for me, there is no

definitive true knowledge. Arriving at truth is a result of our intersubjective views based on consensus. Social reality is a creation of each person's consciousness/unconsciousness emerging from a multiplicity of interactions rather than a fixed phenomenon out there, independent of those involved in its construction (Bryman, 2012).

The term 'defended subjects' is principally associated with Hollway and Jefferson (2013). Defended subjects invest in particular positions in discourses to protect vulnerable aspects of self, an essentially psychosocial phenomenon noted by Gadd (2004c). Walkerdine (1997) describes the need that is sometimes felt, perhaps unconsciously, by subjects in ethnographic work to keep levels of anxiety down. Of primary importance to the notion of psychosocial subjects (who are also the research subject) then, is their habitation in a world of lived experience, including differentiation and oppression arising from the structural realities of class and gender, disability, age, sexuality, race and culture (Frost, 2008). In recent years, a number of scholars have highlighted and challenged prevailing conceptualisations of humans in different disciplines and areas of research in the social sciences (Buckner, 2012). Focusing her critiques on views of humans as socially constructed and rationally motivated, Buckner (2012) has argued in favour of a psychosocial understanding that does justice to the complexity of human beings.

In a similar vein, Roseneil (2006, p.849) notes a prevalence of 'a social constructionist ontology, which assumes the existence of a rational, unitary intimate subject'. Roseneil (2006) highlights a lack of attention of constructionist approaches in general to irrational and unconscious motivations, which for her are critical in understanding humans. Inadequate views of the human subject have also been perceived to have predominated in research on crime and the fear of crime. Hollway and Jefferson (2013) point out a tendency among criminologists and sociologists studying fear of crime to assume a socially constructed and/or rationally driven research subject. They consider such conceptualisations problematic as they fail to enable adequate explanations of differences in people's fear of crime.

As Hollway and Jefferson (2000) argue, taking the inner world as part of a psychosocial project demands an understanding of people and their actions as not only consciously but also unconsciously motivated, and this points to the need to incorporate psychoanalytic understanding into social science. Hollway and Jefferson (2013) work with a postmodern psychoanalytic ontology in conceptualising humans as non-rational, non-unitary 'defended

subjects' as a way of accommodating a dynamic unconscious that defends against anxiety and affects people's positioning and investment in available social discourses. Gadd and Jefferson (2007, p.4) argue that:

> '…[T]aking the inner world seriously involves an engagement with contemporary psychoanalytic theorizing because only there, in our view, are unconscious as well as conscious processes, and the resulting conflicts and contradictions among reason, anxiety and desire, subjected to any sustained, critical attention'.

Making a case for a conceptualisation of the human subject as psychosocial that is informed by psychoanalytic thinking, Henriques et al. (2004, p.206) emphasise that 'psychoanalysis challenges any attempt to separate the individual and the social, and to think about this individual in terms of its consciousness of self or a unitary capacity for rational action'. Within psychosocial theory, psychoanalytically informed theories of subjectivity are the preferred psychological approach, because they assume a dynamic and mutually constituting relation between the psychic and the social (Buckner, 2012). In undertaking my research, my understanding, like Hollway (2009, p.150) was that:

> '… [T]here are two grounds for believing that a psychoanalytically informed paradigm can enrich psychosocial research methods; epistemological and ontological. Epistemologically the paradigm can help the use of researcher subjectivity as an instrument of knowing. Ontologically it can inform an understanding of participant subjectivity. Of course, these two reasons are intimately linked because a psychoanalytic emphasis on unconscious dynamic intersubjectivity ensures that the focus of both epistemology and ontology is on the affective traffic within relationships, be it the relationship between researcher and researched or those of participants in their life world, past, present and anticipated future'.

Within this study I worked against the positivist notion of the researcher as a disengaged 'objective' participant. This helped to challenge the positivist idea of the value-neutral researcher by acknowledging the values I espouse as a registered mental health nurse, nurse educator and as the researcher on the process and the outcome of the study (Clarke and Hoggett, 2009). For example, I suspect that my selection of research subject stems from some unresolved past childhood conflict related to my own career choices that is now disguised as

professional interest in the form of a PhD. Thus, I acknowledge that my unconscious has been influential both in the choice of research topic; in the interplay between myself and those involved in the study; and in how I have interpreted the data (Hollway and Jefferson, 2000).

At this point, I want to stress that I was consciously aware not only that university students as a group are prone to mental health problems, but also, as my research implies, that mental health nursing students might be more so. Moreover, I was aware that my own unconscious biases might intrude in a potentially harmful way in my discussions with the students about their motivations and experiences. I was particularly alert to avoiding manipulating and or coercing students into revelations they might be unwilling to give, especially as I was a tutor (albeit not theirs). Safeguarding against this took the form of reflexivity and the use of relational ethics as I monitored my own feelings, thoughts and observations and operated from a position of mutual respect and kindness. I give concrete examples of the strategies employed in the section 'Ethical Conduct of the Research' in Chapter Five (p.116-120). I was always ready to refer students to the University's 'Wellbeing Services', especially as there was no supervisory support for them (I discuss this further in Chapters Five and Eight).

I initially intended to draw on the external circumstances of the mental health student nurses as their intersubjective lived experiences of career choice and pedagogical experiences in relation to caring and critical thinking behaviours and dispositions. Yet as this study progressed, I realised that the student mental health nurses were subjects whose lived experiences of the world regarding career choice and pedagogical experiences cannot be fully understood without knowledge of the way in which their inner worlds allow them to 'experience the outer world' (Hollway and Jefferson, 2000, p.4). I needed to find a methodological approach that stayed grounded within this psychosocial ontology, not only to help demonstrate the trustworthiness of the findings of this study but also as a novice researcher to find a set of practices dictated by empirical, qualitative, and psychosocial field-based research (Frosh and Baraitser, 2008). The following section explores the methodological approaches used within this study.

Selection of Methodological Approach

In this study I was interested in understanding the coexisting dynamics of the internal context interacting with the external social (psychosocial) worlds of student mental health nurses in relation to their career choice and pedagogical experiences. The students' realities regarding career choice and pedagogical experiences are dynamic and could be negotiated dialogically. Surveys, questionnaires and quantitative analyses of behaviour are not sufficient to capture the complexity of meaning embodied within students' past life experiences in terms of career choice or the nuances of their pedagogical experiences within mental health nurse education (Mitchell and Egudo, 2003). Such complexities and nuances are amenable to the use of qualitative research. Yet, as an interpretive activity qualitative research 'privileges no single methodological practice over another' (Denzin and Lincoln, 2000, p.6). There are complex and interconnected terms, concepts and assumptions that are associated with qualitative research for example, poststructuralism, feminism, Marxism. There is a wealth of separate and detailed literatures on the many methods and approaches that fall under the category of qualitative research (see for example, Denzin and Lincoln, 2000; Alvesson and Skoldberg, 2009). In the following section I first explore ethnography and phenomenology in terms of what they may offer and what they did not in relation to this research, before demonstrating the rationale for choosing narrative methodologies based on co-constructed Life grids and Free Association Narrative Interviews (FANI) used in this study.

Ethnography has its origins in anthropology and historically involved western academics studying other cultures (for example, Mead studying sexual mores in Samoa). Living with, observing and talking with others (immersion) for long periods of time enables researchers to piece together the meanings of the culture. This is based on the premise that if we want to understand the 'other' and how they behave we need to watch and wait (while suspending taken-for-granted understandings) for the meaning of what is observed to present itself. While ethnographic approaches within social research are no longer just that of cultural anthropologists it can be viewed as a qualitative research process and/or method (conducting ethnography) and product (the outcome is an ethnography) all aimed at finding the 'insider's view' of his or her social world. This approach is not just about describing experience but also about representing and understanding the significance or meaning of that experience (Geertz, 1973). The term ethnography has come to be equated with many qualitative

approaches where the intent is to provide details of in-depth description of 'ordinary' life and practice from the point of view of the subject of the study.

Focusing on the collective experiences within certain cultures, ethnographic data is often collected through interviews, participant observations and analysis of documents and artefacts and tends to take a long time. Participant observation and interviews are central to ethnographic data collection methods. Within this study, participant observation would have been possible on-campus, however interest in past life experiences and the diversity of the clinical placements in the off-campus settings and the geographical dispersion of the participants, participant observation was not a feasible option. A convenient sample recruited for the study provided multiple sources of data based on the varying experiences, both personally and professionally. This approach enabled me to compare self-reported incidents amongst participants. While ethnography emphasises the collective experiences within a certain culture phenomenology concentrates on the individual experiences.

Phenomenology is one of the main 'intellectual undercurrents' (Bryman, 1988, p.51) which may typically be regarded as providing qualitative research with its own specific epistemology. Qualitative research has close associations with the phenomenological tradition. Phenomenology as a research approach is of the interpretivist tradition with roots in philosophy and conceived at the start of the twentieth century by Husserl (Holstein and Gubrium, 2005). The term phenomenology does not describe a single philosophical perspective. As an umbrella term, phenomenology encompasses the transcendental phenomenology of Husserl, the existential phenomenology of Merleau-Ponty, Sartre and Schutz and the hermeneutic phenomenology of Heidegger. The phenomenological view of the world rejects that of the empiricist, whereby real knowledge can only be derived by placing distance between how humans experience the social world and the theory that describes it. Indeed, some social scientists have arrived at a view that positivism is deceptive because it inclines towards a reliance on superficial facts without taking account of the underlying mechanisms observed or what they might mean to people (Bryman, 1988).

The focus of phenomenology is people's interpretation of their social experiences and the different ways in which these are expressed. Therefore, the phenomenologist wishes to gain a full understanding of the way people being studied experience the social phenomena being explored. This aim of gaining a thorough understanding of the social phenomena through the

lived experience of subjects is what identifies phenomenology as a philosophy in addition to a research methodology. In particular, phenomenology aims to identify and describe the lived or subjective experience of the research participants through examining that experience from their point of view, with the emphasis on attending to how the social world is made meaningful to the participants (Holstein and Gubrium, 2005).

My own position within the study is one of immersion within the research area, being a mental health nurse working in higher education, this allowed certain insights into the study data. Significant debate in the literature exists on the advantages and disadvantages of having this insider perspective to the research subject. Often described as a dichotomous idea (the 'etic' outsider and the 'emic' insider) (Young, 2005) with the researcher being positioned as either an insider or being an outsider to the research process. Criticism of emic research from a positivist perspective is often aimed at its lack of objectivity and therefore it is argued that it lacks reliability and validity. Conversely, Brayboy and Dehyle (2000) argue that trustworthy knowledge from a cultural group can only be provided by someone from within the community. They argue that this lack of sharedness is a barrier to authentic understanding (cited by Loxley and Seery 2008); a view shared by Bourdieu (1988, p.27) who suggests that insiders have 'a feel for the game and the hidden rules' but asserts the need to challenge assumptions based on insider knowledge, for example, tacit knowledge leading to misinterpretation of data; as well as looking for new, underlying meanings from participants. With this in mind I recognise that I have insider knowledge and experiences of the systems, practices and procedures all of which influences the way I behave and in which direction I proceed, it is important to recognise what is 'me' and what is the students' experience and to ensure that assumptions can be challenged and to get a better sense (more trustworthy account) of the students' experiences.

It can be argued that all investigators of human behaviour are positioned ambivalently. As social beings we are therefore, emic in certain situations and etic in others (Adler, 2004). Furthermore, when examining a social phenomenon, it is not always possible to identify who are insiders or outsiders and, indeed, that one may have characteristics for both groups at the same time. Therefore, a dichotomous view of the insider-outsider may not always be helpful (McCulloch, 2008). Mercer (2007) elaborates and suggests that a continuum with multiple dimensions is more appropriate as the researcher slides along the scale depending on the

location of participants and the varying levels of insiderness. That is, the boundaries of insider-outsider should be regarded as permeable as multiple identities (or roles) are possible.

The term 'psychosocial' covers a varied range of research approaches and indicates a shift of emphasis away from dualistic thinking to questions of subjectivity and the forces that shape it (Clarke and Hoggett, 2009). Lucey et al. (2005) argue that to get beyond conscious and rational explanations of people's behaviour requires a greater understanding of how the psychic and social processes that influence behaviour come about. A psychosocial approach represents a critical stance that challenges the notion of the 'rational and autonomous human' that has characterised social understanding and policy since the Enlightenment (Frost and Hoggett, 2008). Bracketing off rational epistemology and methods is crucial so that the confused and contested aspects of career choice and pedagogical experiences can be explored.

This heterogeneous psychosocial field draws on feminist, anthropological, poststructuralist, discursive and psychoanalytic bodies of theory and research as well as continental philosophy (Clarke and Hoggett, 2009). It enables interdisciplinary non-rationalist, non-reductionist means of conceptualising the connections between body, psyche and society and advocates methodological and theoretical pluralism (Frosh, 2003). In this vein, psychosocial approaches are highly concerned with the philosophical underpinnings to the theories they call upon. The psychosocial field is fundamentally concerned with subjects and subjectivity and provides critical analyses of the tensions between external social and internal psychic formations (Frosh and Baraitser, 2008). Most importantly, psychosocial approaches recognise that the dichotomies of individual-social and psychology-sociology are unhelpful to studies in these areas (Clarke and Hoggett, 2009) and enable a reflexive account of the research process.

Since life experiences are illuminated via social processes between the researcher and the participant, the inquiry is epistemologically relativist, transactional and subjectivist (Denzin and Lincoln, 1998). Adopting a relativist stance recognises that 'there is no objective truth to be known' (Hugly and Sayward, 1987, p.278) and emphasises the diversity of interpretations that can be applied to the world. Transactional means that understanding arises from the interactions between elements within situations (Berlin, 1987) and is the product of these interactions (constructed realities). It rejects the positivist paradigm that sees the researcher as the expert and objective in their collection and interpretation of the data (Bryman, 2008). The

epistemological stance is thus that of 'not knowing' and psychoanalytic understanding is drawn on in order to try and explore beneath the surface. Given the under-researched and invisible nature of mental health nursing and mental health nurse education, the research design was deliberately conceived as flexible and evolved over the course of the study from the initial conceptualisation, data generation, analysis and writing up.

The turn to language in the social sciences has opened up research to a variety of qualitative methodologies and methods, which emphasise the importance of meaning and context. However, most of the qualitative approaches such as ethnography, interpretative phenomenology, critical realism, discourse analysis and narrative analysis still assume rational, unitary subjects, if not explicitly, then by default (Hollway and Jefferson, 2011). In contrast a psychosocial approach utilising the Free Association Narrative Interview (FANI) method assumes that all individuals involved in the research process are defended subjects. Defended subjects invest in particular positions in discourses to protect vulnerable aspects of self, an essentially psychosocial phenomenon also noted by Frosh et al. (2003) and Gadd (2004c). Exploring student nurses' capacities to care and think critically when they may be struggling to do either is likely to produce defended subjects. Thus I (like Hollway and Jefferson, 2000) work with a psychoanalytically-informed model of the 'defended subject' as it considers the effects of defences against anxiety in the narratives that people produce.

The application of psychosocial approaches and thinking is extremely broad and this eclecticism lends it to the study of student mental health nurses in relation to their career choice and pedagogical experiences. In the following section I explain the narrative methods used within this study.

A Narrative Methodology Based on Co-Constructed FANI Interviews

Positioning individuals as psychosocial defended subjects recognises that anxiety is an inherent human condition, and that the unconscious mind defends against it, which influences behaviours, lives and relationships. Consequently, unconscious defences against anxieties come into play for both interviewee and interviewer and are part of the dynamics of the interaction (as is the case for all relationships) (Hollway and Jefferson, 2013). I did not consider the role of myself as researcher as simply eliciting narratives from the students, as if the life of the interviewee is 'just there' waiting to be described. Rather, the interview process

and its resulting narratives were coproduced through the unique interaction and relationship between myself and the students. Negotiating the parameters of the coproduced narratives was an ongoing process whereby power and responsibility was shared, throughout the interview process. I took sole responsibility for the writing up of this thesis once the students had agreed that the interview transcripts authentically represented their thoughts and feelings. How this was done is explored further under the 'Conduct in the Main Interview' section (p114).

The concept of a psychosocial defended subject recognises the different levels of awareness, perceptions and experiences and identifies that we do not always know why we think, say or do things; and/or whether it is possible to articulate these occurrences to someone else. From this perspective, the notion of a private authentic self that can be accessed directly by an interview process is problematic. Truth, or meaning, comes into existence through engagement with the external realities of the world. Consequently, social reality is not fixed but it is flexible (within given parameters) and explanations of a situation are created by human interaction/social construction. These interactions are themselves enactments of meaning frameworks, structures, and are organised as narratives. That is, narratives are a fundamental way in which we organise our understanding of the world (Bruner, 1987; Cortazzi, 2001; Fisher, 1984; Gabriel, 2000; Griffin, 2009; Polkinghorne, 1995).

This approach draws on what Bruner (1987) describes as 'narrative knowledge', which is created and co-constructed through the stories people tell about their lived experiences, and the meanings they give to those experiences over time, that might change and develop as their stories unfold. This kind of knowledge construction invites us to pay attention to the details of stories and the contexts in which they are located. An individual's life story is embedded in the narrator's history, culture, language, gender, and beliefs (Plummer, 1983). Ontologically, there is an alignment with the critical paradigm because of the broader social reality that is captured in the research process (Denzin and Lincoln, 1998). The connection between the individual's life events and social events distinguishes the life history narrative from other narratives, and so provides a social context in which personal experiences are located.

From an interpretivist perspective, the narrative interview is based on the idea that people produce narratives about the self and identity through time that draw not only on their own experiences and understanding, but on culturally circulating stories that help them interpret

and make sense of the world and themselves in it: ‘They are interpretive devices through which people represent themselves, both to themselves and to others’ (Lawler, 2002, p.246). So, over time the approach in this study led to the third position where I regarded myself and the participant as co-producers of the narrative. Meanings and understandings were created in an interaction, which is effectively a co-production. The data was a product of the research process, not simply observed objects of it (Mason, 2002).

The concept of free association was developed by Freud (1938) who would invite patients to relate to whatever comes into their minds during the analytic session and not to censor their thoughts. This technique is used to help individuals learn more about what they think and feel and relies on an atmosphere of non-judgmental curiosity and acceptance. The method of free association has no linear or pre-planned agenda and can be used to access unconscious affective memory (Campbell, 2006). Free association works by ‘intuitive’ leaps and linkages which may lead to new personal insights and meanings; 'the logic of association is a form of unconscious thinking’ (Bollas, 2008, p.21). It assumes that all memories are arranged in a single associative network, and so all may be considered as being relevant (Bollas, 2008).

The evidence to support whether the use of free association is a useful technique in psychoanalytical therapy is contentious (see Fonagy, 2003). In the current neo-liberal climate with the focus on outcome and symptom reduction measures, psychoanalysis compares poorly with other therapies (e.g. Cognitive Behavioural Therapy) due to its’ long duration. Considering this, the application of a psychoanalytic technique to brief one-to-one interviews at first appears unusual, however, free association is a technique where the information produced is unpredictable but matters very much to the interviewee. The stories told, details, points and morals, as well as the way information is shared, contain personal, deep significance arising from the students’ unconscious, and in this way, shares common ground with the free association methods used within psychoanalysis.

However, transferring the free association as a method of treatment into a research method is not without its problems and maybe viewed as incompatible. That is, the purpose of a therapeutic interview is the facilitation of change within the patient. The knowledge gained through therapy can help to instigate the changes required, however this is often viewed as a side effect of helping patients come to terms with their distress. The qualitative research interview by way of contrast may be seen as a construction site for knowledge production,

any changes in the subject is viewed as a side effect (Kvale, 1996). To Freud the psychoanalytic interview was not only a method of treatment, but it was also the research method upon which psychoanalytic theory is based: 'It is indeed one of the distinctions of psychoanalysis that research and treatment proceeds hand in hand' (Freud, 1963, p.120). The main difference is when and where analysis occurs, in the therapeutic relationship this occurs during the therapy session, while, for research purposes, analysis tends to occur after the event. Both approaches enable the analyst and researcher to consider unconscious dynamic processes which are considered attempts to defend against anxiety and can be used to identify incoherence. Examples of these are: contradictions or avoidance; their significance in relation to the story being told and the relationship to the person who they are telling the story to.

Some theorists (Frosh and Baraitser, 2008), while sympathetic to psychoanalysis, have been critical of attempts by researchers working with the FANI method, to adopt clinical concepts such as transference and countertransference to inform data analysis. It has been suggested that these concepts are products of the clinical encounter and are based on the development of a therapeutic relationship between analyst and the person undergoing psychoanalysis, where the latter transfers feelings about figures from their past onto the analyst and cannot therefore be transferred to the research setting. Where this shift occurs, there is a danger of the concepts being used inappropriately in the interpretation of the interviewee's unconscious anxiety. Taking up the idea of the defended subject, another criticism concerns the attribution of anxiety to the interviewee. It has also been argued that non-clinically trained researchers fail to recognise that the anxiety they attribute to the interviewee, is actually an unrecognised emergent feature of the interviewer's unconscious anxieties and desire (Frosh, 2010; Frosh and Baraitser, 2008), particularly for the production of relevant data. As discussed in Chapter One, I am not a psychotherapist but a mental health nurse with 20 years of experience of working with individuals with mental health problems and their families. I am also used to working with student nurses to explore their educational experiences and supporting them when their life circumstances impact upon their studies. I therefore felt competent interviewing student nurses about their pedagogical experiences, yet I was also interested in students' past life experiences as already discussed in Chapter Three, little is known about the motives for choosing mental health nursing, what there is tends to disembody the individual, ignoring past life experiences. This psychosocial approach provides a way to understand and make sense of what influences the choice to become a mental health nurse and how such influences affect behaviours, feelings and relationships.

Biographical narrative interviews however, can be extremely time consuming. Full life histories can take days to complete (Horsdal, 2011), and as such can be resource-intensive (Abbas et al., 2013). To resolve this problem, researchers have developed ways of focussing the interview towards the aspects of life that are considered pertinent to the area of study (Brannen and Nilsen, 2011). Given the psychosocial perspective of this study, early life experiences are considered particularly important in terms of shaping personality development, the capacities to care and learn and the way people form social relationships (Bott Spillius et al., 2011; Klein, 1940; Bowlby, 1979). Complex relations have been found to exist between students' biographies and their higher education experiences (Malcolm and Zukas, 2001; Haggis, 2003; McLean, 2006; Ashwin, 2005) and as such are pertinent to this study.

Life grids are one method that have been found to help the focus of biographical interviews, while still generating rich data (Brannen and Nilsen, 2011; Abbas et al., 2013). Originally designed by Gallie (1988) in *Britain for the Social Change and Economic Study*, life grids have been further developed and tested to consider the relationship between socio-economic disparities of physical well-being and ongoing exposure to health-damaging housing and working environments (Holland, et al., 1999; Blane, 1996). The life grid method is based on the notion that the reconstruction of a life history is a mutual endeavour and when completed and viewed in conjunction with interview transcripts, prompts us to explore new ways of understanding (Parry et al., 1999; Wilson et al., 2007). The structure has been found useful for generating equivalent data for each of the interviewees, making comparisons and analysis easier than using data recorded and transcribed from biographical interviews alone (Abbas et al., 2013). Comparable data was required to consider the influence past life experiences has on shaping individual motivations to become a mental health nurse.

The life grid used in this study was developed through reading literature found on life grid methods (Parry et al., 1999; Webster et al., 2004; Wilson et al., 2007; Abbas et al., 2013); what is known to influence career choice in nursing (Super, 1980; Lent et al., 994); shape educational experience (Paechter, 1998; Hansen and Mastekaas, 2006) and personal involvement in a pilot study. Time-related (based on and around the British educational system) social contexts (family life and social activities) provided a space in which students could imaginatively position themselves. Although not really in line with the unstructured

narrative mode of free association, the life grids provided time specific social contexts that all of the individuals encountered. The life grid method and FANI approach may appear incompatible, in that the life grid was structured by my interests; with the FANI approach aimed at gaining spontaneous information important to the student. Focussing on chronological or experienced 'time' within the life grid might have closed off information about unconscious realities and material causalities (Frosh, 2002; Hollway and Jefferson, 2000; Mishler, 1986; Riessman, 2002; Tamboukou, 2003). I did not want to restrict students' responses, rather I aimed to gain a broad understanding of their life experiences to consider the influence on career choice. Hollway and Jefferson (2000), suggest that the best questions for narrative research using FANI invite the interviewee to talk about specific times and situations, rather than asking about the person's life over a long period of time.

So, the biographical-narrative research, which I adopted for the study, was pertinent for understanding student nurses' meanings, practical knowledge and everyday experiences in the processes of interrelation, identification and personal and cultural reconstruction (Andrews et al., 2008). An interpretive approach is suited to studying subjectivity and the influence of culture and identity on the human condition (Mitchell and Egudo, 2003). It makes it possible to understand the cognitive, affective and active dimensions of a person's life holistically. I used the life grids to gain autobiographical data about past experiences and their influence on career choice and students' narratives about their pedagogical experiences as a way of 'gaining insights into the deeper organisational, political and psychological realities that they contain' (Gabriel, 2000, p.43). I also gave attention to what fell outside the narrative as told by the students, what seemed difficult or impossible to bring into words, or to understand from a straightforward approach to story structure or content (Burman, 2003; Chamberlayne et al., 2002; Frosh, 2002; Hollway and Jefferson, 2000; Day Sclater, 2003). Thus, I used the methods for accessing multiple levels of meaning, considering narrative construction, beyond the conscious, spoken narrative level, recognising that unconscious influences shape the end results (Kvale, 1999). The life grid and FANI methods are critiqued more fully in the next chapter.

Conclusion

The purpose of this chapter is to explain how the psychosocial ontology that I discussed in Chapter Two shaped the decisions I made about what kind of research paradigm and methodological approach I took. It was important to pursue a research design which was congruent with the psychosocial ontology, allowing me to explore research questions related to psychosocial defended subjects. In the next chapter I describe how I operationalised the principles, processes, procedures and methods I have introduced here. It explains the everyday 'nuts and bolts' of the research, including the ethical conduct of this research.

Chapter Five

Methods of Data Generation: Psychosocial Processes and Procedures

Introduction

In this chapter, I first present a timeline (Table 5.1) outlining the sequence of events carried out within this study. Second, I provide information about the context of my research. Third, I explain how I selected and gained access to the 14 third year mental health nursing students who were my research participants and who I then introduce by way of short vignettes. Fourth, I discuss the two methods I used to generate data: the life grid method and two interviews with each participant using the Free Association Narrative Interview (FANI) approach (28 interviews in total). I include a discussion of what I learnt from six pilot interviews and explain the principles I pursued in conducting the main interviews. Fifth, I explain the ethical conduct of the research. In the penultimate section, I discuss how I analysed the data; and, finally, the limitations of the approach are set out.

Table 5.1: Chronology of activities within this study.

Dates	Activities
01.10.09- 01.03.11	Literature reviews and developing research questions
06.04.11	Ethical approval granted
05.05.11- 12.12.11	Pilot interviews
28.03.12- 04.09.12	1st interviews and interview transcription
10.09.12	Transcripts sent to students
22.10.12-21.12.12	2nd interviews and interview transcription
03.01.13- 10.12.13	Data analysis
03.01.14- 30.09.17	Writing up, additional literature reviews

The Research Context

The context of individual lives does not consist only of physical environments, but also the ideologies, values and ways of thinking and behaving; as well as economic, political and cultural frameworks (Phoenix, 2008; Van Dijk, 1993). Understanding context in this

multidimensional way helps to appreciate people's actions, perceptions and meanings (Van Dijk, 1993).

The research-intensive university where I worked, at the time this study began, taught its nursing courses in five teaching centres located across two adjoining counties in the UK. Given the various locations over a wide geographical area, I chose the largest centre in the adjoining county to where I worked, because I was not directly involved in teaching the students based there. I did however, have an indirect involvement in the theoretical component in the final year, through my role as year 3 Module Convenor (across all centres). My contributions included the development and writing of the module specifications, learning outcomes, moderating the assessment process and evaluating the module.

The site of this research illustrates the rapid rise and fall of the asylum system and shifting attitudes and approaches towards the mentally ill in the UK (Nolan, 1993; Cutcliffe, 2003). The building was situated in a large urban city and had been a Victorian mental hospital, opening in 1880. It was originally built for 300 patients, occupying 125 acres, including its own farm, bakery, butcher, church and recreational hall. The main building had huge day and dining rooms with large windows on the ground and first floors and the second storey was for bedrooms only. Over the past century and a half, this building has been extended significantly, first in 1889, with reports of further overcrowding by 1890. Standing at the hospital entrance, it is possible to see the complex systems of intertwined extensions, add-ons and portacabins, demonstrating not only the historical changes within architectural design (the hospital archives describe it as 'mixed gothic'), but also mirroring how psychiatry and mental health nursing has developed from a policy of containment and custodianship towards one based on community care and recovery.

Overcrowding; soaring economic costs, with insufficient resources; developments in a range of pharmaceutical treatments in the 1950s; claims that mental illness is a myth (Szasz, 1961); and anti-psychiatrists highlighting the negative effects of institutionalisation (Goffman, 1963), have all been attributed to more patients being treated in the community. Academia moved to the site in 1973, with prefabricated portacabins being placed in the grounds of a busy mental hospital, providing the space for the 'new' medical school and teaching centre. The site was renamed and became the mental health trust headquarters. Out-patients are still

seen by consultant psychiatrists, with the last of the inpatients leaving in 1994. Many of the original features both outside and in can still be seen today.

Student nurses spend 50% of their time at university, much of it at the above centre and in other university campus sites across the city. The other 50% is spent within practice-based placements across the county funded by the NHS and independent health and social care sectors. This entails working within primary, secondary and tertiary services on in-patient units (acute care, recovery wards and older adult units) and in the community with people experiencing a wide range of mental health and social care problems, with needs relating to drug or alcohol dependency, mental and physical health services for people with intellectual disabilities and community physical healthcare. There are also secure/forensic mental health services.

As discussed in Chapter Three, what constitutes mental health and/or illness tends to be open to interpretation and varies across time and cultures. Given the psychosocial approach within this study, importance is given to both social and individual processes. This includes not only the 'local' context in which the interviews took place between myself and the interviewee, but also how each of us draw meaning and intersubjective understanding from the wider social contexts (Andrews et al., 2008). Intersubjectivity and relationality (Woodward, 2015), what Hollway and Jefferson (2013, p.xi) describe as 'complex socio-cultural, historical-personal sphere of experience', are important. It is not simply a case of exploring the social with an added psychological perspective (or vice versa): rather I consider the micro and macro; the personal and the social; the inner and outer worlds which in my worldview are always interconnected and combined. I return to this in Chapters Six and Seven when analysing the empirical data for this study.

Selection of and Access to the Participants

Strategies for selecting a sample of informants depend on the scope of the study, the amount of time the researcher is willing and able to spend in data collection, and the tradition of inquiry used for the project (Creswell, 1998; Weiss, 1994). Participants for this study were selected based on being third-year students on the undergraduate Diploma or B.Sc. in mental health nursing studying at the centre described above who were willing to be involved in this

research. Convenience in relation to time, money and having students readily available were the reasons for opting for this approach.

I contacted the year-three module leader at the centre and arranged to visit a group of mental health students just starting their final undergraduate year. I was given a 10-minute slot at the end of a morning session, of the introductory day to the management and professional practice module. I felt powerless and anxious that no one would want to get involved and about losing their interest during the study. According to Henry (2003) most researchers have organisation and institutional power, however, I experienced varying levels of power and powerlessness during the different phases of the research. I explore the issue of power and emotion at different stages of the research more fully later.

To recruit participants, I first met with 45 students, seated in the middle of what was once a vast dining room on the first-floor of the main building (originally built in 1880), now divided and adapted to make two large classrooms with high ceilings and large sash windows. I introduced myself to the group as a registered mental health nurse, working in higher education, who was carrying out research into mental health nurse education. I gave out an information sheet (see Appendix 2) and explained that the purpose of my research was to explore mental health student nurses' experiences. I said that I wanted to gain better insight into what kind of mental health nurse is being produced after a three-year pre-registration undergraduate course, within a research-intensive university in the UK, in the first part of the twenty-first century. I further added that I wanted to learn from their experiences to inform the development of mental health nurse education. I told the students that the reason for visiting them was to ask for volunteers to participate in the research and share their personal experiences and knowledge. To do this, I wanted to meet with individuals for two one-to-one interviews which would take about two hours of their time (for both interviews) to discuss what brought them into mental health nurse education, what their experiences were and whether they had any questions about the research or their involvement within it.

A brief question and answer session followed and I provided open honest answers, to enable informed consent (see Appendix 3 for a copy of a consent form). I invited those students who had expressed an interest to get in touch with me directly by phone, by email (my details were on the information sheet) or to write their contact details (with preferred times and mode of contact) down on a piece of paper. This was then sent around the room. The sheet of

paper came back with 12 names and contact details. I was excited about the amount of interest and looked forward to starting the interviews. As I was leaving the hospital site, I met two students. They were just outside the gates smoking and beckoned me over, they had been in the classroom I had just left but did not want anyone in the group to know that they were interested in being involved. On reflection, this reticence to show interest in front of peers was a sign of just the anxiety and defences employed that I wanted to explore. Certainly, sending a piece of paper around the room asking for people's names may have limited students' willingness to get involved in the research. 'Amy' as I later named her, seemed keen to participate, but said that being at university had been the worst two years of her life and would I 'still' want to learn about her experiences. I was saddened to hear she had not been having a positive experience and expressed this, letting her know that I would be interested in her experiences whether they were good or bad. From this, she agreed to participate, and encouraged 'Justin' to do the same. They both gave me their names and contact details.

