University of Strathclyde

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The therapeutic relationship in the context of providing essential nursing care: an exploration of understanding and growth in undergraduate student nurses: Adult nursing.

A Case Study

By

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This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination, which has led to the award of a degree.

Signed:

Date

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Abstract

The study aimed to explore the understanding and growth of the therapeutic relationship in undergraduate student nurses and the factors that influenced its development. A single case holistic research design was utilised in which the 'case' constituted the cohort of students (n=17), and the unit of analysis was the students development over time (Yin, 2009, p. 51). A purposive sampling strategy was adopted and data were collected utilising group interviews at two time intervals, which addressed research question one, and self report vignettes over three time points, which addressed research question two.

The key findings of the study suggested that student nurses had an understanding of the therapeutic relationship from an early stage, and this developed over time. Students recognised key components of the relationship such as trust and good communication. Students identified barriers and facilitators to the therapeutic relationship such as pre-conceived beliefs about patients and nurses' behaviours. An incremental approach to communications skills teaching gave the students a base from which they could further develop their skills, and enabled them to recognise poor practice. Developing confidence and competence was gained from positive interactions with patients, feedback from mentors and observing good practice. Students engaged in reflective practice but found this most helpful with peers. Portfolios were mainly used as a means of documenting learning related to practical nursing skills. Students demonstrated growth in both empathy and respect over time and were able to identify their own feelings. However, students reported feelings of anxiety and guilt if they perceived these feelings to be inappropriate.

The small sample size limits the generalisability of the findings, as does the self report nature of the data collection methods. Nevertheless, some recommendations for practice were identified and include facilitated structured reflection, an incremental approach to communications skills education and raising the awareness of mentors and other clinical staff regarding the influence their practice has on undergraduate student nurses.

Preface

Effective communication and the therapeutic relationship are essential components of good patient care (SEHD, 2003; Nice, 2004; Moore, 2005; NMC, 2007; Audit Scotland, 2007; Living & Dying Well, 2008). Recent reports, both official and in the media, suggest that patients reported perceptions of the quality of care and communication they receive are often poor. (Audit Scotland 2007; Living & Dying Well, 2008; Bosely, 2009; Grey, 2009). This is often related to patients feeling that they are not treated with dignity and respect, and that health care staff lack compassion. I have always believed that good nursing care is inherently therapeutic, and based on my own clinical experience, dependent on developing a good relationship with the patient. Consequently, these are aspects of nursing care that I have always had an interest in, both as a clinical practitioner in the field of oncology, and as an educator.

I commenced my Doctoral degree almost simultaneously with taking up post in the undergraduate teaching team at a Higher Education Institute (HEI) in Scotland. As a nurse educator part of my role is to facilitate the preparation of tomorrow's registered nurses. It is sometimes suggested that the transfer of nurse education to HEIs, with the alleged emphasis on theory rather than practice, is in part responsible for the decline in the standard of nursing care. A desire to ascertain what student nurses understand by the therapeutic relationship and what influences its development provided the impetus for this study. It is hoped that the findings will of inform undergraduate nursing curricula.

The aim of the study was to contextualise undergraduate student nurses' understanding of the therapeutic relationship and their ability to develop this relationship with patients, in the context of providing essential nursing care. The study also aims to surface the pedagogical design elements, which appear to influence this. In order to achieve the aims of the study the following overarching research question was addressed:

What is student nurses' understanding of the therapeutic relationship, and what influences the growth in their ability to develop this relationship?

To operationalise this question, data were gathered to answer the following two specific research questions:

1. How do student nurses reflect on (at two different time points):
    - Their experience of working with patients?
    - Their experience of working with mentors and clinical staff in the field?
    - The contribution of the academic input to their learning?

2. How would students respond (at three different time points) to potentially awkward, embarrassing or sensitive patient nurse interactions, by reporting what they would do and by trying to identify the feelings and potential responses of the patient? Are students able to identify their own feelings in relation to each of the scenarios?

The study was undertaken within the Nursing and Health Care school in an HEI in Scotland. Ethical approval was granted by the University of Strathclyde and permission to access the students was granted by the head of department, following consultation with the undergraduate programme director.

A case study methodology was employed for the study and within that a single case, holistic approach, case study design was adopted. The 17 students, who commenced their Bachelor of Nursing Degree in September 2009, constituted the 'case' and the unit of analysis was the growth in the therapeutic relationship over time. Time constraints related to the degree programme prevented following students to the end of their programme, nevertheless the findings presented have provided insight into the phenomenon and given some direction for undergraduate nurse education and direction for future research.

Organisation of the thesis

The thesis is presented over six chapters. Chapter one will provide an introduction and set the professional context. Chapter two will present a review of the relevant literature. The literature presented throughout the thesis reflects what was known prior to the commencement of the study in October 2009, and what has subsequently been published relevant to the field of study. Chapter three outlines the rationale for the methodological approach adopted for the study. This chapter also incorporates the research design, the methods of data collection employed, sampling technique and the steps taken in the process of data analysis. Chapter four presents the study findings, presented in three sections. The first section presents the demographic data collected at the outset of the study. Section two presents the themes that emerged from group interviews one and two. Section three reports the findings of the vignettes in relation to growth in empathy, respect and student reports of self awareness. Chapter five will present the discussion of the findings and will address how they relate to what is already known in the field of study and what new contribution the study offers. There will also be a discussion of the strengths and weaknesses of the methodological approach and the study design. Chapter six will present conclusions, recommendations for practice, limitations of the study and suggestions for the direction of future research.

References are presented using the American Psychological Association (APA) system of referencing as per University of Strathclyde guidelines.

Chapter 1 Introduction

1.1 Setting the professional context

There is an expectation that in addition to technical competence, nurses will provide compassionate and person centred care, ensuring that the dignity of every patient is maintained (Roach, 1992, 2002; Orb & Davey, 1994; Baillie, 2005; NMC, 2008; DoH 2007; National Service Framework for Older People Standard 2, 2001; NMC, 2008; NHS Quality Standards Scottish Gov, 2010; Kings Fund Compassion Report, 2008). This view is supported in recent policy documents emanating from the NHS (The Health Care Quality Strategy, 2010; Delivering Dignity, 2011). The Delivering Dignity report (2011) emphasises the responsibility of health care educators to ensure that student nurses and other health care students are taught the qualities and values necessary for the provision of compassionate care.

Recent reports - both before and since this research was undertaken - suggest that in some areas nurses are failing to communicate effectively, provide competent basic nursing care and provide care with compassion (Walshe & Higgins 2002; Health Care Commission; 2007; Audit Scotland 2007; Living & Dying Well 2008; The Francis Report, 2010; Sawbridge and Heston, 2011). Official reports appear to be supported by reports in the media regarding nurses' communication skills and the provision of compassionate and empathic care (Bosely, 2009; Grey, 2009). Whilst complaints about nursing care are certainly not new, it seems that there has been an increase in both the number of reports and the number of anecdotal stories related to poor care (Sawbridge & Hewison, 2011).

I have been associated with nursing both as a practitioner and now as a registered nurse educator since October 1973. I chose to undertake an Ed D because I wanted to develop as a nurse teacher and to enable undergraduates to develop nursing skills. The decision to explore communication skills and the therapeutic relationship was driven by a number of things. I have always believed that good nursing care is inherently therapeutic and, based on my own clinical experience, dependent on

developing a good relationship with the patient. All relationships depend on an ability to communicate, therefore good communication skills would also seem to be necessary. I do not recall being taught specifically about communication or the nature of the therapeutic relationship but was always conscious of seeing good (and bad) nursing care.

Current undergraduate curricula in the United Kingdom (UK) do address these topics, although the importance of role modelling in the clinical area is as important as it ever was (Spouse, 2001; Hockley, 2008; Nursing & Midwifery Council (NMC), 2010). Another factor that contributed to the choice of study topic was that I was called to see a student on clinical placement. The mentor was unsure how to manage this particular student. The student was competent in carrying out clinical tasks but appeared to be reluctant to engage with patients. In fact the student told the mentor that there was no point in getting to know them. When I discussed this with the student it was evident that the student had a poor understanding of the nurse patient relationship. The student was likening the nurse patient relationship to personal relationships and believed that a relationship that was short lived and with a definite end point could not be genuine. The situation with this particular student was resolved satisfactorily, but it led me to reflect on the preparation of undergraduate student nurses to engage in the therapeutic relationship and how they develop communication and other necessary skills.

1.2 Communication and the therapeutic relationship

There is now wide recognition that effective communication and the therapeutic relationship between health care professionals and patients are essential components of good patient care (SEHD, 2003; NICE, 2004; Moore, 2005; NMC, 2007; Audit Scotland, 2007; Living & Dying Well, 2008).

Effective compassionate communication is fundamental to establishing a therapeutic relationship with the patient. The main goals of the therapeutic relationship are establishing trust, building rapport, gathering information regarding symptoms, ascertaining problems and concerns, assisting patients in decision-making and

developing a care plan all of which fall within the remit of the nurse (Moore, 2005; NMC, 2007). Effective communication has also been found to influence the rate of patient recovery, pain control, adherence to treatment regimes and psychological functioning (Stewart, 1989; Fallowfield, 1990; Stewart, 1996; Razavi, 2000). Communication skills do not just develop with time and experience; therefore providing good quality education related to communication is vital (Gysels, Richardson and Higginson, 2005). Communication is recognised as a core skill for health care professionals (SEHD, 2003; NICE, 2004; Fellowes, Wilkinson & Moore, 2004; NHS QIS, 2008) and has been identified as a core component of the curriculum for undergraduate nurse education programmes (NMC, 2007; Living & Dying Well, 2008; NMC, 2010).

1.3 The importance of communication skills education

The literature places strong emphasis on approaches to communication skills training that are interactive rather than didactic (Lane & Rollnick, 2007). Didactic methods of training may be important when developing understanding, knowledge, and the theoretical underpinnings of communication skills, but when used in isolation are unlikely to change behaviour. A combination of didactic teaching and interactive techniques, such as communication 'games' and scenario based role play, have been proven to better facilitate the development of communication skills (Chant, Jenkinson, Randall, Russell & Webb, 2002; Farrell, Cubit, Bobrowski & Salmon, 2008). Evaluation studies of the effectiveness of communication skills training identify the key features as role play, feedback, reflection and discussion, and the influence of role models (Gysels et al., 2005; Ramsey, Keith, Scott Kerr, Hogg, 2008) Although there is guidance from the Nursing & Midwifery Council (NMC) regarding the overall training needs of student nurses, and more recently, specific objectives relating to communication (NMC, 2007), the NMC is not prescriptive in how communication skills, or indeed other aspects of the curriculum, should be taught. Higher Education Institutions (HEIs) have the freedom to develop courses as they see fit. However, all courses are subject to validation by both the university and the professional body and are revalidated every five years.

It has been suggested that 'communication is the primary medium of care' and on occasion is the only thing that patients can be offered, suggesting that it is of itself of therapeutic value and is a fundamental building block of the therapeutic relationship (Moore, 2005). My own clinical experience, over 25 years of clinical practice supports this view. I have observed both the negative impact that poor communication can have on patients and carers, but have also seen the positive impact of good communication, where the act of communication itself is perceived by the recipient as therapeutic. Farrell et al (2008) suggest that poor communication skills in nurses are influenced by the following factors:

- The inability of the nurse to understand the patient's perspective;
- A lack of awareness of one's own emotional process in relation to dealing with patients;
- A lack of interpersonal skills.

Many health care professionals have not had effective teaching in communication skills and lack confidence that education could improve their skills (Back, Arnold, Baile, Tulsky, & Fryer-Edwards, 2005). Evidence also suggests that communication skills training in undergraduate programmes sometimes lack structure with little research evidence on the effectiveness of individual methods of teaching communication skills (Chant et al., 2002).

1.4 Professional Imperative

If the ability to establish the therapeutic relationship is essential for good nursing care (Moore, 2005) and this is linked to effective communication, then arguably development of these skills should be at the heart of all undergraduate nursing curricula. The Essential Skills Clusters (ESCs) (NMC, 2007) were developed as a result of the review of fitness for practice at the point of registration. The aim is to provide clarity of expectation for the public and profession alike, and to seek to address some of the concerns about skill deficits. The cluster of skills related to communication, care and compassion was identified by the NMC (2007) as one of five key clusters to be addressed in the undergraduate nursing curriculum. The ESCs were intended to complement the existing NMC pre-registration outcomes and

proficiencies for entry to the register (NMC, 2004). Since then, new standards for pre - registration competencies have been published and these incorporate the ESCs (NMC, 2010). These standards for pre-registration nurse education set out clearly what is expected of the professional nurse in the modern health care environment. The standards make clear the importance of developing the aforementioned skills related to communication, care and compassion in the undergraduate student, so that they are fit for purpose on entry to the professional register.

As policy documents had highlighted the importance of improving communication education for undergraduate students, it was appropriate at this time for the Nursing & Health Care School to review the provison of communications skills education within the Bachelor of Nursing Programme (NMC, 2007; Audit Scotland, 2007; Living & Dying Well, 2008). Taking cognisance of the literature and the input of experts in communication skills education in the field of health care, a new evidence based communication course was developed.

1.4.1 Existing provision

A review of the existing provision within the curriculum indicated that the time allocated appeared to be insufficient. What time was provided, with the exception of year one, was taught within the context of either cancer or palliative care, which reflects where the emphasis on communication skills training is found in the literature. The teaching methods were primarily didactic with little or no simulated learning to facilitate skills rehearsal. There was also no incremental development of the themes and learning outcomes over the course of the three years. Programme revalidation is required by the NMC every five years and, as the undergraduate teaching team were preparing for programme revalidation, curriculum development activity was ongoing. This presented an opportunity to review the current provision and develop a new evidence based approach to the provision of communication skills education.

1.4.2 New communication skills course

The broad approach to curriculum development was outcomes based, where the aim is to enable the student to develop the knowledge and skills necessary for professional practice, including lifelong learning skills such as problem solving and critical thinking (Mtshali, 2005, p. 193). Due to the nature of the required professional knowledge, the new curriculum was also partly content driven (Gwele, 2005, pp. 14-15). The new communications skills course adopted a 'spiral' curriculum approach to ensure that there was incremental development of knowledge and skills, with opportunities for revision and rehearsal. The spiral approach was first developed by Bruner in the 1960s and has been suggested as particularly relevant when integrated with outcomes based education (Harden & Stamper, 1999). As the nursing students combine their theoretical knowledge with clinical experience Kolb's experiential learning model was used as a means of integrating theory with practice (Fig. 1).

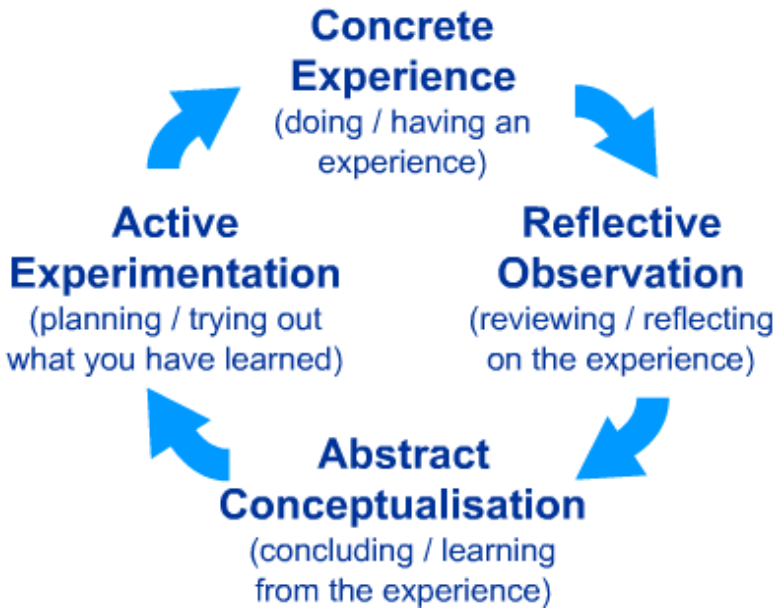


Fig 1. Kolb's experiential learning model, (1984)

In addition, Gibbs' (1998) cycle (Fig. 2) of reflective practice was chosen as the means by which the students would be encouraged to develop reflective practice skills. This model was utilised for the structured, facilitated, reflective practice in which the students participated in as part of the communications skills course.

Although there are a number of models of reflective practice, Gibbs' model is widely used in nurse education and, as students were encouraged to engage in reflection with their mentor, it is the model with which the mentors were likely to be familiar.

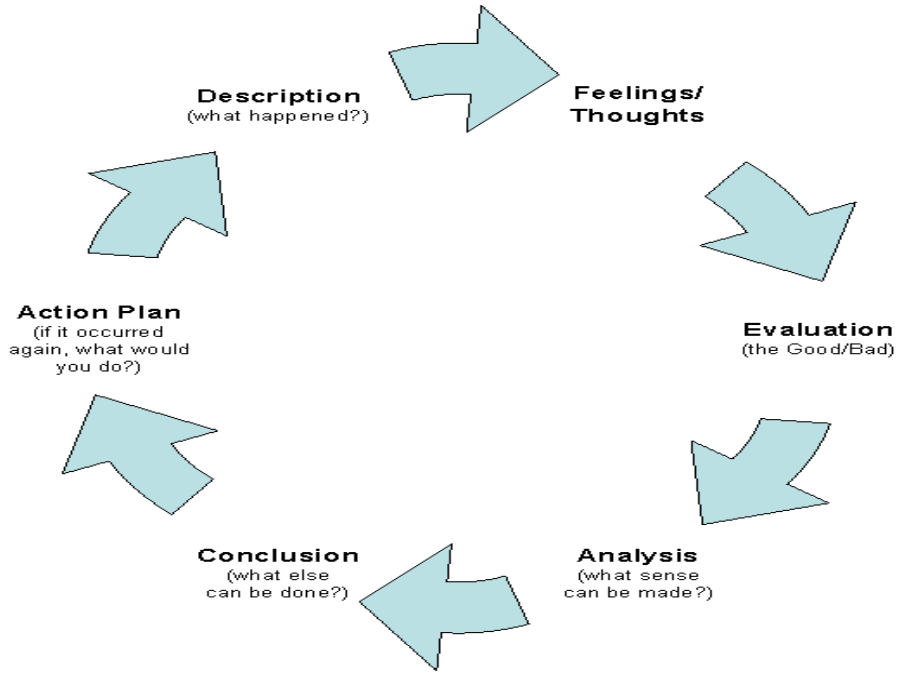


Fig. 2. Gibbs' reflective cycle (1998)

The communication course is delivered over the three core years of the undergraduate programme with an opportunity for further revision and skills rehearsal in year 4 for those who remain to undertake Honours. The course is facilitated by the author of this thesis in partnership with clinical colleagues who have all undertaken formal communication skills training. In addition, all those teaching on the course have undertaken an accredited 'train the trainers' programme, based on the Fallowfield model (Fallowfield, 2001). Training programmes for communication skills facilitators are provided by a number of institutions both in Scotland and across the UK.

Learning outcomes were developed using Bloom's Taxonomy (1956, pp.25-43). Although considered by some authors to be dated (Marzan & Kendall, 2007, p. 47), it is still widely used in the development of educational learning outcomes (Marton, Hounsell, Entwhistle, 1997, p.32; Quinn & Hughes, 2007, p.192) and was used in the

curriculum redesign. Learning outcomes were developed at the appropriate level for each year of the programme in order to demonstrate the development of skills and knowledge. For example, year one outcomes focus on developing understanding and skills, year two on using and applying knowledge and skills and years three and four on critical understanding and application of skills (Quinn & Hughes, 2007, p.196). Learning outcomes were developed in relation to:

- **Cognitive domain** - intellectual capability - knowledge and understanding (K)
- **Psychomotor domain** - manual and physical skills - skills and abilities (S)
- **Affective domain** - feelings, emotions and behaviour - attitude (A)

An overview of the existing provision and the new provision is presented in appendix one.