Working through the list (obtained in the classroom) I contacted the students individually through their preferred method (either via mobile phone or email). I contacted 14 students, two decided they no longer wanted to get involved. I became concerned that 12 might not be enough participants; even though I had read that 'theoretical saturation point' (the point at which no new information is obtained) this is between six to 12 within homogenous groups (Guest et al., 2006, p59). At this time, the university had two intakes per year (March and September), it was simple to repeat the same process with another group (introducing myself at the same point in the course as with the previous group). By systematically contacting students I was able eventually to carry out two interviews with 14 students; 10 from the first cohort and 4 students from the second group. Of these 14 students, 11 were self-selecting volunteers and 3 accessed via snowballing (one student suggesting to another to get involved).

The Profiles of the Student Nurse Participants

In this section, I first provide brief vignettes of the 14 students involved in this study, with a pseudonym for each student I introduce them alphabetically. This was also the order in which I carried out the first interview and helped me to organise the writing up of the transcripts. I carried out the first interviews from March to July 2012 and did not commence the second

interviews until October 2012 after I had completed transcribing all of the first interviews. Transcribing the interviews was time consuming, and I worked around students' availability (and my working commitments) in terms of when and where we carried out the second interviews. The gaps between the interviews ranged from 5-7 months, although during this time I had sent the transcripts to the students and was in email contact. This gap may have led to students disengaging with the research, however, this did not appear to be the case as meeting students for the second interview they tended to provide me with a brief update about what had happened to them since we last met, with some changing their views about previous comments, for example, Amy had been critical of a communication session planned for the third year: 'if you don't know that by now' (Amy, 1st interview, 28.03.12), but after having the session in July sent me an email saying it 'was the best lecture ever' and she explained more clearly when we met again in October.

Amy (47 years old)

Amy was the first in her family to go to university and proud of her achievements and 'working-class background' (her mother was a cleaner and her father was in the navy). She'd worked hard to complete a two-year part-time access course, as well as her and her daughter being able to afford to go on nice holidays each year and to save for deposits for houses for them both. Working on the 'relief bank' as a Health Care Support Worker (HCSW) for 8 years before staring the course, she had a lot of experience within mental health care services and wanted to 'better herself' by going to university. However, the three-year undergraduate experience had been the 'worst time of her life' because 'university is false, fake and not real'. The lecturers fake because they hadn't been in nursing practice for a long time and many of her peers were false because they would often only say what the lecturers wanted to hear. She was not true to herself at University by choosing to 'keep her mouth shut', 'for fear of being judged' (by both staff and peers). University had led to confusion and distress, she often felt 'paranoid' and thought she was 'going nuts' with a likelihood of 'being sectioned'. A particular stressor stemmed from her recent diagnosis of dyslexia and she worried about her capabilities in practice, her ability 'to think straight' and the stigma of dyslexia.

Betty (54 years)

Betty moved around every two years or so because her army father was stationed in different places around the world. She experienced her parents as highly critical, leaving her and three siblings with 'inferiority complexes' and lacking in confidence. Her father 'poleaxed' the

family by leaving when she was 14 years old, contributing to attachment difficulties, abandonment issues and the need to 'please people'. The mental health nurse education course was Betty's third university course, she had already completed a BSc in Landscape Archaeology and had a Master's degree in Museum Studies. She described the nursing diploma as similar academically to previous courses yet found tensions between intended course outcomes and what happened, using the example of reflective practice becoming a 'tick box' exercise. Her career change had been inspired by receiving care from a community mental health nurse after her husband (of 30+ years) had been critically ill and subsequently left her for another woman. Her 'meltdown' and the poor care her husband had received motivated her 'to advocate for others who are not able to do it for themselves.' Betty was having difficulty coming to terms with recent diagnoses of dyscalculia and dyspraxia. While the diagnoses explained her problems with numbers and organisational skills, her confidence was knocked and combined with financial difficulties throughout the course, she was questioning whether becoming a mental health nurse was right for her.

Caroline (early 20s)

Caroline's mother was a matron (adult nurse) and her father a consultant anaesthetist. She'd always thought she'd 'probably want to go in that sort of direction' but did not want to do what her parents did. Caroline was diagnosed with dyslexia at primary school and described the extra support as beneficial for school and university work. While Caroline had limited experience of mental illness before the course, she had a close school friend with anorexia nervosa and panic attacks. This experience helped Caroline to identify different types of nursing and realise that she was good at listening to and supporting people experiencing emotional distress. Caroline was initially homesick at University, compounded by problems with accommodation and friends leaving the course early in the first year. It took her about a year to settle. She found university similar to school, expecting it to be more 'adult' but found 'cliques, competitiveness and people being defensive'. She described the small group in which the first two years were taught as like 'a little family, feeling able to ask questions and be open'. However, the larger third year group became 'us versus them […] like a competition, people whispering about each other, hostile sarcastic comments and a lot of finger pointing'. Work at university was not fun like in the 'real world' of practice and Caroline was eager to finish the course, lose her student nurse 'status' and achieve different relationships with colleagues, patients and their families.

Debbie (31 years old, 7 months pregnant and then on maternity leave)

Debbie had emigrated from Africa as a small child. She had not wanted to become a carer or a nurse like her mother until she visited two family friends in hospital: one had 'a breakdown' the other had been diagnosed with schizophrenia, so she realised there were different types of nurses. Before this, her cultural background had taught her that mental illness was 'a curse' rather than a disease and she became fascinated by the cultural differences. She 'fell in love' with mental health nursing during her first placement. Debbie had been diagnosed with dyslexia early on in her nurse education course and she found the additional support helpful as well as understanding why her thinking 'jumped here and jumped there'. Debbie loved her placements except one on an acute ward. From this placement she learnt to 'keep her mouth shut', 'not be totally honest' and to work with people she didn't like.

Ellen (early 50s)

Ellen came to England from Africa to continue her studies because of political unrest in her home country. Mental health nursing was a career change for Ellen who had qualified in Africa as a teacher and gained a B.Ed. (Hons) degree and a Master's degree in Educational Special Needs in the UK. She planned a PhD. but while working part-time in the independent care sector to fund her studies she realised that she was 'passionate about caring for people' and as the diploma pathway in nursing had a bursary attached to it, she decided on a nurse education course. The UK offered Ellen education as a 'right' rather than a 'privilege.' Her early childhood experiences of education and gaining qualifications in Africa had been difficult. Ellen had numerous health problems including diabetes, high blood pressure and had experienced depression in the past. She accepted treatment for physical health problems, but depression was 'all in her mind' so opted for 'getting on with it', with an underpinning principle of 'there are no limits and nothing can stop me doing anything.'

Fran (52)

A teacher before coming to the UK in 2002, Fran left her home country in Africa because she was politically targeted. Working with pupils in the UK was frustrating because they were 'badly behaved and difficult to control'. Subsequently she found work as a Health Care Support Worker (HCSW) and as there was a bursary attached decided to do her nurse education course. She was interested in different cultural beliefs and approaches to mental health care. Fran had worked hard and enjoyed the three-year undergraduate course, but felt she had age-related difficulties in retaining information. She spent a lot of time in the library,

writing lots of notes in class and then going over the material at night time. She described steep learning curves in all her placements, in particular in the drug and alcohol placement because she knew nothing about either. She spent considerable time 'rote learning' which she found useful for passing her placements. Feeling anxious about starting each new placement she used her HCSW experience to help 'be a part of the team' and found her mentors supportive about her learning needs. Recently she had been diagnosed with diabetes and was being encouraged to lose weight.

Graeme (42)

On his third career choice, initially Graeme had been a coal miner like his grandfather and father before him, but when the mines were closed in the 1980s he gained employment in an independent prison, from there he went to a high secure forensic hospital and was encouraged to do his nurse education. The forensic hospital had seconded him, so he retained his Health Care Support Worker wages for the three years he was on the course. Graeme felt as if he was on a 'rollercoaster ride', he had enjoyed his placement experiences but described himself as 'thick' and was 'scared to death' about the academic elements. His past work experience made it difficult for him to understand why many within the nursing profession described what they did as 'hard work'. For Graeme empathy is key to mental health nursing which he found difficult to practice at times, especially when working with individuals within a forensic setting, although many he had worked with had been traumatised from a young age and he expressed concerns about becoming 'hardened' to this fact. He described the difficulties he'd had when a patient had 'got under his skin' and the way this was managed - as without consultation Graeme was simply moved to a different ward. He was the first in his family to go to university and felt 'damn fortunate' for the opportunity and hoped that he would be an inspiration to his daughter.

Hollie (21)

After leaving school Hollie went to work in a solicitor's office, it was 'boring but I met some nice people'. Her mother was a nurse and this had influenced her to become one, although she hadn't wanted to go into adult nursing. Her first experience of mental health nursing and of caring for anyone was on a busy dementia ward. She'd found meeting the personal hygiene needs of older adults difficult. Mentors supported Hollie and she felt she had learnt most in practice. She did not discuss classroom experiences much, although appreciated the 'kind of reasoning behind things' given in lecturers. Describing herself as a 'geek' she spent a lot of

time on her academic assignments and ‘loved’ doing research for her dissertation. She felt ‘invisible’ as a student nurse, so she was impatient for the title ‘staff nurse’ as she believed she would be able to delegate to others.

Ian (39)

Ian talked at length about his mother’s ongoing physical and mental health problems and about her being ‘on Diazepam for years’. His parents divorced when he was 14 years old when he went to live with his father. He viewed school as a ‘social club’ rather than as a place of learning, he became particularly articulate about ‘bloody educationalists’ because they had not tested him for dyslexia, which he believed he had. At university he studied a BSc in Psychology. He met his partner there and once they had their degrees both decided to do mental health nurse training but he failed to complete for financial reasons. He gained employment as a HCSW, learning what it is mental health nurses do on a day-to-day basis and reinforcing his desire to become qualified. He was seconded to do nurse education again after 7 years. The key differences for Ian between the two courses taken 10 years apart was that there are fewer assessments which are now more practice-based, with an increase in computerisation and the need to use computer for e-learning and emails. He described gathering evidence for portfolios easier than doing academic assignments.

Justin (early 20s)

Justin’s mum was an adult nurse which influenced his career choice. His parents divorced when he was in primary school, his mother had ongoing alcohol problems and he had lived with his father when his mother was not well. He recalls his grandmother being supportive of him and his whole family. University had been a ‘struggle’ for him in terms of organising and disciplining himself to do the work and coming to terms with his sexuality. He found mentors in practice supportive. He grew up, became professional and realised the impact of his behaviour on others. Being exposed to violence and aggression while on placement he felt ‘less scared’ and more confident about the role of mental health nurse. Although he continued to feel ‘scared to death’ of his academic work. He found his peers to be competitive, bitchy and ‘would stab you in the back, in a heartbeat just to be better than you’, as such he had isolated himself to avoid becoming involved with others on the course, although he had a good relationship with Amy. For Justin the course was like being on an ‘emotional rollercoaster ride’.

Katy (21)

Katy was a live-in carer for her grandmother from 10-16 years of age. She experienced her family as unsupportive, with her mother having post-natal depression after the birth of her sibling and her father having a 'love affair', it was 'like a soap opera'. Her parents were currently in the process of getting divorced and at times she feels 'like piggy in the middle'. She has a long-term boyfriend and finds him and his family compassionate and supportive. Although her mother and an uncle had mental health problems, she admitted she didn't really know what that meant and applied for mental health nursing on a 'whim' thinking it would be something she would enjoy. However, she was 'shocked' on her first placement, on an acute mental health ward, because of the verbal and physical abuse and violence, which she both observed and was directed at her. Keeping a reflective diary to keep a record of her experience she realised this all became 'normal' after a while. The staff were 'foul' to patients by 'putting them down'. Nurses should 'empower people and support people and build them up not the opposite'. Her different placement experiences have helped her 'to learn how to play the game and get people on her side'. At university she made friends and recognised 'a lot of rivalry and quite childish behaviour amongst her peers'. She developed anaemia and panic attacks while on the course.

Leigh (21)

Leigh had a difficult childhood, his parents divorced when he was two. His mother then had several boyfriends who were abusive to him, his mother and sister, and Leigh has a difficult relationship with his father. He believed his difficult childhood manifested into his developing obsessive-compulsive disorder (OCD). The heavy work load at university and stress exacerbates his OCD but he accepts his behaviours and recognises that some of them are helpful for study. However, his need for 'perfection […], counting and checking' is being 'kept under control' by Sertraline. Leigh had made new friends but kept himself to himself at university, because he was concerned about the judgemental attitudes of his peers, giving examples of racist and homophobic comments made in class. He described two groups merging for the final year and how this has led to competitiveness, with some students being 'false and think they are better than everyone else, like they seem to know it all'. Getting support for assignments had also 'been a nightmare'. He thinks he annoys his personal tutor as their response to a tutorial request 'well I've got other things to do.' Leigh is 'sick to death' of being labelled a student because 'they get jobs no one else wants to do' and when he is a mentor, he 'won't dump jobs on students'.

Mandy (early 20s)

Mandy's 'family's opinions influence everything' she did. She liked to find out what makes 'people tick' but didn't think she 'was clever enough to do psychology, so nursing was the next best thing'. She was particularly interested in criminology, forensic work and watching thrillers about killers. She did not consider herself easy to get on with because of being 'a bit funny, opinionated and rub[bing] people up the wrong way'. She was 'usually okay with patients, it's just some staff […] can be bitchy'. She described placements and getting on with staff as a 'massive game', keeping her mouth shut and not getting involved. She liked 'a challenge, doesn't want to be bored and needs to keep her brain ticking'. She went to a dementia day unit for one of her placements which was as 'boring as hell' and she spent 'most of the day looking out of the window'. She has found her peers 'really supportive, we're all in the same boat, but more recently everyone was being dead secretive and bitching about others getting job interviews'. She had recently failed her third-year assignment. The 'lecturer was crap, she failed me', she described herself as stubborn not asking for help from some of the lecturers because they weren't approachable.

Nancy (25)

Nancy had always thought about being a nurse but didn't know about the different branches. One of her friend's twin brothers had been diagnosed with schizophrenia when she was 17 years old, which had fascinated her; this coupled with her emotionally volatile teens, her mum's post-natal depression and her dad's use of alcohol meant that she had an awareness and interest in working with people with mental health problems. Everything Nancy discussed was framed very positively (I should have given her the pseudonym 'Pollyanna'[29]). Aware of her positive outlook, she described it as learnt behaviour (from her mother) and as being 'a blessing and a curse' because it might not appear natural and give a sense to a lack of genuineness which might be seen as 'a front a bit like with comedians'. She had found the course positive and challenging. Early on, Nancy tried to avoid 'dying people' because it was too close to the death of her grandad and dad.

[29] Pollyanna is a novel written by Eleanor H. Porter (1913) the title character's name has now become a popular term for someone with the same optimistic outlook.

Commentary on Student Participant Profile

This psychosocial study was not aimed at providing comparable generalisations to the wider population of student or mental health nurses, rather while recognising the importance of demographic factors, the unique biographical experiences of the students were central. Positions in hierarchies of gender, class, age, ethnicity and other dimensions are not merely aspects of the multiple identities of individuals or groups but are experienced, created and enacted in social contexts. However, my focus was on the elements of stories which helped me to understand the motivations of and effects on the student nurses of being psychosocial defended subject, as we all are. I also wanted to analyse critically the similarities and differences within groups as well as individual experiences.

Methods of Data Generation

To start each first interview, I used a life grid to obtain autobiographical data. I then used the Free Associative Narrative Interview (FANI) method for gaining insights into student nurses' experiences of their educational course and for the follow up interview. I provide a brief critique of the life grid method in the next section.

Life Grid Method

As discussed in Chapter Four the life grid used in this study was developed through reading literature found on life grid methods (Parry et al., 1999; Webster et al., 2004; Wilson et al., 2007; Abbas et al., 2013); what is known to influence career choice in nursing (Super, 1980; Lent et al., 1994); shape educational experience (Paechter, 1998; Hansen and Mastekaas, 2006) and personal involvement in a pilot study. Time-related (based on and around the British educational system) social contexts (family life and social activities) provided a space in which I asked the students to position themselves and consider the best, worst and most influential experiences (See Table 5.2, overleaf).

The grid was produced on an A3 sheet of paper and was designed so that the students could represent key life events in writing and symbols (e.g. arrows between the boxes). Life events did not always fit neatly into the predetermined boxes, as such, many negotiated adjustments were made. For example, Ellen's early educational experiences were in Africa. She started

secondary school when she was 13 and was nearly 20 years old when she left. We changed the time line to fit around Ellen's experiences. It was not only changes within the time related elements of the grid. Amy, for example, had difficulties separating her family from her educational experience and this was reflected with connecting lines all over the life grid and within our discussion (see Appendix 4, for completed life grid). For Amy, family related to all aspects of her life and was not viewed as separate from it. The adjustments, connections and conversations were a part of the co-construction of the life grid. Given the wide variety of responses, experiences shared and the different approaches to the structure from the 14 students interviewed, the life grid provided an overall framework for students to associate with but did not determine what students considered to be relevant.

Table 5.2: Life grid

Life Grid FOR:	**Pre-school (0-5 years)**	**Primary/Junior School (5-11 years)**	**Secondary School (11-16 years)**	**College/ Occupation (16+ years)**	**Family/ Personal (0-current age)**	**Social /Leisure Activities (0-current age)**
The best moments (what happened, when)						
The worst moments (what happened, when)						
Most influential experience (what happened, when)						

Comparable data from each participant was important for gauging the influence of aspects of students' past experiences in relation to career choice (see Chapter six), for example, I identified the prevalence of ill health (either in the students themselves or more often with close family and friends) that had contributed to the desire to become nurses. Given the literature regarding wounded healers a more holistic and emotionally based representation of past life experiences was also important. I wanted to explore the significance of different family circumstances and events, which often combined in a complex mix of relative stability (e.g. of housing and schools) and instability (e.g. moving house and repeated family

separation). The relationships between different elements in students' lives were followed and linked across the grid with connecting arrows. Explaining to participants that the significant events could be experiences, thoughts and/or emotions for each theme within the timeframes helped the grids from becoming simple lists of events.

The life grid was used to structure the beginning of the first interview, enabling the student to choose what information to share and as such was used as an 'ice breaker' for the beginning of the interviews (Parry et al., 1999). 'Bricolages' were co-constructed through conversations about students' past life experiences. They told tales of family relationships, who had cared for them; going to school, who they played with and their relationships with teachers. They also talked about certain skills, qualities and values; the different attachments and losses to people, houses and places, conveyed the emotional tone of their relationships with others and the influence these relationships and specific events. The form of the life grid directed the students to foreground their relationships with friends, family and teachers, their pedagogical experiences in different educational settings and express the ways that such experiences had influenced their career choice.

In addition to the sections outlined in the pre-planned life grid, I asked follow-up questions using the same language and phrasing as the interviewee and actively listened to the students' responses. From the outset of each interview I used the techniques outlined in the FANI approach. This method was used to empower rather than restrict students and is explained more fully in the next section.

Free Association Narrative Interviews (FANI)

Challenging traditional approaches to interviews recognises that question-answer interview structures may restrict respondents' narratives. Hollway and Jefferson (2000) provided me with a step-by-step guide to carrying out psychosocial research. They developed 'The Free Association Narrative Interview' (FANI), which positions individuals as psychosocial defended subjects and recognises co-construction of meaning, with emphasis on the unconscious dynamics between the researched and the researcher.[30] This style of interviewing

[30] In their book, this approach produced a wealth of rich, complex and biographically unique data for their research, offering a perspective on gender difference, anxiety and the fear of crime.

allows the interviewee to be a 'storyteller' rather than a respondent and enables them to exert more influence over the research interview process than a traditional semi-structured interview would allow. This method is characterised by a form of questioning which has the aim of generating emotionally significant (biographical) narratives.

Like this study, Hollway and Jefferson (2008) draw on object relations and use the phrase 'defended subject' to capture the conflictual nature of inner emotional experience and the subject's need to allay or defend against unconscious anxiety. They argued that interviewee anxiety impacts on the data, consequently they developed the method as a critical response to the limitations of conventional qualitative question-answer protocol: this tends to reproduce established discourse (including disciplinary expressions), whilst failing to grasp the internal conflicts and emotional significance of the phenomenon experienced by the subject.

Since being first used to examine fear of crime (Hollway and Jefferson, 2000), FANI has been used to explore male violence against women (Gadd, 2000, 2003), violence against men (Gadd et al., 2003; Gadd, 2004a), understanding the experiences of parents of children with gender dysphoria (Gregor et al., 2015), a psychosocial exploration of the lifelong impact of having been in care during childhood (Guest, 2012), a 20 year longitudinal study *Growing up Girl* which is a psychosocial exploration of gender and class during a period of social change (Walkerdine et al., 2002) and theoretical issues, such as agency (Hollway and Jefferson, 2005) and interviewee-interviewer dynamics (Gadd, 2004b, Garfield et al., 2010). From this small body of literature, the FANI method appears ideally suited for interviewees who are being asked to share details of their lives and behaviour that are vulnerable to social disapprobation, for example, mental illness. This approach felt appropriate to be exploring students' experiences of mental health nursing and the influence this has on their capacities to care and think critically.

The FANI technique is underpinned by the psychoanalytical concept of free association and four interviewing principles aimed at facilitating the interviewees' meaning frame or 'Gestalt' (the overall meaning and not just fragmented parts). This is achieved by asking open questions; to elicit stories; while avoiding 'why' questions; and responses given using the same language and phrasing as the interviewee. This approach to interviewing aims to make interviewees feel in control of the conversation, while giving them time to think, reflect and provide opinions and feelings. This 'time' allowed students to think of their answers before

speaking thus helping them to share highly relevant and personal experiences and thoughts. As the students and I discussed elements of past lives I used the FANI technique to seek clarification of stories or ask about any gaps, contradictions or misunderstandings. I avoided using why questions because I wanted to encourage individuals to describe their experiences, rather than analyse or justify any actions. I listened actively and asked follow-up questions using the same language and phrasing as the interviewee. In doing so I aimed to become a catalyst for the students' narratives, with them bringing their meaning to the interview as they told their story in their own way. It was then possible to gain an understanding of their unconscious feelings and motivations in a way that traditional interviewing methods may not achieve (Clarke and Hoggett, 2009), although this was achieved in an entirely ethical and informed way (see section below on ethical conduct), having explained my research aims to each participant.

Before starting the study, ethical approval was granted (see Appendix 5) and my ethical conduct is explained more fully later. I had not used the life grid or FANI approach before, so I conducted pilot interviews which were not used for analysis. I explore these pilot interview experiences before going on to look at my conduct within the main interviews.

Learning from the Pilot Interviews

With 20 years' experience as a mental health nurse and 18 years as a nurse educator I thought I had sufficient qualifications, knowledge and skills to ask student nurses about their career choice and anxieties in relation to their three-year undergraduate programme. However, as a novice researcher I was unfamiliar with the research process and so I carried out pilot interviews with six third-year student nurses who I was working with. The aim of the pilot interviews was to find out what data would be coproduced using the life grids; to develop my interview questions; and to hone my FANI skills. Primarily the pilot interviews highlighted some of the issues related to recruiting potential participants, the power and emotional dynamics of the interview. Secondly, they helped me develop the life grid, the interview questions and practice the FANI technique and consider what sort of data these approaches generate. Finally, I could reflect on the experience, processes and difficulties involved in conducting psychosocial research, for example, the length of time it took to transcribe the interviews and ultimately in modifying the interview questions.

To recruit students for the pilot study I asked for expressions of interest. Several students expressed an interest, six students participated, and two of these were my personal students. I conveniently conducted the interviews in my office at the centre in which I was working. At this time, I had only one broad interview question (in line with Hollway and Jefferson's, (2000), unstructured approach): Can you tell me about your student nurse experience?

As I listened to and transcribed the first life grid and interview, I found myself 'cringing' at times as I asked leading and 'why' questions. For example, Pansy[31] was talking about self-directed study and the concept of adult learning and her views on e-learning. Having asked her what sort of things she had done, she responded by saying: 'all of … Uhm…the stuff on Web CT[32]' and then laughed. I responded by asking: 'Have you really? Or are you just saying that? Or is it for the benefit of the tape?' Still laughing she said 'No, it's for the benefit of the tape [me- yeah that's ok], appearing to be thinking out loud she continued 'Uhm… what have I done...? To be honest, Oh no! I won't be honest'. I then asked: 'why won't you be honest?' She responded 'because if I'm honest, then you'll like think, I have done as little as possible... to get through the course' (Pansy, 1st interview, 04.03.12).

I realised that I had asked leading questions and used a 'why' question, which were not in line with the FANI approach. However, my initial response suggested that I did not believe she had done all the work on Web CT. There was an incongruence between her verbal and non-verbal behaviours (she avoided eye-contact and started to fidget and then laughed) and the pauses suggested she was thinking about what to say. Given that my approach was not in line with FANI in terms of my use of questions, it might be argued that I limited her responses, although it did reveal that power dynamics were enacted within the interviews i.e. lecturer/researcher-student/participant.

I planned the pilot interviews within my usual office, without thinking of context and how this might influence mine and students' behaviours and responses. Elwood and Martin (2000, p.649-650) suggest that the interview site itself produces 'micro-geographies' of socio-spatial relations and meaning that reflect the relationships of the researcher with the participant, but also the participant with the site and the site within a broader socio-cultural and power

[31] Pseudonym name given.
[32] WebCT was an online virtual learning environment system licensed to the University at the time of this study.

context that affects both researcher and participant. This was the case here and influenced my planning of the formal interviews. My experiences with Pansy had indicated that my role and the context influenced her responses, but this did not always happen in the same way. For example, the third interview I carried out was with 'Polly'[33] one of my personal students. Polly was a similar age to me and had visited me in my office regularly, as I supported and monitored her progress throughout the previous two years. During these times, it was common practice for me to give the paperwork to students to fill out. This is aimed at giving the student a sense of ownership over their written records. In the first two pilot interviews, I had filled in the life grids as students shared their past experiences. Polly had different experiences and expectations and so when I showed her the blank life grid, she took it from me to fill in herself. This highlighted for me that relationships are affected by not only by the content of the inquiry, but equally by the context in which the study is carried out and by researcher and participants' past experiences and expectations and the personal motivations for being involved.

During the pilot interviews, I became aware that the students talked mostly about their experiences within practice and not about their academic work or classroom experiences. I was not sure whether this was because they thought that practice was the most important element of their education or whether they were avoiding this area because I was directly involved in their academic and classroom experiences (e.g. Pansy indicated that she would rather not be honest about her academic experiences) or for other reasons. To ensure I gained their experiences of both elements, I included a second question: 'Can you tell me about your classroom/ academic experiences?'

On reflection, it would have been preferable to ask separate questions about practice, university and academic work. I had inadvertently aligned the written work with classroom experiences, perhaps reinforcing the theory-practice gap and reflecting common views about where learning is situated and the value of written assignments in assessing competence in practice (I return to this in Chapter Eight). Throughout my subsequent interviews after the first question: Can you tell me about your student nurse experience? I asked about either the classroom or academic work only when students had not already spontaneously discussed this.

[33] Pseudonym name given.

Gradually improving on open questions, using students' ordering and phrasing, I started to trust in the process of carrying out FANIs. I did not always get this 'right' but felt more confident in my skills and recognised that the life grid and FANI approaches combined generated a wealth of rich, complex and biographically unique data that was pertinent to my area of study.

Learning from the pilot studies I subsequently met students at places and times that were comfortable and convenient for them[34]. I had developed my main interview question: 'Would you tell me about your student nurse experiences?' If students did not discuss academic or classroom experiences, I noted this down and asked them: 'Would you tell me about your academic and/or classroom experiences?' I had an interview schedule and looked forward to coproducing data that could be analysed to answer my research questions. Given the wealth of data coproduced I felt ready to commence the main interviews.

Generating the Life Grids and Conducting the Main Interviews (n=28)

I met with each student individually at their chosen time and place, which included their own homes, mental health in-patient units, community-based services and different university campus sites. Interview locations provided a material place for power relations and can help to provide participants more control, resulting in better rapport, and richer data (Elwood and Martin, 2000). Meeting in their chosen environments helped to redistribute power relations and I gained insights into some of the social settings identified by students throughout their educational experiences. Each student had the opportunity to discuss what was to be involved and if they understood the purpose of the research and signed a consent form (see Appendix 3). I presented the life grids on A3 paper and asked students to tell me about key events, the best, worst and most influential experiences in relation to education, family, personal life, social and leisure activities in pre-specified periods of their lives leading up until they went to university. All of these experiences are considered important in shaping the way we learn and relate to others and are pertinent to this study.

[34] Within Chapters Six and Seven greater attention is given to interview sites, pointing to the importance they have for the research, through generation of data and understanding power relations between myself and the students interviewed.

The relationship between different aspects of students' lives were traced and linked across the grid with connecting arrows. Explaining to participants that the significant 'events' could be experiences, thoughts and\or emotions for each time-frame, this helped to prevent the grids simply being lists of dichotomous events. Typical responses to beginning to fill out a square on the grid included statements such as: 'uhm, I am not sure if I can remember that far back but I did…'; 'I am not sure if it's relevant but…'; 'what sort of things do you want in here?' My response to all of these types of questions was: 'if it springs to mind, I am interested or if it's related to that time frame, then yes I am interested'. This was a helpful way to engage with the students and to let them know that I was openly curious about all of their experiences, whilst letting them know that I had no specific expectations regarding their responses. Such questions may have been indicative of the unequal power and emotional distribution within the interview which are explored in the next section.

I was concerned with the play of power in the interviews. I shared (insider) social status with the participants, for example, social class (working-class) and gender, but also social differences (outsider), for example, being a registered nurse, educator, gender and ethnicity. Using interviews involves asymmetries of power (Edwards and Holland, 2013). I decided the research topic and framed the direction of the interview, however the minimal structure and ongoing dialogue enabled multiple shifts in power. I initiated the interview with a life grid structure, asking students to complete these, putting me in a controlling position, however the power shifted to the students in terms of the responses they chose to give. This illustrated how power can move throughout the course of an interview. However, and despite this, the collection of two forms of data, the first identifying the information students *consciously* gave, and subsequently *unconsciously* provided, afforded a form of triangulation which provided overall findings which were persuasive and healthy. Like other qualitative researchers, I used various areas of symmetry to build rapport and establish trust with the students (e.g. Johnson-Bailey, 1999). I tried to find a balance between developing friendship with participants and maintaining the distance that allowed professional judgment (Lincoln and Guba, 1985; Torres and Baxter Magolda, 2002). During the coproduction of data, I aimed to create a safe environment in which the students could share personal experiences and beliefs (i.e. their stories). Scholars refer to this non-threatening environment as creating 'a feeling of empathy for informants' that enables 'people [to] open up about their feelings' (Taylor and Bogdan, 1998, p.48). The feeling of intimacy is fuelled by the minimal structure,

informal, anti-authoritative, and non-hierarchical approach in order to establish relationships in an atmosphere of power equality.

I have previously worked as a mental health nurse and was a student nurse myself (albeit 20 years ago), I have continued to study since I registered in 1996 and I currently work in higher education on a BSc in mental health nursing. As a researcher carrying out the interviews this could be interpreted as a disadvantage, in the sense that my biases (conscious and unconscious) may have led me to see what I already knew. However, I found my insider status to be an overall advantage as I had a sense of 'what was going on' and which events might be considered as socially significant. By interviewing students about their unique past lives and their pedagogical experiences felt enlighteningly strange, yet still not too strange (Hansen, 1994; Wadel, 1991). This approach has been criticised by positivist thinkers for being less scientific than traditional research as interpretations are concerned with implicit meaning. Yet it has also been suggested that objective observation is a 'myth', as every researcher carries their own assumptions (Walsh, 1996). Throughout this thesis I have engaged in transparent reflexivity and contextualised myself within the issues of power dynamics and how they may have affected the research process and outcomes (Few et al, 2003; Karnielli-Miller et al., 2009).

The implications of my positionality (social status and identity) in relation to the students requires further exploration. There is a considerable literature about power issues and gender in interviews. Ann Oakley (1981) challenged the paradigm of the research interviewer as objective and detached, disengaged from the interviewee on a personal level. She argued that in a situation where interviewer and interviewee were women, both are 'inside the culture' of being women in a male-dominated society and engaged with each other on that level: 'A feminist interviewing women is by definition both 'inside' the culture and participating in that which she is observing' (Oakley, 1981, p.53). Yet other social divisions articulate with gender, such that women are not all similarly socially positioned nor share cultural experiences. In particular, race and ethnicity has been the subject of attention in the interview situation, with debates about whether or not interviewers who are researching people from minority ethnic backgrounds need to share 'race' with their interviewees in order to generate 'better' or more 'authentic' data (e.g. Bhavani, 1993; Bhopal, 1997; Phoenix, 2008), with Edwards (1990) arguing acknowledging racial difference is important to establishing rapport. This was the case in my study, where three out of the 14 participants were of African origin;

these were Debbie, Ellen and Fran. Having these three women as participants gave insight into highly diverse perspectives of education, mental illness and health care provision within their home countries. Their ethnic backgrounds did not affect rapport or intimacy, but in contrast to white British women with whom I could relate due to shared backgrounds and culture, I was not always sure where conversations would lead, and as such was often reliant on my own interpersonal skills and experiences to follow the students' topic of conversation. Similar considerations were necessary for the differences in age, gender, educational background and class, although it was the racial differences which were the most apparent.

The open-ended qualitative interview, with its possibilities for discussing unexpected topics, means that emotional dynamics can be significant for the interview process (see Ellen and Betty's experiences below). My own emotions were also affected during the interviews, particularly when I interviewed Ellen, whose loss of her sister in 1995 and subsequent adoption of her children was like my own experience of losing my sister and becoming guardian to my niece and nephew in 1998. I was aware of my own emotions during and after the interview (sadness and relief, mostly), as I compared her experiences with mine. I consciously chose not to share my personal experiences, as I had wanted to hear her story, although this lack of disclosure may have been indicative of my own defences. On reflection, sharing my experiences may have helped to express a deeper sense of understanding, reduce the power differential and develop rapport and trust.