1.5 Rationale for the study

There is increasing evidence from the media and government reports and audits, testifying to the poor communications skills and apparent lack of empathy in care provision. As undergraduate student nurses are the registered nurses of the future, I was compelled to explore what student nurses understand by the therapeutic relationship and what influenced their development in this aspect of their role. It is important that student nurses develop their understanding of the therapeutic relationship in the context of delivering essential nursing care rather than consider the therapeutic relationship as an attribute of 'specialist nursing' or confined to psychiatry, psychology or other emotional and spiritual interpretations. The ability to provide this care in the context of a therapeutic relationship is seen as an essential attribute of the professional nurse and is a key component of professionalism in nursing (Kristjánsdóttir, 1992, Taylor, 1998, Arnold & Underman Boggs, 2007, p.92; NMC, 2004, 2010).

For the purposes of this study the therapeutic relationship is contextualised in adult general nursing practice and the provision of essential nursing skills, such as assisting with personal hygiene and assisting with nutritional and fluid intake. The communication skills course, previously discussed, was developed from the literature and was designed to allow the students to explore and discuss the underpinning

values that are considered essential for the development of a professional therapeutic relationship in nursing. This will be further discussed in the literature review in chapter two.

By exploring the students' perspectives and gaining some understanding of what factors influenced their understanding and subsequent growth in ability to develop a therapeutic relationship with patients it was hoped to inform curriculum development. Initially this will be confined to my own HEI, but may have the potential to influence undergraduate nursing curricula more widely. It was also evident from discussion with students that communicating and building relationships with patients were elements of the role with which some students struggled. There is a dearth of evidence in the literature reviewed exploring what student nurses understand the therapeutic relationship to be and what influences their abilities to develop this relationship with patients.

Chapter 2 Literature Review

2.1 Search strategy

The research literature review has been described as a systematic process by which the researcher identifies and evaluates the existing literature pertinent to the field of study. It informs the researcher about what is already known in the field and initially may help in the development of research questions (Hart, 2001, p. 3; Fink, 2005, p.3). Identifying relevant literature is dependent on choosing appropriate search terms and databases and should be informed by the words and ideas that frame the research questions (Fink, 2005, p .5). However, it is acknowledged that searching the literature is not a one off activity and should be conducted throughout the study (Hart, 2001, p. 7).

As the main focus of the research was education and development in relation to nursing, Cumulative Index to Nursing & Allied Health Literature (CINAHL) and the British Nursing Index together with Medline were obvious databases to include in the search. As many nurse educators also publish in Education Journals ERIC (Education Resources Information Centre) was included. In order to ensure the broadest range of material related to education and health care the following databases were also included: AMED (Allied and Complementary Medicine), EMBASE (Excerta Medical Database), HMIC (Health Management Information Corporation) and Web of Knowledge. As the study sought to explore the therapeutic relationship in the broadest sense, databases from sociology and psychology were utilised: PsycINFO, PsycARTICLES, Psychology and Behavioural Science Collection and SocINDEX.

The initial search was conducted using ‘therapeutic relationship’ as a key term on all databases, both singly and in combination with other terms such as ‘nurse’, ‘undergraduate nurses’, ‘student nurses’, ‘nursing’, ‘general nursing’, ‘psychology’ and ‘communication’. ‘Communication’ was then used as a key word in combination with, ‘nurse education’, ‘skills’ and ‘student nurses’. Subsequent searches included combinations of ‘nurs$’ (utilising a truncation of nurse to enhance the search) with

empathy, respect and self awareness. Literature searches were also conducted in the fields of role modelling and reflection. In addition, the author also accessed relevant policy documents published by the Department of Health (DoH), NHS Greater Glasgow & Clyde (NHSGGC), NHS Scotland and the NMC. Grey literature such as newspaper reports, internet resources and unpublished theses can often provide useful information and were included (Hart, 2001, p.96). Relevant text books were utilised throughout the research.

The literature search intentionally covered a broad time frame, dating from the 1950s to the present day, to allow the inclusion of seminal work by authors such as Peplau, Travelbee and Rodgers. The vast majority of literature related to the therapeutic relationship in nursing was to be found in the field of mental health nursing. There was some literature related to the therapeutic relationship in general nursing but a dearth of literature related to undergraduate nursing students. This suggests that there is a need for further research related to the therapeutic relationship in relation to undergraduate student nurses in Adult nursing.

The literature review will be presented in four sections:
Section 1: The therapeutic relationship;
Section 2: Communication skills;
Section 3: Empathy, respect and dignity, self awareness;
Section 4: Work - based learning, role modelling and reflection.

2.2 Defining the therapeutic relationship

The therapeutic relationship is a term frequently used in the field of health care. What is not clear is what individual practitioners understand by the term (Moore, 2005). It is important, for the purposes of this research, to clarify how the therapeutic relationship is defined in the literature.

There are a number of authors in the literature who, while discussing the therapeutic relationship in relation to its conduct, the attributes of the nurse and the nurse patient relationship, fail to identify a working definition (Jones, 1994; Barker, 1998; Williams, 2001; McNaughton, 2005). In addition, the terms 'therapeutic relationship', 'nurse patient relationship' 'nurse-client relationship' and 'professional relationship' are used variously by different authors depending on context. However, an underlying feature of how these terms are utilised in much of the literature is that they refer to a relationship between the nurse and the patient where the intention of the relationship is to support the patient to achieve mutually agreed health goals. With the terms nurse patient/client relationship, although it is clear that there is a relationship, the dimension of benefit to the patient is left implicit. The author is therefore of the view that the therapeutic relationship more accurately describes the intended purpose of the relationship.

In her theory of interpersonal relations, Peplau (1952, p. 9) defines what makes the 'nursing process' therapeutic. She states that 'the nursing process is educative and therapeutic when nurse and patient can come to know and to respect each other, as persons who are alike, and yet, different, as persons who share in the solution of problems.' This interpretation of nursing as being more than the skilful provision of practical and technical care is also proposed by other nursing theorists. Benner and Wrubel (1989, p. 4) concluded that technical proficiency and the acquisition of knowledge were not sufficient and suggest that even when treatment is not possible the demonstration of understanding by the nurse can be felt by the patient as a form of healing.

When discussing the nurse patient relationship, it is clear that Benner and Wrubel (1989 p. 9) view this as a relationship that is grounded in providing assistance to the patient in a caring way. The authors further suggest that the attitude of the nurse, while providing aspects of care, may influence the outcome for the patient and either enhance or compromise the trust between the nurse and the patient. Trust was identified as being important in fostering a positive and beneficial relationship. The authors refer to this caring approach to the provision of nursing care as 'The Primacy of Caring' and view this approach to the relationship between the nurse and the patient as central to the practice of nursing.

Taylor (1998) supported the view of Benner and Wrubel (1989) of the centrality of the nurse patient relationship to nursing. She claimed that while there were other areas of nursing that were important, such as nurse education and nursing research, she viewed them as mechanisms for supporting the nurse patient relationship. She suggested that the advent of specialism in nursing risked a reductionist approach to meeting the needs of patients and proposed the view that nursing was essentially a generic activity. It is evident from her description of the nurse patient relationship that she recognises the therapeutic nature of the relationship. She states 'the nurse patient relationship not only serves as a meeting place, but also as the home of therapeutic aims and outcomes, which are negotiated and enacted day to day and place to place.' Thus, similar to Peplau (1952, p. 23), Taylor (1998) proposes that the therapeutic aims of the relationship are negotiated between the nurse and the patient, with both parties working together to achieve therapeutic goals.

Arnold and Underman Boggs (2007, p. 220), drawing on earlier work by Williams (2001) and Henson (1997), define the therapeutic relationship as 'a professional alliance in which the nurse and client join together for a defined period of time to achieve health related treatment goals where the patient engages in the relationship with health care issues that are amenable to nursing interventions.' They further suggest that the nurse's motivation at the outset of the relationship is based on a wish to assist others and a willingness to accept the patient as a unique individual, deserving of consideration and respect, suggesting that the nurse's motivation is

congruent with the conditions for the therapeutic relationship suggested by Rogers (1957).

Trust is a difficult concept and may have different meanings in different contexts (Hupecy, Penrod, Morse & Mitcham, 2001). For example, an individual may trust someone to carry out dental care but may not trust that same person to drive their car. For the purposes of this thesis, trust is contextualised to the relationship between the nurse and the patient. The importance of trust as a component of the therapeutic relationship is identified by a number of authors (Wallston et al, 1973; Richardson, 1987; Benner and Wrubel 1989 p. 9; Gibson, 1991; Semmes, 1991; Forchuck, 1992; Johns, 1996; OCN, 2006; Arnold and Underman Boggs, 2007, p.120). Indeed it has been suggested that trust is an essential component in any relationship (Sheldon, 2004, p. 10). Johns (1996a), writing in the context of nursing, defines trust as 'willingness to place oneself in a relationship that establishes or increases vulnerability with reliance on someone or something to perform as expected.' This view of trust is supported by Hupecy et al. (2001) who, when describing the attributes of trust, also suggest that it can be described as the willingness of an individual to place him or herself in a situation of need, where the outcome may not be known. The individual trusts that the person in whom they have placed that trust will respond in a manner that will enable the need to be met. Arnold and Underman Boggs (2007, p. 120), suggest that the establishment of trust between the patient and the nurse can foster a non-threatening environment, which is essential if the patient is to communicate their needs to the nurse. The authors further suggest that demonstration of respect to the patient by the nurse is an important factor in establishing trust. Trust has also been recognised as a necessary factor in both patient empowerment and in the willingness of patients to accept treatment (Taylor, 1998).

The next four sections explore the therapeutic relationship from the perspectives of both psychology and different fields of nursing, as well as research undertaken with undergraduate nurses, and will explore in more detail how the therapeutic relationship is developed in each of these contexts.

2.2.1 The therapeutic relationship in the field of psychology

Shattell et al. (2007) argue that Freud's (1915-1935) psychoanalytical theory is an essential starting place for any discussion on the therapeutic relationship and underpinning theories. Freud (cited in Shattell et al., 2007), believed that it was the intervention of the therapist that was responsible for any beneficial outcomes and any failure of the client to improve was perceived as resistance on the part of the client. This suggests a paternalistic approach to therapy where the therapist is the one with the power and the client is not perceived as contributing to the relationship (Shattell et al., 2007). In contemporary health care this paternalistic approach, proposed by Freud could perhaps be referred to as a medical model approach (Ewles & Simnett, p. 35, 2003; Scriven, 2010, p. 21), where the patient is perceived as a passive recipient of the intervention, with the therapist holding the power. In contrast, Jung (1967) preferred to refer to patients as 'persons working with him' and is reported to have disliked using the word patient. He argued that the therapeutic process is one in which both parties contribute and both are transformed.

Similarly, Rogers (2007, p. 2) rejects the medical model approach to psychotherapy, which focuses on the identification of specific pathology leading to a diagnosis, and favours a more personal developmental approach. It was Rogers' work from the 1930s that led to the development of the theory of person-centred therapy (Sanders, 2007, p. 9). Sanders and Wyatt (2002, p. 5), exploring the work of Carl Rogers, outline the six conditions identified by Rogers in 1959, as essential for a successful therapeutic relationship. These are:

1. That the two persons are in (psychological) contact;
2. That the client is in a vulnerable or anxious state;
3. That the therapist is congruent or integrated in the relationship;
4. That the therapist extends unconditional positive regard towards the client;
5. That the therapist is empathic of the client's frame of reference (and endeavours to communicate this to the client);
6. That the client perceives, to some degree, conditions four and five.

Rogers (1959, cited in Sanders & Wyatt, 2002, p. 3) established that the therapeutic relationship is an encounter between two individuals and is at the centre of the therapeutic process. In a conference presentation, Rogers (2007, pp. 1-5) presented the three conditions that he considered to be core to the development of the therapeutic relationship: that the therapist is an authentic and congruent person, that he/she cares about the client and values him/her, and that the therapist displays real empathy for the client. Although discussing the therapeutic relationship from the perspective of the psychoanalyst, there are key elements that are equally relevant to nursing.

The first core condition that Rogers (2007, pp.1-5) suggests is essential, is that the therapist must be 'a real person' with a self awareness of their own feelings and emotions within the relationship, and this relates to condition three. This is supported by Yalom (1980, p. 34), who cautioned against an over-reliance on technique at the potential expense of authenticity in communication, for which a level of self awareness was required.

The second core condition is that the therapist cares for the client with what Rogers describes as 'unconditional positive regard', and this relates to condition four. This implies that the therapist will care for the client with no conditions applied. This is again reiterated by Yalom (1980, p. 35), who suggests that the therapeutic relationship can provide a kind of 'dress rehearsal' for the patient on how to relate to others after a period of illness. Although reported in the context of a psychotherapeutic relationship, this interpretation of the role of the therapeutic relationship has been applied to general nursing. Patients may undergo both psychological and physical changes as a result of disease and trauma and it is to the nurse that they first look for reassurance and acceptance (Price, 1998).

The third of the core conditions is empathy and this relates to condition five. Rogers (2007, pp. 1-5) suggests that empathy is perhaps the easiest to explain and understand. He suggests that empathy should be considered as more of a process than a state and that being empathic has several facets. The therapist has to enter the

perceptual world of the client, being sensitive to what is happening with the client from an emotional point of view, temporarily living in their life in a non-judgemental way. It requires that the therapist checks with the client that their perceptions are correct, thereby taking the lead from the client. This necessitates that the therapist puts on hold his or her own views and values in order to view the client without prejudice. Rogers (2007, pp. 1-5) further suggests that this can only be achieved if the therapist is secure enough in themselves to be able to achieve this and remain within professional boundaries. In order to achieve this, the therapist must develop a level of self awareness. The therapeutic relationship is most effective when all of these three conditions exist. It is evident from Rogers' earlier work (1957) that as well as the therapist or practitioner engaging with these core conditions, it is important that the client has some understanding of what the therapist is aiming to achieve. Therefore, ensuring condition six is met would appear to be equally important. The outcomes for the client of a successful therapeutic relationship are a feeling of being worthwhile, the development of a more positive self concept and the achievement of mutually agreed goals.

2.2.2 The therapeutic relationship in nursing - Peplau's model

The literature discussing the therapeutic relationship within the context of nursing dates back to the 1950s and is dominated by the work of Peplau, writing between 1952 and 1997, and Travelbee (1966, 1969). Peplau's work has been the most influential in developing an understanding of the therapeutic relationship within the context of nursing, with the majority of the published work in this field based on her theories. Although not as prolific or as well known, Travelbee (1966) made an important contribution in challenging the thinking around how nurses should engage with patients. It had been the prevailing view that nurses should avoid any kind of emotional involvement and, indeed, that to do otherwise might be indicative of inappropriate behaviour (Shattell et al., 2007). Travelbee (1966) proposed that the nurses could and should engage with patients on some kind of emotional level and it was *how* that relationship was conducted that was key, not *if*.

Three main criteria for establishing the therapeutic relationship emerged from Travelbee's theories: (1) The relationship with the patient is one that is actively and consciously planned for by the nurse; (2) some degree of emotional involvement must be present in order to establish a relationship; (3) that complete objectivity was not possible. Indeed, she suggested that objectivity presented a barrier to developing the relationship. Travelbee also worked with patients in helping them overcome difficulties with the nurse-patient relationship and her early work in this area is supported by Peplau, who wrote in 1997 that the nurse should endeavour to 'struggle with the problem and not with the patient'.

Peplau (1952, p.5) was at the forefront of promoting the view that theory was essential to the practice of all professional nurses and with her interpretation of the theory of interpersonal relations in relation to the nurse patient relationship, made a significant contribution to nursing science. This contribution is widely recognised by a number of authors to the present day, by those in both the field of general nursing and that of mental health nursing (Forchuck, 1992; Haber, 2000; Price, 1995, 2000; McNaughton, 2005; Erci, Sezgin & Kaçmaz, 2008; McCarthy & Aquino-Russell, 2009).

It is clear from Peplau's own introductory chapter to her seminal work 'Interpersonal Relations in Nursing' (1952, pp. 9-11), in which she discusses therapeutic relationships in the context of looking at how people work with 'disabilities, such as diabetes, heart disease, deformities and the like', that she envisaged her model as being an underpinning of all nursing, not confined to one speciality. She defines nursing as a 'significant therapeutic interpersonal process' (p. 18). Therefore, it is not unreasonable to conclude that the therapeutic relationship lies at the core of nursing.

This understanding of the applicability of her theory to all aspects of nursing is supported by subsequent authors, who applied the model successfully in general nursing in both the acute setting and community nursing (Forchuck, 1995; Fowler, 1995; Jones, 1995, McNaughton, 2005; Erci et al., 2008). McNaughton (2005) further suggested that Peplau's theory is consistent with current nursing practice

where the emphasis is on partnership working, patient-centred care and client independence.

In developing her theory Peplau utilised both an inductive and deductive approach. Deductively, she drew on the theory of interpersonal relations developed by Sullivan (1953), a psychoanalyst whose practice was influenced by Freudian theory. However, his work on the development of the theory of interpersonal relations drew more on social science theories than psychoanalytical theory (Peplau, 1992). Peplau's work was also influenced by research conducted by Symonds (1946), whose work on the dynamics of human adjustment was based on clinical studies. Inductively, Peplau remained true to her epistemological stance and drew principally on case studies and clinical work with both patients and nurses (Haber, 2000).

Peplau recognised that the nurse patient relationship was different to other social relationships and that each relationship has its own set of requirements. She suggested that the relationship with which most people are familiar and comfortable is the family relationship. She noted that patients, and sometimes nurses, tended to relate to one another in ways that were successful in the family environment. For example an older nurse might relate to a young patient in the way she would to a son or daughter and vice-versa. In order to avoid this, the nurse must learn to work within professional boundaries in order to establish an appropriate nurse patient relationship. This understanding of the need for professional boundaries within the therapeutic or nurse patient relationship addressed the concerns, alluded to earlier, regarding 'inappropriate relationships' with patients that might result from emotional engagement.

Peplau (1952, pp. 17-41) suggested that the basic structure of the nurse patient relationship, consisted of four overlapping phases, each with its own characteristics: (1) orientation, where the nurse and the client get to know each other; (2) identification - where problems are identified; (3) exploitation - where the nurse and client work towards identifying solutions; (4) resolution - the client achieves goals and becomes independent of the nurse. This early work was refined by Forchuck

(1991) to three overlapping phases - orientation, working phase (combining the identification and exploitation phase) and termination, and was endorsed by Peplau (1992, 1997).

The orientation phase is initiated by the nurse as she identifies and introduces herself, making the purpose and nature of the relationship clear to the patient. This action alone sets out the unique nature of the professional relationship as personal/social relationships do not usually set time limits at the outset (Forchuck, 1991, 1992; Peplau, 1992). Initially the relationship is likely to be a one-way interaction as the nurse seeks information about the patient by taking a history and carrying out an assessment. Forchuck (1992) also suggests that it is in the orientation phase that initial trust is established. Peplau (1997) suggests that some nurses have difficulty moving from the social behaviour in their personal life to the professional behaviour required of a nurse. Peplau recognised that although the nurse may be viewed as the initiator of the relationship, the patient was not a passive participant and can seek ways to engage with the nurse (Peplau, 1988).

During the orientation phase the nurse's behaviour, both verbal and non verbal, signals to the patient the nurse's interest in the patient as an individual. An ability to communicate effectively was seen as fundamental at this stage of building the relationship. In modern health care this part of the relationship is increasingly challenging as patients spend shorter and shorter periods in hospital. Patients are often admitted on the day of the procedure and may only see the nurses fleetingly beforehand. Both nurses and patients may enter the relationship with preconceptions about one another. The patient may have a stereotypical view of the nurse based on images from the media or from stories from relatives and friends. The patient may also have had a poor experience in a previous health care episode (Forchuck, 1994). The nurse may form a view of the patient in relation to factors such as age, gender, social class, ethnic background or diagnosis. These preconceptions may influence the outcome of the relationship and must be explored by the nurse (Peplau, 1964, 1967; Forchuck, 1994). O'Kelly (1998, citing Peplau, 1959) suggests that nurses need to have awareness of their own reactions, values and beliefs in order to ensure good

nursing care. The importance of self awareness in relation to the nurse patient relationship is acknowledged by a number of authors and will be discussed later in this chapter. The inability of the nurse to confront their own pre-conceptions, due to a lack of self awareness may result in difficulty meeting the fourth of Rogers' six conditions, that of unconditional positive regard. O'Kelly (1998) suggests that in order to achieve this, the nurse requires support and supervision.