The life grid method and FANI approach combined helped to reduce the time it took to gain insights into students' past lives and the influence this had on career choice. Comparable data from each participant was important for gauging the influence of aspects of students' past experiences in relation to career choice. Positioning individuals as psychosocial defended subjects the choice to become a mental health nurse was in part mediated through unconsciously motivated drivers (reparation) that defended the individuals from their past life experiences. A wealth of rich, complex and biographically unique data regarding not only career choice but pedagogical experiences were revealed, both were then considered in relation to students' developing capacities to care and think critically. There are concerns about using psychoanalytical interpretations in a context that is not a consulting room and the attempt to apply the notion of countertransference to how participants make researchers feel as it can be seen as a danger that could be used as an underground expert system of

knowledge (Frosh and Baraitser, 2008). Taking care not to abuse such knowledge I conducted this research in an ethical way which is explored in the next section.

Ethical Conduct of the Research

Ethical approval to carry out this study was sought and granted from the University (see Appendix 3, for consent forms). However, researching into individuals' private lives and placing accounts in the public arena raises multiple ethical issues that cannot be solved solely by the application of abstract rules, principles or guidelines that are increasingly static and formalised. In this research study, I sought to pursue relational ethics, wherein I was responsible for my own actions and their consequences on others (Ellis, 2007). I followed the prescribed protocols of informed consent and confidentiality but viewed my social obligation as much larger (Flinders, 1992). I attempted to recognise and mediate the underlying power dynamics in our relationships, asking participants to take active roles in guiding conversations toward their most salient issues (Moje, 2000). I tried to operate from a basis of care, inquiring into their personal as well as professional well-being (Noddings, 1999).

Each student agreed with the accuracy of the transcripts and did not ask for anything to be modified or removed. Some students commented how reading the transcripts made them feel. Graeme, for example, thought he 'sounded common' within some of his responses (Graeme, 2nd interview, 06.11.12) and Debbie felt as if the transcript highlighted her dyslexia. Reading the transcript helped her realise her difficulties with academic writing. For her a story should have a beginning, middle and end, but she described herself as 'jumping all over the place'. This reflected her thinking and approaches to writing (Debbie, 2nd interview, 31/10.12). Interestingly, and on reflection, I had not noticed that she had shared her nurse education experiences and that her story had 'jumped all over'. After this, I agreed that this could be indicative of dyslexia, but could also be reflective of her freely associating, i.e. her narrative was structured by unconscious logic rather than rationally structured logic, that is the associations follow pathways defined by emotional motivations rather than rational intentions (Davison and Neale, 1996).

As a registered mental health nurse, I have a duty of care to be guided by the ethical principles: beneficence (to do good); non-maleficence, (to do no harm); respect for autonomy; fairness; truthfulness and justice. These underpin the professional nursing *Code*

(NMC, 2015), which has similar ethical protocols of practice as outlined by the British Educational Research Association (BERA, 2011). Besides standard or 'procedural' ethics as described above, some, like Ellis (2007, p.4) also describe situational ethics (dealing with unpredictable ethical moments in research) and relational ethics, closely related to feminist ethics and the ethics of care (Christians, 2005; Noddings, 1984). I especially came to appreciate feminist approaches in which mutuality, kindness, respect and connectedness between researcher and researched are valued. As such, while I do not use a traditionally feminist methodology in this study (given the psychosocial design discussed), I do approach the research as a feminist, which has allowed me to take such values and apply them in a way which enhanced the researcher-participant dynamic and reduced power structures.

Beneficence imposes a duty to minimise harm and maximise benefits. The rationale for this study was aimed at exploring student mental health nurse anxieties and defences. I hoped to inform future educational programmes to help students contain their anxieties and support their learning in relation to developing professional caring and critical thinking behaviours and dispositions. I did not believe that as a result of this research students would be exposed to any physical harm. However, the psychological consequences of being involved in this study did require close attention and sensitivity as I was asking questions about their personal lives, including past and present experiences that were intrusive. I asked probing questions (similar to a psychotherapist) aimed at revealing deep rooted anxieties that students may have been repressing which had the potential to stir up emotive memories and experiences which could be potentially distressing to participants.

While I did not deliberately aim to cause distress, I was asking students about their best, worst and most influential moments from their past in regards to their relationships with family, friends and educational experiences and this was likely to evoke some recollected distress. I, like Hollway and Jefferson (2000), make a distinction between distress and harm, as being upset is not always negative, but can be cathartic, so long as it occurs in a safe therapeutic setting. In line with the psychosocial defended subject, I view distress and anxiety as being a part of the process of living and likely to be provoked by some of the questions asked within the study. As such I focused on maintaining a safe environment in which honesty, empathy and respect were central. This enabled me to help those students who became distressed to 'contain' their anxieties. I use examples from Ellen's (first) and Betty's (second) interviews to illustrate this as both displayed signs of distress (tearful, with

increased agitation). While these examples are used here in the context of demonstrating how distress was managed, full details of the interviews are discussed in Chapter Six.

Ellen became upset when talking about her father. She was 'okay with crying', wanting to talk about her father, and was glad of the opportunity, as she felt unable to do so at home as her being tearful would embarrass her husband and so she had stopped talking about him. During her narrative, her tears steadily abated and she continued with her life story and pedagogical experiences. Afterwards Ellen thanked me for providing her with what was a rare opportunity to talk about her father and their relationship. Her experience illustrates that distress and harm are not mutually exclusive, as she had found the experience cathartic and beneficial (as well as upsetting). She had wanted to talk about her relationship, and the positive influence her father had had on her life (Ellen, 1st interview, 04.05.12). What interested me was that she started to cry not when discussing the worst moments but the best, including the time spent with her father, this reminded her of her loss, which she clearly found upsetting. It also demonstrated that I could not predict what individuals will bring to a situation or how they will respond.

Betty also cried during her second interview, seven months after the first, and during her final 12-week practice placement. Previously Betty was feeling optimistic about the third year, was enjoying the academic work and liked analysing her learning and telling me about her past life and educational experiences. At the time of the second interview she identified having problems both academic and clinically, and had issues with her 'sign off' mentor[35]. Betty became extremely distressed about her current situation and so I decided to switch off the Dictaphone. This decision may have had negative implications for my research, but I acted with Betty's best interest in mind. Our first interview had touched on some deep and personal experiences which she felt she had dealt with in counselling in the past. The first interview had brought these to the surface and reading the transcript had brought about further realisation about her motives for wanting to become a mental health nurse. She was now having serious reservations about this decision and had not discussed this with anyone. While Betty's involvement in this research had raised hidden issues, which could be construed as harmful, I was empathic and helped her to contain her anxieties. I afforded her time and a

[35] An experienced nurse who is trained to assess if a third-year student nurse is competent and therefore eligible to register with the NMC.

safe space to air concerns and we considered her options for dealing with her current practice placement problems. Our session concluded only when Betty felt she was okay to continue with her day, an action plan to deal with the problems in her placement and she thanked me for my support. She emailed me four days later to let me know that she had managed to resolve many of the difficulties and thanked me further for facilitating her personal and professional growth.

This research posed several difficult dilemmas, not only in terms of the potential risks for causing harm but also in terms of autonomy and justice. The principles of informed consent, voluntary participation and avoidance of harm to participants are evident in the published ethical guidance documents referred to above, albeit in some cases modified by the consideration that these principles need to be applied flexibly in particular cases. Positioning individuals as psychosocial defended subjects, Hollway and Jefferson (2000) question whether any of us is ever *fully* informed, acknowledging the hidden unconscious influences on motivations, thoughts, behaviours and feelings. It was, therefore, important to consider the information given to the students prior to the research (see Appendix 2), as this enabled them to understand what their involvement would mean and ensure that the information shared would not disadvantage them in anyway and would not be used against them. Hollway and Jefferson (2008) caution giving participants too much information as this can lead to responses being given in an assuming way, in that participants may give answers they feel are expected.

I gave honest, 'good enough' details about why the research was being done and what it would involve. I provided the context and let students know what to expect. Respecting their autonomy, and without coercion, I gave students time to think about the information given and asked if they had any questions and if they wanted to participate or not. I was clear that they could discontinue involvement at any time. The title on my information sheet: 'Learning to Become Mental Health Nurses: Students' perspectives and experiences' reflected the interest and direction of the research.

Confidentiality and data protection were achieved by anonymising all information that could identify places or individuals during transcription, including the use of pseudonyms. Hard copies of the transcripts were kept securely in a locked filing cabinet and the electronic copies stored, on an encrypted secure computer in accordance with the requirements of the

Data Protection Act (Great Britain, 1998). All of this was aimed at safeguarding the participants and data.

Codes, policies, and principles are important and useful, yet like any set of rules, they do not cover every situation, they often conflict, and they require considerable interpretation. As such I deconstructed the research process and considered the fluidity and ongoing tensions that exist between my approaches, needs and goals of the study and the rights of the participants. Wiles et al. (2005, p.8) describe this as a 'situational relativist' approach whereby I made ethical judgements informed by my own moral stance and perceptions prior to the research, within each of the interviews I conducted, and in the writing of this thesis. Grenz (2005) proposes that power is fluid and is not possessed by anybody, the researcher nor the researched. I consider the movement of power between myself and the students as shaped by the different positions that myself as researcher and students as participants within the research encounter. The shaped negotiations of power within our dialogues in accordance with the established norms (some of these broadly based on gender, class, social status, shared cultural norms), subsequently shape the data and outcomes of the study. While not in the role of mental health nurse with the participants, my training and experience enabled me to contain, reflect upon and, at a later stage, to analyse and interpret the narratives that students shared. I return to the ethical issues in Chapters Six and Seven.

Data Analysis

The analysis of qualitative data is shaped by the theoretical framework, epistemological commitments, personal characteristics and researcher's preconceptions. My psychosocial methodology recognises that analysis begins during the interview and these techniques derive from clinical psychoanalysis. FANI examines both the social and psychological aspects of the interview and pays particular attention to unconscious as well as conscious processes, allowing for a deeper, enriched understanding of the interview material. The psychosocial approach thus considers narrative construction, beyond the conscious, spoken narrative level, by allowing unconscious influences of the student to shape the end results (Kvale, 1999).

Hollway and Jefferson (2000) point out, the tendency to fragment, decontextualize and then reassemble data as an example of how qualitative researchers can uncritically share assumptions and practices with quantitative survey approaches. Both typically assume that

the people being interviewed consciously know what they think and feel and are willing and able to communicate their views. Rather than fragmentation of code and retrieve methods of analysis they recommend 'a method based on the principle of working with whole data and paying attention to links and contradictions within that whole' (p.5), exploring 'themes that may have been significant through their absence' (p.44), for example, if no mention has been made of a person's childhood or relationship with parents. Despite their good theoretical argument and misgivings, in practice they eventually resorted to coding and retrieving as it made the large data set easier to manage.

The raw data from the 28 interviews in this study were similarly vast and somewhat descriptive and following Hollway and Jefferson's (2000) guide I developed a two-page pro forma of summaries from the life grid, interview and reflections for each of the interactions (see Appendix 6, as I discussed Betty and Ellen under ethical considerations, I have included their pro forma as examples). These synopses provided a more meaningful sense of each 'whole' person, their unique past life, and educational experiences which enabled me to consider the unconscious communications within the interviews. They formed the basis for my interpretation, critical analysis and discussion. The summaries and reflections do not represent the 'total' information about the person or the social context, but the data used in relation to the research questions.

Immersing myself in the data I searched for commonalities, I considered experiences, statements and phrases, using the notion that hearing an experience from just one participant was an anecdote; from two, a coincidence; and hearing it from three might reflect a trend (Walkerdine et al., 2001). First, I looked and listened for key experiences across the narratives, then I considered what characterised these experiences and how they might be linked to one another. For example, Katy described becoming a carer to her grandmother when she was nine years old and the subsequent loss of moving house and the influence this had on her relationship to her parents, siblings and her own identity. Fragmenting the data from the holistic life grids into common events helped me consider the overall past lives of students. By repeatedly listening to the recorded interviews and using different coloured pens I identified significant events and found broad commonalities, even with the diverse backgrounds and different narratives shared by students about their past life relationships. In line with Hollway and Jefferson's (2000) guidance, care was taken not to overly reduce data and lose the integrity of students' narratives. I approached analysing this coproduced data in

three ways. First, I considered students' narratives at 'face value' to gain an overall understanding of the story being told, Second, I explored unconscious forms of communication, for example, projections, introjections and transferences, by paying particular attention to words, images, metaphor, inconsistencies, omissions and silences. Finally, I considered my own feelings, responses and interpretations, recognising my influences on not only the interaction but also my analysis and interpretation of what went on in the interview. This three-way approach was used to analyse each of the interviews examples of which are within Chapters Six and Seven.

I repeated this iterative process, looking at the overall narrative, its structures, and considering how the students told their life stories (including unconscious forms of communication) as these provided an insight into the way students felt about events and happenings. These were central not only to past life relationships but also pedagogical experiences within mental health nurse education. Themes emerged as I wrote and summarised each student's experiences, revisiting each summary and noting significant events. Seven common experiences were identified: separation from significant others; long term family illness; abuse; family relationships, parental identification, learning difficulties and second career choice.

As I continued to map and record significant past life events, the seven common life experiences included ill health (self and or others); separation from significant other; negative family relationships, parental identification; abuse (including being bullied at school), and having a learning difficulty. From these experiences two key themes emerged: loss; and deprivation (or some unmet need). My initial findings appeared to support wounded healer literature, that is, the decision to choose mental health nurse is in part mediated through unconscious motivations to repair (reparation) loss and past unmet needs. I explore this in more detail in Chapter Six in relation to career choice and in Chapter Seven I consider how reparation influences the capacities to care and think critically as students learn mental health nursing.

Once the life grid had been completed, I asked students to tell me about their student nurse experiences. All of the information gathered was also included within the 2-page pen portraits, immersing myself in this data by repeatedly listening to the recorded interviews and reading the transcripts. Not all of the students interviewed expressed the same anxieties in

relation to their pedagogic experiences, however there were a number of shared situations that were found to be anxiety provoking. Despite this diversity, analysing the students' freely associated narratives I identified seven common anxiety provoking events (the number in brackets indicates how many students reported the experiences: 1. New situations (11); 2. Situations in which physical safety was threatened (7); 3. Being assessed and a fear of failure (13); 4. Having problems with relationships with academic staff, peers, practice staff and patients (9); 5. Concerns about health in self or others (8); 6. Concerns about finances and future career prospects (9), and 7. Coming to terms with a recent learning difficulty diagnosis (3). Such anxiety provoking situations produced four common defence mechanisms: namely fragmentation; systematicity; compliance and reparation. The positive and negative influences of these defences are discussed in relation to students' pedagogical experiences and developing caring and critical thinking capacities. This forms the framework and basis for analysis in Chapter Seven. Having outlined my approach to analysis (the results of which can be seen in Chapters Six and Seven) I next discuss the limitations of this study.

Discussion of Limitations

This research was carefully prepared and supervised, yet there are several limitations that require noting.

The first was the use of a small self-selecting sample which makes the research restricted in terms of generalising the findings to other populations. It may be that students who had unconscious or conscious wounds looked to the study or me as researcher as a form of reparation to help them with their own issues. Indeed, Ellen commented she was still interested in doing her PhD and thought she could get some tips from her involvement. It is possible that those who chose not to participate in this research may have spoken about different situations and perspectives from those expressed by the students who did join the study. It might also be argued that 14 third-year student mental health nurses are too few, to provide an adequate basis to assess the generalisability of the findings to the over-all experience of student mental health nurses or students from different fields of nursing. The group was homogenous regarding current education, however there was a range of genders, ethnicities and age. This was justified by the focus being on student nurses, although further research is required looking specifically at how these demographics influence educational

experiences and specifically in mental health nursing, for example, there are a greater number of men, than any other field of nursing and also attracts mature students with life experience. However, given that the methods used were aimed at gathering in-depth meaning, a small sample size was warranted, in part because of the projected amount of data that would be generated and how this would limit the degree of analysis that could be achieved in the given time period. This approach was good for focusing on something that is rarely researched and not much is known.

It is not possible to consider how representative this sample of students is in relation to the broader population of mental health nurses and is thus not possible to attempt to generalise in the sense of the positivist tradition (Sandelowski, 1995). However, what my sample did do was provide rich and detailed accounts of life and pedagogical experiences from the perspective of student mental health nurses, and as such this was a highly valuable sample in terms of representing mental health student views. Whether my analyses provide general descriptions of the psychosocial factors influencing career choice and pedagogical experience is less clear. Although the students I met with, narrated many similar and general experiences while learning mental health nursing that reflect accepted discourses found within the wounded healer literature and within Menzies-Lyth's study of general/adult nurses. This research was a good starting point to influence future, and wider studies.

It would be impossible to replicate the interviews carried out within this study, because they are viewed as social interactions with many elements coming into play. These include location and context, the physical and social space within which the interview takes place, power relations at the social and individual levels and a wide range of characteristics, predispositions, understandings and emotions of interviewer and interviewee (Crow and Pope, 2008). Bassey (1998) argues that if similar studies yield comparable results the findings may be applicable elsewhere. This, he calls, 'fuzzy generalisation'; a concept supported by Yin (2009) in that external validity of interpretative research can be derived analytically. '[I]t is the quality of the theoretical inferences that are made out of qualitative data that is crucial to the assessment of generalisation' (Bryman, 2001, p.283). However, despite my research focusing on a specific group of student mental health nurses, my findings, as aforementioned, are comparable to wounded healer literature. Therefore, my approach has been successful in 'funnelling down' those suggestions, so while the coproduced data from 14 student interviews is not generalisable in itself, it does provide a

mandate for a study on a larger scale, not of caring professions in general, but in mental health nurses and students. Thus, the small sample has been successful in informing the next stage of research and even identifying some proposed changes to nurse education and student support deemed necessary here.

The main criticism of the use of biographical retrospective methods, like the life grid, is centred on recall bias (Blane, 1996). Recall is reliant on memory, which is often imperfect and as such considered to be unreliable. Several mental processes are involved in memory which further threatens the 'validity' of self-reported data. For example, details of life events may go unnoticed and therefore not be stored, recollection can be distorted or change over time, as new information is added to memories and then restored in an altered way (Fricker et al., 2000). Memories also fade with age, so recollection may be inaccurate. Recall bias is further compounded by the relative psychosocial positions of those involved, the importance placed on any particular event, and what the interviewee feels might be relevant.

Recall from a psychosocial perspective is different. It is not located solely within the individual, rather, it is viewed as a process of ongoing tension between 'truthful' acknowledgement of the (emotional) reality of a past event and defensive distortions of that experience for self-protection (Klein, 1940). It is not only about an individual's biography, but also, the intersubjective dynamics surrounding the telling of an event. That is not to say that the narratives that people give are not theirs, rather, they are products of a unique moment and relationship. Memory works biographically in the sense that past events are reworked in light of later meanings (Scott, 1996). Narrative is almost always said to be about time, not just succession in time, but change through time (Brockmeier, 1997; Bruner, 1990; Ricoeur, 1983), thus there is no unmediated version of the original event.

Furthermore, it could be argued that data generated from the life grid and subsequent interviews were 'merely produced by the discursive frame of the questions' (Hollway and Jefferson, 2008, p.311) and indeed on reflection (like Hollway and Jefferson, 2000), the interview question 'Can you tell me about your student nurse/academic or classroom experiences?' is in fact a closed question in that they invite a yes or no response. Yet none of the students simply replied in this way and given the variety of diverse responses and experiences shared that this did not appear to be the case as the ongoing sensitivity of myself within the interviews did not over-determine what students had to say. In addition to this

reflexivity in terms of power and emotional relations were also explored to consider in what way they may have influenced responses.

Chapter Three, in support of what I argue above, found studies into mental health nurse education are rare, and so it is difficult to consider comparable results, although the concept of the 'wounded healer' is often used to describe both conscious and unconscious factors, derived from personal experiences, that drive human behaviour and contribute to the decision to enter into the helping profession and that these experiences influence the capacity to care for others. Similarly, Menzies-Lyth's (1960) seminal study of the socially sustained systems of defence, occurred as a response to the anxieties evoked by the work carried out by British hospital nurses. Her work also identified that nursing is not just about clinical dimensions of care delivery but also social and emotional processes at work within patient interactions. This can affect the way nurses (and other healthcare professionals) and patients feel and behave (Fabricius, 1999). Scholars following a similar approach to research have demonstrated how groups, organisations and countries unconsciously create structures and cultures to defend against anxiety (Froggett, 2002; Hirschhorn, 2000; Hinshelwood and Skogstad, 2000; Long, 2015).

The concept of the psychosocial defended subject recognises that the unconscious mind defends against anxiety and influences thoughts, feelings, actions and the stories told about them. With regard to this study and its participants, psychoanalytic theory maintains that defences against anxiety influence the way people perceive themselves, mental illness and mental health and their actions within the role of the mental health nurse. A limitation could be that one to one interviews do not illustrate how students interact in groups and the dynamics of this, however the use of focus groups was not appropriate to gain the data I required, since the risk of students 'fitting in' with not only my expectations (as identified above) but also those of the group, would have hindered the honest accounts which were allowed to be given as a result of our unique and non-threatening interactions within environments where students felt comfortable. Thus, the use of interviews was justified.

Furthermore, research quality is heavily reliant on researcher skills, for example, in conducting research interviews and recognising potential individual idiosyncrasies and seeing data through my own eyes and not that of the participants. I achieved reflective practice using both a diary and supervisor support which helped me highlight these issues. These are

detailed within my empirical chapters. This study aimed to address questions concerned with developing an understanding of the meaning and experience dimensions of student mental health nurses' lives and social worlds. Central to this is whether the inter-subjective meanings, actions and social contexts, as understood by both students and myself, are illuminated. I considered the extent to which this report reflects the perspectives of students by using participants' direct quotations juxtaposed with my own words and responses. Detailed description and interpretation aimed to help the reader evaluate the authenticity of claims about the data, while being conscious of and avoiding using these to make such data 'fit' my intended findings. Rather I use quotes as a way of demonstrating the value I place on students' narratives, recognising that the words, discourse, unconscious intersubjectivity, and context in which they occur are themselves the matter of enquiry.

Finally, the wealth of data coproduced with the 14 students was vast and there was a limit to the degree of analysis that could be achieved within the time and space afforded. The vast amount of data was in part as a result of defending against my own anxieties of having sufficient data to analyse in order to answer the research questions and thus inform any suggested changes to mental health nurse education. However, one of the key lessons I have learnt is that research is an ongoing process.

Conclusion

In this chapter I have shown how I conducted my study, provided information about the context and explained how I selected and gained access to the 14 third year mental health nursing students who were my research participants. In particular, I discussed the two methods I used to generate data: The life grid method and two interviews with each participant using the Free Association Narrative Interview (FANI) approach. These methods enabled the co-construction of data that was sufficiently rich for this study, the information on the life grid made it easy to compare and critically analyse students' experiences rather than just recording and transcribing biographical interviews alone. The FANI approach was less structured leaving room for unconscious processes to surface. Attention to the social context and relationship between myself and the students were considered. From this it was possible to reflect on the meanings, social, power and emotional relations intersecting in socio-spatial and time/place dimensions of the interviews, to consider how these dynamics shape interviews and the data generated. Developing an understanding of the similarities,

differences and patterns in students' experiences (and my own), the learning they underwent and the defences they used were all central to this study and formed the basis for analysis and interpretation. Any qualitative research can be criticised from a number of perspectives, and just as with any type of research method, not all qualitative interviews constitute good research. What I have pursued in this study is good practice in understanding and undertaking qualitative interviews within an ethical framework of a specified concept - the psychosocial defended subject.

I now move on to interpreting the data that was coproduced in two main chapters. In Chapter Six I explore data from the life grids in relation to career choice and in Chapter Seven I consider how reparation influences the capacities to care and think critically as students learn mental health nursing.

Chapter Six

Reparation and Becoming a Mental Health Nurse

Introduction

In this chapter, 'becoming a mental health nurse' covers both the choice the students made to become a mental health nurse and their practice experiences as they train. I illustrate how the students' various experiences of loss and unmet needs directed them towards mental health nursing because from a psychosocial perspective such a choice contained hope for amending loss by caring for vulnerable individuals, which corroborates the 'wounded healer' literature discussed in Chapter Three. However, as I show, unconsciously defending against losses and unmet needs can *both* support caring behaviours and critically thinking dispositions *and* put up barriers to them. In their conversations with me, students were consciously aware of how their early experiences of loss and unmet had influenced their career choice and for the most part were not denying their pain; they knew their particular wounds would never entirely heal and that painful experience had enhanced their capacity to empathise and help others. Yet, at the same time, students were unaware of the manic defences they often employed and the negative influence this had on developing therapeutic relationships. Overall, I argue that the capacities to care and think critically are not mutually exclusive and that ongoing unconscious influences are dynamic and highly influential on student mental health nurses' caring and critical thinking behaviours.

This chapter is divided into four subsections. First, I develop the concepts of mourning and reparation (introduced in Chapter Two) to frame the chapter's argument that becoming a mental health nurse is influenced by past life experiences of loss and unmet needs. Second, I give an overview of the students' experiences of loss and unmet needs and link them to the choice to become a mental health nurse. Third, I explore the relationship between reparation and becoming a mental health nurse: I consider how elements of both true and manic reparation appear in the students' narratives and how they influence their capacity to care and think about patients. Finally, I explore the limitations of this study in relation to the intersections of gender, race and class.

Mourning and Reparation

From a Kleinian perspective, our first experiences of loss are when we start to develop consciousness as we shift from the paranoid schizoid to the depressive position when we recognise we are separate from our (m)others and that we have in phantasy annihilated them because they have not met our needs, so we experience both guilt and loss. We move from the paranoid schizoid position in which we are omnipotent and view (m)others as either good or bad to the depressive position when we believe we have done damage (see Chapter Two). From a psychosocial perspective, this developmental process is universal, that is, it is impossible for (m)others to meet all infants' needs all the time. What is important for my research is the social and relational context of these psychological experiences[36]. My focus is on how these experiences influence *how* the students dealt with loss and unmet needs in their subsequent lives, in particular during their course.

The process of dealing with loss and unmet needs is, according to Klein (1940), mourning, which is directed not towards the actual (m)other but toward the internal representation of the object (see Chapter Two). Klein conceived of mourning as a process of reparation. Each of the students told me about loss either through death, divorce, relocation or detention. The separation from (albeit at times temporarily) or the loss of a parent or significant other, gives rise not only to separation anxiety and grief but also to the processes of mourning. The work of mourning is to make good the loss:

> '[I]inner world, the one which [the individual] has built up from his earliest days onwards, in his phantasy was destroyed when the actual loss occurred. The rebuilding of this inner world characterises the successful work of mourning' (Klein, 1940, p.363).

Through this process, the person who is lost is reinstated in the mourner's ego, along with other loved internal objects from childhood. In successful mourning, therefore, the individual is 'recovering what he had already attained in childhood' (Klein, 1940, p3.62). For Klein (1940), the bereaved individual strives to hold on to something from the past, rather than strives to let it go. In normal child development, internalised objects allow children to

[36] It is a criticism of Klein that she overemphasised the terrifying phantasies at the expense of the social.

function independently from their (m)other figures. In mourning, these objects allow individuals to function on their own despite the permanent physical absence of the person who is lost. The concept of mourning provides the basis for a broader reconceptualisation of object relationships after loss. According to Klein (1940), dealing with loss at any age can be linked to the depressive position, which occurs when the awareness of and defences against the loss of the loved object is the beginnings of being an autonomous self. Klein maintains that depressive anxiety is always in relation to the loss of someone or to something and remains the root for psychical life. Gradually as the baby develops, the splitting and part object relations that characterise the earlier phase are succeeded by the capacity to perceive that the (m)other who frustrates is also the one who gratifies. Schizoid defences are still operating, but feelings of guilt, grief, and the desire for reparation gain dominance in the developing mind. The anxiety characteristic of the depressive position shifts from a fear of being destroyed to a fear of destroying others. For Klein (1940), the ability to recognise our destructive impulses towards those we love and to make reparation for the damage we have caused them, is an essential part of mental health.

From this developmental milestone come the capacities for empathy, responsibility to and concern for others. When all goes well, the developing child can comprehend that external others are autonomous people with their own needs and subjectivity. However, if the child is unable to work through the depressive position throughout life they continue to struggle with interpersonal problems as adults. Central to what I show and argue in this chapter is Klein's (1940) distinction between true reparation and manic reparation. True reparation is based on concern and guilt for the damage done to the (m)other, while manic reparation is based on narcissistic control and contempt for the other. Manic reparation denies pain and guilt by using magical methods of repair, maintaining omnipotent control of the object in question and refusing to allow its separate existence. Thus, manic reparation has to be endlessly repeated since success would free the object from the manic person's power (Segal, 1988). Both true reparation and manic reparation have implications for the capacity to care for and to think about others. I will show how this insight from Klein played out in the students' narratives.

Students' Experiences of Loss and Unmet Needs and Choice to be a Mental Health Nurse

In this section, I offer an overview drawing from the life grid data from the 14-student mental health nurse biographies. The data revealed a diverse, complex array of personal, situational and social experiences which brought individuals into mental health nurse education. As discussed in the previous chapter, the 14 students had diverse backgrounds in terms of socio-demographics, lifestyles and culture.

Despite this diversity, analysing the students' life stories revealed remarkable commonalities of six specific experiences (the number in brackets indicates how many students reported the experience): 1. Ill health (13); 2. Separation from a significant other (14); 3. Negative family relationships (14); 4. Following a similar career path to one of their parents - known as 'parental identification' (6); 5. Abuse (6) and, 6. Having a learning difficulty (5). Such learning difficulties specifically included dyslexia[37], dyscalculia[38] and dyspraxia.[39] I show how these experiences appeared in each of the student's accounts of their lives before the course in Table 6.1 overleaf.

Losses, like bereavements, ill health, unforeseen or unwanted disappointments, or changes in life patterns were spoken about throughout all the students' life-history interviews as the life grids were developed. Despite identifying these common experiences, the exact loss or unmet need varied a great deal. From the table above, it is possible to see that there was a high prevalence of adverse childhood experiences (loss, trauma and emotional deprivation). It is not possible to determine whether this cohort of students experienced more or less loss or unmet needs than any other group of undergraduates with similar demographic backgrounds. However subjectively, through reflexive positioning, students ascribed meaning and significance to these events in relation to their career choice as they discussed their past lives.

[37] Dyslexia is a development difficulty characterised by problems with reading and writing due to nuisances identifying speech, sounds and learning how they relate to letters and words. Amy, Caroline, Debbie and Ian described having problems in this area. Caroline was the only student who had this picked up in early childhood. Debbie had been diagnosed at the beginning of the course and both Caroline and Debbie found the extra support helpful. Amy on the other hand had just been diagnosed in the third year and was struggling to come to terms with it.

[38] Dyscalculia is a difficulty characterised by problems with understanding numbers, manipulating them and learning facts within mathematics. Betty had recently been diagnosed with this as she had repeatedly failed her numeracy tests.

[39] Dyspraxia is a difficulty characterised by problems with movement, coordination and spatial awareness. Betty had been tested for this alongside her other test. All of these conditions are considered lifelong and for some can be extremely debilitating and highly emotive. With some adjustments, practical and emotional support these difficulties can be improved. Like Amy, Betty was struggling to come to terms with her new diagnoses.

That is, the events and stories were told in a way that emphasised how a caring and helping orientation led to them choosing mental health nursing, in that students often provided accounts of how they would care for or help others. For example, Katy became a carer to her grand(m)other when she was young and she described this role as having 'a massive impact on who I am' (Katy, first interview, 20.06.12). Similarly, Graeme talked about his experiences in a prison 'as helping the lads' where he worked before mental health nursing (Graeme, first interview, 18.05.12).

Table 6. 1: Students' recalled early life experiences[40]

Pseudonym	Ill health own and others	Separation from significant other	Negative family relationships	Parental identification	Abuse Including being bullied at school	Learning difficulty
Amy	**x**	**x**	**x**			**x**
Betty	**x**	**x**	**x**		**x**	**x**
Caroline	**x**	**x**	**x**	**x**	**x**	**x**
Debbie	**x**	**x**	**x**	**x**	**x**	**x**
Ellen	**x**	**x**	**x**	**x**		
Fran	**x**	**x**	**x**			
Graeme	**x**	**x**	**x**		**x**	
Hollie		**x**	**x**	**x**	**x**	
Ian	**x**	**x**	**x**			**x**
Justin	**x**	**x**	**x**	**x**		
Katy	**x**	**x**	**x**			
Leigh	**x**	**x**	**x**		**x**	
Mandy	**x**	**x**	**x**	**x**		
Nancy	**x**	**x**	**x**	**x**		

When discussing their past lives, the students often linked the motivation for choosing mental health nursing as a career, to quite different events or experiences, some of which were described as problematic, others not. Experiences and events of ill health were often identified as being influential and several sources of inspiration to become a mental health nurse were closely aligned to the virtues of images of nurses. The students linked personal

[40] Interview data revealed no apparent differences between diploma and degree students in terms of their childhood experiences. Two key factors were revealed in the decision to do either the diploma or degree pathway: financial constraints and having a degree prior to the course.

events, experiences and the media as having a positive influence on the decision to become a nurse, although the events and experiences themselves were not always described as positive. First hand experiences of ill health in others and self were often narrated as validating their choice of career and/or the reintroduction to nursing for individuals who had previously considered (but rejected) nursing as a career choice.