The second phase of the nurse patient relationship is referred to as the working phase. The success of this phase is in some way influenced by a successful (or not) orientation phase where the patient may have already formed a view of the nurse's willingness to take a real interest in his/her wellbeing and enter into an empathic relationship. The nurse may have a number of roles in this phase including educator, counsellor and, where necessary, provider of physical care in the form of assistance with personal hygiene or nutritional requirements, the administration of medication or other forms of treatment. However, the ultimate goal of the nurse should be to empower the patient to work towards his or her own positive health outcomes. Nurses must recognise the privileged position they have in having access to the patient's personal space both physically, where they may see patients naked, and emotionally, when patients are distressed, frightened and angry. The nature of this interpersonal communication highlights the patient's need for respect and dignity and their need not to feel shame or embarrassment (Peplau, 1997). This relates to the fourth of Rogers' conditions where he describes this as 'unconditional positive regard'. However, in order to achieve this, the nurse must have an ability to understand the patient's perspective, an awareness of their own emotional process in relation to dealing with patients and good communication skills. This last point regarding self awareness relates to Rogers' third core condition and is arguably the most important as a lack of self awareness may preclude the ability to engage with the other conditions of the therapeutic relationship (Peplau, 1997; Byrne et al., 2001).

Another unique feature of the therapeutic relationship is that there is a defined termination phase. Unlike social relationships, there is no intention that the relationship will continue once it has achieved its purpose. Again, this is a

characteristic of the professional nature of the relationship between the nurse and the patient (Peplau, 1952, p 12; Forchuck, 1992; Arnold & Underman Boggs, p. 95). In some care settings, such as mental health and chronic/terminal illness, the nurse may have a long term relationship with the patient over months or sometimes years. Although the relationship between the nurse and the patient in the acute care setting is often short and, with the increase in early discharge, may become even shorter (Shatell, 2005; NHS Quality Strategy, 2010), a number of authors have successfully applied the model when the relationship has been much shorter than that typified by the relationships in psychiatric nursing or nursing chronic illness. Evidence to support this will be presented in subsequent sections.

The termination phase is an important one, in which there is an evaluation of the agreed outcomes and the nurse prepares the patient to cope on his/her own. The success of this transition for the patient will depend on the success of the working phase where the nurse has been empowering the patient to regain control of his own health. Peplau (1997) concludes by restating the uniqueness of the nurse patient relationship with regards to process and outcome and its dependence on the nurse's style, theoretical concepts and intellectual and interpersonal competencies

2.2.3 The application of Peplau's model in general nursing

The impact of Peplau's theory of interpersonal relations and how that influences the therapeutic relationship in the field of mental health nursing is undisputed and this is reflected in the literature. However, a number of authors have explored the application of Peplau's theory in general nursing. Fowler (1995) undertook an exploration, by means of a case study, into the applicability of Peplau's (1952) model of the nurse patient relationship in the field of palliative care. Although the study was small, the author concluded that the model was transferable to the palliative care setting. Jones (1995) applied the model to the management of patients who had suffered a stroke. Jones found that the model provided a useful guiding framework within which both the patient and the nurse could work towards identification of the psychosocial and physical problems associated with stroke, enabling resolution.

Whilst much of the literature related to the nurse patient relationship refers in one way or another to Peplau's theories, some authors have looked at other aspects of the relationship between the nurse and the patient. Williams (2001), in a review of the literature, explored the concept of intimacy. Although using the term 'nurse-patient relationship', the author nevertheless makes clear her understanding that the aim of the relationship is therapeutic and central to nursing and the potential impact of nursing care on the health, wellbeing and rehabilitation of the patient. The literature suggested that the therapeutic outcome was related to the level of intimacy between the nurse and the patient. The nature of intimacy was explored and grouped into two broad categories: (1) psychological and emotional intimacy in which a degree of self-disclosure, reciprocity and trust are key factors; (2) physical intimacy, which implies physical closeness and touch and, in nursing, would incorporate involvement in intimate aspects of care such as personal hygiene and feeding. The importance of trust in the nurse patient relationship was identified in earlier work by Wendt (1996). Whereas physical intimacy is expected in nursing, emotional and psychological intimacy may present some difficulties either of understanding or application as the nurse struggles to be emotionally accessible while maintaining appropriate professional boundaries (Byrne et al., 2001). Williams concluded by suggesting that there was insufficient research evidence related to the concept of intimacy in nursing and further exploration of the concept was required.

A study by Shatell (2005) sought to explore the nurse patient relationship from the perspective of the patient seeking to access nursing care. A small (n=8) purposive sample of medical/surgical patients participated in semi-structured interviews and were asked to describe their observations related to accessing nursing care. Three themes emerged from the study: 'make them your friend', 'be an easy patient' and 'try to get them to listen'. This highlighted the importance of communication in the nurse-patient relationship. The author concluded that, contrary to what much of the literature suggests, patients had an equally vested interest in developing a good nurse-patient relationship. The relationships explored by the author did not appear to mirror the phases identified by Peplau (1952, pp. 17-42, 1992, 1997) and Forchuck, (1991, 1992). The author challenged the applicability of Peplau's model, developed

in a mental health setting where patients were in care for long periods of time, to contemporary health care settings where hospital stays are considerably shorter and the ratio of registered nurses is lower. The nurse patient relationship, while striving to be reciprocal, nevertheless has an inequality of power, where the patient is dependent on the nurse for care (the Ontario College of Nursing (OCN), 2006). It is important to comment here that the themes identified by Shattell appear conciliatory rather than assertive and therefore may be open to abuse by the nurse.

McNaughton (2005) explored the application of the model in the context of home visiting. The author used a series of dyads (n=10) between public health nurses and expectant mothers and found that the stages of the relationship mirrored the three stages identified by Peplau (1952, pp. 17-42, 1992, 1997) and Forchuck (1991, 1992). The author was also able to establish that the length and intensity of each phase was different in each client, related to that client's situation. This knowledge enabled better planning of interventions. The author concluded that the model was applicable in relation to structuring nurse patient relationships and is under-utilised as a research tool. A case study by Marchese (2006) sought to apply the model to patient education. The model was applied in the original four phases described by Peplau (1952, pp. 17-42) and outlined the teaching activities related to each phase of the relationship. The author concluded that the model allowed staging and pacing of each activity, facilitated the planning of patient teaching and provided a means of evaluation. The author also highlighted the key role of effective communication in establishing the therapeutic relationship.

In 2006, the OCN developed a practice standard based on the principles of the therapeutic relationship. The college supported the view that the nurse patient relationship is at the core of nursing practice. The standard outlines the five components considered essential to the therapeutic relationship, irrespective of the length of the relationship. Trust was considered to be a critical component with recognition of the vulnerability of the patient. There was acknowledgement of the fragility of the trust which could be easily damaged by, for example, not keeping promises, and could be difficult to re-establish. The second component was respect,

which correlates with the fourth of Rogers' conditions, unconditional positive regard. The standard demands that the patient is respected regardless of socio-economic status, personal characteristics or specific medical conditions and reflects the 'dignity, worth and uniqueness of every individual'. Thirdly, professional intimacy was suggested as being a fundamental aspect of nursing, incorporating physical, psychological, emotional and spiritual aspects of intimacy. The difficulty this may present to nurses is not discussed but was identified in earlier work by Williams (2001). The fourth component is empathy, which correlates with Rogers' fifth condition, and the authors refer to expressions of understanding and validating the patient's experience. However, they do emphasise that in nursing this also refers to maintaining professional distance and objectivity. The fifth component identified is the inequality of power within the nurse patient relationship. The authors acknowledged that the nurse had more power in the relationship, which should be exercised appropriately. Although presented in a more workmanlike style, as befits a document intended to guide practitioners, the standard encompasses many of the key elements of Peplau's model. There is, however, no mention of the importance of self awareness, which is the first of Rogers' conditions and is also acknowledged as key, albeit in different language, by Peplau (1952, p. 223, 1962, 1964) and Forchuck (1994).

Arnold and Underman Boggs (2007, pp. 99-100), in a contemporary text book on interpersonal relationships in nursing, also refer to these three phases occurring in the therapeutic relationship and suggested that correlations could be made between each of the three phases and the nursing process. The nursing process is a term that has been in use since the 1950s and is used to describe a systematic approach to planning nursing care (Seaback, 2006). The authors suggest that the orientation phase correlates with the assessment element of the nursing process, where the nurse works with the patient to identify goals. The working phase (identification and exploitation) they suggest is congruent with the planning phase of the nursing process, with the focus on clarifying goals and expectations (identification) and the implementation (exploitation) phase of the nursing process where both the strengths of the patient and the resources necessary combine to achieve health goals. The termination phase

corresponds with the evaluation phase where the treatment/care outcomes are evaluated and the patient is prepared for discharge and, where appropriate, self management. The authors further suggest that key communication skills such as attentive listening, using open questions and observing for and acting on verbal and non-verbal cues were important in establishing and maintaining the therapeutic relationship.

A randomised controlled trial by Erci et al. (2008) investigated the effectiveness of Peplau's model on reducing anxiety in pre- and post- operative patients. Patients were randomly assigned to either the study group (n=60) or the control group (n=60). Anxiety was measured using the Beck Anxiety Inventory (Beck, Epstein, Brown & Steer, 1988). Peplau's model was used as the intervention with the average length of contact with the patient being one week. The results demonstrated a statistically significant decrease in anxiety levels in the study group (p=0.001), while there were no statistically significant differences pre-intervention. The authors concluded that Peplau's model was effective in establishing a good therapeutic relationship that resulted in a reduction in levels of anxiety. This would suggest that the model has application even when the relationship with the patient is relatively short. This challenges the view of Shattell (2005), who suggested that the model was less applicable in contemporary health care.

2.2.4 The therapeutic relationship and student nurses

A review of the literature undertaken by Suikala and Leino-Kilpi (2000) suggested that the literature was limited and research studies largely descriptive in relation to student nurses and the therapeutic relationship. The literature tended to focus on students' experiences of care provision or the experience of providing care for specific client groups. For example, Cooke (1996) explored student nurses' experience of providing care in difficult situations and Rhodhe (1996) looked at the impact of caring for mental health patients. There were few studies that sought patients' perspectives and those tended to be in relation to student learning or patients' views on student nurse performance (Twinn, 1995; Morgan & Sanggaran, 1997). Studies by Johnson (1994) and Wilkes and Wallace (1998) identified that

establishing a relationship with the patient was important to students and that the ability to have a more reciprocal relationship with the patient increased as the student gained in experience. Students also identified the key role communication played in the nurse patient relationship (Wilkes & Wallace, 1998). It was noted that at the beginning of their learning students found it difficult to focus on the individualised nature of the relationship while focussing on the various practical tasks expected of them (Munnukka, 1996). The importance of increasing confidence and experience in both the technical aspects of the role and in managing their own feelings and emotions in developing relationships with patients was also reported by Spouse (2001).

A study by Cunningham, Copp, Collins and Baxter (2006) also reported that personal experience and/or the experience of knowing or caring for someone who had been ill could also impact either negatively or positively on students' abilities to develop relationships. The authors concluded that reflective practice was a mechanism by which students could develop and learn from challenging clinical situations. A more recent study by Suikala, Leino-Kilpi and Jouko (2008) supported the findings of previous studies that student nurses identified that the relationship with their patients was an important aspect of their learning. This large quantitative study (n=192) explored the factors related to the nurse patient relationship from the students' perspectives. Students reported that the relationships they developed with their patient positively impacted on their personal and professional development as well as increasing their confidence and self esteem. Older students were more likely to develop a facilitative type of relationship, described as being focussed on both the nurse and the patient. The authors suggested that this was possibly because of an increased confidence often associated with age and maturity, with the older students being more confident in allowing the relationship to be patient led. The authors concluded that education related to the development of the skills and attributes connected to the nurse patient relationship could enhance students' abilities to develop this relationship. They also suggested that supervised reflective practice was a mechanism for allowing students to reflect on their patient interactions.

2.2.5 Summary - section one

The characteristics of the therapeutic relationship as described by Rogers and Peplau have had an enduring impact on how this relationship is perceived in nursing. There is congruence between Rogers (1957) and Peplau (1952, p. 9) in relation to the conditions required for the relationship to be therapeutic, which is supported by authors from the fields of both mental health and adult general nursing. Much of the literature in nursing is within the field of mental health, Peplau's own field of practice, where there is agreement that the seminal work of Peplau still carries significant weight. However, the literature suggests that the model can be applied in a number of ways, including patient education and as a research tool. The applicability of the model to general nursing has also been discussed, with most of the literature supporting the application of Peplau's model, although its applicability to general nursing in contemporary health care settings has been challenged. However, although much of the literature appears to be in areas where the patient is likely to be in long term care, more recent authors have used it effectively in short term care episodes out with the field of mental health. There is a dearth of literature exploring the development of the therapeutic relationship in student nurses. The literature does, however, highlight that this relationship is important to student nurses and is viewed by them as an important component of their learning.

Key themes that emerge are the importance of respecting the patient as an individual, the need for the nurse/therapist to develop empathy with the patient that is perceived by the patient and the need for nurses to be self aware with insight into their own pre-conceptions and values. Another key theme that emerged was the importance of effective communication in establishing the therapeutic relationship.

For the purposes of this thesis the therapeutic relationship is understood to mean a respectful and empathic relationship between the nurse and the patient, where the intention of the nurse is to support the patient to achieve mutually agreed health care goals, which may be physical or psychological or both. The quality of the interaction and communication within the relationship itself may be of benefit and influence the outcome for patients.

2.3 Defining communication skills

The ability to communicate effectively is now considered to be fundamental to the provision of good patient care and is reflected both in the professional literature and in recent NHS and government policy documents (Faulkner, 1998; Chant, Jenkinson, Randle & Russell, 2002; Moore, 2005; Lewin, Skea, Entwhistle, Zwarenstien & Dick, 2009; The Health Care Quality Strategy, 2010). Chant et al. (2002) suggest that there is inconsistency in the literature with regards to what is meant by 'communication skills' with no clear definition, a view supported in a later report by McLuskey, Heywood and Fitzgerald (2011). The authors suggest that this confusion lies around the use of the single term 'communication skills' to refer to a number of aspects of communication including the process of communication, the mode of communication and the underpinning behaviour, values and attitudes that influence communication.

Chant el al. (2002) suggests that many texts refer to communication skills, which refers to the skills required by individuals in order to communicate effectively and communication strategies, without clarifying the distinction between them. This lack of clarity can result in difficulties for curriculum planning and teaching delivery (Chant et al., 2002). However, the literature does identify groups of different behaviours and traits, including sensory outputs and inputs, as constituting the skills and underlying values that underpin good communication and include active listening, empathy and interviewing skills (Chant et al., 2002; Moore, 2005). Hargie (2006, p. 11) discusses communication skills in the context of interpersonal communication, which incorporates not only what language is used but how it is used and emphasises the importance of non-verbal communication such as body language and facial expressions as well as the tone and pitch of language. Hargie (2006, p. 11) suggests that this is a skilled activity, implying that there are key skills that can be learned. These skills include listening, explaining, questioning, negotiating, reflecting and checking out, opening and closing the communication and self disclosure.

2.3.1 The role of communication in health care

Communication has been recognised as a core skill for all NHS staff and is reflected in the Knowledge and Skills Framework (KSF) (NHS, 2004). Historically, the emphasis and consequently much of the earlier literature, has been in the field of palliative care and oncology. The literature suggests that good patient centred communication has a number of health benefits for patients. These include improved adherence to treatment regimens, improved pain management and better psychological functioning (Stewart, 1996; Fallowfield and Jenkins, 1999; Fellowes, Wilkinson & Moore, 2004; Collins, 2009). There is also evidence that poor communication can leave patients with feelings of anxiety, unmet care needs and a general feeling of dissatisfaction with their care (Maguire, Boothe, Elliot & Jones, 1996; Butow, Brown, Cogar & Tatersall, 2002; Audit Scotland, 2007; Living & Dying, Well, 2008; The Francis Report, 2010; Delivering Dignity, 2011). Patients are also less likely to disclose concerns, reducing the ability of staff to recognise potential problems (Thorne, Bultz, Baile, 2005). In addition, recent reports suggest that poor communication while receiving health care also leaves patients with feelings of not being respected or having their dignity maintained and of not being treated with compassion (NHS Scotland, Quality Strategy, 2010; Delivering Dignity, 2011).

Poor communication with patients often leads to misunderstandings between clinicians and patients, anger and dissatisfaction on the part of the patients and an increase in the number of complaints. The evidence suggests that poor communication is more frequently complained about than a lack of clinical competence (Ammentorp, Sabroe, Kofoed & Mainz, 2007; NHS Quality Improvement Scotland, 2008; HSMO Ombudsman Reports, 2010). This can result in an increase in levels of stress in clinical staff and poor job satisfaction (Fellowes et al., 2004; National Cancer Action Team, 2007).

Sawbridge and Hewison (2011), whilst acknowledging the challenges in care provision and the reality of areas of poor care, recognise the potential burden on the nurse. They refer to it as ‘the emotional labour of care’. There is a body of literature

dating back to Menzies in the 1960s that explores the impact of care provision on nurses. It is beyond the scope of this study to explore this in any detail but it is important to note that emotional distress and burnout in nurses can lead to suppression of emotion and 'emotional dissonance', which may impact on the ability to provide compassionate care (Gray & Smith, 2009; King's Fund Report, 2008).

2.3.1 Communication skills education

Communication education is heavily dominated by the field of cancer and palliative care. This was emphasised in a systematic review by Gysels et al. (2005). The authors identified a total of 47 papers between 1966 and 2003 that purported to evaluate communication skills training. Of these, only thirteen studies met the authors' inclusion criteria, which included intervention studies assessing basic skills and attitudes. The types of studies which were included were randomised or quasi-randomised controlled trials, pre- and post- studies using a combination of paper based questionnaires, audio or videotaped sessions and observation studies. A total of eleven studies were conducted on already practising health care professionals, of which only five were conducted on nursing staff and the remainder on medical staff. All of these studies were conducted in the field of oncology. A further two studies were conducted on undergraduate medical students and although the authors allude in several places to undergraduate nursing students none of the thirteen studies included in the systematic review incorporated student nurses.

The authors provided a list of the rejected papers, none of which addressed communication skills training in undergraduate nursing students, although the authors did recommend that communication skills training should be essential in undergraduate nurse training. The size of the teaching group was found to be important, with small groups (six-ten) being most effective. There was agreement that communication skills courses are best facilitated by experts trained in teaching communication skills, who are able to create a positive and secure environment. Other important factors identified were that the detailed content of the training course should be reflective of the type of participant, current skill base, training needs, attitudes, and goals of those at whom the course is aimed. If these factors are

not taken into consideration there is a decreased chance that participants will be able to transfer communication skills to the clinical setting.

The review concluded that the best approaches to communication skills training included a combination of didactic theoretical teaching, simulated role play, constructive feedback, skilled facilitation and role modelling. The importance of role modelling in communication has been supported by subsequent authors (Hockley, 2008; Ramsey et al., 2008) who suggested that observing an 'expert' in communication is an invaluable way to learn and develop skills in communication. Simulated role play has been found to be an effective means of teaching communication skills for health care students and, to be most effective, the simulation should mirror reality as much as possible (Skelton, 2008, p. 129).

Bowles, Mackintosh and Torn (2001) challenged the validity of what they referred to as the 'Rogerian' approach to communication and claimed that it is this approach that underpins most communication skills training. The authors suggest that this is an inappropriate approach in contemporary health care where time constraints, poor staffing and short hospital stays inhibit the amount of time the nurse has to focus on developing this type of relationship, echoing the view of Shattell (2005). The authors also suggest that the health care culture undervalues intimacy within the nurse patient relationship, which then inhibits nurses in developing this with patients. The features of what are considered to be poor communication skills, such as blocking behaviours including ignoring verbal and non-verbal cues and avoidance of difficult conversations, are mechanisms which nurses may use to protect themselves from emotional harm (Byrne et al., 2001). The authors proposed that nurses would benefit from a communications skills course that allowed them to develop their skills to have short but effective interactions with patients. The sample size was small for a quantitative study (n=16), with only ten participants completing the questionnaire at all time points. Qualitative data were collected by means of a focus group but recruitment was low (n=5). The limitations were readily acknowledged by the authors, who concluded that those who had participated in the evaluation had found the training to be positive and increased their

confidence. There is no evidence that the authors considered the underlying principles related to good communication.