For example, Betty connected her career choice to her father leaving home when she was 14 years old; 'latching onto to her boyfriend' who she married at age 16; and, to her husband becoming ill and leaving her after more than 30 years of marriage (Betty, first interview, 28.03.12). Betty was 51 years old when she started the course and described having counselling about her experiences of loss. She clearly connected her father leaving, her husband's illness and her subsequent 'breakdown' to her decision to go into mental health nursing. Similarly, Caroline described how being bullied at primary school had helped her to empathise with others and be more caring. Supporting a friend to deal with panic attacks and an eating disorder helped Caroline to realise she was good at this type of work and that coming from a medical background had influenced her desire to go into mental health nursing (Caroline, first interview, 31.03.12). She also gave an account of her friend experiencing mental health problems, included her own personal virtues which were a 'good' fit for the profession, thus validating why she chose mental health nursing. Furthermore, Katy's mother had experienced Post-Natal Depression (PND) after the birth of a sibling when she was seven years old, and Katy's experiences of both being a young carer (for her grandmother) and seeing her mother's experience of PND were highlighted as reasons for her wanting to go into mental health nursing. She had selected PND as the topic for her dissertation and had chosen to go to a (m)other and baby unit for her elective/specialist placement (Katy, first interview, 20.06.12).

Within each of the life stories, career choice was represented as a course of discovery and understanding rather than as a static moment in time or about one specific event. For example, as students reflected on their past, telling me about one experience, such as being bullied, they would often link it to other experiences with friends or having a family member as a nurse. The links created evolved over time and were used as way of making sense of and validating their career choice. Generally, there was a sense that the participants constructed their personal attributes to fit with what they perceived mental health nursing to be. That is,

they constructed a self around the perceived qualities and attributes of a mental health nurse and moulded themselves to fit that identity.

Overall, the students' experiences corresponded with the 'wounded healer' literature's central themes in that the students took past negative experiences and used them for good, by cathartically supporting others. Wheeler (2002) observes that it is not that individuals have themselves been wounded, but how they deal with those wounds that produces a 'wounded healer'. Wounded healers are those who have usefully explored their own motivations and gained sufficient insight to help others, although as I show later on in this chapter, this was not always the case because some of the students' wounds were reopened in certain situations, especially when the wounds of patients and or their families were similar to their own experiences. So, the rest of the chapter deals with how helpful (true) and unhelpful (manic) reparation played out in the students' narratives.

True and Manic Reparation

To recap, I have argued above that the capacities to care and think critically are psychosocial in the sense that they evolve as part of self-development. Such development is intersubjective, starting with the (m)other-child relationship and unconscious conflict in early relational dynamics. It is important for me as a nurse educator to keep in mind that this process is not fixed: the life histories of individuals during the course of this development remain relational and derive their meaning from fluctuating social contexts (cultures, practices and discourses). So as life goes on, the capacities to care and think critically are ongoing and dynamic rather than staged or normative (Burman, 1994). While people are a product of their pasts, and this should not be ignored, these pasts should be understood as influencing relationships in the present and that relationships and their meaning are constantly changing. In this sense the choice to be a mental health nurse can be viewed as one of life's opportunities to continue self-development.

In this section, I show how reparation influenced students' developing capacity for care and critical thinking. To do this, this third large section contains two main parts: true reparation and manic reparation. True reparation deals with examples of identification and empathy, and therapeutic relationships. Manic reparation shows how narcissistic injury; the effects of over identification and control, triumph and contempt played out in the students' life grids and

freely associated narrative interviews. In this account, I attempt to separate true and manic reparation for purposes of clarity, however, in reality, individuals manifest both, depending on specific situations. The account also depends on my own interpretations of what the students told me or didn't tell me.

True Reparation

Menzies-Lyth (1959) argued that emotions are stirred up in nurses while taking care of sick, injured and dying patients because of anxieties projected onto them by patients, their relatives and staff. As well as being real people, patients are also symbolic representatives of the nurses' internal (m)others from early childhood, whom they had both loved and injured through aggressive phantasies. Through this symbolic connection the nurse has the potential to make reparation of the internal injured parent by transferring (sublimating) care to the current patient. But to act as a good parent towards others may also be a way of dealing with the frustrations and suffering of the past. In our unconscious phantasy, we make good the injuries which we caused and for which we still feel unconsciously guilty. In this sub-section about true reparation I show how the students' experiences of ill health and troubled relationships allowed them to identify and empathise with patients and build therapeutic relationships with them.

Identification and empathy

Reparation and the desire to care for others is to some extent driven by unconscious identification with the patient. The capacity for identification is an important element in all human relationships. Identification is an interpersonal phenomenon and is about relating to another person on the basis of experiencing similarities within oneself (Hinshelwood, 1991). Individual biographies and family relationships were often identified by the students as stressful in terms of health and care needs. Such experiences for the most part appeared to foster a sensitivity to interpersonal relationships and the desire to understand human relations, both useful prerequisites for the role of mental health nurse. The childhood experiences of watching someone they loved and once depended on endure disease, suffering and death was a powerful motivation to nurse within the narratives. Although as children they could do little to improve the situations, the students might have been repairing childhood feelings of helplessness and dependency by becoming mental health nurses, fending off disease and death in ways previously unavailable to them. Yet, these motivations did not always serve

them well as they attempted to care for those who were suffering (as described below within manic reparation).

To understand and therefore to be able to help another person with mental health problems requires nurses to have the capacity for empathy. That is, to stand momentarily in the 'other's shoes', to identify with and experience their pain, using what has been learnt as a guide of how to respond. Thus, having past personal experiences of health problems in self and or others can be seen as beneficial in this regard. However, the close resemblance between one's own painful and conflicted past and the experiences encountered within healthcare, constantly threatens empathic capacity. According to Klein (1937) we are only able to disregard or sacrifice our own feelings and put the other person's interests first, if we have the capacity to identify with the other person. This identification enables us to:

> '[P]lay the part of a good parent and behave towards this person as we felt at times the parents did to us, or as we wanted them to do. At the same time, we also play the part of the good child towards his parents, which we wished to do in the past and are now acting out in the present. Thus, by reversing a situation, namely in acting towards another person as a good parent, in phantasy we re-create and enjoy the wished-for love and goodness of our parents' (Klein, 1937, p.311-312).

Almost all the students (13) discussed experiences of ill health either physical or mental, either their own or others. These experiences, as discussed above were cited as reasons for becoming a mental health nurse. They also are the basis for identifying and empathising with patients. Only Hollie did not talk about either physical and or mental health problems while filling out the life gird, although she did mention later on in our interview being 'really ill' before her nurse education interview and 'had a meltdown' in year two (Hollie, first interview, 13.06.12). There is no way of knowing whether she had or had not experienced any ill health in others or was repressing memories (she did not fill in the section for worst moments during secondary school). Her comment about not being able to remember may suggest that she was repressing something: 'I can't really think of anything. That sounds silly doesn't it, but I can't think of anything bad that happened. Surely bad things happened but maybe they weren't so influential that …that I can't remember them' (Hollie, first interview 13.06.12).

In terms of physical health, grandfathers, fathers and husbands had the highest incidences, these included cancer, heart complications/attacks and (alcohol related) liver problems. This may also indicate gendered behaviours around seeking out healthcare, and the avoidance of seeing the doctor. Nancy's grandmother and Justin's aunt had both died of cancer; Ian's mother had problems with her lungs and Amy's mother had her hip replaced. Both Ellen and Fran had problems with high blood pressure; Fran also had diabetes and Mandy had broken her leg. A less usual event was when Ellen told me that her sister and brother-in-law had died from Human Immunodeficiency Virus (HIV).

In terms of mental health, two grandfathers, two fathers and three mothers had problems with alcohol. Ian's mother had long term depression (relating to the lung problems identified above); Nancy's and Katy's mothers both experienced PND after the birth of a sibling. Two mothers and three grandmothers had dementia. Mandy described her father as being autistic with limited social skills; Caroline identified a friend as having an eating disorder (anorexia nervosa) as well as experiencing panic attacks; and, both Debbie and Nancy identified a friend with schizophrenia. Betty had been abused as a child and her husband was diagnosed as having Post Traumatic Stress Disorder (PTSD) after having a heart attack. When discussing these issues for the most part the focus was on the illness rather than on recovery or health care provision. Only Betty, Caroline, Debbie and Nancy discussed health care provision within these experiences yet the focus was not about the caring role of nurses. Betty identified the lack of timely care her husband received, for example. However, the emphasis remained on students' lack of knowledge about mental illness prior to these events and on how these experiences had provided insight into different types of nursing opportunities.

More significantly, seven of the students identified their own mental health problems, that is, one in two of the students interviewed had experienced mental ill health. Given that it is estimated that one in four individuals experience some form of mental health problem at some point in their lives (DoH, 2006; McManus, Meltzer, Brugha et al, 2009), this experience is twice the rate of incidence of mental health problems when compared to the general population. While this cannot offer enough evidence to describe the student mental health nurse population, it is however a striking observation. Betty, Ellen and Fran had experienced depression; Debbie described problems with a Generalised Anxiety Disorder (GAD); and Leigh talked about his difficulties with Obsessive Compulsive Disorder (OCD). Hollie described feeling ill, 'stressed and run down' during one of her placements (Hollie,

first interview, 13.06.12) and Mandy stated she had 'really been ill' (Mandy, first interview, 04.07.12), during her nurse education course, but did not want to disclose in what way. Despite this deliberate vagueness, in hindsight this may have had a function in that she wanted me to probe further so that she could show her wound, that is, she needed support to show it rather than hide it. This may be linked to the self-stigma many professionals feel about disclosing their own illnesses and needs.

At times, combinations of ill-health led to a (m)other being unable to carry out their caring role, contributing to loss of intimacy and other unmet needs during the students' childhoods. For example, Ian's mother had a long-term physical ailment, which also lead to depression. Such physical and mental health problems required ongoing care, with his mother not always being able to fulfil her parental role and Ian spent much of his early childhood being cared for by his grandparents. Indeed 11 out of 14 students: Betty, Debbie, Ellen, Graeme, Justin, Ian, Katy, Leigh, Mandy and Nancy identified a mother not always being able to fulfil the caring role of a parent. Circumstances like a parent leaving or having a physical and depressive illness as in Ian's example above, can leave the child with feelings of insecurity and feeling vulnerable but life offers opportunities for reparation.

So, the students discussed illnesses within their life grids and all of these experiences were freely identified without prompts from myself and were linked to an understanding of health and health care. Without a thorough examination of their own difficulties, student nurses are left vulnerable to re-experiencing their wounds if activated by a patient presenting similar problems (Miller et al., 1998). So, what makes the balance between empathy and detachment difficult is that we all bring unresolved, unconscious issues of our own to our work and others too project complex feelings.

I use an example from Justin's narrative to illustrate the difficulties. Justin identified a turbulent relationship with his mother. While filling out the life grid he spoke about his 'Mum losing [her] job because of drink', but it was not until later on in the interview when talking about applying for a job within a substance misuse team did he discuss his relationship with his mother more fully. He explained:

> '[B]ecause my Mum is, oh is, I suppose she's an alcoholic uhm and I have struggled to understand her and then I think, then should I go into a job like that? But it's not

> that I don't understand you know substance misuse and stuff like that, I think it's because, it's because she's my Mum, I can't view her the same as, I think I'd be a lot more understanding and helpful to a client or an unknown than I struggle with my Mum. I get angry and I'm like, 'I know just stop drinking […] it's not as easy as that'. So, I have a debate in my head […] because I would like that job and uhm, it might actually be good. Turn it on its head and maybe I've got more of an understanding about things like that because it's in my family. My Auntie was an alcoholic, so I've actually, she's came 'round and got better and now she's got cancer. […] It could either be a negative that you know, I've had that going on in my life and I felt like I had a lack of understanding towards my Mum and it makes me angry but then on the other hand maybe I have got more of an understanding that how it affects people and how difficult it is' (Justin, first interview, 20.06.12).

Justin's desire to understand his mother's behaviour and he clearly identified with the families of those who misuse substances and viewed this as increasing his ability to empathise with others, and he also recognised his anger towards his mother, although this is a feeling that could be aroused when working with patients when they too don't 'come round' and continue to drink alcohol. Working with others who continue to drink however could help to increase his understanding of his mother's situation.

To summarise, in this sub-section I show how the students' past experiences of ill health and troubled relationships enabled them to identify and empathise with patients. Students' recognised various losses and unmet needs and acknowledged the pain that these experiences caused and that this directed them towards mental health nursing because such a choice contained hope to make reparation. In the following sub-section, I show how these reparative drives influenced their therapeutic relationships.

Therapeutic relationships

The therapeutic relationship is still considered to be the primary intervention within mental health nursing (Peplau, 1952; Gallop, 1997; NMC, 2015). Despite painful experiences, each student talked about other relationships or what happened afterwards that had helped them deal with the situation. Demonstrating an ability to recover or cope with difficult relationships - getting a positive out of a negative - was perceived as an attribute or value of

potential nurses. They also discussed the other relationships that were going on around them. Some of these experiences were identified as both negative and positive and both were influential. That is, within the broader social context there was evidence that families, friends and others play a part either in assisting the mourning process or in hindering it. For example, students felt that mental health nursing would allow deep interaction with patients. The negative relationships within families and with others highlighted the positive aspects of relationships and it was this that students wished and chose to emulate by becoming a mental health nurse.

On speaking about what inspired their desire to work as a mental health nurse starting their careers, participants placed a consistent emphasis on the unique relational context inherent to the mental health care setting. The decision to become a mental health nurse was motivated by an aspiration to have 'authentic therapeutic relationships' with patients, a tradition which had been internalised as the core of mental health nursing. While I listened to Debbie's account (for example), I thought that she had *not* wanted to provide hands on physical care to patients but rather wanted to spend time talking and listening to people. However, as she continued to talk about her first 'dementia' ward experiences I realised this was not the case:

> 'The first time I had to wash someone I was shaking like a leaf and I was, 'Oh my God, how am I going to do this? I can't even wash with all that shaking' and I was saying 'I apologise, I'm so sorry, I hope I'm not hurting you'… and the nurse was like: 'You're fine, you're not hurting them, they are fine, they're not screaming out, are they?' I was like 'Yeah but still, but still, but still…' [*laughs*]. And after a week of being there I was thinking 'Oh my God, this is what I actually want to do, this is it' and the longer I was on the placement and the longer I spent time with the patients I was just like 'Oh my God, maybe my Mum, was right' (Debbie, first interview, 04.05.12).

Having to find out about the person or developing a therapeutic relationship with people was what students thought mental health nursing was about. As Betty put it:

> 'You've got that opportunity to really engage with people and time to build up that therapeutic relationship because they are long term, it's long term care, so I really like that, it's about the relationships for me' (Betty, first interview, 28.03.12).

Caroline gave a similar view point in terms of the difference between adult and mental health nursing:

> '[P]artly why I love mental health compared to adult because physically it's really facts, like if you have broken an arm you do this and this and this, whereas if someone has got depression it changes for every person and its, even though you've got maybe like an intervention, that could maybe help it doesn't necessarily help for everyone and the reasons they have got depression changes for everyone and it is just, you have to kind of, they give a deeper, learn more about the person and put your own kind of thoughts I guess, it's not so factual, it's not so: this is what you do and that's it kind of thing, which I like' (Caroline, first interview, 31.03.12).

A recurring theme of unmet dependency needs and resulting separation difficulties emerged in the interviews of the 14 students. However, 11 of the 14 students identified being cared for by a grandparent or close relative at an early age often this was due to the ill health or absence of (m)other (as discussed above). I am interested here in explaining how the loss was dealt with so that these students appeared capable of therapeutic relationships. Nancy, Mandy and Graeme had grown up in small industrial (steel) and mining communities within the east of England. They described coming from extended families and spending much of their early childhoods being cared for by their grandparents. Caroline, Debbie, Ellen, Fran, Hollie, Ian, Justin, and Katy also spent a great deal of their early childhoods being cared for by their aunts and/or grandparents suggesting that they also came from extended families. Moving away from these networks or the loss of one or more of these surrogate (m)others (often due to age related deaths) was described as painful, influential in both career choice and in changing behaviours and lifestyles. For example, Nancy stopped smoking and drinking after her grandmother died of lung cancer and her grandfather and father from (alcohol related) liver cirrhosis. However, this was not the case for all students. Ian's mother, for example, had problems with her lungs all of his life, but that did not deter him from smoking cigarettes.

It is not unusual to have negative family relationships at different times throughout life, however, these were often not discussed in isolation, but viewed in relation to other positive relationships, as can be seen within the examples given above. Such experiences were discussed as providing an understanding of the difficulties in these situations which could be

used to help empathise with those who have mental health problems. But as Justin identified this may have both positive and negative impact on the capacity to care for and think about others. Providing care for those with mental health problems may be viewed as a way of helping to support individuals who often have negative family relations. Thus, a motive for career choice was that they want to give to others, that which they did not have when they needed it. It is the unconscious reparative drive that underlies the desire to help and to return with another to an area of difficulty or unresolved conflict that resonates with something familiar in oneself.

All the students interviewed recounted some other family relation (mostly grandparents) having a significant influence on their emotional and physical well-being in early life, the loss of these individuals and subsequent mourning/reparation was identified as contributing to career choice. At times students tended to have an idealised view of their lost grandparent, although this was not always the case, most viewed the relationships as positive and influential. Loss is about how we experience the absence of those we love and how we process the emptiness we feel without them. An internal emptiness can be filled with symbols and/or symbolic activity, mental health nurses can be publicly viewed as symbols of reparation and carry out reparative work through the care they provide for people with mental health problems, especially if, as I show above, the individual has experienced a good surrogate m(other). Such experiences seemed to foster students' abilities to adapt to the realities of life, however this was not always the case as manic defences were also employed and are explored in the following section.

In this part of the chapter, I have shown the relation between students' past experiences of ill health and their desire to become mental health nurses. It appeared that the students had all internalised caring values, norms and expectations and had chosen an aspect of a helping role that afforded the opportunity to develop therapeutic relationships. The extent to which the process of identification and assumption around the role of the mental health nurse, may have been overt and unconscious is difficult to determine. However, since the role of the mental health nurse was conceptualised as fulfilling wishes that stemmed from past experiences of ill health and both positive and inadequate relationships, it seems reasonable to assume that the process was largely unconscious.

Manic Reparation

While, as I have shown, the students were able to be caring and think about patients, there was also evidence that the use of numerous defences allowed them to ignore their own wounds and project their reparative needs onto others, leaving their own unconscious injuries untreated. According to Segal (1988) true reparation and manic reparation differ in that within true reparation individuals experience pain and take appropriate action to relieve it in phantasy and reality[41]. Manic reparation on the other hand is a defence that aims to repair the object in such a way that feelings of guilt and loss are never experienced. Manic defences as defined by Klein are characterised by denial and omnipotence, denigration, control and idealisation (Hinshelwood, 1989). Developmentally, manic defences arise from the infants attempt to maintain an illusion of omnipotence and control when faced with threatening experiences of vulnerability and frustration. As infants develop and enter the depressive position the use of manic defences lessens and is common to everyone (and Klein argued that the propensity to enact manic defences is never completely transcended) and can be seen in everyday phenomena, for example, when a small child grazes its knee and the (m)other offers to 'kiss it better'. For Klein the concept of manic reparation describes the situation where attempts at reparation become and remain fused to infantile omnipotence and often possess an element of compulsion. Manic reparation manifests as a compulsive need to put things right, with a propensity to react rather than to reflect before responding. Such reaction tends to avoid realities; both the complexities of the situation and the feelings of vulnerabilities. Segal (1988) emphasises that when a person develops a pattern of manic reparation it tends to be carried out in relation to remote objects/persons, as the individual has no prior responsibility, so the sense of satisfaction can be free of guilt about the person as being damaged by self. This is not to suggest that the presence of manic reparation is in itself a pathological phenomenon, as I have already identified they are a positive part of self-development. However, when manic reparation is excessively strong, vicious cycles are created and points of fixation occur which can interfere with future development.

In the following section I consider the concept of narcissistic injury and the manic defences employed in order to explore their influence on students' capacities to care and think about others.

[41] Segal (1988) questions whether true reparation can be described as a defence as the mechanism is important for growth and adapting to reality.

Narcissistic injury and unmet needs

Narcissistic needs are always present in early childhood (Klein, 1940) and are usually met through a 'good enough' environment and parenting (Winnicott, 1984 [1949]). Narcissistic injury results in individuals whose spontaneity and 'true selves' were not responded to or validated by their (m)others and who subsequently develop a 'false self' (Winnicott, 1960). Winnicott used the concept of 'true self' to describe a sense of self based on spontaneous authentic experience and a feeling of being alive. The false self, by contrast, is a defensive façade, constantly seeking to anticipate demands of others to maintain the relationship. We all have a false self because it allows individuals to function in wider society fulfilling the expectations placed on its members. As such the false self-acts as a form of self-protection against criticism by showing only positives to the other, such as politeness and social courtesy. Ironically, accepting imperfection, faults and failures are necessary for personal growth and future success and so the false self never gets what it is they need, which is others' acceptance. Excessive people pleasing can lead to the person lacking spontaneity and feeling dead and empty behind an appearance of being real.

The danger for would-be nurses might therefore lie in striving for perfection and a desire to foster an idealised image of themselves to defend against their own limitations and vulnerabilities. Feelings of inferiority and experiences of humiliation may give rise to a need to feel loved and admired. Winnicott (1984 [1949]) has described how the nurse, in the best interest of patient development, needs to be able to hate appropriately, as a function of the real relationship. Mental health nursing is a non-reciprocal relationship, in that nurses are providing care to patients. Nurses may have had early experiences of narcissistic parenting in which they became parents to their parents. As children they were good, compliant, 'invisible', putting the needs of others before their own (DiCaccavo, 2002). This may give them a special sensitivity to the needs of patients but they may also feel overly responsible for making the patient better and guilty if this does not happen.

I will illustrate this process using Betty as an example because she identified herself as a 'people-pleaser'. She described having highly critical parents, which had left her with an 'inferiority complex' and to a people-pleasing pattern of behaviour as she learnt to put the needs of others before her own. She had grown up in different environments, moving house and schools many times. Moving house is recognised as a stressful life event and each time she moved she would have experienced loss, resulting in a need for reparation. For her a key

moment was through the loss of her father; such a loss can result in fear of recurrence. The child within still believes that 'if I do everything I can to make this person happy they will not leave'. The intense need to please and care for others is deeply rooted in the fear of further rejection/abandonment and/or fear of failure. The underlying feeling is that: 'If I make a mistake, I will disappoint people and/or be punished'. This approach works for a while and feels natural because there is often less conflict with others, but inner conflict and fear of failure grows. For example, if Betty would like to say 'no' or put her needs first, this can lead to feelings of guilt and resentment when she says 'yes'.

Wanting to please others was found to be a commonality among the students. It is not possible to please everybody all of the time, so trying to do this, is an unrealistic expectation of self and this impulse created immense challenges at times for some of the student nurses. People-pleasers can be sensitive to the needs of others, which is a good quality to have as a mental health nurse. Yet if not adequately supported, a negative consequence of the need to please others can lead to dishonesty, manipulation and inconsistency in the efforts to please everyone all of the time. These latter traits are viewed universally as negative and even immoral which may have the consequence that they (the behaviours) are denied or rejected by the people pleaser who needs positive and consistent affirmation. This subsequently leads to a lack of insight into self, which inhibits the ability to empathise and develop intimate relationships with others. Betty for example, admitted to lying to two of her mentors because she did not want to upset them or let them know that she was herself upset.

For the students in my study narcissistic injury was often as a consequence of ill health in the family and/or separation. Early lives had felt restrained and restricted in some way, owing to the demands and needs of others taking priority. Leigh for example, described having a 'difficult relationship' with his father after his parents separated when he was two years old. This demonstrates quite a high level of self-awareness of this individual experience of loss. For him the loss of his father through marriage breakdown at an early age not only influenced the father-son relationship but also that with his sister (described as close) and peers at school. Leigh had a 'difficult childhood for me and my sister due to Mum having different boyfriends who were abusive' (Leigh, first interview, 27.06.12). He added that he had been bullied at school and that this was in part due to him being brought up in an all-female household, as well as being small and effeminate.

Leigh was not the only student to identify abuse, five others recounted experiences of abuse within their childhoods. There were different types of abuse identified, ranging from physical, emotional, sexual to neglect. At times different types of abuse occurred together, for example, Betty described being sexually abused as a child (she did not say by who), was constantly castigated by her father (emotional abuse) and identified being neglected by her mother after she turned to alcohol. Leigh also described his mother having different boyfriends who were (physically and emotionally) abusive and Debbie described her mother as being emotionally absent.

I have considered the experience of being bullied at school as an aspect of narcissistic injury[42] because such experiences threaten self-worth and, in some cases, the true self can be virtually obliterated. Caroline, Debbie, Graeme, Hollie and Leigh all described being bullied while at school. Caroline, for example, recounted after moving school: 'being bullied from year 3 to 6, made me more empathetic to others, stronger, more able to care. Maybe at the time made me shy' (after moving schools) (first interview, 31.03.12). Caroline's conversation with me started with an account of being bullied and led to an explanation via her friend's illness, compounded by her father being a doctor and mother a nurse as contributing to her career choice. She consequently identified with the vulnerability of others and wanted to care for them.

During the teenage years and associated development of self and personality, trauma in the form of any abuse, including bullying, can be damaging. Often bullying is insidious, it cannot be identified through acts or even recognised by others but the bullied individual is painfully aware it is there. Any individual who is afraid, shy or different in some way (small and effeminate, for example) can become an easy target as the bully seeks out the fear in others; projecting their unwanted or disowned parts, feelings, behaviours and experiences, onto another object, and then the bully imagines that the part belongs to the other (Huffington et al., 2004). It is also true that perception and subjective experience play a large part in determining what abuse is and/or bullying and what it is not, as different individuals construct meanings including realities, in different ways.

[42] Where Freud (1914) concentrated on the 'primary injury' in childhood, Heinz Kohut, also from the psychoanalytic background, developed theories about the 'secondary' injuries. Kohut (1971) argues that any failure causes shame which repeats the experience of injury.

From the students' past life experiences (identified above) it is possible to recognise how a true self and false self can develop. People pleasing patterns of behaviours were noted as being employed to defend against fears of rejection and disappointing others. In the following sub-section, I explore how manic reparation can lead to over-identification which can hinder independent decision making, setting healthy boundaries and the well-being of mental health nurses.

Over-identification

As previously discussed, reparation and the desire to care for others is to some extent driven by unconscious identification with the patient. Over-identification includes denial of separate identities; splitting from one's own pain; and projection of one's own reparative drives onto the others. It comes in many forms which vary depending on relationships between individuals and groups and how successfully one is able to recognise the other as separate from oneself. It is possible to see that over-identification with patients can negatively affect students' capacities to care and think critically: Klein (1959, p.295) warned that although identifying with other people enables us to empathically understand them it may lead individuals to 'lose themselves entirely in others and become incapable of objective judgement'; Bion (1959) similarly argued that analysts (and nurses) are required to be sufficiently detached in order to think about the feelings projected onto them.

Striking a balance between engaging emotionally with a patient and maintaining a professional distance can be difficult to achieve, but it is vital, both to provide the best service and to avoid unnecessary personal distress. I illustrate using two examples from Betty's narrative how difficult this balance is and show how her feelings hindered her ability to make autonomous decisions and the capacity to care for herself and others.

Betty gave a number of examples from her student nurse experiences that illustrated how she dealt with her wounds and how these were managed by teachers and mentors. What follows are two examples that she provided from her practice experience. The first shows how she dealt with her wounds, coupled with a lack of containment from her mentor not only hindered her capacities to care and think but ultimately ended in negative outcomes for all those involved. The second demonstrates reparation and professional growth on the one hand and her self-stigma and self-neglect on the other.

Examples of how Betty managed her wounds and also how others supported her when she felt vulnerable, included a patient she had met with her mentor, he was described as anxious and had previously attempted suicide. She sat in the room behind the patient as the nurse carried out a mental health and risk assessment. The patient did not look at Betty throughout the interaction, which she described 'was just as well', as she had 'tears pouring down her face' as he told his story to the nurse. This was evidence of her ability to empathise with the patient but also that she was overwhelmed by emotions:

> '[A]nd I thought I'd be anxious, I wouldn't want to live […] he felt such a failure but it was easy to see why, because his parents had let him down, everybody had let him down and I could really relate to that personally and when he left the room to get his lunch, […] she [the mentor] said: 'oh, he's just anxious' and I said, 'if I was him I wouldn't want to live. I've got a really bad feeling about him you know, that is awful, it's not just anxiety, it is really deep seated' and he had said to me: 'he wished he could get this pain off his chest, because it's so awful'. She said: 'well, I have asked him if he feels suicidal and he's saying no'. And I said: 'but two weeks ago, he was, he was trying to jump off a bridge and he's self-harmed in suicidal ways', not self-harmer per se[43] but, [...] and she said: 'well he has', she didn't use the phrase he's ticked the box but something not dissimilar' (Betty, first interview, 28.03.12).

The nurse had dismissed Betty's concerns and tears describing her as 'a bit of a softie'. The patient left the community centre and subsequently died by means of suicide. Both the nurse and Betty were devastated when they found out. Betty became guilt-ridden and was unable to disentangle her own emotional responses from those of the patients. She was however, able to offer reassurance to the nurse for having done the 'right things', although acknowledged that she 'had lied' as she had felt that this was not the case, but did not feel anything could be gained by saying what she really thought. The nurse subsequently left her job and no one spoke to Betty about the suicide or about how she was feeling.

[43] Although often conflated, self-harm and suicide usually involve a person inflicting pain on themselves, but generally those who self-harm, do not wish to kill themselves, while suicide is aimed at ending life.

Although individual features of the nurse and the patient are significant in determining engagement and outcomes within community work, both Betty and the nurse were vulnerable to context-related anxieties as described in the literature on vicarious traumatization (McCann and Pearlman, 1990). One of the dimensions of this experience was the degree of identification and engagement with the patient. It seemed that Betty could relate to the patient's feelings but also felt overwhelmed by them and was unable to convert the anxieties and rawness of the encounter into something more integrated. She further expressed feelings of guilt: 'I felt I should have stamped my feet and shouted about it so to speak, but I am polite so… and I kept thinking 'what do I know?' Throughout the interaction Betty had remained silent whilst in tears, she doubted her competence, felt helpless to do anything about it and after the suicide questioned the value of being a mental health nurse at all. At the same time, the nurse seemed to under-identify with the patient and with Betty, this was characterized by her lack of affect, detachment and an over-intellectual approach to the situation. Thus, missing the opportunity to make use of the feelings expressed (by both the patient and Betty) to understand what was being communicated and to turn the raw emotional experiences of the patient into something that could be borne, thought about and learnt from. This example illustrates the limited capacity of both the nurse and Betty for containing and tolerating the patient's projections and there was no orientation to perceive these projections as potentially communicative of his struggling state of mind. The result of which meant that the patient's emotions remained unchanged or indeed may have been reinforced by both Betty's feelings of helplessness and the lack of concern demonstrated by the nurse.

The example of suicide that Betty spoke about was an extreme and tragic experience, however, the patient's feelings of anxiety, helplessness and isolation were similar to those she had herself experienced. I will return to this, but want to introduce the second patient and use both examples by way of comparison, highlighting the psychosocial factors that shaped both encounters. Like with the first patient Betty was able to relate to another patient and his experiences from a personal level. He was a 21-year old man in his third year at university, he was struggling with anxiety, 'hearing derogatory voices' and had recently been prescribed medication. Betty's engagement in this patient's care was different to that of the previous example as she was actively involved in helping him to navigate the university system, which was something she was familiar with. She also described being open and honest with both the patient and her mentor, perhaps highlighting her learning from the previous experience whereby she remained passive and felt unable to talk in the session (in part because of the

seating arrangements) or speak honestly with her mentor. There were a number of other differences too, not least that the first patient was suicidal, in a way that the second was not. So, the emotional transferences were likely to be different in each case. In the first example, Betty was unable to deal with the distressing and disturbing projected emotions and felt overwhelmed by them. In the second example, she was able to tolerate the emotions projected, separate her own feelings and look for ways to help:

> 'I have learnt that anxiety, like when I'm anxious I get a migraine but some people get voices and I have learnt that often it's associated with past life trauma or abuse and so my mentor said to me: 'it's all about helping to maintain and minimise people's anxiety and then the rest can follow' (Betty, first interview, 28.03.12).

Repairing the patient in the external world can help to heal the damaged patient within. It can also be used as way of ignoring or denying one's own emotional pain as the focus is on others with little or no time for self. This can mean running the risk of producing individuals who, might have an invested interest in maintaining the appearance of good mental health while struggling to hide and deny their wounds. One way to deny the wound could be to accentuate or split differences between patients and staff, in that, patients are sick, mad or needy on the one hand, while on the other, nurses and other healthcare professionals are well, sane and helping others.

An example of this was given by Mandy. As she was talking about her practice-based experiences and briefly mentioned one of her second-year placement on a dementia day unit she said: 'that was the awful, awfullest placements ever. Boring as hell! Couldn't do anything. Just sat looking out the window basically' (Mandy, first interview, 04.07.12). Although not an infallible process, given the number of activities that invariably occur on a day-to-day basis and the auditing process in place that 'matches' learning opportunities to student competency levels, I found it difficult to understand how she could have been bored. She described patients coming in for four hours a day to 'play games' and then staff spending the rest of the shift on computers (which she was not able to access). She did not seem to understand the purpose of people coming to the day unit, for example, playing games can be an enjoyable form of social interaction (loneliness within the elderly population is a growing problem and has clear links to mental health issues - see Singh and Misra, 2009). In addition to this, such games can be used to assess and improve cognitive functioning (Wang et al.,

2012). I reminded myself that Mandy had made it clear that she was only interested in working with younger adults with a particular interest in the 'criminal mind'. It was only when transcribing her interview that I was reminded that both her 'Mama [grandmother] and auntie' were ill with dementia and subsequently died not long before this placement. I then considered that she might be having difficulties engaging and empathising with the patients. She 'couldn't do anything' because to do so would have brought her closer to people with problems similar to those of people she had recently lost.