Moore (2005) emphasises the central role of effective communication to the therapeutic relationship. She further suggests that the development of self awareness is an important mechanism for developing this relationship. This is consistent with the literature related to developing the therapeutic relationship in nursing and with Rogers' (1980) third condition for developing the therapeutic relationship. Moore further links the two concepts by suggesting that effective communication skills such as rapport building and active listening can foster empathy and reinforce for the patient that the nurse has a genuine interest in their wellbeing and respects them as unique individuals.

Collins (2005, 2009), while acknowledging the increasing demands on nurses and the challenges of the modern health care environment, argues that building a therapeutic relationship remains central to nursing. Communication, the author suggests, is key to achieving this relationship. The author highlights the benefits of good communication with patients, such as feeling able to report symptoms, being able to voice anxieties and fears and having their situations fully explained. The author identified a number of barriers that can prevent good interaction between the nurse and the patient such as pre-conceived beliefs about the patient, the use of jargon and language barriers.

2.3.2 Communication skills in pre-registration nursing

Chant et al. (2002) reviewed the literature related to communication skills training in undergraduate nursing programmes. The authors identified seventeen evaluation based studies of which only five were deemed to have sound methodology. Criteria for categorising studies included sample size, use of non-validated measures and research design inappropriate for the research question. Only four were UK based with the most recent study conducted in 1995. With regards to content and structure of communication education the authors identified common trends in those studies deemed to be rigorous. A range of experiential learning methods were identified

including role play and the use of simulated patients and role models. There was also evidence of theoretical input and exploration of basic concepts that underpin good communication, such as empathy. Methods used to evaluate communication training included evaluation of course outcomes using quantitative methodologies and satisfaction questionnaires and more qualitative approaches such as student feedback using interviews and focus groups. The authors concluded that there was a dearth of sound evidence regarding both the design and the effectiveness of communication education in pre-registration nursing programmes. They recommended greater rigour in the approach to evaluating communication skills education and suggested that a mixed method approach incorporating elements of experimental design with qualitative approaches would be most useful.

McCarthy, O'Donovan & Twomey (2008) reviewed the provision of an advanced communication skills course for final year nursing students. The authors argue that advanced communication skills are best taught in the final year of training as student nurses at this stage have more clinical experience to draw on and are more likely to be in a position to apply these skills in practice. The course included simulated role play with video recording, group work and feedback with facilitators skilled in communication skills education. The course was developed from the literature, evaluation material from previous communication courses, and built on the communication taught in years one and two of the programme. Students were asked to keep a personal development portfolio which, although they were not required to submit, they were encouraged to share during facilitated group work. The module was evaluated using both lecturer and student satisfaction with the structure and process. Information was collected both verbally and with satisfaction questionnaires. Feedback from students and lecturers was reported as positive. The structure of the course would therefore appear to follow broadly what has previously been discussed in the literature, though disappointingly the evaluation is weak.

Farrell, Cubit, Bobrowski and Salmon (2008) reported on a novel approach to communication skills education in undergraduate nurses. The authors developed and evaluated a web based approach to clinical skills education. The programme was based on previous findings by Salmon (2000), who identified three key factors that result in poor communication by clinical staff: the inability to understand the patient's perspective; lack of awareness of their own emotional processes in relation to patients and deficient communication skills. The authors suggest that there are limitations to the more traditional skills based models of communication training. They argue that many clinicians who communicate poorly with patients are good communicators in other situations and that poor communication in the clinical setting occurs either because they fail to see the patient as an individual or they are distancing themselves emotionally from the patient. This view was supported by an earlier paper by Byrne et al. (2001) who identified three key factors that influence communication skills in nurses: the inability of the nurse to understand the patient's perspective, a lack of awareness of their own emotional process in relation to dealing with patients and, in some cases, a lack of basic communication skills such as establishing rapport and listening skills. This would appear to support the premise that empathy, respect and self awareness are the underlying principles of good communication. It could be argued therefore that communication education for undergraduate nurses must address the broader concepts from the outset.

An incremental approach was taken with some skills based education introduced at level three when students were taught basic interviewing skills. The course was delivered in four web based modules over a thirteen week period with face-to-face sessions in weeks one, two, and seven. A qualitative approach was taken for the evaluation using a five point Likert scale (strongly agree to strongly disagree) on the perceived relevance and benefits of the course by a range of questions related to the learning outcomes of the course. Data were analysed using the SPSS statistical package. However, as no baseline data were collected it is impossible to identify change. Most students were positive about the content and structure of the course. However, as this is essentially a self report mechanism, it is difficult to confirm that communication skills had improved. Other, less subjective measures included

looking at students' grades. Although results showed that students had acquired knowledge, it was impossible to know whether there had been an improvement in skills. One way that might have given a greater insight into skills acquisition would have been to conduct a thematic analysis of the interviews that students conducted on patients as part of the assignment for each module, but this was not explored by the authors.

It would seem that there is agreement that any communication skills training for undergraduates should consider the broader concepts that underpin communication such as empathy, respect and self awareness (Farrell et al., 2008; McCarthy et al., 2008). McCarthy et al. (2008) propose that an incremental approach to communication education leading to advanced skills training in the final year of training appears to be the best approach. Apart from the importance of embedding the underlying principles early on, skills atrophy is a possibility and it would seem logical to facilitate development of more advanced skills such as managing emotionally challenging situations and breaking bad news prior to registration when the student is more likely to be in a position to utilise them.

2.3.3 Summary - section two

The literature supports the belief that good communication is important in the provision of good health care. There is also consistency in what are considered to be appropriate methods for teaching communication with strong emphasis on approaches to communication skills training that are interactive rather than didactic (Fellowes et al., 2004; Lane and Rollnick, 2007; McCarthy et al., 2008). Didactic methods can be useful for developing understanding, knowledge, and the theoretical underpinnings of communication skills. However, these methods will not change behaviour when used alone and require to be combined with interactive techniques. Evaluation studies of the effectiveness of communication skills training identify the key features of good communication skills training as role play, feedback, reflection and discussion and the influence of role models (Gysels et al., 2005). Of the few papers related to undergraduate communication education there would appear to be agreement that any communication skills training needs to consider the broader

concepts that underpin communication such as empathy and confronting one's own emotional response (Chant et al., 2002, McCarthy et al., 2008, Farrell et al., 2008).

2.4 Empathy, respect and self awareness

Empathy, respect and self awareness have been identified in the literature as being key elements in both the therapeutic relationship and in effective communication. This section will give a brief overview of these three concepts.

2.4.1 Empathy

The importance of empathy in nursing has been identified by a number of authors and it is suggested that it is the ability to empathise that provides the nurse with the ability to develop the therapeutic relationship and is the essence of all nurse patient communication (Kristjansdóttir, 1992; Kunyk & Olsen 2001; Arnold and Underman Boggs, 2007, pp. 99-100). Empathy was also identified by Rogers (1957, 2007, pp. 1-5) as being a core condition of the therapeutic relationship and is the fifth of his six conditions.

Empathy is the ability to feel the thoughts, emotions and direct experience of others and focuses on trying to understand the experience of another as opposed to feeling sorry for them. It is different from sympathy, which is a feeling of care and understanding for the suffering of others and has a focus on sharing (experiencing) another's bad news or feelings and feeling sorry for the person suffering from the bad news/feelings. In other words, to express sympathy is to make it known that you are aware of another's distress and that you have compassion for them, whereas empathy takes things a step further by not only expressing compassion, but also showing a deeper level of understanding (Kunyk & Olsen 2001; Davies, 2011).

Kunyk and Olsen (2001) further suggest that empathy can be seen as a communication process occurring in three phases. In the first phase the nurse attempts to identify and understand the clients'/patients' feelings and their situations, in phase two the nurse expresses his/her understanding of the patients' situations and in phase three, the patient perceives that the nurse is trying to understand what is

happening for them or what they are feeling. This supports the work of Rogers (1957, 2007, pp. 1-5)) who also suggested that it was important not only for the clinician to try and understand what the patient was experiencing but to convey to the patient that that is what they were trying to do. This was a view supported by Kristjánsdóttir (1992), who emphasised the importance of the nurse not only accurately identifying the patient's situation but communicating this to the patient.

Empathy is defined in the Oxford English Dictionary as 'the ability to understand and share the feelings of another'. Other definitions include 'the capacity to see with the eyes of another, to hear with the ears of another and to feel with the heart of another' (Katz 1963, cited in Arnold & Underman Boggs 2007, p. 98) and having the ability to understand another's experience without loss of self (Arnold & Underman Boggs, 2007, p. 98). The latter definition would appear to signal the need for boundaries within an empathic relationship and there are perhaps arguments against the belief that one can fully understand another's experience (Smyth, 1996).

Rogers (1967, p.52) defined empathy as:

> 'The therapist is sensing the feelings and personal meanings which the client is experiencing in each moment, when he can perceive these from the 'inside', as they seem to the client, and when he can successfully communicate something of that understanding to his client.'

This definition suggests that empathy is only of benefit to the patient when the patient perceives that the nurse is attempting understanding. Earlier work by Rogers (1959, cited in Cooper, 2007, p. 15) implies this in the fifth and sixth conditions.

The definitions outlined above suggest that someone who is empathic has an ability and willingness to try and perceive and understand the thoughts, feelings and emotions of another. However, this presumes that thoughts feelings and emotions are readily identifiable. Bach and Grant (2009, p. 54) suggest that emotions are often hidden and that nurses need to learn how to interpret patients' feelings and emotions

and find ways of communicating this to patients. An individual's behaviour may often contradict what he or she is actually feeling. For example, it is not unusual for angry or aggressive behaviour to mask feelings of fear and anxiety. Nurses must try and avoid 'labelling' patients and attempt to look beyond their behaviour (Collins, 2009). A number of barriers to developing empathic interactions were identified and include busy clinical areas where the nurse is perceived as being 'too busy' and there is lack of privacy (Bach & Grant, 2009, p. 62).

A small (n=10) phenomenological study by Burhans and Alligood (2010), demonstrated that nurses still viewed compassion, empathy and respect as central to good patient relationships and therefore as key components of quality nursing care. This supported earlier work by Kristjansdóttir (1992), which identified empathy as an essential component of nursing practice. Six themes were identified: advocacy - which was identified as a protective role; caring, empathy, and intentionality - which was identified as 'wanting to give the best care I can'; respect - which was reflected in phrases such as 'treat them with respect and dignity' and 'don't lie to them'; and responsibility – which was interpreted with phrases such as 'doing the right thing'. The authors concluded that for nurses to be enabled to realise these aspects of the role, managers need to develop supportive strategies for nurses. They also suggested that these themes should inform nursing curricula. A more recent large survey (n=600) across a number of nursing schools explored the role of nursing curricula in facilitating the development of empathy and empathic communication in nursing students (McMillan & Shannon, 2011). The results showed that placing this in the early part of the curricula significantly impacted on preventing students from developing poor techniques in the later stages of training. The authors concluded that nursing curricula could play an important role in the development of empathy using techniques such as case study scenarios, simulated role play and reflection.

A quantitative study (n=860) by Brown, Boyle, Williams, Molloy, Palermo, McKenna and Molloy (2011) established a correlation between communication skills education and the development of empathy in health care undergraduates. The sample included undergraduates from nursing, medicine and physiotherapy. In

particular listening skills were highlighted. These findings supported earlier work by Nerdrum and Lundquist (1995), who found a statistically significant increase in empathy following communication skills education. Brown et al (2011) concluded that educators should consider communication education when aiming to improve empathic skills in health care students.

2.4.2 Respect and dignity

There are two definitions of respect in the Oxford dictionary (2011). The first is 'a feeling of deep admiration for someone's […] qualities or achievements.' The second is 'due regard for the feelings or rights of others'. The latter of the two definitions would appear to be more relevant to nursing, as one is required to treat individuals with respect regardless of whether one has admiration for them or not. This latter definition is what Rogers (2007, p.3) refers to as 'unconditional positive regard' and is the fourth of his conditions. Beauchamp and Childress (2009, p. 68) suggest that every individual, because of their moral autonomy, has value and should be respected for that value.

Kunyk and Olsen (2001) suggest that although respect is something that we may feel for another, it is also something that we can convey by our behaviour, for example giving up a seat for an older person, not ridiculing individuals because of culture, race or beliefs, and dressing appropriately in certain situations. Patients have reported that behaviour they consider to be respectful includes, being asked what name by which they would like to be called, the nurse introducing him or herself and having their dignity and privacy maintained (Audit Scotland, 2007; Francis Report, 2011). Milton (2005) defined respect as the recognition of the inherent dignity, worth and uniqueness of every individual regardless of the individual's socio-economic status, personal attributes or the nature of their disease or health problem, for example, avoiding stigmatisation of patients with alcohol related problems or mental health problems.

In the health care literature dignity has been defined as the innate right of the individual to be considered deserving of respect and ethical treatment and is closely allied to the concept of privacy. Both these concepts are considered fundamental to

the provison of good care and central to the caring professions. (Haddock, 1996; The Essence of Care, NHS 2003; Price, 2004; NMC, 2007; Delivering Dignity, 2010). Haddock (1996) suggested that the concept of dignity for the nurse was about a shared humanity, emanating from recognition of similarities and differences, and the need for the nurse to be treated in this way themselves. This echoes the view of Peplau (1957, p. 9), who suggested that the nurse and the patient must come to respect each other as individuals who have similarities and differences. Haddock (1996) further suggested that a degree of self awareness in the nurse was also important to enable the nurse to provide care in a non-judgemental way. However, although the nurse is being asked to respect the individual's beliefs and values and his inherent dignity, this does not mean that the nurse must agree with another's values and beliefs. Nurses are entitled to their own values and beliefs (Arnold & Underman Boggs, 2007, p. 118).

Chochinov (2007) suggests that 'how patients perceive themselves to be seen' is closely related to how patients perceive their dignity. Earlier work by Chochinov, Krisjanson, Hack, Hassard, McClement, and Harlos (2006) suggested that if patients felt themselves to be a burden, this had a negative impact on their dignity. Equally, when patients felt that they were being treated with respect by health care providers, this had a positive impact on their sense of dignity. Chochinov (2007) discusses what he considers to be the ABCD to maintaining a patient's dignity. The A is related to the attitude of the health care professional, B relates to their behaviours, C relates to compassion, which Chochinov describes as 'a deep awareness of the suffering of another, coupled with the wish to relieve it'. The D represents dialogue and emphasises the importance of communicating with the patient in a meaningful way.

Earlier work by Price (2004) emphasises the important role of communication in maintaining patient dignity. The author suggests that the development of effective communication can enable the nurse to have a therapeutic dialogue with the patient enabling the communication of respect for the patient's dignity. It is evident therefore that the behaviour and attitudes of health care professionals and their ability to engage in effective communication are crucial in respecting the patient's dignity.

It would appear therefore, that demonstrating respect for the patient's dignity is essential for the development of a therapeutic nurse patient relationship.

2.4.3 Self awareness

Bradley and Eidenberg (1984) suggested that in order to know aspects of one-self, we must have an understanding of how we view others, as well as how others view us. Aspects of self include personal characteristics such as values, attitudes, prejudices, beliefs, assumptions, feelings, personal motives, competencies, skills and limitations. This is reflective of what Rogers (2007, pp. 1-5) referred to as 'being congruent' or a 'real/authentic person'. Rowlinson (1990) suggests that for the nurse this is not just about recognising 'who I am' but, more importantly 'what is the effect of me on this moment and on other people', such as the patient. Rowe (1999) suggests that developing self awareness is important in developing and improving communication skills and improving nurse patient relationships. Rowe (1999) suggests a number of ways in which the nurse can work towards developing better self awareness, but cautions that these can sometimes be a painful process as one may not always like what one learns. Strategies for improving self awareness range from self initiated activities such as reflective practice and feedback from mentors to more formal methods such as transactional analysis and the Johari window (Luft & Ingham, 1950).

A paper by Jack and Smith (2007) discussed the concept of self awareness and identified its importance to nurses in relation to both personal and professional development. The authors also emphasised the importance of developing self awareness as a means to improving communication skills and thereby improving nurse patient interactions. An important strategy for developing self awareness was identified as reflective practice utilising models such as Gibbs' (1998) reflective cycle. The author suggested that maintaining a personal development portfolio and a reflective diary also provided a means of developing self awareness and this is now widely recommended in nurse education. The Johari window was also suggested as a means of developing self awareness. A later paper by Jack and Miller (2008) used

the Johari window to develop a three-stage experiential learning model to facilitate development in self awareness. Although the case study presented appeared positive there was no formal evaluation of the framework.

A number of authors identify the key role that self awareness plays in the development of the therapeutic relationship. It is also recognised that it plays a key role in the nurse's own professional and personal development (Burnard, 1996; Bach & Grant, 2009, p. 52). Rana and Upton (2009, p. 457) also suggested that developing self awareness may help nurses to develop, reflect and learn from experience and identify barriers that could negatively impact on the care that they provide for patients.

2.4.4 Summary-section three

It would appear evident from the literature that the concepts of empathy, self awareness and respect for the patient's dignity play a key role in enabling the development of the therapeutic relationship. It is important, therefore, that student nurses are enabled to both understand and develop skills in these areas as part of their development as professional nurses. The literature also suggests that the early work on empathy and the therapeutic relationship by Rogers (1957) has application in nursing. The distinction between empathy and sympathy is an important one and should be explored as part of the development of student nurses so that they have clarity regarding what is expected of the nurse. The literature also establishes the importance of respect and the preservation of the patient's dignity in developing the therapeutic relationship and the innate right of the individual to be treated with respect. The literature makes clear the links between the attitudes, behaviours and communications skills of the nurse and patients' experiences of respect and dignity. In order to develop these skills the nurse must develop a level of self awareness. The literature identifies mechanisms that could be incorporated into the nursing curriculum more overtly to enable students to develop these skills. However, further evaluation of these approaches is required.

2.5 Work based learning, role modelling and reflection

In addition to academic learning, other ways of student learning have been identified in the literature. This section will give an overview of the role of work based learning, mentorship and reflective practice. Students are required to spend 50% of their training in clinical practice and while in clinical practice are expected to spend 40% of that time with a named clinical mentor (NMC, 2004, 2010). As these two are linked they will be discussed together. A separate section will review reflection.

2.5.1 Work based learning and role modelling

Learning in the workplace is not a new concept in nursing (Bradshaw, 2001; Campbell & Small, 2006, p.2). Work based learning shares a number of similarities with approaches to adult learning, such as the active role of the learner in the learning process and the relevance of the learning to work (Knowles, 1990, p. 67; Boud, Solomon & Symes, 2001, pp. 34-36). This approach is based on the principles of experiential learning proposed by Kolb in 1984, who proposed that development occurs from learning gained through experience (Campbell & Small, 2006). Kolb's experiential learning cycle (1984, p. 20, Fig.1) emphasises the central role that experience plays in the learning process. This approach requires an androgogical approach to learning and teaching, which encourages the learner to become more self directed.

The theory of adult learning known as androgogy was developed by Malcolm Knowles (Knowles, Holton & Swanson, 1998, pp. 61-72). This approach differed from the pedagogical approach to learning in that it placed the learner not the teacher as the driving force. Developing skills in self directed learning are important for nurses as the dynamic nature of health care requires them to constantly update their knowledge and skills (Sharples, 2009, p. 19; NMC, 2010). However, due to the essential knowledge and skills required, much of the nursing curricula are driven by pedagogical imperatives. Foster (1996, pp. 20-21) suggested that work based learning is the bringing together of self knowledge, expertise at work and academic learning. More recent work by Suikkala et al. (2008) identified the key role that

learning in the clinical area played in student nurse development. In particular, the relationship with the patient was valued by students.

A role model has been described as an individual who portrays the skills and qualities relevant to the role and provides a model on which the learner can base his or her own practice (Morton-Cooper & Palmer, 2000, p. 43). A study by Spouse (2001) exploring the perspectives of student nurses about their experience of work based learning identified the key role of the mentor in enabling the student to make the most of the clinical learning experience. Spouse further suggested that other important factors included peer group discussions and the students' understanding of the nurses' roles. A study by Roberts (2008) found that students found learning from peers while in the clinical area was valuable and that the friendships that developed between students were found to be supportive. Harding (2002) suggested that students should be encouraged to develop a portfolio of their clinical learning and should engage in reflective practice with their mentors. Students, of course, observe the practice of more than their mentors and are exposed to other role models. The importance of role modelling in the clinical area was highlighted by Hockley (2008), particularly in relation to interacting with patients. Hockley stressed that observing an 'expert' is an invaluable way to learn and develop skills. Hockley observed that with nurses now being educated in HEIs, there was a danger of this important tool for learning being underestimated.