Mandy had not discussed her family problems with the staff on the ward or with anyone at the university, yet she had attended placement for three months. So, while she was there in body, her mind seemed to be focused elsewhere (looking out the window) perhaps this was the only way she could tolerate her painful feelings (related to the loss of two family members) during this time. It may be that Mandy had difficulty in outwardly expressing distress and had learnt how to suppress her negative affect, which helped her 'get through' the placement and she 'passed' her competencies for this stage of her course. She did not discuss any work-related activities or relationships with the patients during this time so it is difficult to assess the impact this had on Mandy's capacity to care for those on the day unit. Although the lack of information regarding her engagement and her lack of understanding of the activities involved on the unit suggests that her caring and thinking capacities were negatively impacted upon. She had avoided speaking to someone about her own experience and had an 'awful' 12 weeks, whereby she was affected on a deep emotional level, with no support from the staff on the unit, the university or her family (as she later described not being able to talk about this highly emotive issue at home).

In both examples provided within Betty's and Mandy's narratives there were failures in support and managing nurse-patient boundaries, which led to an inferior outcome for the patients, students and staff. Klein (1940) proposed that defences against anxiety are intersubjective, that is, they come into play in different interactions and in this sense, are relational and developed through social relationships, thus it is not just about the individual but the person and the social. Using the concepts of projective identification and containment offer a useful theoretical framework and discursive space to make sense of the intense emotional encounters. These concepts offer plausible explanation as to why Betty had such intense sensations of anger, guilt, anxiety, isolation and pressure and why the capacity to care became difficult and challenging.

While I have been discussing the effects of manic reparation on nurse patient relationships, students' well-being was also compromised. Bowlby's (1979) psychodynamic theories of attachment and loss have been used to describe 'compulsive care giving' as a pattern of adult behaviour in which people's early attachments have been unsatisfactory and so they go on to engage in many close relationships with the emphasis on giving care rather than receiving it (see also studies carried out by Boszormenyi-Nagy and Spark, 1973; Minuchin et. al., 1967). Interpersonal intimacy can be experienced with patients within controlled and safe environments, whereby the degree of conflict or stress can be regulated by the nurse.

Malan (1979, p.139) likewise coined the term 'helping profession syndrome' to describe his observations during psychotherapy, specifically that people choose (often unconsciously) to work as a helper or carer in response to individual vulnerabilities, to help heal the 'patient' within. He purported that individuals defended themselves using a form of over-compensation, giving the care to others that they themselves would like to receive but that over a period of time, the needs of others would be experienced as demands, often leading to feelings of guilt, resentment and ultimately depression and burnout. These individuals have an idealised concept of healthcare and unrealistic expectations for the self in performing the role. Malach-Pines (2000) too notes that burnout may stem from nurses' lack of control in childhood experiences. Further studies consider nurses developing 'compassion fatigue' which is broadly described as the 'cost of caring' for others in physical and emotional pain and is regarded as deep psychological and physical exhaustion that has a negative impact on the nurses' ability to empathise with others (Figley, 1995; Joinson, 1992; Anewalt, 2009; Lombardo and Eyre, 2011).

In this section on true and manic reparation I have discussed examples of students when they encountered situations in practice which reopened their own past wounds and how the defences that they employed both enhanced their being able to care for others and independent decision making by setting healthy boundaries; and, how these hindered caring and critical thinking behaviours through denial and detachment of personal pain meant that the students at times were unable to empathise or think about others. True reparation and manic reparation as I have described, are not only an internal process but have an external component that reflects the internal psychodynamics of the depressive and paranoid schizoid positions. The result of true reparation can lead to effective therapeutic relationships and

positive outcomes for those involved. The result of manic reparation is further anxiety for the individual student nurse, which if left unchecked can contribute to poor mental well-being in the individual and may ultimately lead to compassion fatigue and poor therapeutic relationships with patients.

Limitations of the Research

I have already covered methodological limitations to this research in Chapter Five. In this section I consider a further limitation: that the intersections of gender, class and race have not been explored sufficiently.

Intersections of Gender, Race and Class

Narrative research methodology, as an interpretive method of research, is not concerned with generalizations, so much as it is particularity, and how each person views their own experiences. I have looked for patterns within the individual narrative and across narratives. This holistic approach to interpreting narratives draws attention to the interconnections in the experiences of the participants. Although gender, race, and class are often perceived as three separate issues, the intersection of gender, race, and class holds true, whether the researcher is trying to analyse the elements of a group's subjectivity or trying to analyse the social structures that shape this subjectivity.

It was not the intent within this study to consider whether women care more (or less) because they fit or resist the polarised gendered categories, nevertheless such categories do have subjectifying effects (Hollway, 2006). Gender is not the only category, positions of race, class, sexuality, religion, region and age, for example, also ensure that the discourses of femininity and masculinity are taken up (and resisted) in different ways (Skeggs, 1997). According to Chodorow (1989, p.184), 'as a result of being parented primarily by a woman, men and women develop differently constructed selves.' Generally, from earliest childhood boys and girls are socialised differently: the qualities of caring/nurturing and attending to the affective states of others are nourished in females and may be selectively discouraged in males, as a sense of individuation, becoming separate, limiting the primary identification with the (m)other. That is, a sense of self for males is based more on denial of the relationship and a sense of self as separate. I have not discussed gendered relationships thus far, but given that nursing is a predominately female profession, the debate about 'male nurses' has been

ongoing (Berkery et al., 2014; Daniels, 2013; Evans, 2004; Myungkeun and Keogh, 2016; Pfeffer, 2012). Conversely, women, perhaps as a consequence of their psychosocial construction, often have the opportunity for a more developed form of empathy, empathy however is not exclusively within the realm of women.

Hollway (2006) argues that the categories boys and girls are problematic within the context of feminist post-modernism's deconstruction of fixed gender categories, which asserts that lived experience of subjectivity is more fluid. Nevertheless, women and caring have strong cultural associations within western societies (Hallam, 2000), which can lead to the assumption that caring is a natural or genetically inherited attribute of those born female rather than a socially learnt pattern of behaviour. Feminists have challenged this supposition arguing that caring is a socially acquired characteristic, a part of the process of gendering female subjectivities in western cultures through the discourse of femininity (see, for example, Brown and Jordanova, 1981). Nursing, like femininity, is not a unitary construct; yet nursing's relationship to femininity is a recurring theme in much of the literature on images of nursing that has originated from the profession (Hallam, 2000).

In relation to both this and the following chapter, my discussion about how loss and unmet needs and the drive to reparation influenced the student participants' choice to become mental health nurses and their experiences of becoming one, has ignored how gender, race and socio-economic class shapes experience. This is a limitation of the study. Using the National Statistics Socio-economic Classification (ONS, 2001): 1 of the students was from group 6; 3 from group 5; 5 from group 4; and 5 from group 2; 10 were women; 4 of these from ethnic minority backgrounds; and 3 came from African countries. The 4 males involved in the study were all white British. From this it was clear that 9 out of the 14 students were from less powerful groups in society and this will have affected their sense of self and what they decided to do. Had they come from more powerful social groups, the reparative drive might have been directed to becoming a doctor where, for example, critical thinking is foregrounded. It also means that their circumstances as comparatively poor and low status people in society could continue the sense of unmet need. However, from this small sample 5 students were from group 2 which included lower managerial and professional occupations (parents of the participants were: teachers, nurses and one doctor). Focussing on one aspect of individual lives like social class, for example, often neglects other aspects like gender and race and other collective identities. To use an example, Caroline's background was from

group 2 (her father was a doctor and her mother an adult nurse) was white and could be considered middle class, yet chose to go into mental health nursing rather than studying to become a doctor or an adult nurse (more often associated with white middle class women). However, from an early age was diagnosed with dyslexia which may also have influenced her decision to choose mental health nursing. While I acknowledge this weakness in my study, given the often extreme experiences of loss I was told about, I didn't have the analytical reach to manage intersecting variables in a systematic way in a small group, so I decided to focus on the student participants as individuals without making judgments about the extent to which their assigned identities as a woman, black person, or foreigner influenced their desire for and ability to manage reparation.

Conclusion

In this chapter, I have illustrated how the students' various experiences of loss and unmet needs directed them towards a reparative career because such a choice contains hope for repairing their own psychological damage by caring for vulnerable individuals allowing them to be in control of the intimacy. A psychosocial defended subject lens shows how these experiences can both put up barriers but also support caring and thinking behaviours. Individual biographies and family relationships were often stressful, such experiences seemed to foster a sensitivity to interpersonal relationship and the desire to understand human relations. Given that I interviewed students towards the end of their three-year undergraduate course, this sensitivity could also have been influenced by their mental health nursing and educational experiences. Searles (1960) warns against working through our own reparative needs, as we should be helping our patients to find their 'personal truth'. However, Freud (1914) argued it is possible to achieve both: he described therapeutic learning at its best is through mutuality: learning of the patient, learning from the patient, learning by the patient, remembering, repeating and working through. This is what I hope for these students. I present further analysis of the relationship between students' reparative needs and their lived experience of nurse education in the following chapter.

Chapter Seven

The Psychosocial Defended Subject and Pedagogic Experiences

Introduction

In the previous chapter, I used the Kleinian concept of reparation to argue that the students unconsciously defended against the effects of loss and unmet need by choosing a career in which they could care for others. The main focus of this chapter is to present the analysis of students' freely associated narratives by exploring the relationship between students' reparative needs and their lived experience of nurse education, thus responding to my second research question: How do psychosocial factors influence students' pedagogic experiences? The positive and negative influences of these psychosocial factors are discussed in relation to students developing both caring and critical thinking capacities. By positioning individuals as psychosocial defended subjects, I first discuss Klein's notion of 'epistemophilic instinct'. I then show how the group as a whole experienced a number of shared situations that were anxiety provoking, which generated common defence mechanisms, namely: splitting, systematicity, compliance and reparation. I show that the capacities to care and think critically depend upon how these defences are employed. Analysis through Bion's (1961) concept of projective identification and the container-contained model is used to illustrate how students deal with their anxieties and how academic and practice staff and the organisations they work in facilitate and contain the `vulnerable' student.

Epistemophilic Instinct

According to Klein (1931) every child is born with the desire to learn about the world, this she calls the 'epistemophilic instinct'. Initially, the infant is focused on the initial care taker (the (m)other) and what is going on inside their body. This curiosity is then expanded to include other members of the family and the relationships they have with each other. In these early stages, the infant is dependent on the (m)other to help think about and make sense of the world. Youell (2006) believes that young children need a lot of help with this process for two reasons. First, they need to share the experience of finding out about the world; this discovery is shared with a parent, carer or teacher. If the pleasure of this discovery is matched by the other person then the child is encouraged to discover more. The opposite is also true in that if disinterest is shown then this can dissuade discovery. Secondly, learning itself can be an

anxiety provoking experience, when we learn new things, we come to realise that what we thought we knew was not the case. This then prompts the notion 'what else might not be known' and can give rise to feelings of inadequacy, vulnerability and other anxieties. The more unstructured and stranger the new experience, the further we are removed from the familiar and the more terrified we may feel.

It is this early relationship and development that sets the scene for all subsequent experiences. This learning model is based on learning from experience and has been extended by Bion (1962) in his container-contained theory. It is this learning from experience that I am particularly interested in when it comes to student mental health nurses. According to Klein (1931) and Bion (1962) each of us has a lifelong struggle with the desire to learn and the urge not to know: a tension exists between wanting to find out more and not wanting to know the 'truth'. This tension can lead to feelings of angry opposition. Britton (1998, p.38) writes:

> 'It [new knowledge] arouses our hostility, threatens our security, challenges our claims to omniscience, reveals our ignorance and sense of helplessness and releases our hatred of all things new or foreign'.

How well an individual can cope with each new situation and knowledge will depend on the 'good internalised' early experiences, as with these intact, a person can venture into the unknown and explore new things. The experience is still anxiety provoking, however as children develop they can gain more confidence in dealing with new situations and become less reliant on (m)others for support, although peers often take on some of this role, so for example, a three-year-old is still largely dependent on its parents and so would probably feel terrified when left alone, in a way that a 15-year-old would probably not. However, there might still be times when an adolescent becomes anxious and requires the actual presence of the (m)other: having an internalised feeling of previous containment can help with anxieties in the present moment. However, no matter how mature or capable we are and feel, we tend to continue to have memories of such early experiences and dread feelings of helplessness, of being lost and of fear of the unknown (Salzberger-Wittenberg et al., 1983).

From this perspective, we can think about the experience of formal education. Putting knowledge into a formal curriculum supports the notion that knowledge is certain and fixed. It also implies that some information is more important than others and that all the knowledge

included is desirable (Bibby, 2011). Following on from this, the knowledge that is not included is perceived as less important. Assessments are then created and applied to enable us to think that we can monitor or measure the learning that has taken place and implies that knowledge is measurable and is directly accessible. Anxieties thus do not arise from knowledge being uncertain, or problematic when new knowledge can be prepared for. Individuals no longer have to worry about knowledge and learning being difficult at times or that there is so much to learn. Knowledge may not always be easy to obtain and then retain, however, these difficulties are alleviated by the presence of a curriculum and assessment processes (Bibby, 2011). Currently within educational institutions it is the curriculum and assessment which provide the parameters of what 'needs to be known' for students at each stage of their education and passing the assessments are evidence of meeting the necessary standard at the time it is required.

For Bass (1998, p.426) 'whenever one finds systematicity, one can, from a psychoanalytical point of view, ask the question of what unbearable piece of reality is being defended against by the means of the system'. This asserts that all systems and routines are put in place to protect us from something we consider unpalatable. Bion (1961) suggests that within education, such systems often defend against thinking, which is the very thing we are trying to get students to do. Considering that education has the purpose of providing new knowledge to students, albeit within strict parameters determined by outside agencies (NMC and DoH), how facts are taught and recalled is a conventional way of giving and testing knowledge. Such prescriptive structures in learning are not always congruent with the acquisition of knowledge, but rather students' demonstrating the ability to recall facts in an acceptable way. In earlier stages of education, such as GCSE assessments, an understanding of a given curricula is required, such parameters evolve slowly throughout the pedagogic process until there is a complete turnabout in how knowledge is given and understood. Critical thinking can occur quite late on in this journey and contradict everything a student has previously been taught.

Why Students Find Caring and Critical Thinking Difficult

It can, therefore, be difficult to teach students to think critically. Some take on the challenge naturally, while others struggle. Exploration, interpretation and analysis of pedagogy is key to understanding why. In order to do this, I first offer an overview of the anxieties experienced

by the 14 students during their nurse education experiences. Not all of the students interviewed expressed the same anxieties, however there were a number of shared situations that were found to be anxiety provoking. Despite this diversity, analysing the students' freely associated narratives I identified seven common anxiety-provoking events (the number in brackets indicates how many students reported the experiences): 1. New situations (11); 2. Situations in which physical safety was threatened (7); 3. Being assessed and a fear of failure (13); 4. Having problems with relationships with academic staff, peers, practice staff and patients (9); 5. Concerns about health in self or others (8); 6. Concerns about finances and future career prospects (9), and 7. Coming to terms with a recent learning difficulty diagnosis (3). In table 7.1. below I show what students acknowledged as being anxiety provoking in some way:

Table 7.1: Students' anxiety provoking experiences.

Pseudonym	New situations	Physical safety	Assessments and fear of failure	Relationships	Concern about health	Concern about finances/career	Recent diagnoses
Amy	**x**		**x**	**x**	**x**		**x**
Betty			**x**	**x**	**x**	**x**	**x**
Caroline	**x**		**x**	**x**	**x**	**x**	
Debbie			**x**	**x**		**x**	**x**
Ellen	**x**				**x**		
Fran	**x**	**x**	**x**		**x**	**x**	
Graeme	**x**	**x**	**x**	**x**		**x**	
Hollie	**x**		**x**				
Ian	**x**	**x**	**x**			**x**	
Justin	**x**	**x**	**x**	**x**		**x**	
Katy	**x**	**x**	**x**	**x**	**x**	**x**	
Leigh		**x**	**x**	**x**	**x**		
Mandy	**x**	**x**	**x**		**x**	**x**	
Nancy	**x**		**x**	**x**			

Despite acknowledging these common educational anxiety provoking experiences, the exact type of anxiety and defences employed varied (as I show below). In the following sub-sections I unpack the elements of table 7.1, under each of the headings provided. The defences mobilised to deal with these anxiety provoking situations: splitting, systematicity,

compliance and reparation, are also explored in relation to both capacities to care and think critically.

New Situations (11)

New situations were the most common source of anxiety identified by students and were a constant feature throughout the course. The mental health undergraduate course that the students were attending was designed to offer them a wide range of different learning experiences within a variety of health and social care environments. These included working in the community and inpatient facilities as well as working with older adults, young people and adults. The placements were within primary, secondary and tertiary services and students were given the opportunity to work with people with a wide range of mental health problems including Anxiety Disorders, Depression, Schizophrenia, Alzheimer's disease and many others. Students would typically spend two-three months at university and then go out into diverse practice environments which would last from between four to 14 weeks. This structured way of learning is still used to teach student nurses both clinical skills and academic knowledge. The way the course ran meant that all of the mental health nursing students experienced a lot of new situations when going into practice. They also experienced new situations each time they went to university as they undertook various modules involving different lecturers and subject content. For instance, alongside learning the biological functions of the body, they explored social theory to understand social exclusion and its influence on patient wellbeing and healthcare access.

Similarly, clinical skills learnt in practice were (and still are) tested in regular assessments known as 'OSCEs' (Objective Structured Clinical Examinations) as well as by way of a number of academic assignments. OSCEs are designed to assess clinical competence while academic assignments are designed to assess knowledge and critical thinking abilities. Thus, students must successfully pass through many assessments before being eligible to register. The transitions to and from these different environments and educational experiences were the most common new situations discussed by the students in this study.

There were two other types of new situations that were discussed by several students: first, changing job role from a Health Care Support Worker to student nurse. Seven students, (Amy, Debbie, Graeme, Ian, Justin, Katy and Leigh) experienced this job role change, so

individuals found themselves in a familiar place but had a different purpose and role for being there. Secondly, five students (Caroline, Hollie, Justin, Katy and Leigh) had left home when starting university (although Justin had returned to live with his father during the course) and so had a number of changes to deal with, including living independently, moving into a new home and to a new city. As I focus on the changes within the course in the next section as well as leaving home, I also explore the changing roles identified by students under the relationship section.

11 of the 14 students identified feeling anxious starting the course and then before going into each new placement. For example, Hollie recognised feeling nervous on the first day of the course because there were so many people. She also felt anxious about each of her placements, although she described different reasons for her anxiety. For her first placement, Hollie felt anxious because she had no previous experience of mental health nursing and felt she knew nothing and thought she was 'rubbish'. Yet, when we met she was about to embark on her final placement and expressed concern that the staff would think she would 'know it all' (Hollie, 1st interview, 13.06.12). Hollie's anxieties seemed to be based on what others expected of her and about how much knowledge and what skills she thought she possessed at different stages of the course. Although the reasons she provided seemed to be different, the underlying anxiety remained the same in that she was not 'good enough' or that she would be found wanting in some way.

Similarly, Nancy acknowledged:

> 'I'd say, a really positive experience. A challenging one uhm, I don't think they explain anywhere how difficult it is. [J Right] I don't think you can imagine how kind of intense it is. Uhm and not just in the work load but in what you experience on your placements and the quick change that you kind of take between one placement to another, to uni and I think that's quite, I dunno, uhm difficult but challenging in a good, you know it's challenging in a good way…' (Nancy, first interview, 04.07.12).

As Hollie had not experienced working within mental health before, each new placement was a new experience (this was the case for all students whether or not they had experience in mental health care, however for Hollie everything was new whereas others had had more insight and may have had more understanding of, for instance, the culture of healthcare and

expectations of staff, and/or the knowledge of mental illnesses and treatments) and she identified having a number of preconceived ideas about what happens to people with mental health problems:

> 'I thought everyone should be locked up before I started. I don't mean that, but I suppose I didn't really know and I went there [community placement] and I was like oh right ok' (Hollie, first interview, 13.06.12).

Hollie described what she had learnt from new situations:

> '[S]ometimes you feel like you just have to go along with what the qualified members of staff were doing and that goes for a lot of things though on placement, I think. Some people say to you: 'oh we don't do it that way here. We do it like this, or I do it like this' and then the next day you'll be with someone else who does it totally differently again and I think sometimes it is just easier to follow their way of doing things' (Hollie, first interview, 13.06.12).

It was not uncommon for students to use this approach to getting through their placements, that is, to comply with whichever member of staff they were working with. This approach makes sense given that each member of staff would be assessing the students' competence either overtly or covertly. Yet, Hollie also acknowledged that, with hindsight, it was not always the best approach for patients. She described visiting with a male patient in the community early on in the course, she had concerns about how he was managing his finances and while his care-coordinator was:

> '[K]eeping an eye on it, but knowing what-having had the placement experiences that I've had since, and knowing what I know, more about safeguarding and things since. I think I would have pushed it further if I'd have known. That is something I regret actually about that placement because I worried for that guy afterwards and thought: ohh, I wonder whether I should have done more about it' (Hollie, first interview, 13.06.12).

In this situation, Hollie deferred to her mentor's judgement as she did not know that there were alternative approaches to care or safeguarding protocols that could have been used in

support of the patient. With further experience and reflection, she came to understand that perhaps more could be done. This provides evidence that Hollie had learnt from her experience, although she also felt guilty (regretted) that she did not do enough for the patient. Being worried about him after the event suggests that she felt responsible (in some way) for what had happened (or rather did not happen, that is, that the situation had not resolved in a way which was positive for, or had helped, the patient discussed). She also felt guilty about not having the knowledge needed. It's not clear whether, if she had the knowledge at that time, she would have been able to assert herself and push it further. Being in the position of student, she found it easier to follow the qualified staff and required their approval for passing the placement.

With all of the different placements and changes throughout the course carried out by a variety of academics and practitioners, it is understandable that, for student nurses with neophyte levels of understanding, following the nurse/mentor learning with and practising in their 'ways' becomes an option which is more likely to attract positive feedback and successful completion of the placement. For five of the students (Caroline, Hollie, Justin, Katy and Leigh), not only did they have these new situations to deal with, they all additionally left home and moved into new accommodation at the beginning of the course. Doing so was problematic for all of these students in different ways. Caroline, for example, was put into accommodation that included meals but found that her changing shift pattern during placements meant that she often missed meal times and would go without food. Leigh shared a house with a number of international students who did not speak much English so he felt isolated and lonely and Hollie recalled:

> 'I moved out of my parents' house on the weekend and I started that placement at the bungalows[44] on the Monday, so personal life - personal things were getting in the way of it to start off with, until we just got ourselves settled a bit in our house. So that was a bit difficult, I can remember being really tired for a couple of weeks' (Hollie, first interview, 13.06.12).

[44] A group of bungalows, in a nearby housing estate, it is a residential home for people with long term mental health problems.

The five students discussed their loss of home and childhood; issues around gender identity (Justin and Leigh); intimacy with peers; conflicts between dependence and autonomy; and, finding effective ways of learning to work and play. As a result of these transitions, students were faced with a number of challenges, and it seemed as though 'getting through' the course became a metaphor for the transition from childhood to adulthood. The way these challenges were met and defended was dependant on how similar issues had been dealt with in the past. Hollie for example, was excited about her new experiences, although recalled being tired. Leigh on the other hand described having 'a horrible time the first year':

> '[I]t was just a regular accommodation but it had like two sides to it over like a bridge, and uhm the other side was where all the student nurses were and everything kind of went off there you know like going out and things and I was on the other side and I was with uhm like 2nd and 3rd year foreign students who couldn't speak much English so obviously I didn't go out at all […] I spent most of my time in my room' (Leigh, first interview, 27.06.12).

For Leigh, the loneliness he felt in University accommodation was problematic, particularly given that new situations had been difficult for him at numerous points of his childhood. As described in Chapter Six, Leigh's father left the family home when he was two years old, after which he described their relationship as being difficult (this was discussed under the topic of relationship difficulties previously). He had maintained relationships with his (m)other and sister, however during his childhood he recalled many new situations and changes which had affected him emotionally. The way his (m)other changed partners, and the different stepdads he had, instigated life changes that Leigh would describe as being 'quite a difficult childhood'. The feelings of separation (the initial injury of this being his father) during his childhood, alongside the changes regarding his stepfathers and also being bullied at school, all provoked feelings from previously denied issues about the emotional separation he felt, and subsequently resulted (from a psychosocial perspective) in his student nurse experience living in university accommodation being lonely and unhappy. The feelings of being an outsider triggered past memories as he felt separate from the foreign students, with the feelings of being an outsider within his own home. Leigh disclosed that he had OCD (obsessive compulsive disorder) which is a condition often arising for a need to control certain aspects of life. That is, where obsessions arising from anxiety (usually thoughts,

which are often about bad things including for instance something bad happening, or being full of germs and unclean) are distressing to the person.

Compulsive behaviours are how an individual manages the obsessional thoughts externally, and can appear irrational and bizarre, such as not being able to step on cracks, or needing to check things over and over again. Leigh's newest compulsion was: 'counting, I consistently count, just counting up to like a hundred and things, I don't know why, I just do it...' Leigh was keen to stress that he could control this by medication, and 'keep it at bay' and this suggests he had a need to control things that were happening to him, in a way which was manageable to him (taking Sertraline; an antidepressant which is also approved for OCD), thus maintaining control externally for internal conflict, and mirroring his feelings and previously denied issues about emotional separation and his inability to control this every time there was a change at home (specifically his (m)other's new partners).

From a Kleinian perspective the insertion into an unfamiliar space evokes primitive states characterised by a fear that the external environment is hostile and full of persecutory objects (Klein, 1946). Klein (1948) theorises that fear of annihilation is a fundamental human anxiety. These anxieties about harm, rouse infantile feelings of helplessness and persecution and may lead to the increased use of primitive defences such as denial, splitting and projection (Klein, 1946). Using Leigh's example above, he made a clear distinction (split) between the nursing students and the other students and were literally separated by a bridge. Everything was going on the other side of the bridge (projection), but he was not a part of this and were given as reasons for him not going out at all. There is thus a space in which internal phantasies and unconscious processes may merge with, shape and be shaped, by external realities. He chose (for whatever reason) not to cross the bridge and remained alone in his room. This was anxiety provoking for Leigh at this time but was not the only challenges he faced. One of these was the reality of the ongoing assessments, these are discussed more fully in the following section.

Assessments and Fear of Failure (13 students)

In this sub-section, I explore the anxieties related to assessment, being observed and fear of failure. Ellen was the only student who did not talk much about assessments or fear of failure within the course. She described herself as 'doing well with my assignments' to the extent that she wished she was doing the degree pathway as she would have been 'in line for a 1st

class honours degree'. Instead, she was doing the diploma pathway because it afforded a bursary, which she required to continue the course. Ellen also described getting on well in practice which she put down to having 'good mentors' and to her experience working as a health care support worker. Ellen had started the course with a Master's degree in Special Needs education and had previously been a primary school teacher for over 19 years. She applied to do adult nursing, but changed to mental health because her 'body couldn't cope' (she has diabetes, and diabetic neuropathy which at times caused a great deal of pain in her feet and legs). On the face of it, Ellen appeared not to be concerned about failing, in terms of carrying out the academic work, but it was the practical side of nursing and her 'failing' health that was the issue. So, although she did not express concerns about failing the course, she had transferred to mental health nursing because she felt she would not need to be on her feet for as long. What I found interesting about Ellen as she spoke about her experiences was that she did not manage her diabetes very well. At times, this impacted on her abilities to do the 24-hour shifts that adult nurses work (24 hours being indicative of shifts running around the clock, but mostly 'earlies' in the morning (7am-2pm), 'lates' in the afternoon (1pm-8pm), and then approximately 12-hour long day (8am-8pm) and night shifts (8pm-8am). Ellen dismissed her ability to do this type of work stating that she couldn't stand for this length of time, ('my body can't cope', Ellen, first interview, 04.05.12). Yet on the mental health wards that she was working and standing on her feet, shifts lasted for about the same amount of time as she would have been working as an adult nurse.

It is possible that the focus on her failing health and her difficulties in this area were the reasons for not achieving, and she did indeed have a number of physical health problems, but from Ellen's perspective there was nothing she could do about these and as such the reason for potential failure was not be attributed to any of Ellen's personal weaknesses or mental health problems. Rather, failing physical health can be used as a smoke screen against a lack of resilience or struggles with academic work, clinical work and/or the ability to integrate into ward culture, a common requirement of all student nurses.

All of the other students discussed some concerns about being observed, assessed, and whether they would or would not pass elements of the course, whether that be in practice or their written work. Fear of failure from a psychosocial defended perspective can be seen as concerns about being exposed and not being 'good enough' which triggers deep feelings of inadequacy arising from initial wounds as young children. Students employed numerous

strategies to avoid the disapproval of others and exposure to potentially shaming experiences. It seems that the students' narcissistic fear of being found lacking or deficient, of being found out or challenged in some way, sets up an anticipatory anxiety which students found difficult to control. The educational context of the course, and the need for everyone to complete academic essays makes it impossible for students to evade anticipated narcissistic injury by avoiding such encounters[45].

Another point to note is that at the time, (2012) nursing was still viewed as a 'hands on' profession where degrees were the rarity rather than the norm. Many students hoping to 'move up the ranks' did so due to being skilled in the clinical aspects but weaker academically. For these students, the anxiety was about writing assignments and so on, and while this is still an issue for many student nurses, they are now aware of the academic content before starting the course because nursing is a degree-only profession in line with other healthcare professions including occupational therapy and midwifery. These feelings sometimes created (and still create) covert hostility towards academic staff for placing students in such situations. As avoidance is not possible, two other kinds of defensive styles tended to emerge. Some students adopt an over-apologetic, compliant style often linked to idealisation of the patient and a compensatory style of intervention corresponding with Wilson and Lindy's (1994) over-involved dimension of the countertransference spectrum. So, for example, Betty described herself as a 'people pleaser' and consistently apologised for herself in whatever she was discussing within her interview. As a further example (and as already discussed) Hollie described finding it 'easier to follow their [mentors] way' of doing things. Compliance to mentors' ways of working and learning how to work in the system and follow routines were all identified as being beneficial when it came to practice and studying at university.

Fear of failure may be construed as a self-evaluative framework that influences how the individual defines, orients to, and experiences failure in achievement situations (Heckhausen,

[45] A significant point here, which would not be the case today, is that at the time of recruitment and interviews, the nursing qualification towards which the students were working, was a diploma. First year students always started off on a diploma pathway which was funded by an NHS bursary, and due to this the entry qualifications were 5 GCSEs grades A-C including maths and English. Equivalent qualifications were considered, including Access to Nursing courses and National Vocational Qualifications (NVQs). Students were invited at the end of their first year to move up to the degree level qualification. Many did so however the consequence of this was that the funding was significantly lower.

1991). The minimal research that has been conducted on the origins of fear of failure seems to suggest that it is rooted in parental socialisation and parent-child relations. Alternatively, students became somewhat distant or detached, relying on their professional role to achieve some status and tended to over-intellectualise their work with patients. Intellectualising experiences helps to remove emotions out of the equation, thus making difficult and distressing occurrences easier to deal with. Although a common strategy, it is hard to define or measure, because, unless outsiders also experienced the event, they cannot know how it truly affected anyone who was there. As such, it is not a categorical marker of how a student nurse reacts to difficulties arising at work and can be quite hard to identify outside of the cold detachment mentioned above. A different way of understanding how intellectualisation occurs is to turn it inside out and look at what happens when emotion is in the equation and the effects of this has on the student nurse.

From all of the data coproduced, one of the most memorable reactions to practice was Betty's experience of a patient who suicided while working under supervision of her mentor.[46] Betty and her mentor had been involved in assessing the patient's risk of suicide and both were devastated at the loss. While Betty was emotionally distressed by this, the nurse she worked with left the job quite quickly afterwards. Both experienced negative feelings about the situation and felt bad. After the event, intellectualising this situation helped Betty to reduce these feelings: as although she had been able to 'pick up' on the patient's distress, her role as 'student nurse' meant she had limited input and she deferred to her mentor's status, knowledge and experience. In doing so she was able to minimise any perceived feelings of failure or fear of not being good enough. Intellectualising is a defence which can develop over time and which may not be subjectively realised. However, it was identified within the Francis Report, as previously explored (in Chapter Three), and found to be dangerous and neglectful.

Fear of failure was clearly acknowledged by the students and, having a curriculum and assessment process allowed students to think about knowledge in concrete and fixed ways.

[46] Betty at the time was a student nurse and as such practising under her mentor's PIN (the number given to a qualified nurse and which is conditionally given on the basis of three things: passing the qualification, having good health and having good character). It also as a side note, requires renewal every year at a fee to each nurse, and revalidation every three years, to prove a nurse is up to date with their knowledge and ability to practice safely.

While this helps to reduce the anxiety around the ambiguity of knowledge, the focus becomes on meeting the assessment requirements. In higher education, knowledge is idealised and 'not understanding' appears as a weakness that is not compatible with the intellect and which almost contradicts it. Idealisation of scientific knowledge keeps the difficult facets of the learning experience hidden; ambiguity and confusion are not recognised as inherent parts of the learning process, although '[...] confusion may be the seeds of future creativity' (Coren, 1997, p20). An academic culture that emphasises the superiority of 'knowing' draws students towards easy solutions. It's perhaps not surprising that students try to avoid states of confusion and misunderstanding during their studying, following the competencies as a method of keeping them on track to get through the course. Although perhaps the key to development is to embrace these difficulties and help students to deal with the confusion. A number of students did seek support from tutors, mentors and practice staff, these relationships are explored in the next section.

Relationships (9 students).

In this sub-section, I first discuss student - academic relationships and second, student - mentor/practice staff relationships, and finally student - patient relationships to explore ways in which these relationships both hindered and helped the capacities to care and think critically.