2.5.2 Reflection

Reflective practice as a mechanism for professional learning dates back to the early work of Schön (1983) and has continued to play an important role in nurse education (Jasper, 2003; Howatson-Jones, 2010, p. 8; NMC, 2010). Skelton (2008, p. 57) suggests that it is also an important aspect of simulated learning as it allows students to explore their feelings and emotions related to the scenario. Reflection has been described as a mechanism for systematically and critically exploring practice, with the aim of learning from the process and taking action (Schön, 1991, pp. 272-28, Jasper, 2003; Rolfe, Freshwater & Jasper, 2010, p. 41). There are a number of models of reflective practice, based on the basic principles of reflection, but the one

most commonly used in nurse education is Gibbs' (1988) reflective cycle (Howatson-Jones, 2010, p. 59). Students are encouraged to engage in reflective practice throughout their training and most students find it an important component of their learning (Green & Holloway, 1997). Students are encouraged to keep a written record of their reflection using their learning portfolio and/or a reflective diary and are encouraged to engage in reflection with their clinical mentor (NMC, 2004, 2010).

2.5.3 Summary - section four

Work based learning and role modelling are key components of student learning in addition to the academic component. The literature suggests that students value these aspects of their learning.

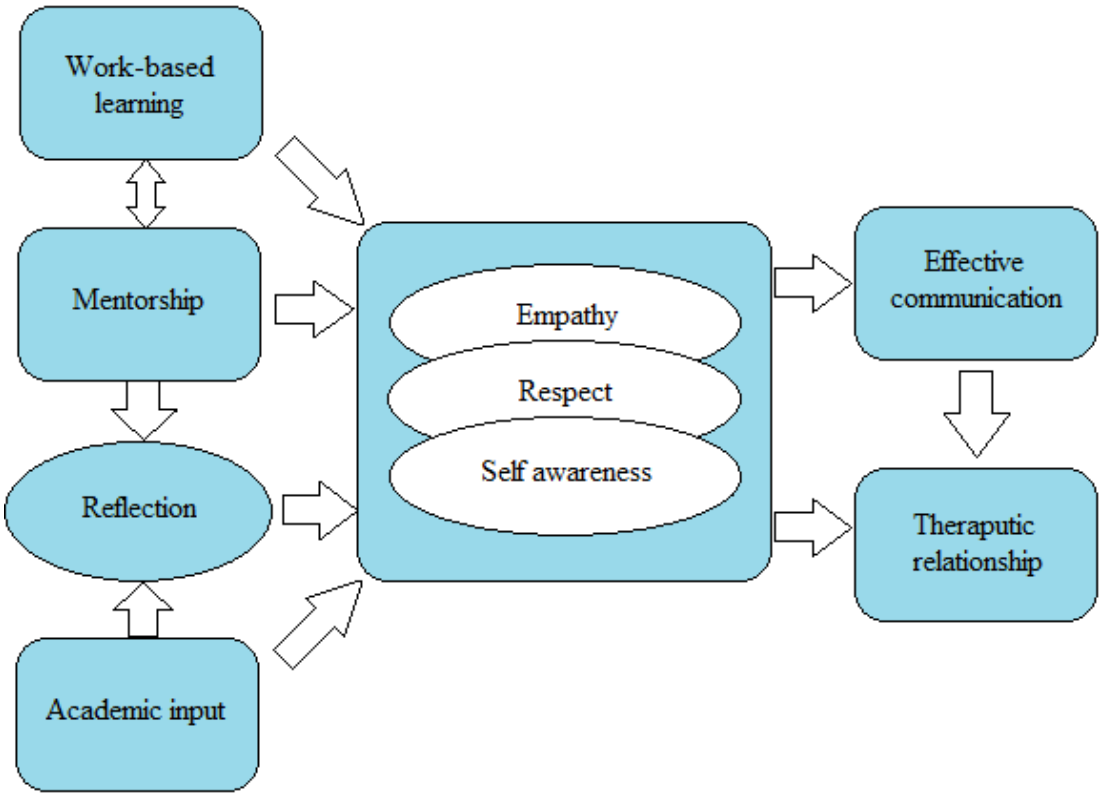
2.6 Conceptual framework

It would appear then that there is general agreement in both the literature related to the development of the therapeutic relationship and the development of communication skills regarding the key elements or conditions that are required. It is important that the nurse develops self awareness and is able to acknowledge his/her own pre-conceptions regarding the individual to be cared for. The nurse must be able to care for the patient with what Rogers (1957) describes as 'unconditional positive regard', the ability to treat the individual with respect and without prejudice. Finally, the nurse must be willing to embark on an empathic journey with the patient, prepared as far as possible to see things from the patient's perspective. For ease of reading when discussing the results in chapter four, Rogers' conditions will be referred to in relation to the three core conditions.

The literature reviewed thus far supports the view that the theoretical concepts underpinning the study are those of the therapeutic relationship and communication. The literature also supports the importance of both the therapeutic relationship and effective communication in the provision of good nursing care. Furthermore, there would appear to be a link between effective communication and the ability to develop the therapeutic relationship (Moore, 2005). But, as has been argued so far,

the significance of the therapeutic relationship is largely absent in the literature on the pedagogical support of undergraduate nurses. This study seeks to contextualise students' understanding of the therapeutic relationship and observe growth in their ability to develop this relationship in pre-registration nurse education. The three common themes which emerge from the psychological literature and the nursing and the communications literature are empathy, self awareness and respect for the individual. These are the conceptual pillars of the study and their growth in undergraduate student nurses will be the main focus of the study. The literature would suggest that the mechanisms by which these underpinning concepts can be learned or nurtured are theoretical learning, simulated role play, experiential learning and role modelling, and reflective practice. The development of these underpinning concepts and how they link with communication and the therapeutic relationship (Fig. 3) will form the conceptual framework of the study.

Fig. 3 Conceptual framework



2.6.1 Aims and research questions

The study therefore aims to:

Contextualise undergraduate student nurses' understanding of the therapeutic relationship and their ability to develop this relationship with patients, in the context of providing essential nursing care. The study also aims to surface the pedagogical design elements, which appear to influence this. In order to achieve the aims of the study the following overarching research question was addressed:

What is student nurses' understanding of the therapeutic relationship, and what influences the growth in their ability to develop this relationship?

To operationalise this question, data were gathered to answer the following two specific research questions:

1. How do student nurses reflect on (at two different time points):
    - Their experience of working with patients?
    - Their experience of working with mentors and clinical staff in the field?
    - The contribution of the academic input to their learning?

2. How would students respond (at three different time points) to potentially awkward, embarrassing or sensitive patient nurse interactions, by reporting what they would do and by trying to identify the feelings and potential responses of the patient? Are students able to identify their own feelings in relation to each of the scenarios?

Chapter 3 Methodology

3.1 Introduction

It is in the nature of the human species to seek to understand both the environment in which they exist and the phenomena observed and experienced through the senses (Cohen, Manion & Morrison, 2011, p.4). Mouly (1978, p.6) proposed three ways in which this might be achieved - experience, reasoning and research - and suggests that these categories do not stand alone but may overlap, with some of the more complex problems requiring utilisation of elements of each of the three categories.

There are three types of reasoning employed by individuals in an attempt to understand their environments. Deductive reasoning was the first important contribution to the discovery of knowledge, made by Aristotle, who perfected the syllogistic method of deductive reasoning. This was based on internal consistency and the assumption that a valid conclusion could be reached from a valid premise by employing formal steps of logic (Mouly, 1978, p. 9; Cohen et al., 2011, p. 4). Inductive reasoning was the next major evolution in reasoning and the progress of science. This was largely the work of Francis Bacon in the 1600s, who challenged the deductive reasoning approach on the grounds that the premises were sometimes no more than pre-conceived notions that ultimately led to bias in the conclusions (Mouly, 1978, p. 9; Cohen et al, 2011, p. 4). Bacon proposed that one should collect data with no pre-conceived thoughts of their significance and no pre-formulated hypothesis. The vigilant researcher would become aware of the relationship between the data, be able to formulate a hypothesis and thereby reach a conclusion.

The inductive-deductive approach to reasoning attributed to Darwin (Mouly, 1978, p.10) combines both the inductive and deductive approaches whereby the researcher employs a back and forth approach from observation to hypotheses (inductive) and from hypotheses to implications (deductive). Hypotheses can then be subjected to further testing to establish validity at the empirical level (Mouly, 1978, p.10; Cohen et al, 2011, p. 4). The methods described above have their limitations. For example, an answer reached by a process of deductive reasoning depends on the integrity of

the original premise (a false premise will lead to a false conclusion). In inductive reasoning there is the possibility of overlooking possible hypotheses and beginning with the analysis of only a few occurrences, prior to the formulation of hypotheses, and this risks the development of hypotheses based on insufficient data (Mouly, 1978, p. 10). However, Cohen et al. (2011, p. 4) suggest that the contributions to the development of scientific enquiry of Aristotle, Bacon and Darwin have been significant and as a result of this earlier thinking, we have the notion of hypotheses, the logical development and testing of hypotheses and the interpretation and synthesis of scientific findings into a conceptual framework.

The third category proposed by Mouly (1978, p. 11) was research. Research was defined by Kerlinger (1970, cited in Cohen et al., 2011, p. 4) as a systematic, controlled, empirical and critical investigation of hypothetical propositions about the presumed relationship between phenomena. A similar definition, proposed by Mouly (1978, p. 12) stated that it was 'the process of arriving at dependable solutions to problems through planned and systematic collection, analysis and interpretation of data' and would appear to imply that the goal of research is problem solving.

Cohen et al (2011, p. 5) suggest that there are three main characteristics related to research. Research is based on the inductive-deductive reasoning method and is systematic and controlled. Research can be said to be empirical where the researcher looks to experience for validation. However, empiricism has come to mean something broader in modern approaches to research. Empiricism has its roots as a philosophical doctrine dating from the 17th century and has been described as the foundation of 'logical positivism', although Gillies (1993, pp. 18-19) argues that the earlier term 'logical empiricism' is more appropriate. The central tenet in empiricism is that knowledge can only be validated through either experience or other means of accessing experience, for example qualitative interviews (Jupp, 2008, p. 90). However, contemporary social scientists adopt the view that empiricism is the combination of both the formulation of theory and methodological inquiry (Patton, 2002, p. 92). This view is supported by Seale, Gobo, Gubriam and Silverman (2007, p. 7) who suggest that research is not served by rigidity to one view or another but

rather that the researcher should aim to seek and test truth by a combination of appropriate methods. Finally, research has inbuilt mechanisms to mitigate against error as far as possible, and results are open to scrutiny.

3.2 Methodological approach

Methodology is a term used to describe the philosophy of research methods and has been described as the philosophical stance, or the world view, that underlies and informs the approach to research (Cohen et al., 2011, p. 707; Jupp, 2006, p. 175; Polit & Beck 2008, p. 14). This is distinct from method, which discusses the process and procedures utilised in carrying out the research or the 'recipe' that could be followed by another researcher either carrying out similar research or wishing to repeat the study (Polit & Beck 2008, p.13). The method will be discussed later in the chapter.

Most research questions can be addressed by utilising one of two broad paradigms, which represent the complexities of a particular world view. The positivist paradigm purports that there is an objective reality, which is independent of human observation. In contrast, the naturalistic paradigm presents the view that reality is contextual and that there may be multiple interpretations. Both of these paradigms reflect cultural phenomena often referred to as modernism and post-modernism respectively (Polit & Beck, 2008, p. 15; Cohen et al., 2011, p. 5). Although not exclusively, naturalistic enquiry tends to favour qualitative approaches such as ethnography and phenomenology, whereas the positivist enquirer tends to favour more scientific or experimental approaches such as randomised controlled trials and surveys. Research in nursing is conducted mainly within these two paradigms and both are legitimate in nursing research. Polit and Beck (2008, p. 14) suggest that positivism, or logical constructivism, has dominated nursing research in the past, fuelled by the drive towards evidence based practice. More recently, qualitative research has gained ground and credibility within nursing. Streubert and Carpenter (2011, p. 4) argue that it is not a question of one being better than another but rather that different approaches are necessary depending on what the researcher is aiming to find out.

3.2.1 Methodological assumptions

These positivist and naturalistic concepts of reality are underpinned by four sets of assumptions (Polit & Beck, 2008, p. 15; Cohen et al., 2011, p. 31). Ontological assumptions refer to the individual's assumptions of the nature of reality. For example, whether reality is external to the individual and objective, or is internal, constructed by the individual. From a positivist perspective there is the belief that the world exists and is driven by real and natural causes, whereas those researchers who come from a more naturalistic paradigm believe that the reality is subjective and is constructed by individuals. Epistemological assumptions are concerned with the nature of knowledge and the relationship of the researcher to the participants in the study. Positivist researchers remain independent from the research subjects and aim not to influence the results. Researchers from a more naturalistic paradigm see interaction with the subjects as desirable. Axiological assumptions are concerned with the role of values in the research. The positivist will see objectivity and control as important and aim to eliminate bias and their own values as much as possible. The naturalistic researcher is comfortable with subjectivity and views this as an inevitable and desirable aspect of the research (Polit & Beck, 2008, p. 14). Methodological assumptions are concerned with how evidence is best obtained. Naturalistic researchers seek in-depth understanding and may focus on the subjective and unquantifiable. The positivist researcher will employ deductive processes, focussing on the objective and quantifiable (Polit & Beck, 2008, p.14).

The methodological approach chosen by the individual researcher reflects the researcher's own world view and he or she may have an innate preference for one paradigm or another. However, the approach best suited to addressing the research question(s) must remain the most important consideration. The researcher intends to adopt a naturalistic paradigm as the broad approach to the study. This reflects the researcher's own view that the experience of the individual is most important and that richer data, which may be accessed through this approach, will increase the understanding of the students' development related to the therapeutic relationship and the influencing factors.

A naturalistic approach to research does not, however, imply that the researcher is not required to adopt a scientific attitude. Robson (2002, p. 18) suggests that the naturalistic researcher can demonstrate a scientific approach by the application of three key principles:(1) The research must be carried out systematically with the researcher making clear the what, how and where, as well as being explicit about the nature of the observations and the role of the researcher; (2) the research must be open to scrutiny by both the researcher and others and; (3) the research must be conducted ethically, ensuring that all those involved in the research have their interests and wellbeing safeguarded. The means by which these three principles will be addressed is discussed later in this chapter.

3.3 Case study

A case study methodology has been adopted for this study and is congruent with the naturalistic paradigm chosen for the research. The following section will present an overview of the literature pertaining to case study research, the advantages and disadvantages of the case study as a methodological approach and the justification for its selection as the methodological approach for this study.

A case study has been defined as an approach that uses in-depth investigation of one or more phenomena utilising a range of data sources. The case study allows the flexibility to approach a topic from a relatively simple narrative perspective to a more rigorous randomised approach (Yin, 1881a, 1984, 1994, 2003, 2009; Bassey, 1999, p. 28; Hakim, 2000, p. 63; Stake, 2003, 2008; Jupp, 2006). The ‘case’ is a single entity and may constitute either one individual or a group. A case study aims to understand the issues that are of importance to the development of the ‘case’ and while the principal aim is to explore the case under study, case studies can sometimes generate understanding of phenomena that have not previously been subjected to rigorous investigation (Yin, 2009, p.14; Polit & Beck, 2008, p. 235; Stake, 2003, p.88). A case study is not a series of anecdotal reports but a systematic and disciplined process of enquiry, often conducted over an extended period of time (Yin, 1994, p. 5; Stake, 2003, p. 88; Polit & Beck, 2008, p. 236). Yin (2009, p.17)

argues against earlier views that case studies were no more than the exploratory stage of research methods.

A prominent researcher in the field of case study research is Robert Stake whose writing spanned three decades (from 1978 to 2008). Stake (1995, p. 2) defined the case study as 'the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances'. He further claimed that whereas people and programmes could be viewed as appropriate subjects for a case study approach and could be defined as cases, this was less likely to be a suitable approach when looking at events and processes (Stake, 1995, p. 2). Later Stake (2003, p. 86, 2008, p. 119) asserts that, although case studies are a frequently used method in qualitative research, they should not be viewed as essentially qualitative. Rather he suggests that the case study is not a methodological choice, but a choice of what is to be studied. This resonates with what prompted the researcher to choose a case study approach - the nature of what was to be studied led to the methodological choice.

Robert Yin is credited as being one of the most notable social scientists to write about the case study as a methodological approach, with his work also spanning three decades (from 1981 to 2009). Yin (1994, p. 13) described the case study as 'an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident'. Yin viewed this as a somewhat technical definition and added to this that: (a) case studies cope with the situation in which there may be more variables of interest than data points; (b) therefore, they rely on multiple sources of evidence, with data requiring to converge (triangulation) and, as a result; (c) benefit from prior development of theoretical propositions to guide data collection and analyses.

Of these two prominent authors, Bassey (1999, p. 27) observed that although both Yin and Stake advocate the view that case study research, when applied appropriately and conducted rigorously, is a legitimate methodological approach, each views it from a slightly different ontological stance. Stake's discussion of case

study methodology indicates that he is working from a primarily interpretive viewpoint, whereas Yin, with his references to theory development and approaches to rigour, would appear to favour a more positivist view. There are a number of other authors who have written regarding the use of case studies in social science research, though none as prolific as those previously discussed. Stenhouse (1985) and Sturman (1994), (both cited in Bassey, 1999, p. 26), both emphasise, though a decade apart, the importance of the 'case', whether it is an individual or a group, as being worthy of in-depth investigation.

Bassey (1999, pp. 57-64) explores the use of the case study specifically within the field of education as a means of educational theory development, developing and clarifying educational policy and consequently enhancing practice within education. He asserted that, although there was more attention paid to educational research, the research evidence available lacked clarity and cohesion. In order to address these issues Bassey (1999, pp. 57-64) proposed a reconstruction of the case study that would ensure that case studies undertaken within the context of education would lead to findings that would improve educational practice. He suggested that this could be achieved by ensuring that the data collected enabled the researcher to:

(a) Explore the significant features of the case;
(b) Create plausible interpretations of the findings;
(c) Establish the trustworthiness of the findings;
(d) Develop a worthwhile argument or narrative;
(e) View the findings in the light of the existing body of literature;
(f) Report findings in a meaningful way in order for them to have the desired impact;
(g) Provide an audit trail to facilitate validation/challenge of the findings and potentially develop an alternative argument.

3.3.1 Types of case study

Yin (2009, p. 19) states that both qualitative and quantitative methods have a role within case study research. Although in earlier literature Yin is allied with a more positivist ontological stance (Bassey, 1999, p. 27), it is evident that he also identifies the value of the interpretive approach. It could be argued that the case study refers therefore not to the methodological choices but to the object or 'case' to be studied (Stake, 2003, p. 86, 2008, p. 119; Yin, 2009, p. 18). Yin (1993, p. 5) proposes three main types of case study and further states that within these three categories cases can be either single or multiple. A single case study is focussed on a single case whereas multiple case studies may contain two or more cases within the same study. Yin further suggests that in multiple cases they should be selected so that they replicate each other. An exploratory case study seeks to define the questions and hypotheses for a subsequent study, even though the second study need not be another case study. Yin (1993, p. 4) suggests that it is this type of case study that has fostered the belief that case study research is not a legitimate methodological approach in its own right. Yin also asserts that exploratory case studies may also develop theory by observing phenomenon 'in the raw' in a similar way to the grounded theory approach developed by Glaser and Strauss (1967). Descriptive case studies aim to provide an in-depth description of the phenomenon under study. In contrast, an explanatory case study gathers data with the aim of determining cause and effect relationships.