Student/academic relationships

When discussing relationships with academic staff there was a tendency to describe academic staff as either good or bad (another example of splitting). Such relationships were invariably discussed in relation to getting help with their academic work or resolving problems within practice. Leigh, (first interview, 27.06.12) for example, found that 'trying to get support for assignments has been an absolute nightmare,' he continued to explain that, while he understood that people were busy, staff often appeared to 'get annoyed that [he was] asking for help'. He further added that when he did get a tutorial for an assignment asking for some 'clarification' that he was on 'the right tracks' and 'is this kind of what you're wanting?' That staff would 'dance around' his queries and he would 'come out more confused than when [he] went in'. When I asked him: 'Is this one particular tutor?' he responded: 'The whole kind of, no individual, though my personal tutor is difficult to kind of…' He went onto to describe how lovely she was, but that she was 'busy' and 'difficult to get hold of', before

going on to talk about another lecturer who told him that the work that he was doing was right, yet he only got 45% for the assignment. He didn't feel able to go back and ask the tutor how he might have improved his grade. His experience of disjointed understanding and a lack of clarity links back to the lack of consistency he experienced during childhood. The relationships and the frustrations from these, a lack of stable figure to approach and the uncertainty of this course and his capabilities, provoked deep-rooted anxieties about his learning.

Only two (Graeme and Leigh) of the 14 students discussed their relationship with their personal tutor and neither of them had positive experiences to share. For example, Graeme did not like his personal tutor, stating that if he went to see her regarding anything her stock response was to refer him to the module guidelines. He described her as treating him like a child, in that she accused him of not attending lectures. He went onto to explain the problems with another lecturer who had failed to submit a number of registers, so he and many other students had been marked as absent from class, when they had in fact attended.

Graeme had needed support for a number of issues during the course, but preferred not to go and see his personal tutor; he went onto to describe getting alternative support from one of the other lecturers. When I asked him what it was about this lecturer, he liked he quickly responded 'she believed in me' (Graeme, first interview, 18.05.12). He elaborated and went onto to say that he thought his personal tutor was a 'service user' (suggesting she has mental health problems) and as such he really did not want to burden her because she seemed to have 'enough on her plate already' (Graeme, first interview, 18.05.12). It is interesting to note that Graeme was reluctant to approach his personal tutor with her perceived vulnerabilities, rather, he turned towards another member of staff who believed he could achieve. The feelings provoked in each situation are representative of past relationships with authority figures and can be viewed as transference, when feelings toward a current person are irrational and based on past experiences, which is common particularly when involving relationships where there are power dynamics such as patient - therapist and in this case, student - teacher.

Relationships with practice staff and mentors

Relationships with mentors and staff were varied within each of the narratives and between the different students. Past experiences were described as being both an advantage and

disadvantage amongst the students. Ellen for example, viewed her past experience as an advantage, as she was able to build on her previous knowledge and skills:

> 'I was already working in care homes anyway, so we were doing now at a higher level with my mentor, going to the same places, not the same place where I was working, but the same settings where I was working. So, I was looking at it in a different way, so I was putting myself in the position like a carer, like I was before, what I was doing and now I could see things in a different way, that I was wrong doing this. I think this is the right way of doing it, so it is modifying what I was doing before' (Ellen, first interview, 04.05.12).

Ellen identified past wrong doing, but through her educational experiences and reflection had modified them and she thought this had developed her capacity to care. Not all students found past experience to be helpful, especially when it was felt to be 'taken advantage of' when staffing levels were short. For example, Debbie described her feelings of frustration being treated as a HCSW and not a student nurse:

> 'I had a very bad experience on one of the acute wards and that was [*big sigh*] the worst. It wasn't anything to do with the course, I think it was just how they manage students on there. […] I'm supposed to be learning how to be a nurse, I'm supposed to be learning how to manage such areas and all that you are getting me to do is open […] the cigarette door and do intermittent obs[ervations]' (Debbie, 1st interview, 04.05.12).

Debbie described putting up with this for three to four weeks, but started to dread going onto to placement to the extent that she thought about going off sick. She decided not to do this, but instead started to complain to staff about her role:

> 'I would say: 'I'm sorry but that is not why I am here' and then you know, some people get their back up and you know it gets my back up because obviously I can see their reaction and they can see mine and I'm just like, what are we going to do because I wouldn't back down' (Debbie, 1st interview, 04.05.12).

There were a number of different responses to Debbie's complaints: 'are you not here to help us? You know, you can see we are short staffed… are you not going to help us out?' 'We're gonna have to talk to your university because we're not gonna have students come here if they can't do those checks' (Debbie, 2nd interview, 31.10.12). She described her experience cautiously, saying:

> '[A]s a student it puts you in a very difficult position because you want to help out but you don't want to be taking the Mick out of and generally that placement was just about… they were treating you like you were another member of staff, even though you were supposed to be supernumerary and the things that you wanted to do, some of them wouldn't let you do it' (Debbie, 1st interview, 04.05.12).

The conflicts Debbie experienced from staff were about the different agendas and expectations of those involved. Since the move to higher education, students have been afforded supernumerary status, so that they can prioritise their learning. However, staff have a number of tasks that needed to be carried out for any day and problems with staffing levels often thwarts student learning. For example, Debbie wanted to learn how to do 'the drugs round' and to administer medication and to carry out this task she needed to be directly supervised by a registered nurse, thus it takes two people to carry out this undertaking rather than just one, so the task invariably takes longer because it is a complex process and a mistake could be potentially fatal. Staff often felt resentful towards her for being there because she was not willing to help out and wanted to do things which were seen as adding to the workload. The main thing she learnt was 'to get on with people I don't particularly enjoy working with.' Ultimately, Debbie did back down, and became compliant (did what was needed to survive the environment she was in and pass her competencies), 'counting the days off' to meet the necessary hours required to complete the placement. However, she felt denied the learning experience she had been promised, and realised that much of passing the course is fitting into the setting within which one needs to work. In Winnicott's terms she developed a new 'false' self.

It is not uncommon for students to carry out HCSW roles, in fact students are usually happy to do so having entered nursing to care. This is usually expected from the HCSW that students 'muck in' and help them and there are blurred and changing boundaries between the roles of HCSW and staff nurse. From all the tasks there are plenty of learning opportunities, it

is also important to learn these different aspects of care as qualified nurses are expected to delegate similar tasks when qualified and so is important to know what is required to ensure that delegation is carried out with the appropriate people; but as Graeme said 'Once you have done the physical obs[ervations] on 17 patients twice a day for five days a week you kind of know how to do physical obs on patients.' (Graeme, first interview, 18.05.12). However, this task orientation rather than patient orientation is reminiscent of what Menzies-Lyth found in the 1950s whereby tasks were fragmented and divided which insures each task is carried out and the demands of the ward are being met, but has a way of splitting up the nurse patient relationships and depersonalising care.

Sometimes, learning experiences were put aside to accommodate the needs of the ward, which was best for the current patients. However, the learning experience of the student nurse was not what it should have been, in so far as students were not being able to practise the nurse role but rather complete the tasks needed for the ward to function. Given Debbie's experiences of needing to 'fit in' to 'get through', sometimes becoming subservient is helpful. This is, however, problematic in that subservience is not a positive trait in a nurse expected to act as patient advocate, to delegate to other staff and to communicate with other medical professionals including doctors, physiotherapists, occupational therapists and healthcare assistants/support workers. Also, and aside from the skills needed to develop a therapeutic relationship, confidence and professional autonomy is vital for the very basis of patient care across all branches of nursing, that is, the ability to assess, plan, implement and evaluate care.

Relationships with patients

Student nurses are often confronted with some ugly and dark human experiences, and this is especially common for patients with mental health problems. Early trauma is often the basis for many mental illnesses and these include images of serious physical injury and danger, of death and dying, of sexual assault and degradation, of sadism and cruelty, of inhumanity and apathy, and of extreme deprivation. Every patient copes in a variety of ways with different experiences, which can provoke anxieties in the student's own experiences, of being able to cope and of wanting to manage the difficult images, feelings and thoughts that looking after patients with traumatic backgrounds creates. While it is important that nurses and students acknowledge these past traumas, how they themselves cope with this needs much support.

This anxiety relates to the anticipation of hearing harrowing material that may be beyond one's capacity to bear. Will one be traumatised oneself in the sense that the 'trauma consists essentially of a contained that destroys its container'? (Hartke, 2005, p.282). Much of this is determined by personal individual attributes, as is the way patients react to trauma. In this way nurses and patients have much in common. Some are resilient and can cope with serious trauma without injury, others meanwhile find 'lesser' (and note the inverted commas as what might be lesser to one person will be serious to another and this kind of measurement of trauma is heavily subjective) traumas are often highly distressing and disabling.

The literature on the treatment of traumatic stress has emphasized the potential impact of empathically engaging with such distressing and shocking patient accounts (Figley, 1985; McCann and Pearlman, 1990). Mentors need to be mindful of assisting students to manage fears of contamination, to hold on to the good, to minimise over-identification and to curtail the impact of the bad. I return to this in chapter eight. Trauma comes in many different forms and one of these can be a new diagnosis. For two of the students in this study their recent diagnoses of learning difficulties were traumatic and influenced their capacities to care and think critically. These are discussed in the next section.

Diagnosis of learning difficulties (5 students)

Amy, Betty, Caroline, Debbie and Ian identified having some form of learning difficulty. Caroline was the only student who had received a diagnosis early on in life during her primary school education. She had found this diagnosis helpful because she had received extra support to help her with her reading and writing. Ian did not have a diagnosis of dyslexia 'because I never went for the test because I didn't think it would be that helpful, but I definitely was. I could hardly read until I left senior school' (Ian, first interview, 15.06.12). He continued to elaborate:

> 'Bloody travesty! Bloody educationalists […] I was put in the bottom group for everything. They assumed that I was completely thick, couldn't do anything, couldn't add up or anything, but I couldn't read. […] So, I quickly convinced them that I could count, probably as good as them by the time I was about six […] that was a constant fight all the way through school […] my reading was absolutely awful. […] The first book that I ever read all the way through because I was interested in it was Aldous

> Huxley's Brave New World then I was off and running, haven't stopped since. […] I have to compensate for [my reading] if I'm writing in notes and I know the word I want to use but I can't spell it, I'll think of a shorter one that means more or less the same thing' (Ian, first interview, 15.06.12).

Ian had never received educational support for his difficulties but had learnt to adapt and had started his nurse education with a BSc in Psychology. Amy, Betty and Debbie only found out they had a learning difficulty during their nurse education experience. For Debbie, this was at the beginning of the course:

> 'I found out when I started a course this January time that I was dyslexic and again I think, I kind of understand it because it's the same with my speech I'll jump here, jump there, so my writing is the same, my grammar isn't particularly brilliant, so I thought like ok, but university in that sense has been really helpful because I have got a support tutor who helps with all my assignments, and helps trying to keep me focussed on my assignments with subjects, uhm helps with the grammar, gives me things to take away'.

For Caroline and Debbie, receiving support with their learning had assisted them to get through the course and both had appreciated this. Amy and Betty on the other hand, had only been tested towards the end of the course both as a consequence of failing. Amy with her written work (dyslexia) at the beginning of the third year and Betty with her numeracy test (she had a diagnosis of dyscalculia and dyspraxia), this was diagnosed in the six months between our first and second interview. Neither Amy nor Betty could see the benefits of these diagnoses and were having problems coming to terms with them.

Of her diagnosis of dyslexia at university Amy said:

> 'It just floored me […] I wish I would never have known, at this point […] at Uni [because it] just [made me] doubt my capabilities all the time […] My dyslexic tutor said, it makes people feel a lot better because you can say … but has not with me. I can't handle it' (Amy, first interview, 28.03.12).

Betty was having similar problems with her recent diagnoses:

> ‘I’ve actually just been diagnosed with dyscalculia and dyspraxia which was quite illuminating, so my mentor said that’s a huge impact really and I said: ‘well I’ve got it in a box at the moment’ and then she said, ‘is your communication skills affected?’ And that was the one area I felt safe with and I said: ‘well, no, not that I know’ and she said: ‘well you have got an odd way of communicating’, so I said: ‘I’m going home now’ and I just went home. So, I had a bit on an identity crisis about that but I’ve been assured by friends who are real with me that I haven’t got a weird way of communicating’ (Betty, first interview, 28.03.12).

Now in receipt of two diagnoses, Betty acknowledged that she knew what it feels ‘like to get a label’ although she knew she had problems with numbers she did not realise she was ‘so terrible you’d need a label’. People with learning difficulties, as with people who experience mental health problems have long experienced prejudice and discrimination. Researchers have been able to study prejudice, and discrimination as stigma and have begun to examine ways of reducing this stigma (Corrigan, Watson and Barr, 2006). Public stigma is the most prominent form observed and studied, as it represents the prejudice and discrimination directed at a group by the larger population. Self-stigma occurs when people internalize these public attitudes and feel weak, ashamed and embarrassed. On asking Amy what this diagnosis meant for her, she replied: ‘well I think it means you’re thick. Whereas, I know it don’t…’ Both Amy and Betty viewed their diagnoses as evidence of a weakness, which would be perceived by others as such so they had started to doubt themselves and appeared to be ashamed. As Amy described:

> ‘I think the stigma, I don’t like to tell people, I would tell them if need be. I’ve dropped it this year because I failed but I have never used, you know, like I would never had extensions up until yesterday actually’ (Amy, 1st interview, 28.03.12).

While the diagnoses received might have explained the difficulties, they had both experienced at school, it had an impact on their self-identity which they were struggling to come to terms with. Both had been punished for their ‘failings’ while at school, Betty was ‘castigated’ for not being able to read; Amy was ‘kept in’ for two weeks every time it was report time, for not concentrating. It is perhaps not surprising that they felt ashamed of the label, the defences employed to right these wrongs can be seen in Betty by going to

University and by becoming a ‘wordsmith’. Amy had become active ‘I have always got to be doing something, I’m like, manic sometimes’. Both were proud of their achievements which were validated by Betty gaining her two degrees and Amy by buying two houses and going on expensive holidays. Both had used manic reparation as a way of overcoming these difficulties, Betty by constantly reading and Amy by relentlessly being active. This offered a measurable indicator of success for both of them, in spite of implied failure which results from difficulties with academic success.

Conclusion

In this Chapter, I continued to position individuals as psychosocial defended subjects, and highlighted the anxiety provoking pedagogical experiences, which generated common defence mechanisms, namely: splitting, systematicity, compliance and reparation. The chapter has revealed a wide array of dimensions within the social, including the understandings, significance of meaning and experiences of participants, and the way that social process, institutions, teaching and learning relationships work. It has demonstrated in detail the complexities of the pedagogical experiences’ student nurses must face, and illustrated the anxieties arising from numerous aspects of the course including around academic expectations, clinical practice, forging relationships with clinical and academic staff, mentors, dealing with highly unpleasant and distressing past experiences of patients and the need to cope with these in a way that the capacities to care and think critically are maintained.

Chapter Eight

Conclusion: Review of the Research and Implications for Becoming a Mental Health Nurse

Introduction

In this final chapter I summarise my research findings and the contribution they make to understanding the experience of becoming a mental health nurse, including students developing capacities to care and think critically. Chapters Six and Seven showed that by positioning students as psychosocial defended subjects, reparation can be seen as a motivating factor for becoming a mental health nurse, which has an influence on students' pedagogic experiences thus affecting their capacities to care and think critically.

This chapter is divided into four subsections. First, I recapitulate the purpose and findings of this study. Second, I critically examine my contributions to knowledge in three areas: theoretical, methodological and practical. Third, I offer a brief autobiographical account of my own learning. Finally, I explore the implications of my findings and make suggestions in relation to education, policy and future research.

Review of Purpose and Summary of Findings

The central purpose of this study was to use a psychosocial framework to explore the previously neglected interrelationship between becoming a mental health nurse and the student experience of nurse education in a research-led university in the UK. It was carried out at a time when concerns have been raised within nursing, the media and the public about the art of caring being lost within contemporary nurse education and practice. This purpose was framed as two research questions that I addressed by developing a methodology built on a synthesis of my teaching observations, psychoanalytically-inspired psychosocial theories and narrative research. As a reminder, my research questions were:

- What psychosocial factors influence the desire to be a mental health nurse? and
- How psychosocial factors influence students' pedagogic experiences?

Applying the concept of the psychosocial defended subject, I intended to challenge dualistic thinking about care and intellect and the individual and the social by conceptualising subjectivity as, simultaneously, the product of the unique psyche and a shared social world.

My findings corroborate the 'wounded healer' literature, in that students' various 'wounds' directed them towards mental health nursing because from a psychosocial perspective such a choice contained hope for amending childhood loss and unmet need by caring for vulnerable individuals. I found that reparation is a strong motivational factor for wanting to become a mental health nurse and as I have demonstrated, there is a relationship between student mental health nurses and their care work, which results from the interplay of internal and external processes which operate throughout life.

Childhood experiences, especially in the areas of attachment, care giving and illness predispose the need to care for others as a defensive response to feelings of anxiety, helplessness and/or isolation. The desire to care for others is, to some extent, driven by unconscious identification with patients, based on students' projection of losses and unmet emotional needs. I found that such wounds were acknowledged and seen as enhancing therapeutic capacity, that is, my research participants could identify and empathise with others. However, for some, manic defences were often employed and these had a negative influence on students' capacity to develop therapeutic relationships and think about how to care. Left unexamined, these difficulties had damaging influences on the patient, and the student.

Both the 'wounded healer' literature and Kleinian informed psychosocial theory suggest that people are drawn to certain occupations like mental health nursing because it offers an opportunity to work on mourning (loss of people, ill-health) through reparation and helping others to work through unresolved issues. My findings show that mental health nursing attracts individuals with similar internal needs to those of their patients and with each other. They have a propensity or valency to fit with certain kinds of defences which, if the reparation is 'manic', hinder task performance, in this case the capacities to care and think critically. Being compliant, getting over involved, and depersonalising patients and staff can become ways of protecting against the anxieties created not only from working with people with mental health problems but also from meeting the organisational and learning needs required to get through the course. Understanding the psychosocial aspects of becoming a

mental health nurse can help with finding ways of enhancing caring and thinking capacities and are explored further below under implications for education.

Contributions to Knowledge

I make contributions to knowledge in three areas: theoretical; methodological and practical.

Theoretical Contributions to Knowledge

By positioning student mental health nurses as psychosocial defended subjects in relation to their pedagogical experiences I have extended literature by highlighting how the complex dynamic interplay between individuals, objects and environments is influenced by unconscious processes and associations that are often overlooked in the field of mental health nurse education. This study drew from a psychoanalytical informed psychosocial theory which has not before been associated with research about choosing a career as a mental health nurse. I have thus offered fresh insight into how psychosocial influences shape mental health students' career choice and pedagogical experiences. Adopting a relational ontology, enabled me to approach the interplay and consider each element as equally significant. No one else has articulated how the links and processes of reparation add to previous research on the 'wounded healer' contributing to understanding about students' conscious and unconscious experiences.

I have built on Menzies Lyth's (1959) original social defences against anxiety proposition, by using contemporary research to describe the evolution and maintenance of organisational and individual defences within mental health nurse education and practice. My study provides evidence that student mental health nurses invest in certain discourses as a way of defending themselves against their anxieties. I found that both true reparation and manic reparation motivated the desire to become a mental health nurse. As discussed within Chapter One and Three, nurses being educated to degree level has led to them being discursively positioned as 'too clever to care' suggesting that intellectual ability and relational caring are diametrically opposed. This study has shown that both intellect and caring are inextricably linked: that nurses require both capacities to give individual patients the most appropriate and effective care; and both capacities can be affected simultaneously when certain defences are employed (for example, compliance).

Motives for wanting to do mental health nursing is rarely investigated, so my study offers some insights into this career choice. Perhaps few studies being carried out is due to our own defensiveness about what might be found. Acknowledging vulnerabilities and our identification with people with mental health problems does not fit well with the notion that as helping professionals we should not have feelings of helplessness that require exploration. I have contributed to the idea that having a better understanding of such vulnerabilities, while emotionally difficult to explore, can prove beneficial when it comes to caring and thinking about those with mental health problems. By acknowledging rather than denying these vulnerabilities, student nurses and nurses may engage with, reflect upon and manage their own and others' emotions, which can greatly improve practice and the standard of patient-centred care (see my suggestions for policy and practice below).

In this way, I have added to the theoretical debates within contemporary nursing education in England and the link between university-based education and poor-quality nursing care provision. By applying the concept of the psychosocial defended subject, I have challenged two forms of dualistic thinking *both* about care and intellect *and* the individual and the social. In Chapters Six and Seven I show theoretically and empirically that caring behaviours and critical thinking dispositions are mutually inclusive and are essential components of being a capable mental health nurse. I revealed a wide array of dimensions within the social, including the understandings, significance of meaning and experiences of participants, and the way that social processes, institutions, teaching and learning relationships work. It is therefore of equal importance to not only consider the qualities of the individual mental health nurse but also the workplace culture in which that care is provided. That is, both caring behaviours and critical thinking dispositions are influenced by dynamic *psychosocial* factors.

Methodological

The second contribution to existing knowledge is uniquely combining the two methods adopted in this study. I used a life grid to obtain autobiographical data. I then used the Free Associative Narrative Interview (FANI) method for gaining insights into student nurses' experiences of their educational course in two interviews. By combining these methods, I was able to shed light on the relationship between individual development, motives for career choice and how these might influence student responses to education and their capacities to care and think critically. This psychosocial approach revealed a wide array of dimensions

within the social, including the understandings, significance of meaning and experiences of participants, and how social processes, institutions, teaching and learning relationships work. This approach was innovative and reflexive and involved bringing together many strands of data through students' narratives about their past life experiences and pedagogical encounters as they learnt to become mental health nurses. I also focused on the interaction between myself as a researcher and the students as participants, exploring how researcher subjectivity can be interrogated as a source of evidence.

Practical Knowledge

The third contribution to knowledge stems from the use a psychosocial approach to understanding associations between students and educators and the nurse-patient relationship. This approach provides a framework for students, nurses and educators to understand their emotional experiences when working with others. I have argued that reflecting on feelings with student mental health nurses psychodynamically may help them to integrate their theoretical and practical learning. Learning to work with feelings means that, following Menzies-Lyth, the nurse is aware that as well as the clinical dimension of delivering care, there are also social and emotional processes at work within interactions with patients which affect how we feel and behave. Sometimes we are aware of these feelings and can reflect in action, this means we can recognise the patient's feeling and our own responses, and act appropriately. Sometimes we can only reflect on action, that is, after the event and learn from that reflection to work differently in similar situations in the future. Working with feelings is as important now as when Menzies-Lyth first observed nursing practice because the conditions for exploring emotions are frequently not present and students end up feeling unsupported and unable to link theory and practice effectively. Working with feelings can help students, nurses and educators to tolerate the difficult emotions that are part and parcel of mental health nursing practice and education.

Autobiographical Reflection

Undertaking this research has challenged me both intellectually and emotionally. Engaging in reading, talking to student nurses in depth, thinking and writing has challenged my understandings of the nuances and complexities involved in deciding to become and learning to become a mental health nurse, which includes myself. It has also challenged my understanding of my immediate environment and how I could emotionally be engaged with

people without being consciously aware of it. I have gained some insight into the cyclical, sometimes messy, nature of the research process. I have discovered, for example, that things do not fit neatly into categories and that research can be challenging, frustrating and tedious, yet at other times immensely rewarding and exhilarating.

Furthermore, I have also learnt to beware of the danger of drawing a conclusion that gives an indication that I know myself and others, when I don't really know. For instance, I started this study as someone who thought I knew myself and student nurses, and their experiences very well but my lack of understanding of the anxieties and defences within mental health nurse education has been highlighted. My awareness of the limitations of my own thinking and of the need for me to learn more about the visible and invisible aspects of myself and others has been increased.

I have decided not to reveal my personal narrative in this research, but my narrative parallels the student mental health nurses who are the focus of my study. The ideas about reparation and psychosocial defence have helped me to develop personally and professionally as I have examined my own motives for career choice, professional values and guidelines for possible changes to my own future practice. Carrying out and writing up this thesis has been a challenge for me, that is, as a mental health nurse working in higher education, I continue to have similar fears of failure and about 'not being good enough'. And I felt guilty about not representing the students' voices sufficiently or my interpretation of the data not being an accurate reflection of those I spoke with. Moreover, I am working in a culture where I am subject to the same pressures, persecutions and projections from students, staff and public and so perhaps am now more sensitive to the anxieties and defences experienced by mental health student nurses, nurses and educators. Such an exploration into self and others within mental health nursing keeps me alert to the anxieties and the defences employed. The problems I have had in thinking when immersing myself in data and then analysing and constructing the chapters reminded me of the defences, we all employ when knowing becomes too painful to tolerate.

If we hope to improve critical thinking and caring within mental health nursing practice, then my research suggests the need to explore the complexities of individual and collective defences that are evoked when learning to become a mental health nurse. Given the rapidly changing and often conflicting influences on nurse education as outlined in this thesis, it is

vital that as a nurse educator, I reflect on my future role in terms of credibility and consider how this is measured and evaluate my influences in the present, and to consider how I maintain my values as a mental health nurse and educator in the future.

Implications for Mental Health Nurse Education, Policy and Research

This study proposes that there are unconscious processes that propel student mental health nurses' career choice and pedagogical experiences; and that such processes affect their practice, in particular their capacity to be caring and to think critically. If this is the case, institutions and organisations that educate mental health nurses need to equip students with the means of developing an understanding of themselves emotionally in their dealings with their patients. Education, practice and policies need to work differently to account for reparation as a central motivator and for defensive mental health nurses interacting with other defensive professionals and defensive patients. This is of particular importance given the national nursing shortage and 'moral panic' amongst professionals, the public and within the media about the quality of nursing care in the UK. Understanding how individuals perceive and come to choose and experience mental health nursing and its education holds implications for recruitment, education and the retention of healthcare staff who are capable of caring and thinking about others.

Education

Within this section I offer three key suggestions for mental health nurse education, the first relates to the recruitment of a compassionate work force; second I consider introducing object relations theory into the curriculum; and, finally I explore developing supervision or 'learning groups' as a space to contain students' anxieties, help them to develop self-regulation and focus on self-care.

Recruitment

In terms of education the first issue is the selection of people who are able to learn to be competent, compassionate and thinking mental health nurses. The NMC (2010) offers guidance about recruits, including academic criteria and evidence of 'good health' and 'good character'. The guidance includes the values, beliefs and attitudes deemed appropriate for the nursing profession. Examination of individual vulnerabilities during selection would be

helpful, remembering, however, that it is about acknowledging, recognising and embracing vulnerabilities rather than discounting or excluding them. So, during the selection process, it would be useful to explore applicants' motivations and whether they have sufficient insight to help others, to judge in theoretical terms whether true reparation and/or manic reparation dominates their defences. Asking potential recruits what it is they like about helping others, rather than taking responses at 'face value', may indicate the underlying motives for individual altruistic behaviour. Such questioning would require that those involved in the interview process have the knowledge and skills to identify (through transference and countertransference) unconscious motives and so some training and education for university and practice staff would be necessary. Mander, (2004, p166) suggests 'link[ing] the wound and the wish' at the assessment stage of applicants for training. Exploring the altruism that often emerges in interview by using a FANI approach could be a way of gaining a gestalt view of the individual.

The Curriculum and Object Relation Theory

From an early stage in the course the vulnerabilities of students should be more closely explored. During the course, students could be encouraged to recognise and discuss the link between their own life experiences and their career choice, emphasising that their personal vulnerabilities have both positive and negative potential in their careers. Likewise, nurse educators need to be open to self and students in this regard. The concepts of loss and deprivation and reparation need consideration and the defences used to manage them. So, in addition to the regular curricular requirements, students could be taught how to work with their vulnerabilities. The challenge for educators is to contain vulnerability, rather than control or project it. Vulnerability should be acknowledged not as a hazard but as a part of life, learning and mental health nursing. This aspect of helping students to recognise and contain vulnerability relates closely to Klein's concept that working through anxiety is the precondition for all development.

Student nurses are not routinely educated in object relations theory. Yet, psychodynamic training, with its emphasis on careful evaluation, exploration of unconscious conflict, transference and countertransference, and other therapeutic phenomena, could enable nurses to provide care and be thoughtful. A psychoanalytic approach to the nurse-patient relationship provides a framework for nurses to understand their emotional experiences when

working with others. It can also offer a way to make sense of patients' difficult presentations, in terms of unconscious communications about their emotional states at a time when they are unable to verbally express how they feel (Gallop and O'Brien, 2003; Warne and McAndrew, 2005; O'Kelly, 1998; Warne and McAndrew, 2007). Importantly, a psychoanalytic approach may help nurses to accept patients' experiences as true reflections of the distress they feel; however, it is being manifested (Warne and McAndrew, 2005).

An exploration of transference and counter transference (of all those involved) within a containing environment could enable students to work with people they find challenging. Students in this study who struggled with the emotional demands of practice placements, who were offered supervision[47], expressed profound relief on encountering the concepts of unconscious communication and that under pressure we can all regress to infantile or primitive states of mind where empathic understanding of the other is prevented. Having an awareness of the different states of mind can help students to realise what they need to ask of themselves, their mentors and their placements when it is difficult to empathise with others.

Students require sufficient space and support on a regular basis to explore the dynamics of relationships because they frequently feel overwhelmed within practice and university environments. Having a regular safe space can allow students to share and process feelings which can provide valuable learning experiences. Such group supervision can be carried out in a variety of ways and it is up to the nurses and nurse educators to choose the best model for their students and their practice. Although not always labelled as supervision, similar groups do already exist elsewhere and are usually traced back to the 'T' groups or training groups of the social psychologist Kurt Lewin (Shaffer, 1978). Lewin's T groups were not therapy groups but were designed to help managers within large organisations to become more sensitive to the interpersonal and group dynamics within their work place (Lewin, 1952). The aim of the groups was to provide an appropriate space for experiential learning, based on the notion that personal experience and reflection can lead to transforming knowledge and understanding. I propose that similar groups are developed to support students' learning and well-being and is considered within the next section.

[47] Supervision consists of a (or groups) practitioner(s) meeting regularly with another practitioner (supervisor) to discuss working experiences in a structured way and is considered to be 'good practice' by the NMC (2015). It has three objectives: normative (e.g. quality control), restorative (e.g. encourage emotional processing) and formative (e.g. maintaining and facilitating supervisees' competence, capability and general effectiveness).

Learning Groups and Self-Care

My analyses revealed the need for student mental health nurses' anxieties to be contained, so that they can learn to think critically about and care for others. One well known model of supervision that is pertinent to this study is that of 'learning groups' as developed by Patrick Casement (1985), where he emphasises the need for the supervisee or students to develop an `internal supervisor'. This is not a model of an internalised supervisor in the sense that the student thinks about what the supervisor might do or say under certain circumstances, rather that the student develops a process of self-dialogue, so that in the presence of their patients, they can think on the spot or develop the capacity for `reflection-in-action' (Schön, 1983). Casement advocated the use of group supervision as peer learning and feedback from within the group because this can help reduce an over reliance on the supervisor/leader. Learning groups can help provide a 'third space' relative to the supervisor - supervisee relationship which can help the student to develop this internal supervisor. Although from my own experiences as a group supervisor there are added aspects of peer relationships which can hinder the learning process, there is thus the need for supervisors to have a good understanding of group dynamics and the need for the supervisor themselves to have their own supervision to help with the further development of the group and offer containment for the container (the supervisor within learning groups). I suggest that the psychoanalytic concepts that have contributed to enhancing relational elements of the therapeutic process within nursing may also enhance the ability of educators to work in the relational dimension during the educational process, which can reinforce learning as applied to the practice situation.

In addition to helping students understand the unconscious processes involved when working with others, within the learning groups, it would also be useful to help individuals identify the socially structured defences in the particular organisations where they work (Menzies Lyth, 1960; Bower, 2005). For example, how an outcome-led culture of service delivery can either support or substitute for professional responsibility, depending on whether service outcomes are used as the only standard of evaluation or as a support for triangular thinking where the often-competing concerns of patients, institutions and professionals must be held in balance. That is, to help students both understand and 'feel' differences between governance as regulation and governance as containment.

As well as considering the nurse patient relationship from a psychosocial perspective and the social defences employed, I also recommend that the notion of self-care be considered throughout the educational process, as this can assist with the students' anxieties and the defences they employ. It may also aid in alleviating some of the negative stigma that seems to exist among students (and nurses) regarding vulnerabilities among professionals. There is scope for supporting students' vulnerabilities as they arise through the educational processes whether that be within practice or in the classroom and space to contain these anxieties is required in order to assist students to better engage with their experiences and manage anxieties in more integrated ways. Incorporating this into the nurse education course as a way of encouraging nurses to start taking better care of themselves, recognising that self-care needs to be carried out in order to maintain their own mental and physical well-being when working with vulnerability. That is, the emotional side of nursing and its education needs to be considered to help those involved to contain their own vulnerabilities.

In order to meet these needs, students could be encouraged to seek support and this can be done in a sensitive and compassionate manner. Possible sources of support include support groups, personal 'maintenance', counselling or therapy. However, mental health nurse education is not a substitute for therapy. As Bion (1961) put it, the group cannot be used as a vehicle for individual therapy. The role of personal therapy or counselling is unfortunately contentious, perhaps epitomising the defensive relationship nurses have with their own vulnerability. Most will defer seeking personal help until a crisis forces it. It is not yet fashionable, at least in public health services in the UK, to be in therapy. As professionals, we tend to think of therapy as a remedial treatment, overlooking its potential as a prophylactic or maintenance activity. Therapy can offer an opportunity for personal reflection away from the workplace, and also allows a review of the balance between work and other parts of one's personal life. Many resources can be accessed, directly or indirectly, through local psychotherapy departments, most of which are happy to provide both consultative and direct clinical services. There are also University well-being services offering: counselling, support for mental health problems, disabilities and provision of mental health mentors and special allowances; in addition to peer supporters and funding for practical items which may help students, for example, Dictaphones when they cannot focus or things for dyslexia.