Stake (2008, p. 123), also proposes three types of case study: (1) intrinsic, where it is the case itself that is of primary interest; (2) instrumental, where the case is of secondary interest and its function is to facilitate understanding of a particular phenomenon; (3) collective case study, which he describes as an instrumental study that involves more than one case. On reviewing the types of case study outlined by both Stake (2003, p. 86) and Yin (2009, p. 19) the researcher has concluded that the case study being undertaken falls into the category of instrumental case study according to Stakes' definition, where the researcher is using the 'case' (student nurses) to explore the student nurses' understanding and growth in their ability to develop the therapeutic relationship, which is the phenomenon of interest.

In Yin's description the case study being undertaken falls into the category of a single descriptive case study where again the 'case' is utilised as a means of providing an in-depth description of the phenomenon under study. Although both approaches are very similar the researcher has chosen to use the terminology proposed by Yin (2009, p.19) as it seems to best fit the aim of the study and the approaches to research design in case study described by Yin (2009, p.47).

3.3.2 Advantages and disadvantages of the case study

The tradition of utilising a case study approach within the field of education began in the 1970s. Although it was acknowledged that this approach had made a useful contribution to the body of knowledge, Adelman, Kemmis and Jenkins (1980, pp.45-61) observed that that case studies were poorly understood, viewed with some disdain and consequently underdeveloped as a research methodology. Yin (2009, p. 40) commented that the case study was often stereotyped as a 'weak sibling' when compared to other methods in social science research. Adelman et al. (1980, pp. 45-61) suggested that there were a number of possible advantages of utilising a case study approach For example, case study data is strongly based in reality and can allow for generalisations as their strength lies in the complexity of the case in its own right. He also proposed that the insights elicited from case study data can be directly interpreted and utilised and present research and evaluation data in a readily and publicly accessible format.

According to Adelman et al. (1980, pp. 45-61), two of the greatest advantages of the case study are the ability to study the case in depth and its ability to capture complexity. Case studies can establish cause and effect and are able to observe effects in context, acknowledging that the context may influence both the cause and the effect (Polit & Beck, 2008, p. 260). Other strengths of case studies are that they have a strong focus on reality and can capture unique information that may not be accessible from other types of data collection such as experimental studies or surveys (Nisbet & Watt. 1984, cited in Cohen et al., 2007, p. 256).

A common criticism of the case study approach is the lack of generalisability of the findings. However, case studies can play an important role in challenging the generalisations that are based on other types of research, which may prompt further research into the phenomena (Polit & Beck, 2008, p. 236). Yin (1994, p. 5) suggests that the same criticism may be made of experimental research as generalisations cannot be made from a single experiment. He further suggests that, just as generalisations are usually made from the results of a number of experiments, so too can generalisations be made from multiple case studies. In later work, Yin (2009, p. 14) questions the validity of a hierarchical concept of research methods where some methods are suited to exploratory research, some to descriptive research and others to explanatory research and argues that every research method can be utilised in all three scenarios. He also reiterates the importance of matching the method to the research question and reviewing the advantages and disadvantages of each method rather than adhering to a stereotypical hierarchy (Yin, 2009, pp. 8-7).

Case studies are often criticised for their lack of rigour. However, Yin (1994, p 6) argues that this criticism is a result of individual researchers permitting biased views and equivocal evidence to influence the direction of the research and subsequently the findings, rather than any intrinsic flaw in the case study approach. Other potential weaknesses of the case study approach include subjectivity, the difficulties in cross checking and observer bias. However, these potential weaknesses can be addressed through peer debriefing and reflexivity (Gerrish & Lacey 2006, p.425; Polit & Beck, 2008, p.432).

Flyvbjerg (2007, p. 391) challenges the 'conventional wisdom', regarding the criticisms and alleged weaknesses levelled at case study research. He suggests that there are five misunderstandings or misconceptions about case study research that largely encompass the negative beliefs about case study as a methodological approach. Flyvbjerg emphasises the necessity of context dependent knowledge in the development of practitioners from novices to experts in their field and argues that exposure to only context independent knowledge would hinder the learning process. However, he does not dismiss the role of context independent knowledge, particularly

in the early stages of the learning process. As the development of context dependent knowledge lies at the heart of case study research, this presents a convincing case for the use of case study research within an education/developmental context.

With regards to the lack of generalisability attributed to case studies, Flyvbjerg asserts that formal generalisation is overvalued as a source of scientific development and that lack of formal generalisation does not preclude the admission of that knowledge into the growing understanding within a given field. The third misunderstanding, according to Flyvbjerg, is that case study is more useful in the early stages of research in relation to the generation of hypotheses. He suggests that although case studies can generate hypotheses, they can also be used to test hypotheses. Flyvberg also argues that the potential for bias and subjectivity exists in all types of research and is not exclusive to qualitative designs.

The issue of generalisation within qualitative methods is explored in depth by Larsson (2009), who argued for a pluralist view of generalisation. Most relevant to this study is Larsson's view that generalisation can be understood to the extent that there is some form of context similarity, whereby the context of the research can be transferred to other similar contexts, and is similar to the 'transferability' described by Lincoln and Guba (1999, p. 404).

3.3.3 Summary

Yin (2009, p.2) argues that although there are other ways of conducting research within the field of social science, a case study approach is favoured over other methods when, asking '*how'* or '*why'* questions, when it is likely that the researcher will have little control over events and the phenomenon under study is contemporary and occurring in a real life context. The proposed study would therefore appear to meet the above criteria as the researcher is asking a '*how'* question, there are elements of the student experience and development over which the researcher will have no control such as clinical experience and personal experience, and the phenomenon under study is occurring in a real life context as it is occurring as the students progress in their nurse training.

Yin (2009) further suggests that methods utilised within the case study approach may overlap with those of other approaches to research, therefore the case study will allow the researcher to look in depth at the experience of the students (the case) in the context of their understanding and growth in their ability to develop a therapeutic relationship, using a range of data collection methods (Cohen et al., 2007, pp. 254-257; Yin, 2009, p. 2). This approach would appear therefore to be an appropriate method for the proposed research.

3.4 Research design

Kumar (2005) suggests that the refinement of the research question and developing the research design are the first steps in the research process. The development of the research design is the plan of the strategies the researcher will utilise to answer the research question(s) and is arguably one of the most important aspects of any proposed research involving important methodological decisions (Polit & Beck, 2008, p. 203; Cohen et al., 2011, p. 115). Yin (2009, p. 25) suggests that there is not a 'catalogue' of suitable research designs from which the researcher can choose but rather that the development of research designs in case study methodology is a new area of methodological development. Yin (2009, p.25) cautions against the false assumption that case study research designs should be seen as variations or subsets of research designs for example as a type of quasi-experimental design. He further argues that the case study is a research method in its own right with its own approaches to research design (Yin, 2009, p. 26). Yin (2009, p. 27) proposes that there are five essential elements to research design in case studies:

- The study questions;
- The propositions (if any);
- The units(s) of analysis;
- The logic linking data to the propositions;
- The criteria for interpreting findings.

As previously discussed, the research questions utilised in the case study approach address the '*how*', and therefore as this research is concerned with how student

nurses develop the therapeutic relationship, the choice of case study would appear to be an appropriate methodological approach. The propositions of the study are based on the underlying conceptual framework (chapter two, Fig. 3). The unit of analysis is the student nurses' understanding and growth in their ability to develop a therapeutic relationship, as this is the phenomenon under study, with the cohort of students constituting the case.

Yin (2009, p. 46) suggests that within these more general characteristics of case study design there are four specific designs:

- **Type 1** - Single case holistic designs;
- **Type 2** - Single case embedded designs;
- **Type 3** - Multiple case holistic designs;
- **Type 4** - Multiple case embedded designs.

As the research is concerned with a single case - a group of student nurses - then type three and type four were rejected. The choice of a single case is supported as it meets the criteria of one of the five rationales proposed by Yin (2009, p. 49) (table one).

Table one **Five rationales for single case study design** **(adapted from Yin, 2009, p. 47)**	
1	*Critical case*- testing a well formulated theory
2	*Extreme or unique case* - where an occurrence is so rare or unusual that it merits documenting – often in clinical psychology or rare medical phenomenon
3	*Representative or typical case* - objective to capture information on everyday common place situations
4	*Revelatory case* - where the researcher has an opportunity to observe and analyse a phenomenon previously inaccessible
5	*Longitudinal designs* - where the same case is studied over a period of time at different intervals

The fifth rationale supports the use of the single case study design when the study is longitudinal in nature, observing the same 'case', looking for differences, at different points in time, those times being chosen at time intervals where the desired or expected changes would be expected to occur. The data collection points selected for

the study were chosen as they represented milestones in the students' learning, both clinical and academic.

Within the single case study approach the design can be either holistic or embedded. In order to determine which is the most appropriate, the researcher must first be clear about the unit of analysis. In an embedded design, although looking at a single case, there may be more than one unit of analysis, in which case the research design would be a single case embedded study. A single case, holistic approach is the appropriate research design where there is only one unit of analysis (Yin, 2009, p. 51).

3.5 Data collection methods

A qualitative approach to data collection, using multiple methods of data collection, has been utilised for the study. This is appropriate within the naturalistic paradigm, reflects the epistemological stance of the research and is congruent with the case study approach (Hakim, 2000, p. 60; Stake, 2003; Jupp, 2006, p. 20; Yin 2009, p. 114). Hakim (2000, p. 61) suggests that the use of more than one data collection method was already established within case study methodology prior to the formalisation of triangulation. The methods utilised in data collection should be informed by the nature of the research questions rather than any pre-determined belief regarding the suitability of data collection methods for particular methodologies (Punch, 2006, p. 4; Yin 2009, p. 116).

Demographic data were collected at the beginning of the study and included age, gender, previous care experience and previous communication skills training (appendix two). Participants were also invited to disclose any experience of being nursed as it was deemed possible that this experience may have influenced their understanding of the therapeutic relationship.

3.5.1 Focus groups

Focus groups can be an efficient way to obtain a broad understanding of phenomena from different perspectives. Bloor et al (2002, p. 43) state that it is important to be clear on the distinction between focus group discussions and group interviews, the key distinction being what is looked for from the participants. Focus group discussions are aimed at stimulating discussion as a means of studying the norms and meanings underlying the group's responses, which are subsequently analysed. The data is generated by stimulating discussion by the group around the phenomenon under study, although the researchers may utilise some form of topic or question guide to focus the discussion (Bloor et al, 2002, p.43; Parahoo, 2006, p.331; Denscombe, 2007, p. 177; Streubert & Carpenter, 2011, p.38).

In a group interview, the main aim is to elicit responses to a series of set questions, sometimes considered an inferior approach to individual interviews (Bloor et al., 2002, p. 43). However, Noaks and Wincoup (2004, p. 78) state that focus groups can be used as a form of interview and suggest that, depending on the aim of the research and the population under study, group interviews can be an appropriate method of data collection. As the researcher was seeking to ask a range of specific questions on a pre-determined topic, a group interview was considered an appropriate means of data collection and this decision informed the approach to data analysis. Yin (2009, p. 106) suggests that interviews are one of the most important sources of data in the case study. Although there were pre-determined questions, the interview structure was designed to be flexible and open enough to satisfy what Yin (2009, p. 106) describes as fluidity within the line of enquiry.

3.5.2 Group interviews

The group interviews were aimed at answering research question one and facilitated exploration of influencing factors such as working with other clinical staff and reflection. Interviews can range from structured interviews, where pre-determined questions are asked, to completely unstructured interviews, which are conversational and interactive (Denscombe, 2007, p. 175). Unstructured interviews usually

commence with some general questions to put participants at their ease, allowing them to relate their stories in a narrative fashion (Morse, Swanson & Kuzel, 2001, p. 83; Denscombe, 2007, p. 175; Polit & Beck 2008, p. 395). Another approach, between the two types of interview described above, is the semi-structured interview using a topic guide to ensure that the interview remains focussed but flexible enough for participants to describe their experience in their own way (Denscombe, 2007, p. 177). A semi-structured interview approach with the use of a topic guide was adopted for the group interviews (appendices three& four).

The first group interview was conducted at the beginning of year two of the students' education and explored five broad areas. The main part of the interview aimed to ascertain the students' understanding of the therapeutic relationship. The remainder of the interview explored the influence of both the students' own clinical experience and the experience of working with and observing other clinical staff, the academic input and the students' own personal experience. Although a topic guide was used to ensure that the group discussion remained focussed, the researcher endeavoured to ensure that the interview was participant led as it is their perspectives and viewpoints that are of importance. The facilitator requires skill in steering the group without taking control and potentially stifling group interaction (Bloor et al., 2001, p 49; Todd, 2006; Denscombe, 2007, p. 183). For this reason, and as a means of minimising bias, a colleague facilitated the interviews with the researcher present to manage the administration of the interview and take field notes. Field notes are invaluable in aiding the transcription of interview tapes, particularly in group interviews where more than one person may speak at once, rendering the dialogue unintelligible. Field notes can also offer insights into elements of the interview that are not recorded on the tape such as facial expressions, nods of agreement (or not) and other body language which can enhance the data, add to the realism of the transcript and assist with the analysis (Noaks & Wincup, 2004, p. 129; Bloor et al., 2001, p. 61; Litosseliti, 2003, p. 69).

The second group interview was conducted 14 months later, at the beginning of the students' final year of study, and aimed to explore any changes in students'

perceptions and understanding of the therapeutic relationship over time. In addition, a continuing review of the literature had raised other relevant questions. The topic guide was modified to include questions related to barriers and facilitators to the therapeutic relationship (appendix four).

3.5.3 Conducting the interviews

Ground rules were established at the beginning of each group interview, which reinforced the confidentiality of the group discussions (Bloor et al., 2002, p. 43). Although opinions vary, six to twelve participants is generally thought to be an appropriate number for a group interview (Polit & Beck, 2008, p. 394; Denscombe, 2007, p. 180). Due to the size of the cohort (n=17) it was divided into three groups. The aim was for two groups of six and a group of five. However, one participant came to the wrong group so there were two groups of five and one group of seven. It was intended to keep the participants in the same groups for the second phase. However, on the day of the interview one participant was sick and another came to the wrong group so there was one group of four, all of whom had been together for the first interview, a group of six, who had also been together for the first interview and another group of six, one of whom had been in another group for the first interview. However, as all the students knew each other well, it was not thought that this would adversely affect the dynamics of the group.

3.5.4 Vignettes

Data related to the development of empathy, respect and self awareness were collected by using vignettes and were aimed at answering research question two. Vignettes are a self report mechanism utilising brief descriptions of situations or events, real or fictitious, to elicit a range of responses and reactions and can provide insight into perceptions, beliefs, judgements and knowledge (Polit & Beck, 2008, p. 243; Barter & Renold, 1999; Hughes, 1998). They have been defined as short stories or scenarios based on hypothetical situations and/or characters that provide concrete examples on which participants can offer a view, and are widely used in sociology research and research involving children and vulnerable adults (Finch, 1987; Hazel, 1995; Hill, 1997). The hypothetical nature of the vignette allows exploration of

difficult issues or topics (Gould 1996; Chau et al., 2001). Vignettes have also been used in both qualitative and quantitative research within health care to explore attitudes to topics such as pain management, advance directives and decision making (Ouslander, Tymchuck &Krynski, 1993; Loveman & Gale, 2000; Thompson, Barbour & Swhartz, 2003). A possible methodological flaw of vignettes is that one cannot assume that the simulated situation will parallel real life or that the respondent would respond in the same way in an actual situation (Hughes, 1998; Quinn, 2000, p. 283).

The aspect of the therapeutic relationship that is under study is the relationship between the student and the patient, in the course of providing essential general nursing care. The scenarios were therefore developed to mirror probable situations that the student might encounter, such as feeding a dependant patient and assisting with personal hygiene, and are nursing activities that the nurse is required to undertake throughout her training and as a registered nurse (appendix five). These core nursing skills need to be undertaken with due regard for maintaining the patient's dignity, which requires the nurse to communicate well, be empathic to the patient's needs and treat the patient with dignity and respect. Empathy and respect were key constructs in the study. Scenarios that more closely reflect the real life situation are more meaningful to the student and will be more likely to elicit a true response **(**Kristjánsdóttir, 1992). Although not previously used in relation to exploring the development of the therapeutic relationship, vignettes have been used to explore other areas of development in undergraduate nurses, for example, attitudes to sexuality and exploring how students develop critical thinking skills (Stewart, 1999; Van Eerden, 2001; Chau et al., 2001).

The vignette utilised in the study consisted of two sections. The first section incorporated two short progressive scenarios, in which students were asked how they would respond in the particular situation, and were designed to observe growth in empathy and respect. Students' responses were then analysed for the presence of the pre-determined key indicators of empathy and respect (appendix five). Section two presented the student with four simple questions that asked them to identify what

they might be feeling in each of the scenarios and were designed to gain insight into students' self awareness.

3.5.5 Time intervals vignettes

Data were collected at three time points: at the beginning of year one, prior to any clinical experience or academic input to gather baseline data, at the beginning of year two and again at the beginning of year three. These time points were chosen as they reflected key points in the students' training programme in relation to clinical experience and theory. Another influencing factor was the completion date for the thesis. It was decided to use the same vignette throughout the study as this would allow for consistency when comparing data over the three time intervals. However, the researcher acknowledges that this is also a potential weakness as the student may become familiar with the scenario and may be able to remember previous responses (Chau et al., 2001). However, it is believed that sufficient time elapsed between each exposure for this to be minimised.

3.6. Triangulation

Triangulation is a means by which the researcher can enhance the rigour of the research (Robson, 2011, p. 158). There are four ways in which this can be achieved: (1) data triangulation - using more than one source of data; (2) observer - triangulation - using more than one observer; (3) methodological triangulation - combining qualitative and quantitative methods; (4) theory triangulation - the use of more than one theory (Denzin, 1988b; Patton, 2002, pp. 555-61). Yin (2009, p. 115) suggests that a core strength of the case study is the opportunity to utilise multiple sources of evidence. This use of another source of evidence may strengthen the data garnered from other data collection methods within the same subject and allow a deeper and richer understanding (Bloor et al., 2002, p. 13; Patton, 2002, p. 149; Robson, 2011, p. 158). Bloor (2002, pp. 12-13) suggests that this can open the possibility of contradiction between the two sources and suggests that data collected from different sources may raise problems when making comparisons. Yin (2009, p. 116) cautions against confusing data triangulation where the multiple sources support the fact(s) of the case study by making a comparison of data from two or more

sources. He refers to the former as ‘convergence of evidence’ and the latter as ‘non-convergence of evidence’. In this study data were collected from two different sources with the aim of answering the overarching research question from two different perspectives. The achievement (or not) of triangulation will be discussed in chapter five.

3.7 Reliability and validity

Establishing reliability and validity is essential in both qualitative and quantitative methods, although threats to validity and reliability can never entirely be avoided (Cohen et al., 2011, p. 179). However, as the epistemological stance of the study falls within the naturalistic paradigm, reliability and validity will be discussed primarily within that context.

The term reliability is most often associated with the methods and/or instruments used to measure research variables within quantitative research (Polit & Beck, 2008, p.196; Jupp, 2006, p. 262). Lincoln and Guba (1985, p. 290) challenged the appropriateness of using terminology commonly associated with a positivist paradigm to establish the rigour or trustworthiness of qualitative research. The authors suggested that the term dependability be used as alternative to reliability (Lincoln & Guba, 1985, p.300) and this has been supported by subsequent authors in the field (Strauss & Corbin, 1990, p. 250; Seale, 1999, p. 266).

Some authors have suggested that the terms reliability and validity can apply to both research paradigms and that the view that reliability is only relevant in quantitative research is no longer true. What is important is that the methods used to establish reliability and validity remain faithful to the principles within the research paradigm (Patton, 2002, p. 543). Golafshani (2003) argues that the concepts of reliability and validity defined in quantitative terms do not apply within the naturalistic paradigm and need to be redefined within the context of naturalistic enquiry. This view is supported in a more recent text by Miller and Crabtree (2008, p. 359), who suggest that quantitative methods are not relevant in qualitative research.

Validity is the key to meaningful research; if the research is not valid then it is of no worth. Lincoln and Guba (1985, p. 316) proposed that validity was the key to establishing rigour in qualitative research and that it could not exist without reliability, therefore establishing validity was fundamental. This view was supported by Patton (2002, p. 547) who stated that reliability occurs as a consequence of the validity of the study. It would therefore appear that establishing the validity of the study is of primary importance in qualitative research. Terms used to describe validity in qualitative research include credibility related to the internal validity, transferability in relation to external validity and confirmability as an equivalent of objectivity (Lincoln & Guba, 1985, p. 316; Seale, 1999, p. 45; Patton, 2002, p. 546; Brymen, 2004, p. 273; Polit & Beck, 2008, p. 538; Cohen et al, 2011, p. 181)

Lincoln and Guba's (1985, pp. 226-285) framework for establishing trustworthiness consists of four criteria: (1) dependability; (2) credibility; (3) transferability; (4) confirmability. In response to some of the criticism levelled at their criteria, a fifth criterion of authenticity was added (Guba and Lincoln, 1994; Seale, 1999, p. 46; Brymen, 2004, p. 276). Despite the controversy surrounding the issue of reliability and validity in qualitative research, the approach proposed by Lincoln and Guba (1985, p.318) continues to be considered as the 'gold standard' for many qualitative researchers (Polit & Beck, 2008, p. 538). Having reviewed the literature the author is persuaded that, despite the debate, the criteria suggested by Lincoln and Guba (1985, p. 320) are the most relevant for the study.

3.7.1 Dependability

Dependability is evaluated by the clarity of the decision-making process and the conduct of the research. This can be made transparent in providing an audit trail, which is a clear outline of the research design, how data were collected, how the analysis was conducted and how conclusions were reached (Lincoln & Guba, 1985; Golafshani, 2003; Bryman, 2004, p. 275; Holloway & Freshwater 2007, p. 303; Robson, 2011, p. 159). The author achieved this by maintaining an accurate record of all steps of the research process, including the selection criteria and sampling strategy, interview schedules and examples of other data collection tools with details on how they were developed.

3.7.2 Credibility

Credibility relates to the belief in the truth of the data and can be achieved in a number of ways. Peer-debriefing is a process whereby peers are asked to review and explore aspects of the study and may include for example, inter coder checks. Another strategy is member checking where respondents verify the accuracy of, for example, interview transcripts. Credibility can also be strengthened by the researcher having engagement over time with the participants and the study subject. Other important mechanisms are the use of field notes, audio taping and rigorous transcription of interviews, triangulation, reflexivity and appropriate sampling strategies (Lincoln & Guba, 1985; Seale, 1999, p. 44; Polit & Beck 2008, p. 544).

Peer-debriefing was conducted throughout the various stages of the study with colleagues considered to be knowledgeable in the fields of nursing, education and communication. They formed what is referred to as a 'panel of experts' and participated in the development of both the vignettes and the focus group interview schedules. This ensured a degree of content validity, whereby the researcher seeks to ensure that the data collection instrument covers all of the domains related to the research questions. The development of the instruments was also informed by the relevant literature (Cohen et al., 2007, p. 137; Polit & Beck, 2008, pp. 475 & 750). In addition the data collection tools were piloted and changes made accordingly. In order to minimise bias, a colleague conducted the interview with the researcher taking field notes. Inter coder checking was conducted on both the focus group data and the vignettes. Member checking, whereby study participants were invited to review the transcripts to confirm accuracy, was conducted at each stage of the data analysis process and is more fully documented in the data analysis section (3.12). An audit trail has been kept of the processes of both data collection and data analysis. Audio tapes were transcribed verbatim and listened to repeatedly using field notes to clarify and enhance the dialogue. Although a purposive sampling strategy was adopted, care was taken to ensure that the inclusion and exclusion criteria afforded a degree of rigour.

3.7.3 Transferability

This refers to the generalisability of the research findings and can be difficult to establish in qualitative research. Numbers are often small and the findings do not lend themselves to the statistical analyses typical of quantitative research. For this to be addressed in qualitative research, it is the responsibility of the researcher to provide the audience with an in-depth depiction of the study setting and the study participants, and full discussion of the findings so that they can consider the relevance of the work to other contexts (Lincoln & Guba, 1985, p. 316; Guba & Lincoln, 1995, p. 110; Seale, 1999). The researcher believes that sufficient information has been provided and the rigour of the study addressed in such a way as to enable the audience to judge the transferability of the findings to another setting.

3.7.4 Confirmability

This criterion is concerned with the elimination of bias and ensuring objectivity is maintained throughout the study. Strategies employed to achieve this mirror those essential for establishing credibility and include inter coder checking to ensure that the data are representative of the voice of the participants and the methods of data collection and analyses.

3.7.5 Authenticity

Authenticity relates to the wider impact of research (Guba & Lincoln, 1994; Seale, 1999, p. 46; Brymen, 2004, p. 276). According to Brymen (2004, p. 276) the criteria outlined by Guba and Lincoln (1994) have been perhaps less influential and regarded as controversial. Brymen (2004) further suggests that they may have more in common with action research. This might perhaps explain why other authors have presented a more limited interpretation of authenticity (Fade, 2003; Polit & Beck, 2008, p.540; Streubert & Carpenter, 2011, p.93), describing something more akin to credibility and confirmability. Authenticity, as originally proposed, is concerned with issues such as whether the participants are fairly represented (fairness) and whether the research lead to better understanding of the subject area (ontological authenticity), whether the research enables better understanding among the participants (educative authenticity), whether the research prompts action (catalytic

authenticity) and, finally, whether the research is empowering (tactical authenticity) (Guba & Lincoln, 1985, p. 301; Seale, 1999, p. 46; Brymen, 2004, p. 276). Some of these criteria can be achieved by applying the measures outlined above such as, accurate transcription and reflexivity and it is believed that authenticity has been achieved in relation to fairness, ontological authenticity and educative authenticity. The achievement of the final two criteria can only be judged once the final report is made available to the professional community; therefore the author is unable to state categorically that these have been achieved.

3.7.6 Reflexivity

Reflexivity is considered by many authors to be a key component of establishing the trustworthiness of qualitative research and is an acknowledgment that the researcher, the subject matter and the participants are linked, with the researcher having a central role (Lincoln & Guba, 1985, p. 327; Tesch, 1989; Seale, 1999, p. 45; Brymen, 2004, p. 500; Polit & Beck, 2008, p. 386). Miles and Huberman (1994, p. 38) suggest that in qualitative research the researcher is also an instrument and therefore needs to be alert to the possibility of personal bias and assumptions.

Reflexivity is concerned with the development of an ongoing and dynamic self awareness. There are a number of definitions of reflexivity and ways in which it is understood. For the purposes of this thesis, it is defined as a process of critical self reflection vis á vis the relationship between the research and the research participants and the researcher's own assumptions and beliefs about the subject under study, with a view to ensuring that, as far as possible, these biases are prevented from influencing the research process and findings (Lynch, 2000).

As an experienced nurse and nurse educator the researcher holds certain views and assumptions related to both communication and the therapeutic relationship within nursing. These assumptions and views are informed by a combination of clinical experience, academic study of the topics and informal learning from colleagues and students. Indeed, Tesch (1987) suggests that for a qualitative researcher to claim that they have no interest in the topic and are completely divorced from it would be

disingenuous. These assumptions are that the interaction between the nurse and the patient can be of therapeutic value to the patient in isolation to any physical nursing activity. By this the author means of potential benefit to the patient, physical or psychological, without the need to carry out essential nursing care This is achieved by the nurse communicating well with the patient, demonstrating a willingness to engage with the patient, and being respectful and empathic. However, the author acknowledges that holding these beliefs and assumptions does present the risk of bias and prejudice on the part of the researcher. In order to mitigate against this, the researcher documented in a research diary pre-conceptions and suppositions prior to data collection and analysis. This was also supported by regular peer-debriefing and discussions with the academic supervisor.

3.8 Sampling strategies

The suitability of the sampling strategy is a key factor in the overall quality of the research (Cohen et al., 2005, p. 100). With the exception of large epidemiological studies it is not usually possible or even desirable for the researcher to include entire populations in the study. This necessitates the selecting of a sample or subset of the population of interest to the researcher to ensure that the information obtained will be representative of the total population. Cohen et al. (2005, p. 101) suggest that there are four key factors to be considered regarding sampling: the sample size, the representatives of the sample, the access to the sample and the sampling strategy to be used.

Quantitative researchers are usually looking to perform statistical analyses so therefore need to consider a sample size large enough to generate statistically significant results. Qualitative researchers on the other hand commonly use smaller sample sizes as they are looking for depth and richness of data rather than quantity. Exact numbers may vary depending on the method, with methods such as a case study approach sometimes focussing on a single subject (Stake, 2003, pp. 86-109; Yin, 2009, p. 29). The two main methods of sampling are probability, or random sampling and non-probability sampling. In a probability sample the chances of wider population being selected for the sample are known and every member of the

population has the same chance of being included. The inclusion or exclusion of the subjects from the study is a matter of chance. In non-probability sampling some members of the population will definitely be excluded and some will be included. With this type of sampling the researcher has deliberately selected a particular section of the wider population (Cohen et al., 2005, p. 110).

In the main, quantitative researchers are more likely to select a probability sampling method. As it seeks to be representative of the wider population it is more likely that the results will be generalisable. The qualitative researcher is most likely to adopt a non-probability or purposive sample. The researcher is targeting a particular group in the knowledge that it does not represent the wider population but can only represent itself. There are a number of non-probability sampling methods such as convenience sampling, which involves selecting the most accessible subjects and continuing until the required sample size has been achieved. In purposive sampling the researcher handpicks the participants because of a particular characteristic that the researcher is investigating (Denscombe, 2007, p. 17; Cohen et al., 2011, p. 156). Drawing on earlier work by other authors (Le Compte & Preissle, 1993; Miles & Huberman, 1994), Teddlie and Yu (2007) developed a typology of purposive sampling strategies and suggested that there are three broad categories of purposive sampling: category (a), where the aim is to achieve representativeness or comparability, category (b) when sampling is in special or unique cases and category (c) where sampling is sequential. They also suggested an additional category (d) when a combination of purposive sampling techniques might be utilised.

The purposive sampling strategy employed in this study falls into category (a), where the goal is to recruit to the study those subjects that are, far as possible, representative of the larger population (Teddlie & Yu, 2007). Access to the sample is an important consideration for the researcher and must be addressed early in the research process. Access usually requires permission, so the researcher must seek this from the appropriate person(s). For example, if conducting research on students, permission may need to be sought from the head of department or course leader in addition to any ethical approval required from the appropriate institutional ethical committee.

3.8.1 Population and sample

A purposive sample of all new students commencing academic session 2009/10 (n=50) was invited to participate in the study. A purposive approach to sampling is appropriate when the researcher is best qualified to identify the subjects that are most appropriate for the study (Cohen et al., 2007, p. 114). A total of twenty-three students agreed to participate in the study.

3.8.2 Inclusion and exclusion criteria

All students commencing the Bachelor of Nursing in September 2009 were potentially eligible for recruitment to the study. However, students were excluded if they met the following exclusion criteria:

- Those students joining the class who had previously studied nursing either because they were repeating the year or because they had transferred from another academic institution;
- Those students with a degree in psychology;
- Those students who had completed a recognised counselling course.

3.9 Ethical considerations

Research is usually justified by the need to seek new and better knowledge aimed at the good or benefit of society. Ethical tensions and dilemmas in research occur with the need to balance this objective against the rights of individuals and groups (Jupp, 2006, p. 93). In other words, there is tension between the ethical principles of beneficence and non-maleficence (Beauchamp and Childress, 2009, p. 150). The proliferation of research within nursing has led to growing concerns about the protection of the rights of research participants. Ethical concerns within practitioner research can be particularly difficult because the line of demarcation between the role of the practitioner as researcher and the role of the practitioner within the context of his or her professional role can become blurred (Polit and Beck, 2008, p. 167; Cohen et al, 2011, p. 75).

Research in the field of education must be conducted with due regard to ethical principles such as anonymity, confidentiality and compliance with the Data Protection Act (1998). Informed consent is also an important ethical consideration as it is the process by which researchers ensure that potential participants understand the risks and benefits of participating in the study. They are also informed about their rights not to participate. This information should be presented in a manner that is free from coercion (Parahoo, 2004, p. 79; Cohen et al., 2011, p. 78). In 2004 the British Educational Research Association (BERA) published guidelines for educational researchers to ensure that all those engaged in this type of research are aware of their ethical responsibilities. This guidance was updated in 2011. Irrespective of the field of research, researchers have a duty to take into account any impact that participating in the research may have on the individual and must adhere to the principles outlined in the Declaration of Helsinki (Cohen et al., 2007, p. 57).

Prior to consent the participants were given an information sheet as part of the recruitment process (appendix eight). The information sheet provided the necessary assurances regarding anonymity and confidentiality. Participants were also assured that they could withdraw from the study at any time without giving a reason, with no impact on the quality of teaching, support and supervision they would receive as a normal part of the course. After reading the information sheet the students were asked if they had any further questions. They then gave informed consent and completed a written consent form (appendix eight).

All data related to the study were stored on a University computer and password protected. Any written material was held in a designated locked filing cabinet within a locked room and all data was anonymysed and stored in accordance with the Data Protection Act (1998). Only the named investigator had access to the data. Tapes were destroyed following transcription; other data will be stored for a maximum of five years to allow for audit.

3.9.1 Ethical approval

Ethical approval was sought and granted by University of Strathclyde Department of Educational and Professional Studies Ethics Committee (appendix six). A telephone discussion with the chair of the researcher's HEI ethics committee confirmed that approval from the University of Strathclyde was sufficient. Permission to conduct the study was granted by the head of department (appendix seven).

3.9.2 Access

Written permission was obtained from both the head of department and the Director of Undergraduate Studies (appendix seven). Students were identified from the year one register and all students were invited to participate. The students were initially approached by a member of staff other than the researcher to eliminate any perception of coercion as the researcher is also the year one coordinator.

3.9.3 Positionality

The field of enquiry is likely to be pertinent to the researcher's professional role and time limitations and other constraints may mean that the researcher is engaged in research within his or her own work environment. Although this is likely to facilitate access, there are inherent issues of bias and ethicality related to confidentiality and anonymity (Cohen et al., 2005, p. 101). These were overcome in this study by ensuring that all data were stored in accordance with the Data Protection Act (1998), with only the researcher having access. Initial recruitment to the study was undertaken by a colleague at the start of year one, before any of the students were known to the researcher. Students were given an information leaflet prior to being invited to participate in the study to allow them time to assimilate the information and give them an opportunity to prepare any questions regarding their potential involvement. The information leaflet also assured students that all information would be confidential and anonymysed within the study and that they could withdraw without prejudice to their assessment or any other aspect of the course.

3.10 Developing the data collection instruments

3.10.1 Demographic questionnaire

This was a simple questionnaire, designed to capture information about the participants that might have a bearing on the findings. It also served to add to the 'thick description' described by Lincoln and Guba (1985, p. 316) essential in any attempt at establishing transferability (appendix two).

3.10.2 Vignettes

The first section of the vignettes consisted of two scenarios divided into three progressive sections and designed to detect empathy and respect in students' responses to each scenario. The vignettes were developed by the author and based on scenarios that the student might encounter in clinical practice. A set of descriptors, words and phrases were then formulated as indicators of empathy and respect and informed by the literature and the researcher's own clinical experience (appendix five). The second section of the vignette was designed to capture students' self awareness and consisted of four simple questions asking about their own feelings in relation to each scenario. The completed vignettes were then reviewed by a panel of experts to establish credibility. Following this review, changes were made as indicated and subjected to further review prior to piloting. Following the pilot, the final version was reviewed again by the panel of experts.

3.10.3 Group interview topic guides

A similar approach was taken to the development of the focus group topic guides (appendices three & four). The areas explored in the focus groups were informed by the research questions and the literature and reviewed by a panel of experts to establish credibility.

3.11 Pilot study

A pilot study should be considered as the first stage in any data-gathering process and should aid in the identification of any problems with the design or data collection tools (Robson, 2011, p. 405). The pilot study allows the researcher to have a 'trial

run' and can identify problems with (a) study design, (b) the data collection instrument. It also gives the researcher experience of using the tool and any equipment and allows some opportunity for testing out the process of analysis (Cormack, 2000, p. 24). Pilot studies are also useful in timing interviews or the length of time needed to complete a questionnaire (Cohen et al., 2011, p. 118).

3.11.1 Vignettes - pilot

A purposive sample of the current year one students (n=10) was invited to take part in the pilot study. Students were selected for the pilot because they were the nearest match to the students to be recruited to the main study (Polit & Beck, 2008, p. 355). Academic grades were reviewed and students were selected from the top, middle and lower ends of the academic range to ensure that, as far as possible, the vignette could be understood by all students. Two students were also selected because English was not their first language - there are usually a few overseas students in each year and the researcher wanted to ensure, as far as possible, that language would not be a barrier to participating in the research.

The students were given an information leaflet (appendix 8) and asked to give consent. The students were advised of the purpose of the pilot and informed that the data they provided would not be included in the main study. On the day of the pilot two students were absent, therefore only eight students took part. The pilot aimed to:

1. ascertain how long it would take students to complete the vignette;
2. Check that the language used in the vignette was comprehensible to junior students and students for whom English was not their first language;
3. Check that the subject matter of the vignette was appropriate;
4. Review the responses in order to ensure that they were fit for purpose;
5. Provide an opportunity to review the data analysis strategy.

As a result of the pilot minor changes were made to the wording within the scenarios. For example, 'pulverised diet' was changed to 'soft diet' as this was deemed to be more 'ordinary' language and therefore easier to understand. Each scenario in the vignette had been assigned certain words and phrases that indicated the demonstration of either respect or empathy. On reviewing the responses from the

students, it was evident that they had used words not previously identified but which were appropriate. This was discussed with the panel of experts and as a result some additional indicators were included. For example, confused was added to 1c (appendix five). The students took between 20 and 30 minutes to complete the vignettes and did not feel that this was too onerous.

3.11.2 Group interviews - pilot

A purposive sample of students (n=4) was invited to take part in the pilot. Students were selected for the pilot because they were the nearest match to the study population. This is appropriate when the researcher aims to select the participants most suitable for the purpose (Polit & Beck, 2008, p.355). The aims of the pilot were to:

1. Ascertain how long the interview would be likely to last (the aim was for 45 – 60 minutes);
2. Check that the prompts in the interview schedule were understood by the students and lacked ambiguity;
3. Review the responses in order to ensure that they would answer the research questions;
4. Ensure the equipment and environment chosen were fit for purpose;
5. Provide an opportunity to review the data analysis strategy.

Following the pilot minor changes were made to the interview schedule. For instance, examples were given of what was meant by clinical staff. The venue seemed to suit the purpose and the digital voice recorder worked well. The group interview took approximately 50 minutes to complete, which was within an acceptable time frame (Robson, 2011, p. 294).

3.12 Methods of data analysis

Data analysis is the means by which four cognitive processes are achieved - comprehending, synthesising, theorising and recontextualising. Qualitative analysis therefore involves not only systematic and mechanical handling of data, but also the processes of reflection and creative interpretation (Ingleton and Seymour, 2001).

Analysis consists of identifying, coding and categorising patterns found in the data and relies on the analytical intellect of the researcher (Denscombe, 2003, p. 237). Stake (1995, p. 71) suggests that there is no specific point at which data analysis begins, rather it is about assigning meaning to both the first impressions as well as to the final interpretation. Although it has been claimed that the analyses of qualitative data may be in some part intuitive, more structured approaches to data analysis must also be employed in order to extrapolate meaning from the raw data as the raw data in itself provides no answers (Stake, 1995, p. 78; Robson, 2011, p. 408).

It is now common practice to utilise computer-assisted qualitative data analyses software (CAQDAS) in the management and analysis of qualitative data and there are a number of software packages available, for example, NVivo, Nudist, and ATLAS-Ti' (Yin 2009, p. 177; Peters & Wester, 2007; Leech & Onwuegbuzie, 201l). The literature suggests that there are advantages and disadvantages to both approaches. The key advantages in the use of CAQDAS are the facility to organise, code and categorise large amounts of narrative data, reduce the amount of time required for analysis, and remove an element of the tedium involved in qualitative data management and analysis (Tesch, 1989; Miles & Huberman, 1994, p. 44; Polit & Beck, 2008, p. 513; Yin, 2009, p. 176). However, other authors urge a degree of caution in their application. MacMillan and Koenig (2004) suggest that their use is often misguided and that many researchers use them with limited understanding of how they should be utilised. Yin (2009, p. 129) points out the two key words to consider in the use of software, namely *assisted* and *tools,* emphasising that the computer will not undertake the actual analysis and that the researcher must continue to be the analyst. Robson (2011, p. 408) supports this view and comments that a major disadvantage in the use of CAQDAS is the potential that opportunities for teasing out hidden aspects of the data may be lost, as ideas for interpretation often occur during the process of analysis.