I believe that we need to establish a professional ethos in which self-care is viewed as a moral imperative (see also Carroll et al., 1999). At a systemic level, the inclusion of guidelines

regarding the practice of self-care needs to be incorporated within professional codes of practice. At the institutional level, the current focus in universities and professional schools of nursing clinical skills is not enough in that, it ignores the intimate forms of human engagement that exists within mental health nursing and mental health nurse education. Such relationships evoke powerful feelings of love and hate, desperate dependencies, and rescue ph/fantasies that can be unsettling for patients, nurses, students and educators alike. Similarly, it can be unsettling for students to realise that the patient is not the only one who is driven by unconscious motivations. Many students have gotten into university through hard work, the university setting is based on meeting learning outcomes and their interest in mastering information. For these students, it can be anxiety-provoking to sit with the ambiguity inherent in mental health nursing and mental health nurse education situations. The wounded healer can remain hidden in a profession that implicitly, and at times actively, encourages denial of vulnerabilities. Through the learning groups students may be able to transform the unfamiliar through containment and reflection, possibilities arise for greater capacity to contain patients' anxieties and also for personal transformation. Learning groups have a potential role to play in this regard by helping nurses and students to accept and detoxify the projections and then tolerate these anxieties, rather than simply experiencing them. Through the sharing of personal experiences with others, in similar positions, provides a space, whereby the group as a collective can develop theories that can be further tested and refined within practice. Thus, these groups foster learning through experience and developing ways to understand the unconscious communications that both they and patients bring to the therapeutic relationship.

Therapeutic relationships between patient and nurse is at the heart of good nursing care (as discussed in Chapter Three). The relationship includes the nurse's capacity to 'be with' the patient, in addition to carrying out therapeutic procedures. The 'being with' aspect of the relationship makes emotional demands on the nurse, but it is intangible and cannot be measured, whereas the 'doing to' skills can be acquired through measurable competencies. Being with patients in psychologically disturbed states of mind is an important part of good mental health nursing care. Exposure to disturbed states of mind, however, can leave professionals and nursing students with difficult and sometimes undigested feelings that may impinge on their capacity to think about and care for others.

This section has focused on suggestions for nurse education, in relation to recruitment, introducing object relation theory into the nursing curriculum and developing learning groups

to support students as they become critical thinking and caring mental health nurses. Given the psychosocial approach there is also the need to consider the wider social issues of policy and this is explored in the next section.

Policy

Within the context of rapid change within mental healthcare and higher education, under threat of neo-liberal endeavours, this section centres on the wider context of surveillance and scrutiny by a range of stakeholders. There is a sense that current approaches to management within healthcare and education contain elements of what Patterson et al. (2011) call a 'perform or perish' culture, that emphasises quick fix, short-term top-down change; with punitive transactional leaders and superficial metrics as indicators of success (for example, reduction in suicide rates and National Student Survey scores). Reflecting on Menzies Lyth, the perform and perish culture influences the anxiety generated by such surveillance of the NHS by patients, the government and the media. The Francis Report (2013) for example, may well be adding another level of anxiety as a response to poor standards of care that were seen at Stafford. The report identified a number of contributing factors to the poor quality of care provision. These include a target driven management culture of fear; secrecy and bullying; poor leadership, poor staffing levels and a lack of compassion portrayed by healthcare staff. Despite the report highlighting systematic failings right across the organisation, much of this criticism fell on the nursing profession.

Blaming nurses refocuses attention away from more difficult problems and implies easy solutions. For example, in the Francis Report recommendations regarding nursing recruitment and that this should include a test of compassion, a concept difficult to define let alone measure, such an approach also implies that it is something individuals bring to the course and not something that can be learnt or developed through the educational experience. Anxiety and blame are pushed around the systems from, to and between patients, nurses, managers and the government. This is indicative of the defences that stem from the paranoid-schizoid position as the institutions employ, splitting, projection, denial, idealization and denigration. A more integrated approach is needed (indicative of the depressive position) to shift from a 'blame culture to a learning culture'.

Approaches to mental health nursing and education requires a 'relational and responsive' model (Patterson et al., 2011) that recognises complexity and uncertainty, can be tailored to individual situations; transformational leadership, with all stakeholders being included in the planning and change process and success being measured by meaningful relationships and quality indicators. Indeed, a new 'learning from mistakes league' was developed by the Department of Health (2016) the aim of which is to drive up safety standards and to learn and make improvements, not to find fault, attribute blame or hold people to account. The Nursing and Midwifery Council and the General Medical Council have both agreed to amend their guides for registrants so that when a nurse or doctor is honest about a mistake made, they will be awarded credit for their honesty, failure to be honest will result in more serious sanctions. A range of 'success' indicators have also been suggested to include staff measures about how supported they feel and whether they feel able to contribute towards improvements in the work place (DoH, 2016). Although, time will tell whether such changes will improve the working relationships of staff and patients or hinder improvements as NHS and foundation trusts will be publicly ranked on their openness and transparency. Although I can't help thinking that by adding further elements of surveillance and leagues will create a different set of secondary anxieties as highlighted by Menzies-Lyth.

Mental health nursing and its education needs to focus on the quality of relationships, the needs of people rather than diagnoses or competency outcomes, clear and explicit values regarding the rights and dignity of people who use *and* those who provide services; taking account of the diversity of perspectives and perhaps above all valuing social and practical support and relational care equally with biomedical interventions and educational outcomes.

Research

Given that research into mental health nurse education is rare further exploration is indicated. This section considers four direction for future research:

First, the findings of this study found that reparation is a key motivator for wanting to become a mental health nurse. Further investigation into how this influences care and critical thinking is required, to explore new ways of improving both. For instance, the desire to care for others is, to some extent, driven by unconscious identification with patients, based on students' projection of losses and unmet emotional needs. It would be useful to compare

mental health student nurses with other student groups (including other fields of nursing and different professions) to explore the process of identification and how this influences career choices and the capacity to perform the work required within different professions.

Second, mental health student nurses' motives for career choice and pedagogical experiences and subsequent theoretical analysis identified that containment is key to minimising the potential negative and damaging effects of manic reparation. While mental health nursing will always remain an anxiety provoking occupation, finding ways to contain these anxieties are crucial. Further research into how anxieties can be contained is indicated. As discussed in Chapter Two, work at the Tavistock Clinic and within some hospital settings (for example, Cassel), provide a number of psychosocial approaches that can be employed to help contain student anxieties. For example, evaluating learning groups and supervision in terms of their containing capacity and the influence this has on therapeutic nurse-patient relationships.

Third, there are multiple sources of anxiety within mental health nursing and mental health nurse education and there is a reinforcing interaction between individuals within everyday lived experiences of engaging in unconscious defences, as well as the organisationally constructed social defences. These interactions operate within specific social, political and ideological contexts. Further research into the way such processes work could benefit not only nurse-patient relationships, but also educator-student relationships.

Finally, the findings of my study are limited to self-reported accounts of students' past life and pedagogical experiences and their motives for wanting to help others, yet, there is a gap in the evidence regarding the motives for wanting to help others and their actual helping behaviours, as it is possible to want to help others without actually helping (for example, see Batson, 1991). Observing the same students during their practice placements may offer further insights into their actual helping behaviours. Interviewing mentors might also have offered further insights into the pedagogical relationships. Further investigations into the implications of psychosocial influences for all those involved is warranted.

Mental health nurses are educated by their life experiences as well as by the education they receive within the three-year undergraduate course. Students must feel secure enough in themselves to have the potential to manage the task in hand and to develop their expertise to

an acceptable level during the course. They must be able to use the educational process to mature, to learn about themselves and others.

Conclusion

This thesis offers a rare insight into contemporary mental health nurse education, mental health student nurses' motivations for career choice and pedagogical experiences and the influence these both have on the capacities to care and think critically. Taking a psychosocial perspective, care and critical thinking have been positioned as key elements of the helping profession and conceptualised as clusters of complex processes, difficult to define and open to interpretation: being a caring and critical thinking nurse involves (conscious and unconscious) moral, relational and practical dimensions; it is interwoven, intersubjective and expressed in practical situations.

The findings have significance wider than mental health nurse education. Viewing the NHS as a 'collective unconscious system' which is aimed at protecting the public from anxieties about illness and mortality highlights the challenges faced by those working within the system. These challenges need to be acknowledged. Within the NHS staff are expected to provide competent and compassionate care. The mental wellbeing of the future NHS workforce is crucial and it is of importance to consider *both* the workplace culture *and* resilience in care staff. Policy makers, the NMC (and other professional bodies), educators and practitioners could work differently to account for reparation as a central motivator for working within the helping professions. This is of particular importance given staffing shortages and 'moral panic' amongst professionals, the public and within the media about the quality of care in the UK. My findings indicate that proper containment of anxieties and conflicts is required to foster care, compassion and critical thinking.

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Appendix 1: Literature Review Methods

Literature Review Methods

This Appendix provides an overview of the methods I used to find relevant published literature for this study. From September 2016 to June 2018, I took a systematic approach to searching literature using databases through the library at the University of Nottingham. Databases searched included: CINHAHL (for nursing and allied health journals); Cochran Library; E-book central; EBSCO; Education Source; ERIC; Medline; PsychINFO; PubMED; RCNi; Scopus; Social Policy and Practice; Web of Science; Wiley Online Library. Since starting my PhD 'NuSearch' has been introduced to the library system, this 'one stop' search tool allowed me to access a wide range of databases (as mentioned above) and electronic resources simultaneously which reduced my search time and enabled me to identify and locate the most relevant range of published material related to this study. Search terms were built around nursing (and related terms), mental health (and related terms), career choice, psychosocial (and related terms), nurse education (teaching and learning, training); care and critical thinking (see Tables 1,2 and 3 below for exact words, related terms and combinations of searches).

Using the *advanced searching option*, I applied the principles of Boolean logic (Aveyard, 2014) because inputting single terms produced vast numbers of 'hits', so to limit the search to key terms relevant to my research questions I used the Boolean operator 'AND', for example, mental health nursing AND career choice. To maximise the search, I used 'OR' to include different terms, for example, mental health nurse OR psychiatric nurse. I did not apply 'NOT' as this may have limited potentially relevant papers. There were variations between terms used, so in addition to Boolean searching, I used truncation to provide flexibility for multiple forms of a word, for example nurs* was used as a search term to also include the words nurse, nurses and nursing. Despite the advances in electronic databases, they may have not identified all of the relevant material to my study (Papaioannou et al, 2010) so I supplemented this electronic search by searching for 'grey' literature on Google Scholar (Haddaway, et al., 2015) as well as through 'snowball sampling' (Greenhalgh and Peacock, 2005) by hand searching the most frequently cited authors, journals and looking through the reference lists of articles and books found. This strategy was carried out regularly over the past eight years in response to the literature found and to ensure that my review was up to date (NMC, 2015).

Appendix 1: Literature Review Methods

Each search was conducted in a similar way, strategies being built up by initially searching key terms (see Table 1) and then applying Boolean operators (see Table 2). Inclusion and exclusion criteria were then applied to further filter searches (see Table 3).

Table 1: Key terms.

Key term	Truncations, synonyms and related terms
Mental health nursing	Mental health nurs*, Psychiatr* nurs*, OR mental health profession*, OR healthcare profession* OR helping profession*
Career choice	Choos* career choice, vocation
Wounded healer	
Psychosocial	Psychoanalysis, OR psychoanalyt*, OR psychodynamic, OR psycho-social,
Nurse education	Nurs* education, nurs* train*, teach*, learn*, pedagog*
Care	Car*, compassion, empathy
Critical thinking	
Socialisation	Professionalisation

Table 2: Combinations of search terms

Concepts (plus related terms for each as identified above) and combinations	Number of hits	Number of papers after all exclusion criteria applied (see below)
Mental health nurs* (OR related terms) AND career choice	528	12
Wounded healer AND nurs*	85	19
Wounded healer AND mental health nurs* (OR related terms) AND career choice	0	0
Psychosocial AND mental nurs* (OR related terms)	20,173	20
Nurs* education AND learning AND care	37,025	56
Nurs* education AND learning AND care AND critical thinking	1,393	45
Nurs* AND socialisation OR professionalisation AND care	9,841	30
Teaching AND learning AND nurs* AND car* AND critical thinking	1,142	1

To ensure the review was focussed (Aveyard, 2014) results were further screened against inclusion and exclusion criteria (see Table 3 overleaf).

Appendix 1: Literature Review Methods

Table 3: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria	Rationale
Written in English language only	Not English language	Problems with translation
Published and 'grey' literature.	Full text of study was not available	Reduce publication bias (Haddaway and Bayliss, 2015)
Studies involving learning for health professionals (undergraduate, postgraduate or continuing professional development		All studies relating to teaching & leaning within nursing and the helping professional
1950 onwards (for psychosocial nursing)	Pre 1950	This period is identified as the first wave of psychosocial nursing (Tilley, 2005)
1980 for teaching and learning care & critical thinking in nurse education	Pre 1980	Keeping literature up to date (NMC, 2015)
Relevance to this study: Career choice in MH nursing Studies measuring caring and critical trajectories over the duration of the 3-year programme	Studies not deemed relevant.	Maintaining focus of this study

The library search engine removed exact duplicates. Once the literature had been identified - titles were read, those that did not match the aim of this study were rejected. When it was unclear from the title, abstracts were read and literature found not relating to my research questions were rejected. Following Sadoughi et al (2013), no assessment was made regarding the quality of selected articles, given that the selection was done based on words, phrases and relevance to this study, this was because valuable insights from methodologically *weaker* but conceptually sound articles would otherwise have been lost. I do offer critical appraisal of the studies within the body of the thesis.

Appendix 2: Student Information Sheet

Student Participant Information Sheet:

Learning to become mental health nurses: Students' perspectives and experiences.
You are being invited to take part in a research study. Before you decide whether to participate it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that you are not clear about or if you would like any further information.

What is the purpose of the study?
The underpinning purpose of pre-registration education is to prepare newly-qualified nurses to be two things: they must firstly be 'fit-for-practice', that is, to deliver effective patient care within contemporary healthcare systems. They must also be 'fit-for-purpose', that is, provide students with higher-order intellectual skills (the knowledgeable-doer) and the abilities for life-long learning (Nursing and Midwifery Council, NMC, 2008).

Learning to become a registered mental health nurse is a long, rewarding, and, at times, difficult process. Student nurses navigate through complex social systems, including The National Health Service, Higher Education Institutions, families and other social networks.

The aim of this study is to explore:

- What kind of nurse is being produced after a 3-year pre-registration undergraduate course within a research-intensive university in the UK in the first part of the twenty-first century? and
- How do students construct their professional identity, develop critical thinking skills and learn to practice competently?

I am collecting this information as a nurse doing research which also contributes towards a PhD (Doctor of Philosophy) qualification.

Why have you been invited to participate?
You have been asked to participate because you are nearing the end of your undergraduate studies within a research-intensive university. I plan to interview up to 12 students in total, and you will be asked to discuss and reflect upon your learning experiences.

Do you have to take part?
Taking part in the research is entirely voluntary. It is up to you to decide whether or not to take part.

If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason and without penalty. Your decision to participate, to withdraw at any time, or a decision not to take part, will not affect or influence the course that you are currently undertaking.

What will happen if you take part?
If you decide to participate, you will be involved in two interviews with me. These will take approximately 45 minutes, at a time and place that is convenient for you. The interview will be recorded and then written up. This is because I need to look carefully at what you have said

and compare this with what other people have said. After the interview, you will be asked to arrange another interview with me later on in your year of study. This will be a change to reflect on the first interview, read the transcripts of the interview and check you are happy for me to use these and that they are representative of what you said. I will be giving you a copy of the interview transcript for your own record which you can keep after we agree that you have again verbally consented to their use.

What do you have to do?
You do not need to prepare for this study. I am simply interested in your responses to questions about your learning experiences.

What are the possible risks of taking part?
The privacy, dignity and views of all participants will be respected at all times throughout the research. All information that is collected about you during the course of the research will be treated with the strictest confidence, in that you will be given a fictitious name and all information will be stored in such a way that you will not be identified (Data Protection Act - 1998). However, regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact, the supervisor and/or ethics committee identified below.

What are the possible benefits of taking part?
You may find it beneficial to have the opportunity to talk and reflect on your experiences during your meetings with me. The long-term outcome of this study is aimed at improving undergraduate nurse education, to increase the learning opportunities for students and the information you provide may contribute to future curriculum development and ultimately improve mental health care provision.

What will happen to the results of the research study?
The findings of this study will be published in the form of a PhD thesis, peer reviewed journals, books and conferences. Confidentiality and anonymity will be maintained and you will not be identifiable in any report, publication or presentation. Whilst I will maintain confidentiality and anonymity it may be possible for readers of this published work to identify which University has been used in the study as I discuss my insider position and my place of employment can be easily found on the internet.

Who is organising and funding the research?
The School of Education at the University of Nottingham is supervising the study. My course fees are being sponsored jointly by the School of Education and School of Nursing, Midwifery and Physiotherapy as a part of my professional and personal development. None the less this research study is independent of both schools.

Who has reviewed the study?
Ethical approval has been gained through School of Education. The study has also been reviewed by the Ethics Officer who operates within the Research Governance structure within the School of Nursing, Midwifery and Physiotherapy.

Contact for further information
If you require any further information or have any questions, then please contact me. My contact details are:

Appendix 2: Student Information Sheet

Julie Dixon
Lecturer (Mental Health)
Nottingham University
School of Nursing, Physiotherapy and Midwifery
Education Centre
County Hospital
Greetwell Road
Lincoln
LN2 5QY
Tel No: 01522 848158
Email: julie.dixon@nottingham.ac.uk

If you have any further queries, concerns or complaints. Please contact my supervisor and/or the ethics committee:

Dr Monica Mclean
C82 Dearing Building
School of Education
Jubilee Campus
University of Nottingham
Nottingham NG8 1BB
Tel 0115 9513704

The ethics committee email address:
EDUCATIONRESEARCHETHICS@NOTTINGHAM.AC.UK

Thank you for considering whether you would like to take part in this study. Should you choose to take part, you will be given a copy of this information sheet and a signed consent form to keep.

Appendix 3: Informed Consent Form

Informed Consent Form:

Learning to become mental health nurses: Students' perspectives and experiences.

Points for the Participants to consider:	Please initial.
I have read and fully understood the information detailed in the Participant Information Sheet. Any questions which I have asked have been answered to my satisfaction.	
I understand that my taking part is voluntary and that I can withdraw from the study at any time without the need to provide an explanation and without any penalty.	
I understand that this research will be conducted ethically in line with the University's Research Code of Conduct (2010) and the British Educational Research Association's Revised Ethical Guidelines for Educational Research (BERA, 2011).	
All data collected will be treated with the strictest confidence and fictitious names will be used for all of the participants. All raw data will be stored securely in a locked filing cabinet in accordance with the University's ethical requirements and all electronic information will be stored in such a way that each participants' anonymity will be protected under the Data Protection Act, 1998.	
I understand that extracts of the findings of this research may be published in the forms of a PhD thesis, within peer reviewed journals, in books and at conferences. Whilst confidentiality and anonymity of the participants throughout these publications	
I understand it is not possible to guarantee anonymity of the University as the researcher acknowledges insider status; making finding where the researcher works relatively simple as this information is in the public domain.	
I understand that I will not be paid or compensated for my participation in the research study.	
I have received a copy of the Participant Information Sheet and this Consent Form.	
Having considered the written and verbal information provided, I agree to participate in this research study.	

Appendix 3: Informed Consent Form

I verify that I have provided participants with a copy of the participant information sheet and this consent form, having and provided the opportunity for each participant to ask questions.

Researcher's Name.....

Researcher's Signature.....

Date.....

I consent to all of the above and wish to participate in this study, I am free to withdraw at any time without consequence.

Participant's Name.....

Participant's Signature.....

Date.....

Any further queries please contact julie.dixon@nottingham.ac.uk

If you have any concerns or complaints, please contact the ethics committee: EDUCATIONRESEARCHETHICS@NOTTINGHAM.AC.UK

Appendix 4: Debbie's Life Grid and Transcript

Debbie's Life grid and 1st interview transcript.

1. Name: Debbie*

2. Date life grid completed: 04 May 2012

<u>Personal information</u>

3. Age: 30 - 39

4. Gender: Female

5. Ethnicity: Black British

6. Parents'/Guardians' highest educational qualification

1. **NVQs**

7. Parents'/ Guardians' current/former occupations (if retired)

1. **Supervisor Carer**

Appendix 4: Debbie's Life Grid and Transcript

Life Grid FOR: **Debbie**** **(0-5 years)**	**Pre-school** **(5-11 years)**	**Primary/Junior School** **(11-16 years)**	**Secondary School** **(16+ years)**	**College/ Occupation** **(0-current age)**	**Family/ Personal** **(0-current age)**	**Social /Leisure Activities**
The best moments (what happened, when)	I don't remember.	I used to make snacks with friends after school. 'Gari ground soup' – till 9. Being with my Mum again.	Making friends (12-16).	Met best friend (16). Went to college qualified, got a job at Tesco at 16. Finally going to Uni at 29, feeling I fit.	Initially my Mum, then Grand-mother coming to England, brother older – older he got. Good friend (few). Meeting my husband. Buying my house and having a baby.	Movies, socialising at home and outside. Parties, reading, running.
The worst moments (what happened, when)	I don't remember.	Brother was born (10). Started primary school (9), difficult with language.	Being bullied (14-15). Failing school at 16.	Battling with stress and anxiety about losing everything. Not working for a few months when	Getting into debt. Also, not getting support from Mum.	Not as active. Being lazy throughout.

Appendix 4: Debbie's Life Grid and Transcript

				I moved to Nottingham.		
Most influential experiences. (what happened, when)	I don't remember.	I don't believe I had any at this time.	Mother not being as supportive. Not being available emotionally (13-16). Grandmother taking over emotional support.	Getting into Uni. Helped to focus me at 29.	Moving to Nottingham changed my life. No longer party-ing, more focused on long term than just short-term enjoyment. Family friend mental health diagnosis.	None?

Appendix 4: Debbie's Life Grid and Transcript

INTERVIEW

J can I ask you to fill this out in the 1st instance

D yes

D oh, Ethnicity, I always get that one a bit confused. I was born in Africa but I am a British citizen.

J Ok

D So am I Black British, because I am not English. I always get confused when filling out forms.

J How long have you been here for?

D I came here the 18th November 1989 that is when I landed. (*Laughs*) I am uncertain about my parent's higher educational level. My Mum didn't go to university here but I am aware that she does college courses for her work. She is a carer. [J right] So I don't know how, I know she has done some NVQs and stuff but I don't know how high they are.

J Ok perhaps put NVQs

D I think she is supervisor now. My father is in Africa. So I don't know him well so I can't answer that one I'm afraid.

Pre-School… I don't hmmm… I don't remember …can I put I don't remember?

J Yes

D This is when I was in Africa. I don't remember much from under 5…Uhm … (laughs) [long pause, whilst filling in life grid]. This is going to be very petty… laughs… [long pause, (3 mins) whilst filling in life grid]. Oh, dear I've put this in the wrong box….

J That's ok – just put an arrow… [D yep] (Back to filling in life grid long pause 5 mins)

D Blimey (filling in life grid pause, 1.30 mins) [D hands over completed life grid and states:] I'm not sure about that!

J that's ok, thank you, I'm just wondering what Gari Ground Soup is?

D Yeah it's Gari Ground Soup….[pronouncing it correctly]

J Ok, can you describe it?

D It is like dried cosaba, the vegetable, grated and you would have it with fish and lemon and some peppers and you mix it together and eat it and for us it was really delicious. So, when we'd leave school and we were outside, we'd go, it's really very feint but it is one of the few memories I have of going to this place and we'd all bring our own ingredient whatever we could take from our own parents and we would make it and eat it and then after playing go home. [J laughs] So I did really enjoy that. And that was before I came to England and I can't remember from... I'm sure it was after I was five.

Appendix 4: Debbie's Life Grid and Transcript

J Ok thank you. I think I can understand the rest…. It was just that one, I wasn't sure about… that's lovely thank you. Ok. I only really have one question [D ok] and it's if you could tell me about your student nurse experiences?

D Ok, as in placements, assignments?

J All of the above

D Ok. When I started the course, for me it was really difficult. I hadn't done any kind of care work before and I didn't really understand it. My mother always used to say to me 'you should do nursing, you should do nursing' and I was 'ohh I'm not doing that' and that was because I thought the only nursing that there was, was what you see in the hospital, like general nursing, so for me it was a no, no, but we have a family friend who, Oh I should have put that, yeah because we have 2 family friends whose children who were diagnosed, one had a breakdown and the other one was diagnosed with Uhm schizophrenia.[fills in life grid further adding the 2 family friends] Yeah he was diagnosed, one of them was diagnosed with schizophrenia and it used to make me think, oh my God what is this, what is that? Because where I'm from in Africa*, you don't get stressed. There is no such thing as schizophrenia. There is no such thing as bi-polar, what do you mean? It's a case of, you know, stress? We just don't have any money, get on with it. Ok. Schizophrenia in my country would be, well in Africa*, would be: he's just been cursed, someone has put a curse on him that's why he's behaving like that, that's why he is seeing things because you know. It's very, it can be, kind of backwards, you know, they don't…. it's nothing more than a curse, you know, black magic, someone has done something, he has done something to someone and they've cursed him, so when I heard he's got schizophrenia I thought what do you mean? I was like: 'Mum, did someone put a curse on him?' and my Mum was like 'yeah someone must have done it, must have done it'.

J So your Mum still believes that?

D yeah, although she, part of her is very much europeanised, she has still got that African mentality. That yeah, it's a curse. Someone must have done something and I went to see him in a mental health hospital in London, and it was just a bit of a surprise really how the nursing staff were there and I was like, what these are nurses? Like yeah yeah and there are some doctors that come on and I was looking around like: this isn't the nursing that I know of! Ok you know, da da da the way they spoke to him and the way they treated him and everything. It kind of I suppose inspired me and I thought – what's this? So I wanted to know more but by that time I was living in Nice town* and I was working part time just doing whatever, and I was like, ok I want to know more and I want to get into this and finally managed to do some

additional courses to be able to get into the uni course and I went for a few open days and I was kind of like – 'how am I going to do this because I can't afford to do this – *laugh/giggle* – *you know* and at the time when I kept on going to those open days, no one was really answering, in my opinion, no one was being really honest, but then again I'm slowly starting to realise that their honesty and my honesty are really different. I expected to be told the big grand truth 'it's going to be hard' but this is how you can survive even if you are poor, broke, in debt, because I was in a lot of debt before I started my course so for me it was like: 'how am going to survive?' And for me nobody was answering that question. But when I did get in, I was like 'how am I going to cope?' *laugh out loud* 'I have debts to pay!', but by that time I met my … I was already seeing my husband and we just got married in 2009 and I was like don't worry we'll figure out a way so when I started, I was like I don't know if this is the right thing because I kind of stopped everything to get into this course and then the first few lectures I thought Oh my God! I don't know if I can do this, what am I doing here? And then they sent us on placement and mine was at A Hospital* and it was on a dementia ward and it was amazing. The first time I had to wash someone I was shaking like a leaf and I was oh my God! how am I going to do this? I can't even wash with all that shaking and I was saying I apologise, I'm so sorry, I hope I'm not hurting you…and the Nurse was like: 'you're fine, your not hurting them they are fine, they're not screaming out are they? I was like 'yeah but still, but still but still'… *laughs*

And after a week of being there I was thinking Oh my God, this is what I actually want to do, this is it and the longer I was on the placement and the longer I spent time with the patients I was just like Oh my God, maybe my Mum, was right…. *Laughs*… all those years ago… oh my God, this is amazing! Oh my God this cannot be nursing…I instantly fell in love with mental health nursing. I was always looking forward to going into placement and for me I never experienced anything negative because for me every time I went in I had a smile on my face and I was just ready to go. Sometimes I knew that, because, you know when you are writing reports it can be. Everyone thinks you're a bit nutty or stuff because you are always so ...What else can I do? Or what do you need doing now? And they were like, calm down and I don't know if it's because I enjoy doing it so much. I'm so enthusiastic? I can't hide being excited to go into placement, I can't hide wanting to wash someone or take you know someone to the toilet because for me it is really exciting. *Laughing* I'm learning to do something and I am doing something for someone else that they need and I just think oh my God I'm really privileged to be given this opportunity. I'm always quite happy in placement and that one just really set me off because after that placement I just knew I was definitely on the right course.

Appendix 4: Debbie's Life Grid and Transcript

I was going to do whatever I had to do to make sure I completed the course and it has just been like that going forward really and going back to uni and doing assignments and the last time I was in school was I think 2002, now they are talking about plagiarism and I was like 'what I can't just copy it from the internet. What do you mean I have to read a book to get the information *laughing* what do you mean I have to put it in my own words… *laughing* it was quite funny because I was like: ok right I need some of you to help me pass this course! Saying it to my peers because some of my peers were what 18 or 19. I don't know what age it is you go to Uni. I think its 18, and some were about my age 29, 30 and oh go, I was going, I don't know what I'm doing and I did get quite a lot of support from my peers. I found out when I started a course this January time that I was Dyslexic and again I think. I kind of understand it because it's the same with my speech I'll jump here, jump there so my writing is the same, my grammar isn't particularly brilliant, so I thought like ok, but university in that sense has been really helpful because I have got a support tutor who helps with all my assignments, and helps trying me focus on my assignments with subjects, uhm helps with the grammar, gives me things to take away so I can obviously look at them and try to improve it for the next one, and although I do sometimes still make the same mistakes but from where I started and where I am now is a big improvement so it is quite good in that sense but I am a bit of a… how can I put it? People get a little deceived by me because my spoken English is very good as I've been told, but my written English is not so good, so they expect a lot better from me with written work but no! Some of my mentors comment on my evidence based thesis because again, if I am asked a question I can answer it no problem but when you ask me to write it in an articulate way, it doesn't always come across like that so it's like wow, ok…*giggles* so that side has been difficult to get hold of, you know, to be able to grasp grammar-wise, but I think I'm doing ok. I've got the support and lecturers, bless them, some don't like to see me I'm sure because I am constantly in their face. When can I come and see you again and I don't understand, and I want to pass and I need you to give me all the information I need to pass this course, I need you to tell me what you need to see in my essay duh duh duh duh duh duh and I will do that consistently to make sure I get what I want out of it because I know I'm at an age where if I don't push myself to get the information I need, I'm not going to get anywhere and with Uni… I was starting to realise you don't put any kind of effort in you don't get nothing out and I'm constantly in my lecturers' faces. What do I do here, what do I do? Which can be nice, for me because I get everything I need, but for them it's just constant harassment. Well yeah, my experiences of assignments has been really good, lecturers have been really helpful, some more than others. I think they are trying to get rid of me *laughter* placements have been good. I had

a very bad experience on one of the acute wards and that was *big sigh* the worst. It wasn't anything to do with the course, I think it was just how they manage students on there and I do believe it's because of my age, I kind of stand up for myself, because if I was 19 or 20 and was told to do something, I wouldn't challenge it even though I knew I shouldn't be doing it but when I was 30 and they were saying 'do this do that' no… I'm not supposed to be doing this, do you know what the guidelines say, my lecturer says I shouldn't be doing this that and the other whereas, some of that particular placement area was well, are you not here to help us? You know, you can see we are short staffed… are you not going to help us out? And as a student it puts you in a very difficult position because you want to help out but you don't want to be taking the Mick out of and generally that placement was just about. They were treating you like you were another member of staff, even though you were supposed to be supernumerary and the things that you wanted to do, some of them wouldn't let you do it, they'll get one of their healthcare assistants to do it, who was either on a nursing course or about to start a nursing course and you know, get that experience. For me I used to be so frustrated, that was the one place I never looked forward to going to. I was just ohhhh it was always a chore. Three months of a chore! Ochh it was horrible. Ochh… I am sorry; I just can't get over that place. [Breathes in and then sighs]

J are you able to give me some examples of things they asked you to do that you didn't feel you should be doing as a student nurse?

D I can, in that placement a second-year student who shouldn't be doing those intermittent Obs. every 10 minutes because if we find something that we cannot manage it's, well partly our fault, but it's the nursing staff. Well within our student guidelines we are not supposed to be doing them and apparently placements are aware of that, but we shouldn't be doing them but this particular placement. I don't want to say they didn't care, or that bothered, but they wanted me to do it and what they were doing is they were put, er uhm on a 7 ½ hour shift I'd be doing it for – Uhm because you do it for an hour at a time and I'd be on the list to do it like 4 out of 7 hours as a student and my feeling was I was supposed to be here to do medication. Every time I asked to do medication, they were like 'oh no we are too busy' go and do uhm Obs. or go and open the cigarette door which you have to do every half an hour, so it was like: why am I here? I'm supposed to be learning how to be a nurse, I'm supposed to be learning how to manage such areas and all that you are getting me to do is open, sorry the cigarette is open once an hour, is open the cigarette door and do intermittent Obs. What am I learning? Ok I am learning to get on with people I don't particularly enjoy working with *laugh* that's fair but after a while it got really on my nerves because medication, I can, even if they give it to me

and I take it to a patient, I was fine, but they wouldn't, they wanted, they gave it to their healthcare assistants and I at a cigarette door, what am I doing at a cigarette door? And that happened for about uhm 3 – 4 weeks I kept on doing that, but again it's some of the staff, some of the staff would give you nursing related roles to do, would ask you to go and do handover, would ask you to fill the observation but some of them really just consistently. This is all you are going to do today and it was awful because I wasn't learning anything and for me, going into a placement and I'm not saying I'm not learning anything but again I was talking to patients every day or throughout the shift but not being able to do nursing and stuff was really frustrating and I would say: I'm sorry but that is not why I am here and then you know, some people get their back up and you know it gets my back up because obviously I can see their reaction and they can see mine and I'm just like, what are we going to do because I wouldn't back down and I would constant consistently complain to my mentor, to the uni and then get in touch but you know it was just always the same thing and it was just ochhhh! I hated that place. It put me off acute nursing. That was probably my worst experience in training so far. I don't think I've had anything culturally, I felt negative, in any of my placements, everywhere I've been I felt I always had positive feedback but that was just for me, it was the worst experience I've had during training because it, you know, it was at a time as well when I was really stressed with some assignments and you know when you are dealing with an area where you don't particularly like and you don't particularly want to go there every day, and then you've got assignments on top of that, and you just feel really bad, it was just, it was the one place I considered actually going off sick for a while, but again part of me was like: pull your finger out! So, what you don't like the area, what do you mean you're feeling stressed, get on with it… Do you know what I mean... *laughing…?* That side of my culture probably kicked in because I was close to say I'm not very well today and I'm not very well for the rest of the week, see you at the end of the month… *laughing*… quite a negative thing I know but that is how I felt and I've consistently going into supervision just like half in tears because it was. I wasn't used to not enjoying placement, it was kind of a shock to the system. Not enjoying it, not particularly enjoying the people I worked with or feeling motivated to go in or feeling anything, it was just horrible. It was probably my worst. I haven't had anything really in case of my assignments. I just got a bit stressed uhm with, when we had to do the dissertation. Part 1 of an assignment which was part of your dissertations overall but I had a really good lecturer... Am I allowed to say a lecturer's name?

J You can do and then I'll actually remove them… if that helps?

Appendix 4: Debbie's Life Grid and Transcript

D His name is Daniel Smith*, he's amazing because I went to see him with the same…I go to see most of my other lecturers. I need to pass this and I need you to help me and I want to get a really good mark *loud laughter* ok! You have to put the effort in Debbie*, yeah but you have to help me understand so that I can get a good mark… and he spent 5 weeks with me seeing me every week. He went through what the assignment was about so I understood it because before I got it I was just like: what is this? What are you asking me to do? This is horrible, I'm never going to get this, I'm never going to understand… and he literally broke it into tiniest little chunks which I could digest and I could understand and after my second week of going to see him, and talking about the assignment I loved it and I was so excited about researching for it and trying to make the reader understand I know what I am talking about and it was the best experience working with him, ahh he's amazing and yeah within, 5 weeks working on it but within 4 weeks my assignment was done and I got the highest mark I've ever had in school which was 75% and I was so chuffed. I was like oh my God, next year… when I've got the dissertation: it's me and you…. *Laughter*. It's like ok yes, we're going to start early because I can't have the stress of last year. And yeah, he's amazing. And then I found out I was pregnant so I couldn't do the dissertation anymore and I was like: you're not leaving in the next 5 years, are you? Because I'd never come back and finish my degree. I have no intention of … no no you're not going to leave are you because I don't want anyone else but you, because for me it was a really big deal and he, the way he broke down the assignment. I think it was the way he broke down the assignment so I could understand it and once I understand it it's fine, it's when I don't understand it I don't know what I'm doing. It's like you are saying gobbledegook to me. Yeah, I don't get it, so yeah, I was really. I love him, in a professional sense *laughs*…

J So he helped you break down the work that you needed. You describe him as being amazing. Can you think of any other ways in which he was amazing?

D Gosh, I think I need a dictionary now, uhm how I can describe Mr Smith* for me he was just really helpful, he was supportive, he always appeared to be available, you know because some lecturers you go and see them and they are always busy. And he always appeared to be available. I don't know if it was just that he wasn't busy at that time but you know when I'd email for book appointments for the following week, but his, I can't really, I don't know if it was just that he knows his stuff so well that he is able to cater to different individuals needs he sees this one needs just, some people just need, I dunno, a phrase and they'd get it, some people need it to be chopped down into little quarters, and maybe, I don't know but he just seemed to understand how to work with me and how to make me understand what is expected

of me in that assignment and I really cannot think of any other word but amazing because for me it was just 75%! OH MY GOD! This is amazing, this is great. I have been raving about him to like every other student, you need to see Daniel Smith*… you need to, because obviously this year we all know it's really stressful for the rest of us, or them who are doing it and I'm just like, just go and see Daniel*... He'll help you. He'll find a way to help you understand what you have got to do. Because for dissertation, because that's what he's involved with, it's Daniel* well I've got someone else, doesn't matter, go and see your someone else and then go and see Daniel*. Cos for me I can't, I don't have the vocabulary to express any other ways other than amazing but I think he's really good at his job. For what he did for me because at that time I was at my horrible placement, he made a little difference when for me my world was just grey because I'm usually a happy bubbly person and I was just really miserable and sad all the time and going to see him that one day and researching and enjoying that little part of my uni life was really helpful because och. Hmmmm (deep breath in) yes it was difficult, so I'm sorry I can't give you any better word than amazing.

J That's ok

D If I had a dictionary I might.

J That's good I think you've explained that you found him helpful in terms of he helped you understand [D yeah] what it was that you needed to do.

D Definitely. I think that was a major thing within the uni that some lecturers are really good at expressing what they want from you: Jane Doe*, love Jim*, oh he looks so miserable, but I love him to pieces. He is another one that is also very, he tells you what is needed. Who else is very good at that…. Tom Jones* when he does some lectures, he is also amazing but yeah… there are a few lecturers who, when they talk to you and they give you the lectures and they tell you what they need, it just – again, for me I get it instantly but others I need to go back and say I don't understand. I don't know what you mean, I don't know what you want and with those it can be a bit of a struggle. You try to find out what they want and although they are saying probably the same thing they said in it, because I usually record my lectures and I go back and say sorry I still didn't get it. Sorry about this, just very friendly *laughs* …but yeah, those three for me are amazing. But Daniel* is at the top, Jim* is second and Jane* third, yeah. Don't know what else you want me to talk about? - *laughs*…

J I was wondering – you were saying that you are not doing your dissertation at the moment, are you on interrupt?

D I am, yeah. I am. That was interesting. I was so looking forward to finishing my degree this year and then found out I was pregnant. It's kind of funny because when I left the

second year, stressed, English word and on holiday with my husband, 4 weeks in Spain and all I did was drink, *laughs* I just wanted to, you know, wash it out you know? Get rid of that second year, horrible feeling, stressed thoughts, everything. I just wanted to get rid of everything and we just happened to get pregnant. At my most stressed or maybe not so stressed because I was just drinking every day, I don't know, but yeah, because me and my husband have been trying for a number of years and nothing was happening so for me I didn't think it was going to happen so when I came back it was like your pregnant. No Way! You can't be serious!! And the first thing I thought actually was ohhhhhh how am I going to do my dissertation? *laughs* that was the first thing I thought… and the first person I rang was Daniel*, I'm like Daniel* what am I going to do I'm pregnant? Congratulations…!!! And I'm like No!!!!! I can't do my dissertation you know if the third year is anything like the second year I wouldn't be able to cope because I was really at a low ebb and he's like, it's manageable Debbie*. You can do it if you think you can manage but if you think it's going to be real stressful then you might just want to do the degree and then come back. So, I said if I come back are you going to be here? He said well yes, I'll be here. I'm like are you going to be here for the next 5 years because I think that's how long I have got to do it? He said I don't see any reason for me not to be here I don't plan on leaving. No but you have to tell me for certain if you are definitely going to be here because I don't want to come back and you are not here and can I have you as my dissertation tutor and he's like you can have anyone you want Debbie*, but I'm like, no I want you, *laughs* so he was the first lecturer I actually spoke to, not my personal tutor… *laughs* Daniel*was the important one, in my eyes anyway, he was the important one, but yeah, he was the first one I rang. *Laughs.* When we had a chat and he was like he basically just helped me, not freak out because obviously I was like, oh my God! I wouldn't be able to cope with the dissertation with a baby, with the rest of uni and so on so it kind of helped, again. I don't think I would have focused anyway, but at the time, all I could think about was my dissertation, what do you mean? I 've got to do it and it kind of helped put things into perspective for me and I was like thinking a bit more rationally and yeah decided to go to the diploma which was really good because the stress of getting the additional words and so on at a time when I was not feeling very well and everything else was just perfect, because I don't have that stress and I know I can come back and do that later which was good and now I am on a break which is also good. I left early, I would have left in May but I left early because I thought being away with a child for a year and then coming straight into my management placement I don't think I would have had my nursing head on and my third year is supposed to be when I am potentially in charge and running things and I need to know what I am talking

about and I need to be focused and I think if I come back from just changing nappies I don't think I would have had the same focus as I would normally have with my other …. Because I am really ready for whatever is thrown at me and I don't think I would have been as focused so I asked to leave in April so I come back, I have a few weeks at university. Again, just kind of acclimatise myself to the situation, what I am supposed to be doing, be prepared mentally, physically for what is the next 3 months of placement will be like, so yes that was a decision I made. I think it was probably the best one really rather than wait until May because I don't think I would have done justice to my placement or to myself, because I like to think of myself as a pretty good student *laughs* and I don't like to let myself down or my school down because I get pretty good grading while I am on placements so and I always get, well I say always get, but I have had two job offers - kind of, you know you can't get a job offer but it was one of those: you qualify and two years under your belt of experience and you come back, ok?' And finally, the other job offer, job offer I had was from the placement I absolutely hated! The manager rang me and says oh you know there is a position going?... I says I haven't qualified yet! *Laughs* she said, oh you should really apply when you qualify and I said 'yeah sure'… *laughs* Never!!! But yes, it's been good, so yeah, I want to make sure I do well. I want to pass and come back and finish off the degree and because I have got such a good mark in my first part of the essay, I think it might help me when I come back because, yeah, I dunno. –

J So have you, are you doing the diploma rather than the degree at this moment in time?

D At this moment, I am doing the diploma.

J Ok because there is the option when you go back to do the dissertation to complete the degree within the five-year period.

D Yes, I have that option, yes, I still have that option so I am going to take that. I don't know when I'll be able to take that, I am just going to see how our life situation changes. How things are, but yes, I am hoping to do that relatively quickly, but we'll see, I don't know. I know I want to do it but I don't know what is going to happen, haven't had a baby in our family in many years *laughs* so I was like: what do we do with them? *Laughs...*

J When is your baby due?

D 4th June!!! I'm so excited.

J So you've only got a few weeks left…

D Yeah only a few weeks… yeah 30 days I believe, today…*laughs.* Just not counting down or anything. [laugh together] It's exciting times. Is there anything else you'd like to know that I haven't answered?

Appendix 4: Debbie's Life Grid and Transcript

J I don't think so, is there anything else you can think of about your nurse education that you would like to share? You have talked about different placement areas, one that you really love within dementia care and another one on an acute ward that wasn't so good

D No, it was horrible.

J Have you had any other placements?

D Oh yeah uhm, I have been to a rehab setting in the community, another one I absolutely loved, that was in my first year and I learnt a lot from that and generally. It sounds kind of sad but with my placements that I have enjoyed and they have enjoyed having me there, I tend to visit quite regularly, so the rehab placement I go maybe once a month if I am at uni maybe two or three times a month, once a week or something just because it is only down the road, I've also had a placement in the community where, it was just, uhm, where was it can I say the name?

J Yeah and I'll…

D Ok so it was the Sunflower Unit* which was a community one and really enjoyed that place…

J and that's a rehab, recovery unit, was it?

D No that one's a community and the rehab one is A* & B* wards, that was in my first year that's near Jayne's Hospital*, Recovery Unit* is in Welten* which is a community setting where you go out to see the patients and so on, enjoyed that. I'm still friends with my mentor and we see each other every couple of months because him and his partner and me and Jack* will go to the cinema and have lunch or dinner whatever, same with my other mentor from A* ward and really enjoyed that placement. Hated leaving. Then there was my acute placement, aghhhhhh, didn't enjoy that. It was the only one I haven't enjoyed, then most recently I was at Florence's centre* which is: themed, it is a drugs clinic. I absolutely love that, had a very, I don't know if old fashioned is the right term, but it is a gentleman that has been in the profession for a very long time: old school (laughs) and oh it was amazing working with him. The team I never imagined I would enjoy working in a drugs team and I absolutely loved it. Love it, still love it and its literally about 5 mins walk, less than 5 mins walk to my part time job, I'll go there across the road, going to my part time job, so if I am early for work I'll go there and say hello and see everyone and yeah, I just visit, I like visiting my old placements. I enjoy, I dunno, I just enjoy it I like to see them and they seem to like seeing me and no one has told me not to come back yet…*Laughs.* So those were my placements so far, loved them all except for the acute one. Yeah och, the nurses are amazing… the way they treat people is, I can't really describe it, cos but when I thought 'drugs clinic– what!!'?' and they sent me there because I

am pregnant and it was supposed to be the safest place for me and I had my own preconceived ideas. Oh, these people they just come in and do whatever and then go and then my first week of being there it was just like wow! This is not what I expected, you know, people that have ended up taking substances you know, I suppose like with anything else, they have had their own life, histories, problems that have led them down that path and I was just really trying to understand it and not be so judgmental and I think probably part of it is because of where I was born because you know it was just like what do you mean your stressed? Just get on with it, so you just haven't got any money, so what your mother beat you, what?... my mother beat me, *laughs* it's called discipline… but you know, everyone manages things differently and I know, I don't know whether it's how I was raised so for me it was normal? I don't know; if normal is a good thing *laughter*…... but being a mental health nurse has made me challenge a lot of things because I have to take a step back because I always have an initial reaction which is What!!!???? What do you mean???!!! Then I kind of have to rein that in and go, ok… so it's not personal, you have got to think about this in your role, you are here as a nurse to help and you can't think: what? You have to look at what's underneath the problem that is facing you and that helps sometimes. But when I talk to my mum about my course it's quite funny because she will say: 'oh it's a curse'…'No Mother…it's not a curse, some people's just experiences are just different to what you or anyone else has experienced and I have to take them through it and it's quite funny because I think oh I do know more than I think I know…*laughs.* She's like: uhm… and then she will bring something else up and I'm like No! Because her thoughts can be quite negative, mental health wise, so it's kind of I'm educating as I go along. My grandmother, because I believe my uncle, my grandmother always used to describe my uncle to me with symptoms of seeing things, behaving strangely and talking to things that are not there… so on and so forth… and I said to her one day: so, what happened to him and she said oh he got cursed. I said ok, because he must have done something, whatever…. But when I think about all the things she was saying it sounds very similar to some of the, his symptoms…is it symptoms? You know when you look on the label of schizophrenia, it seems very similar, so I ask is it possible that uncle had schizophrenia? And she went through the roof: 'what do you mean!!!? What do you mean he's got schizophrenia? No! No! He was cursed!' *laughs* and I was going, it just sounds really similar to what I learnt in school (*sounded like a small child when she said this*) you don't talk back, if you talk back to grandma she will kill you!! *Laughs.* She just wasn't, for her, for it to even be mentioned that he potentially had a mental health problem. No, he was cursed, that's why he behaved that way. So yeah, it was not really acceptable, but I think because I have been here for so long I'm not so, I haven't got

that temperament that my mother and grandmother have and I can kind of see outside of the box. But they are really, my grandmother particularly is very, 'it's a curse', my mum you can sway her with reasonable argument but yeah, maybe it will change going forward but I don't know, it is very much there is no such 'what do you mean – that's an English disease, we don't have that'

J and your grandmother is living here?

D my grandmother is living here, she is 79 years old, battle-axe! And although she herself is very europeanised, she just doesn't believe in mental health problems so for me it's going to be interesting because my grandmother is 79 and I think, I wonder if this will happen to her, because she is at the age when all sorts of different things might happen. I was thinking about that. Especially as I worked in the dementia unit. Ah it was horrible because I always think of my grandmother when I see these ladies and gentlemen, you know, and I think now if she got that. I wonder if she would acknowledge that she's got what is classed as a mental health problem, in the field of mental health but I don't know if she would, because she has a friend who's got dementia but she doesn't see it as a mental health problem, 'she is just sick'. *Laughs*

[J Right] And I'm like, you know on my course, it comes under mental health problems…'No she's sick' [J ok].

D *laughs*… So, you don't argue with grandma. *Laughs* Ok but yeah my mum you can, with reasonable argument you can sway her but her initial reaction is 'it's a curse – or… what are you talking

they don't want to work… they want to stay at home and get benefits. I have to go and work, they don't want to work. I'm like mum it doesn't work like that. But yeah. There are times I'm tired and I don't want to go to work but I have to go to work, I have to pay bills, so it's really, really different. [J -Mmm] But I don't know if it's because I came here when I was so young and not so entrenched in the idea of… I am open to other cultural issues or problems. I am open, I'm open to but my grandmother in particular is not, she is not, my mother you can sway her one way or other but for me it's just, maybe I am lucky? But I can see both and I can accept both, ok… but all my books I have got say: it's so and so but if you want to say it's a curse that's your way maybe of managing it and maybe dealing with it because when you talk to Africans and you say anything to do with mental health problems it's kind of like aghhhhhh, but if you say curse it's more bearable. So, curse is ok, but it's a mental health problem. Because when a family friend had it, my mum was like: Huh! I wonder what he was doing to get this? I wonder what happened. And who he upset? Because it's not possible - he has been cursed'

(said with an African type accent, mimicking her mother). Mum, he's not been cursed…. *Laughs*

J I was going to ask when somebody has been cursed are they cursed forever?

D Yeah! Apparently

J It never gets lifted?

D No

J Oh

D unless that individual apparently put it on them

J they can remove it?

D but Yeah, they can remove it but with again, black magic, or in my country we call it juju – or tuju. It's rarely taken off, once you have got it, you can't, they have done it because they are so angry you haven't recompensed for whatever you have done… that's that so there is no begging that can be done to get out of it and, I wish my mum was here she has some African videos that she watches religiously and most of them are about families who have a conflict then someone goes and sees the juju man and he does his: give me a chicken leg, give me I don't know a cow's ear and he mixes a potion, give this to someone to drink and then in the film you see it messes them up. [J right] And they are like that forever so she sees that on her movies and its constantly on, she has, she watches African movies all the time although she's a Christian. *laughs* and believes in God she watches that and I think part of me thinks, maybe that influences her because that's what she sees and in Africa you hear about that a lot and you know it turns the individual. Can either go you know they start acting and behaving differently to how they normally would. Someone who dresses smartly and speak appropriately will then start wearing rags and stop doing the things they would do, stop going to work and just start speaking to himself, laughing to themselves and these are African movies which most Africans enjoy watching, the older generation I would say my mum's generation upwards, the younger ones tend to not be so bothered, although a few us watch them because I have watched a few and I think – this is ridiculous *laughs*… this is so poor, but you know what that generation, maybe from about, I would say from about 10 years older than me, about 40 onwards who will watch and part believe it because: 1) when you are in Africa you hear about it all the time, 2) you may see it, 3) maybe a member of your family, extended family there are lots of extended families, one of them has experienced it and it goes around 'ah did you hear what happened to Paul*? Oh my God, Paul* did this and look what they have done to him!' and it kind of goes around in the family so obviously you are aware, look what they did to Paul*, don't do this….do you know what I mean? It is kind of, it's just there…but I

would think those African movies help *laughs*. I wrote about that in one of my recovery assignments that a lot of people, you know, in Africa there are a lot of countries that talk about juju, they talk about voodoo, they talk about witches, they talk about everything and they do it and they film it and there are documentaries about it and I think, you wonder why Africans, some West Indians might not understand or accept schizophrenia or mental illnesses, it laziness – 'they have been cursed'… but that is just an opinion… An opinion I have I don't know, could be wrong, could be totally wrong…

J it's very fascinating…

D It's interesting isn't it just…. I should get you a video! You'd be interested in watching one?

J yes, I would actually… I really would, yeah

D I'll get my mum to send me one and I'll forward it on to you, you'll see what I mean because it's all the same.

J so watching one film would give me an idea of how all these films are?

D yeah, yeah some of them are, not all like it but most of them are all about voodoo… Do you have Sky?

J no I don't...

D ok because there is a channel dedicated to African movies and some of them that they show on there are about that.

J ok I have a friend who has Sky so I might ask her if she can …

D let me see if I can…do you mind if I ring my mum and ask her about the channel because I don't watch it...

J yeah… - I was thinking perhaps I'll switch this off and …

D er are we finished? *Laughs*

J I was going to say… is there anything else you want to say about your nursing education

D No, no no… for me it's great, for me it's great. For me it's made me really focus and it has helped me. I have made some good friends there and I've enjoyed, I am still enjoying every minute and I can't wait go to be back. I am really gutted I can't finish this year with the rest of my peers but yeah, I have found what I am supposed to be doing, for me that's like the most important. I've got focus, for so many years I was just bouncing from one job to another so for me now it's like it took me this long to find you. I can't wait to qualify, I can't wait to start working. I can't wait to start doing what I enjoy doing which is working with people and getting to understand people and understand all sorts of weird and wonderful things that come out of working within mental health so yeah – I love it all. That's all.

Appendix 4: Debbie's Life Grid and Transcript

J Thank you

D Your welcome.

Appendix 5: Ethical Approval Form

The University of Nottingham

School of Education – Research Ethics Approval Form

Name: Julie Dixon

Main Supervisor: Melanie Walker

Course of Study: PhD (pt)

Title of Research Project: Learning to become Mental Health Nurses: students' perspectives

Is this a resubmission? Yes

Date statement of research ethics received by PGR Office: 31.03.11

Outcome:
Approved [√]
Revise and Resubmit [ ]

Signed:

Name: Dr Alison Kington
(Research Ethics Coordinator)

Date: 6th April 2011

Appendix 6: Betty's and Ellen's Pen Portraits

Betty* (interviewed twice 1st at home 1:09:33 and then practice area 1:10:54 hours)

Betty is a 54-year-old white English female. Her father was a regular soldier in the Army and her mother a cleaner. Neither of her parents had any formal educational qualifications. She however has been actively engaged in educational activities since she was 30 and as such has 2 degrees; one in Landscape Archaeology and a Master's degree in Museum Studies. Betty describes herself as a Londoner, but spent her early life living in Cyprus (her Dad was stationed there). She is still fond of Mediterranean food but states she didn't have the best of childhoods. She moved back to the UK, and remembers feeling cold enjoying Christmas and playing with friends and being away from home. As Betty's dad was in the army they tended to move every 2 years and Betty didn't like this. Betty was bullied whilst at secondary school and her Dad left her mum when she was 14. Her mum then went on to become 'an alcoholic' (although Betty thinks she'd probably been drinking prior to this time). She became pregnant at 16 and then married her only boyfriend. Betty describes her parents as highly critical, leaving her and her 3 siblings with feelings of inferiority and lacking in confidence. She recognises that she has attachment and abandonment (Dad and later her husband) issues and remembers feelings of insecurity and constantly seeks approval.

Betty's two children and her education are the most important things in her life. She also enjoys History (archaeology), Art and Literature, meeting with her friends and going to Church. Betty decided to do her nurse education as a consequence of her husband (the boyfriend mentioned earlier) not receiving appropriate care after he had a heart attack and nearly died. Soon after this her husband left her for another woman and she had 'a bit of a breakdown' (p19) Betty was working in a Museum at this time and received care from a mental health nurse. This nurse thought that Betty had the right attributes to become a mental health nurse. Betty felt she would like to advocate for people who are unable to.

Placement experiences:

Betty described feelings of conflict within practice and the paperwork that was required for her to complete. For example, she likes the concept reflective practice as this is about doing things better, however the outcomes/proficiencies are about ticking boxes and there is no need to think or reflect (see below). She was having problems on her final placement, (she was very tearful about this when I met her for her 2nd interview). The staff hadn't had and didn't want a management student, and there was no space: she was sitting on the floor in the office. A lecturer had visited her in practice to discuss the difficulties she'd been experiencing but she couldn't say anything because the mentor was sitting there. She gave an example of a patient who had committed suicide and the impact this had on her and her mentor (p15) Betty had cried when the patient was talking with the nurse and expressed her concerns, but the concerns were not shared by the mentor. This was used as an example of the dangers of just using a tick box approach to care. We discussed intuition and gut feelings and later discussed how these could be measured (p16). Betty gave a good example of self-disclosure and empowering a patient.

Classroom experiences:

She had problems with some of her peers' judgemental attitudes towards others (it's their personality) and questioned how they would be in practice; she gave examples of overt racial and homophobic comments made by students within the classroom. Betty linked theory to practice whilst we were talking throughout and used Maslow's Hierarchy of Needs (1954). She felt that because the course had a bursary that this might have motivated some to do the nurse training.

Academic experiences:

Betty had found the diploma in nursing to be completely different to the other Higher Education courses she has done. Academically they're similar but she has struggled with the practice outcomes/ proficiencies due to there being a lot of replication, was often a tick box type exercise. She had observed professionals just using the tick boxes and not thinking outside of the box, (as in the case of her husband which she kept returning to) others she noticed did use reflective practice. Betty used an interesting tick

box assessment analogy, she likened it to a Geo Physics machine which moves along the earth's surface and is able to detect a general direction of something that may be buried underneath. This then provides a direction (the tick box) but then there's also the need to dig deeper, it should be the starting point not the end point. She described writing evidence for the outcomes as a bit like writing up about what you did on a school outing.

Anxieties/concerns:

Betty had been struggling with her numeracy skills throughout the 3-year course and as such has recently (in between my 1st and 2nd interview) been tested and found to have both Dyscalculia and Dyspraxia. This diagnosis has meant that Betty is now questioning whether she should have done her nurse education at all. Receiving this diagnosis has had a negative impact on her confidence. Betty was extremely worried about her financial situation and her job prospects; she'd been in receipt of food parcels from some of her friends. Her recent experience of being without money was memory provoking, she stated 'like when my Dad left and Mum started to drink the money we had left' (Betty became tearful was really upset and stated so).

Interviewer/ interviewee relationship:

I was late arriving at Betty's house (an RTI en route from Harmston*) Betty only had an hour to spare by the time I got there, but we seemed to just sit comfortably on the couch chatting. She would often ask question about me personally and talk a lot about the theories she likes e.g. Rogers and the importance of listening to others with warmth, being non-judgemental, genuine and empathic. She then goes onto please me saying I'm warm and used my non-verbal skills as examples of showing warmth. It's a long time since I've read Eric Berne's' Games People Play (1964) but I was struck by the thought of playing the 'psychiatrist game'[48]. Betty was able to articulate and express herself well. She gave some beautiful examples of working with people in practice and the difficulties she has coming to terms with some of the practises, sometimes it felt like we were having philosophical debates e.g. can empathy be taught and the mad/bad divide. I also kept wondering whether this student was one of the fake ones Amy had described as Betty had tried to please me and so would have perhaps done similar in the classroom? She tended to seek approval from me throughout the interview and she described herself as a people pleaser. Our 2nd interview was in practice and Betty was highly distressed at the time and was very tearful about her experiences, this was contained at the time and I gave her some time to express herself and ensured she was okay. I directed her to appropriate avenues of support when we finished the interview; she emailed me after this to thank me for listening and subsequent guidance.

Other comments /themes:

Betty admitted to 'lying' to 2 of her mentors, the first time was after the successful suicide (mentioned earlier) and the second was during her current placement as her mentor had stated she had got an odd way of communicating. This had upset Betty as this was one area she felt she was particularly good at (1st interview re getting people to tell their stories and building therapeutic relationships p.17). She shares a wonderful story about being with a friend's mum who was almost catatonic and how she had connected with her by using all of her senses (e.g. touch, smell and humour – p.20). Betty had a tendency towards black and white thinking, talked about patients a lot and engaging with them and the importance of social inclusion. We discussed the concept of reasonable adjustment on the grounds of disability and what this might mean for Betty. She also identified academic hierarchy that existed between Dip/BSc/MSc students. Checked permission throughout and put herself down regularly, she stated that she could forgive anyone except herself.

[48] Describe Psychiatrists game: Psychiatric practice is not the same as the psychiatrist's game, this is a benevolent position – I am a healer which given appropriate training can do good, the other side of this game however is to apply learnt procedures and apply them in the hope that it will be beneficial.

Appendix 6: Betty's and Ellen's Pen Portraits

Ellen* Interviewed at Jayne's hospital 1:55:58 and then a rehab unit 45:38

Ellen is a Black African female in her 50s. She came to England to continue her studies, in part because of the political problems in her home country. Her father was a medical doctor and her mother a primary school teacher. Ellen describes having a good early education. This was because her father had favoured her and she had an expensive private education, with the school having mostly Asian pupils with few black (indigenous) people. She lived with her father in the town whilst her 3 siblings lived away with their Grandma in the village (very remote, grass huts with no electricity or running water). Ellen believes that this early positive education experience contributed to her success today. Unfortunately, Ellen's father was arrested and detained for political reasons, this meant she had to return to the village and whilst she was pleased to be with her siblings, school was very different and her Mother became one of her teachers. Ellen describes this as an unpleasant experience at the time, she was regularly used as an example and when she got things wrong would be severely punished. Ellen has reflected on this and now views this as an influential experience and appreciates that her mum was trying to shape her, help her learn and be a role model. Secondary education in Ellen's home country is a privilege not a right. Ellen did not do well in her exams so was sent to live with her Grandma's sister to re-sit the class and the exam. This was done because education is considered important. She re-sat her exams and managed to get into one of the best schools in the country. She then left and lived at the boarding school, where she was free to do what she wanted, manage herself and she had her first boyfriend (this wasn't really permitted within her culture). She was 15 when she started secondary education and 19 when she finished. Ellen describes a difficult childhood, staying with different relatives and her father being detained. She had to work hard to achieve, for example, whilst staying with her Grandma's sister she felt treated like a slave. She had to walk 3 miles each way to get to school. But on reflection she now appreciates and is influenced by what her grandma's sister did for her. When Ellen left school, she trained to be a teacher for 2 years. Before she qualified as a teacher she got married as this enabled her to be with her boyfriend, because as a 'miss' she could have been sent anywhere in the country to teach. So, they got married and told her parents after the event. Ellen has had 19 years' experience working as a primary school teacher. Since coming to England, she has continued to learn and added to her formal qualifications; she now has a B.Ed. (Hons) degree and an M.A. in Special Needs. Ellen needed to financially support herself (although her husband has supported her and takes care of the children) but whilst doing these courses she couldn't find part-time work as a teacher and the only work she could find that would fit in with her studies was care work. Whilst doing this realised that she was 'passionate about caring for people' (p.17) and so decided to do a diploma in adult nursing. She chose the diploma pathway because of the bursary. Unfortunately, Ellen has physical health difficulties (diabetes and high blood pressure) which made it difficult for her to do the long shifts and the physical side of adult nursing. This contributed to her decision to change branch and she started her MH nursing in the 2nd year. Ellen is a Christian and she believes her faith is highly influential in her life. She has experienced some significant losses and she is still grieving for her father who died in 2004. She has also lost 2 of her siblings and as a consequence has adopted her sister's children. During this time Ellen became depressed and she provided an interesting account of her treatment of this health issue. She is mentally well at present and enjoys singing, dancing, knitting, crocheting and cake decorating.

Placement experiences:

As Ellen had worked in nursing homes as a carer she learnt a lot from different perspectives when going out with a Community Nurse, they visited nursing homes, she felt like she'd been promoted and this enabled her to view the caring role differently. Ellen described a great sense of satisfaction when she saw someone in the street that she had assisted (whilst on the acute ward). The fact that they were walking down the street and out in the community and not in hospital was evidence for her that they were now well. Ellen did talk about her work with older people with Dementia and the use of covert medication given to cognitively impaired patients who didn't want to take them. She had a good mentor

who was able to discuss the proper procedures for this and the ethical implications and we discussed the MH Act (1983) in relation to this. She had some good mentors and when having conversations with them about what they know and don't know, she was encouraged to keep up to date, e.g. when administrating medicines to check in the British National Formulae (BNF, 2013). For her, good mentors rely on students to help them keep up to date. The concept of recovery is about getting better, so she couldn't link recovery and dementia because individuals don't get better (recover).

Classroom experiences:

Ellen didn't discuss her classroom experiences or anything else much to do with her student nurse experiences. Instead she went on to talk about her cake decorating course and her future plans which would be something to do with cakes, training people back home, setting up a business, showing people how to make and decorate cakes.

Academic experiences:

Ellen has found the lecturers and resources at the university 'incredible'. (Perhaps in stark contrast to her home country) She gained more knowledge and received a lot of support. She feels lecturers have assisted her learning, been influential and she believes tertiary education in the UK to be very good.

Anxieties/concerns:

Ellen hardly talked about her student experiences at all. She did talk about her first experience within medicine. She had gone to the surgical theatres in Africa with her Dad and was present during the operation he performed, this however left her with a phobia/fear of blood to the extent that if she saw it oozing she would faint. She has an underlying principle by which she lives her life, this is there are no limits and nothing can stop her doing anything. So, she decided that the phobia had to go and so when she did her first placement on a surgical ward she went there with no fear and was fine. She went on to talk about her own physical health problems and how they influenced her decision to change from adult branch to MH branch.

Interviewer/interviewee relationship

Ellen became tearful when talking about her Dad. She said she was okay with crying but that she often embarrassed her husband with her tears, she apologised for the emotional display. Ellen's sister had died and as such she had adopted her 3 children (a similar experience to my own), although one of the children whilst now an adult is HIV positive. The medication to treat this virus was not available in her home county and it's for this reason under humanitarian grounds (Article 8 HRA, 1998) that she and her family are now resident in the UK. Ellen took great pride in explaining what her children are doing now and which universities they go to. Ellen describes having children as being the best and worst experiences of her life. Ellen would have been doing her PhD if she hadn't changed career.

Other comments /themes:

Ellen described becoming what both her parents wanted her to be. Her mum wanted her to be a teacher and her Dad wanted her to do something medical. She wanted to be a singer when she was younger. I'd included age ranges alongside schools in the life grid but this did not match Ellen's school years. Ellen describes being depressed and not taking the medication. Like Debbie, Ellen had been brought up in a culture that hadn't recognised mental health problems as an illness. In Ellen's home country, all nurses have the same training; there is no MH training there. She takes medication for her physical health problems, but not her depression stating, that 'it's in the mind', so something can be done about it. She'd like to be minister of education in her home country but as she can't do that she'll make the most of what she is doing now. Her mother was a home economics teacher. She uses these skills today in her baking, knitting and crocheting. She's never been involved in research which is why she wanted to participate in my research. She also wanted to learn what was involved and maybe get some tips she gave some examples of my good verbal and non-verbal skills that I used to get her experiences so she found the interviews useful.