Another, though not less important, rationale for managing the data without the use of CADQAS was that the researcher has had limited experience in qualitative data analysis. The researcher is also a teacher and supervisor of students, many of whom

do not have easy access to computer software. By undertaking data management and analysis 'the old fashioned way' the researcher aims, not only to hone her own skills, but to enhance her ability to supervise students based on actual experience, rather than from a theoretical perspective. Future forays into larger qualitative studies in collaboration with other researchers will undoubtedly necessitate the use of CADQAS. The researcher believes that, having worked through the process of data analysis and having gained an understanding of the underlying principles, she will be able to make more judicious use of such packages.

3.12.1 Data analysis group interviews

Bloor et al. (2001, p. 58) state that analysis of group interviews should be grounded in established approaches to the analysis of qualitative data and there are several ways in which this can be approached. The researcher could adopt a process of conversation analysis, which may be appropriate if not only the *what*, but the *how* of what was said is also important (Myers, 1998, 2006; Myers & Macnaghton 1999, p. 173). This may be particularly important in a heterogeneous group and where the topic for discussion is more open. As the group interview in this study was guided towards a specific topic and the group was largely homogenous, this approach to analysis was rejected. In this study it was the content of the discussion that was of primary interest and, as the data collection method was determined to be a group interview rather than a focus group, a method of analysing interview data was considered to be most appropriate.

From the literature it appears that there are two main approaches to the analysis of qualitative data from interview transcripts. One approach is based on Glaser and Strauss' (1967) grounded theory, whereby themes and categories emerge from the data and is proposed by a number of authors (Burnard, 1991, 1996; Noaks & Wincup, 2004, p. 131; Polit & Beck, 2008, p. 523; Burnard, Stewart, Treasure, & Chadwick, 2008). Burnard (1991) gives a systematic breakdown of the steps necessary for analysis and this framework is widely used in qualitative nursing research. The other approach is based on a phenomenological approach and Hycner (1985), citing work by earlier researchers (Colaizzi, 1973; Giorgi, 1975; Tesch,

1980) proposes an approach to analysis that is rooted in phenomenology. Although emphasising the need to remain 'true to the phenomenon' and avoid what he terms a 'cook book' approach to data analysis, he nevertheless sets out a step by step process by which data should be analysed.

On comparing the two approaches, it would appear that there are a number of similarities. For example, both authors emphasise the importance of reading and re-reading the transcripts to gain a sense of the whole. Where Hycner (1985) refers to 'identifying units of general meaning', this correlates with the process of 'open coding' referred to by Burnard (1991). Where Hycner refers to 'clustering units of general meaning', this would appear to be similar to 'grouping categories into higher order headings' or axial coding. Similarly, stage five in Burnard's framework appears to mirror stage seven in the Hycner guidance, whereby repetitious or redundant units of meaning are removed. Both authors propose member checking and the use of independent analysts in order to establish validity. What is interesting in comparing the two approaches is that Hycner (1985) has an additional stage whereby the units of meaning are compared to the research questions, a stage which is not explicit in Burnard (1991).

On deciding which of these two approaches to adopt there were a number of factors to consider. Although the study utilised data collection methods often associated with phenomenological research, the study was not a phenomenological study. On the contrary, in case study methodology the researcher often approaches the study with propositions already formulated (Yin, 2009, p. 28). Neither was the study adopting a grounded theory approach. The steps outlined by Hycner (1985), while having some elements similar to the grounded theory approach outlined by Burnard (1991), seemed to be more directed to individual interviews rather than group interviews. Although the framework described by Burnard (1991) is also primarily related to individual interviews, it appears to lend itself more readily to focus group interview analysis than that of Hycner (1985) as it did not look to identify themes related to each interview. The other consideration was that, having reviewed a number of research texts related to analysing interview data, it would appear that the majority of

researchers favour the grounded theory approach (Glaser & Strauss, 1967). Having reviewed the literature the researcher has broadly adopted the approach outlined by Burnard (1991) and has applied it in the way that seemed to best suit the data. An advantage of Hycner's approach is that it asks the researcher to identify the 'units of meaning' in relation to the research questions, which facilitates the elimination of 'redundant units of meaning'. The researcher has therefore included this step in the process of analysis (table two).

Table two
Process of analysis undertaken for the group interviews

Stage	Activity
1	Tapes transcribed verbatim and supplemented with field notes re. non verbal communication
2	Member checking - transcripts
3	Transcripts read and re-read with note taking
4	Categories freely generated using literal excerpts from transcript - open coding
5	Categories grouped into higher order headings - axial coding
6	New list re-worked with removal of repetitious or similar headings
7	Reviewing themes and sub categories in relation to research questions
8	Inter coder agreement
9	Transcripts re-read alongside final coding – adjustments made as necessary
10	Inter coder agreement
11	Allocation of code to sections of the transcript – items of code collected together - then pasted under headings & subheadings

3.12.2 Process – group interviews

The process of analysis was conducted in exactly the same way for both group interviews. Therefore, to avoid repetition, the process will only be outlined once with any variation noted. Onwuegbuzie, Dickenson, Leech and Zoran (2009) suggest that transcript based analysis is the most rigorous method of analysing interview data. Transcription of the taped interview by the researcher is a valuable way of bringing the researcher close to the data and makes analysis of the data more complete (Bloor et al., 2001, p. 59; Denscombe 2007, p. 289). This inductive form of analysis allows

the researcher to become ‘immersed’ in the transcript, enabling identification of recurring statements (Burnard 1991, 1996; Bloor et al., 2001, p. 59; Streubert & Carpenter, 2010, p. 43).

Both group interviews were transcribed verbatim. This process allowed the researcher to become immersed in the data and facilitated the later identification of themes. It also allowed for annotation from field notes to be applied directly to the transcript and for para-linguistic language such as nuances in tone and facial gestures and body language to be noted, which ensured that participants had a full account of the discussion and added to the trustworthiness of the findings. Each group interview participant was then given a copy of the transcript to read in order to verify the accuracy of the transcripts. This process of member checking statements is a means of enhancing the credibility and confirmability of the findings. All group interview participants were satisfied that the transcript was an accurate summary of the discussion.

Interview transcripts were read and re-read, with general notes taken on each read through and used in addition to the field notes to aid analysis. Following this, open coding was undertaken where categories were freely generated using literal excerpts from the transcripts. Once this process had been completed, data were reduced and categories were then grouped into higher order headings or themes, a process often referred to as axial coding and the determination of sub-categories. At this point higher order headings were allocated colour codes to enable allocation of text to each code (appendix nine). These themes and sub categories were then reviewed a number of times in order to remove duplications. At this point the researcher reviewed the themes in relation to the overall aim of the research and the research questions. From the emergent themes and subcategories, it appeared that there was correlation with the research aim and questions. The data was then subject to inter coder checking. The transcripts were analysed independently by the researcher and the co-analysts prior to comparing findings.

There was unanimous agreement between the researcher and the inter coders on the main themes but there was some discussion of subcategories - for example, whether rapport was a sub category of 'communication', or of 'the nature of the relationship'. Mutual agreement was reached after returning to the raw data and repeating the coding process. Similarly, in the second group interview there was unanimous agreement on the emergent themes with a need for discussion and teasing out on some of the sub categories - for example whether 'keeping promises' was more a sub-category of 'trust' or of 'professionalism'. Again, both the researcher and co-analysts returned to the transcript to look at the context and agreement was reached. Following this, the themes were reviewed in the light of the research questions and 'redundant units' were discarded. The next stage involved re-reading the transcripts alongside the final coding and undertaking a final inter coder check. The final stage involved allocating text to the identified themes and sub categories using colour coding to facilitate writing up the findings and ensuring that quotes were not taken out of context (appendix ten).

3.12.3 Data analysis vignettes

Although a quantitative approach to data analysis had been considered initially, it was evident on reviewing the first tranche of data that this form of analysis would fail to capture the richness of the data that was being generated. There was a realisation that to simply measure whether the student used more or fewer words or behaviours over time might in fact result in misleading or false results. For example, a student may use six to eight words or behaviours at the beginning of the study and by the end of the study may only be using four to six words or behaviours. This could potentially lead to two opposing conclusions. It may mean that the student has become more skilled at writing and therefore is able to convey the sense of respect and/or empathy either in fewer words or in more sophisticated language. However, it may mean that as the student has advanced in training and is more engaged in the technical aspects of nursing, no longer as in touch with these more 'basic' aspects of care provision.

Qualitative approaches to data analysis were considered. The sheer volume of data at first appeared daunting, particularly as it was initially handwritten. Most students, by the time they had reached time point three, were generating a lot of narrative and were writing down the sides of the page and on the reverse of the page. The vignettes were transcribed, which allowed the data to be organised so that that the three data collection points for each student could be viewed simultaneously (appendix ten). Prior to transcription, member checking was undertaken with each individual student to clarify anything that was not understood by the researcher. Apart from assisting with the analysis, this had an unlooked for benefit for the students, who expressed surprise at how they had developed their knowledge and skills over time and found it very affirming.

Although different to the group interview data, the vignette data was nevertheless narrative data and needed to be approached with the same rigour, using established approaches to the analysis of narrative data (Robson, 2011, p. 467). However, unlike thematic analysis, outlined in the grounded theory approach, the researcher was not looking for themes to emerge, but rather to detect evidence of the existence of pre-determined behaviours related to empathy and respect. This was facilitated by a table of indicators formulated as phrases or words that had been developed alongside the vignettes, based on the literature and reviewed by a 'panel of experts'. This approach provided a systematic means of determining the presence of the words or phrases reflective of empathic and respectful behaviour. The full range of indicators and how they relate to the sections of the vignette can be seen in appendix five. An overview of the indicators related to respect is presented in table three, and indicators of empathy are presented in table four. Section two of the vignette sought evidence of students' awareness of their own feelings in relation to the scenarios and had no pre-determined indicators.

Table three - Behaviours indicating respect	
• Introducing yourself and asking what the patient would like to be called • Seeking permission to carry out the task • Ensuring that the patient is comfortable • Make sure the patient's clothes are protected • Make sure you are on the same level • Giving the patient time to chew and swallow • Engaging in conversation • Ensuring mouth/chin are wiped clean as necessary • Asking if the patient likes the taste and if the temperature is ok • Giving the patient your full attention • Stopping feeding the patient • Discreetly take the patient to a quiet private space	• Help him to wash and change • Ask if he would like to go back to the dining room • Remain calm & patient • Ask if she has her own toilet things • Ensure screens are drawn to ensure privacy • Ask if she is able to carry out any aspects herself such as hands and face • Ensure that dignity is maintained by ensuring that patient is adequately covered

Table four **Indicators of empathy** **Potential emotions experienced by the patient & nurses' response**	
• Embarrassed • Ashamed • Angry • Frustrated • Helpless • Worthless • Loss of dignity • Humiliated • Confused • Frustrated	• Not being dismissive of the patients' anxieties • Reassuring the patient that it is not distasteful • Trying to change the topic by asking the patient about family etc. • Providing reassurance • Checking for underlying problems

3.12.4 Process – vignettes

An inductive approach to the analysis was adopted where the researcher reviewed the data at various times. This enabled the researcher to consider what was occurring for the students at each time point, allowing the researcher to gain a sense of the students' overall development. The aim of the analysis was to detect growth in the students in relation to empathy and respect in section one of the vignette, and to explore the students' awareness of their own feelings in relation to the scenarios in section two.

In section one, the students' responses were reviewed at each time point for evidence of respect and empathy, using the pre-determined indicators, to detect either phrases or words that indicated these behaviours were present, and colour coded accordingly (appendix eleven). It was evident that the students were developing skills in relation to communication and, as this was relevant to the research questions, they were colour coded and reported in the findings. Colour coding allowed the researcher to have a visual picture of changes over time, which assisted in the analysis (Tesch, 1990, p. 87). The data was then read and re-read to ensure that meaning and interpretations related to the students' development were accurate. The process of analysis is outlined in table five.

Table five-Process of analysis undertaken for the vignettes (section one)

Stage	Activity
1	Vignettes read and re-read - note taking first impressions
2	Member checking with participants to seek clarification then vignettes typed onto a database
3	Vignettes read and re-read with note taking
4	Vignettes read together with indicator framework and colour coded
5	Inter coder agreement
6	Vignettes reviewed again for evidence of other development and colour coded
7	Identification of supportive evidence from the narrative
8	Inter coder agreement

Analysis of the vignettes could have been open to bias - perhaps more so than the group interview data - because the students were and are known to the researcher and it is possible that the researcher's knowledge of and beliefs about an individual student might lead to misinterpretation of the data. This was considered to be a particular risk if what the student reported in the vignette seemed to be at odds with what the researcher believed about that student. It was decided at an early stage in the process that a co-analyst (inter coder) was necessary. A deliberate decision was taken to invite a researcher with experience in qualitative data analysis and vignettes, who had no possible knowledge of the students. The vignettes were analysed independently by each analyst prior to comparing findings. In the main there was agreement but, where disagreement occurred, both analysts returned to the raw data and agreement was reached.

Section two sought to identify examples of students' awareness of their own feelings in relation to the scenarios. Responses to all four questions were analysed together and then compared over the three time points. The volume of data generated in this section was small in comparison to the data generated in section one of the vignettes and in the group interviews. As there were no pre-determined indicators for this aspect of the vignette, the same analytical approach as that taken for the group interviews was adopted and is outlined in table six.

Table six **Process of analysis undertaken for the vignettes section two**	
Stage	**Activity**
1	Responses read and re-read - note taking- first impressions
2	Member checking with participants to seek clarification then responses typed onto a database
3	Responses read and re-read with note taking
4	Categories freely generated using literal excerpts from transcript - open coding
5	Categories grouped into higher order headings - axial coding
6	New list re-worked with removal of repetitious or similar headings
7	Reviewing themes and sub categories in relation to research questions – removal of redundant units of meaning
8	Inter coder agreement
9	Transcripts reread alongside final coding - adjustments made as necessary
10	Inter coder agreement
11	Allocation of code to sections of the transcript - items of code collected together - then pasted under headings & subheadings

Chapter 4: Main study findings

4.1 Introduction

Chapter four will report the main themes and findings obtained from all three methods of data collection. The findings from each data collection method will be reported separately and then links made to formulate a conclusion. The first section will present the demographic data collected at the outset. The second section will present the findings from the group interviews and section three will report the findings from each section of the vignettes.

4.2 Recruitment

The aim of the study was to contextualise undergraduate student nurses' understanding of the therapeutic relationship and their ability to develop this relationship with patients, in the context of providing essential nursing care. A case study methodology with a qualitative, single case, holistic design was adopted for the study with the cohort of students recruited to the study representing the case, and the development over time constituting the unit of analysis (Yin, 2009, p. 51).

The whole cohort of the 2009 intake to the Bachelor of Nursing Programme (n=49) was invited to take part in the study. A total of 23 agreed to take part and completed the written consent form, response rate 47%. Response rates in qualitative research do not have the same significance as in quantitative methodologies where the aim is to generate statistical results. In qualitative research the emphasis is on the adequacy and appropriateness of the sample (Polit & Beck, 2008, p. 360).

A total of 17 students completed the study. Six students withdrew during the course of the study:

- Two left the course as a result of ill health;
- Three withdrew from the course to pursue other career options, two in first year and one in second year;

- One student gave no reason and withdrew from the study at the end of first year, no reason was given. Data collected from these students were excluded from the analysis.

4.3 Demographic data

Of the 17 students who completed the study two were male and 15 were female. This ratio is representative of the demographics within nursing, as female nurses out number male nurses by approximately 20:1 (Davis & Bartfay, 2001; Loughrey, 2008). Nine students had some previous nursing experience, mainly undertaken as part of work experience or voluntary work (n=6). Two participants had worked as health care assistants (P10 & P14) and one student had completed two years of medical training (P3). Six students had had previous experience of being nursed. Six students had received some form of communication skills training/education, mostly undertaken as part of work orientation (n=4). One student had undertaken some counselling training but this was job specific (P14). Six students had undertaken some communication training whilst at school or as part of training programmes (P3, P7, P8, P14, P15, P16). Four students had undertaken psychology as part of previous courses (P3, P15, P16, P18), with one student (P16) having a psychology degree. Although psychology knowledge and/or qualifications had been an exclusion criterion, further reflection determined that since many people have some lay knowledge of psychology and since the student with formal psychology knowledge had no clinical experience, it was not necessary to exclude these particular participants. A summary of the main demographic findings are presented in table 7 and more specific details in appendix 12.

Table seven **Demographic Findings**		
Category	**Participant N^{o}**	**Total**
Male	7 & 14	2
Female	1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18	15
Previous nursing or caring experience	3, 4, 7, 9, 10, 11, 14, 15, 17, 12	10
Experience of having been nursed	3, 8, 11, 13, 15, 18	6
Previous education/training in communication	3, 7, 8, 14, 15, 16	6
Previous education/ training in psychology	3, 15, 16, 18	4
Previous education/training in counselling	14	1
Age17- 25	1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 17, 18	14
Age 25-45	14, 15, 16	3

4.4 Group interviews

A total of two group interviews were conducted, with the students divided into three groups on each occasion. One group interview was conducted at the beginning of year two and another at the beginning of year three. These times were chosen as they represented key points in the students' overall training programme in relation to the combination of theory and clinical practice. As previously discussed, the groups were small with a range of four to seven participants in each group. As far as possible the demographics of the groups were maintained between the first and second group interviews. All the groups were interviewed consecutively on the same day at each of the data collection periods.

In the first group interview there were five broad areas of discussion: (1) understanding the therapeutic relationship; (2) the role of the mentor and other clinical staff; (3) the impact of teaching; (4) personal experience; (5) reflection. In the second group interview there were seven broad areas of discussion. Five were the same areas as explored previously (although there were some new prompts), with two new areas of exploration: (1) the role of communication; (2) barriers and facilitators to developing the therapeutic relationship. These new areas were included as further exploration of the literature had suggested them to be important. Details of how each area was explored in both focus groups can be reviewed in the topic guides (appendices three & four). Findings from group interview one and group interview two will be reported separately.

4.4.1 Group interview one

As the group of participants constitutes the case, the findings represent the views of all 17 participants. There was general consensus within the group in most areas. Any area where there was disagreement will be clearly identified. The themes are represented both in the construct formulated by the researcher and in the actual words of the participants as it was believed that this afforded a sense of reality to the construct. Codes related to each theme are expressed in single words or phrases and are evidenced by direct quotes from participants. Additional paralinguistic language taken from field notes and the audio tapes is included where relevant and is un-italicised in brackets. The themes have been allocated colours to facilitate locating the text in the appendices. Identified themes and related categories are presented in table eight.

Table eight **Themes - group interview one**	
Themes (construct)	**Related codes (reality)**
Trust *"I think one of the most fundamental things, is trust"*	Competence Confidence Cooperation Mutual understanding
Effective communication *"no communication, no relationship"*	Introductions Listening and picking up cues Exploring problems and other aspects of their lives Body language Explaining and ensuring understanding
The nature of the relationship *"extra kind of relationship"*	Establishing rapport Empowering Being there, patients can talk to you Respecting individuality Good bond Being open and being yourself
Benefits to patient and practitioner *"they get better quicker"*	Patient is comfortable and less anxious Mutually beneficial Understanding & meeting needs Inclusion of family important Getting well and gaining independence Motivation

4.4.2 Main focus of the discussion

Exploring students' understanding of the therapeutic relationship and what contributed to its development was the main focus of the discussion. From this general discussion, four themes emerged. These themes will be presented and evidenced by direct quotes from the participants.

4.4.3 Trust

The first theme to emerge was *'Trust'* and its importance in establishing the therapeutic relationship. This was considered by all students to be fundamental.

"I think one of the most fundamental things is trust."

Trust was seen as key to gaining the co-operation of the patient, which students believed facilitated recovery.

"A patient who trusts you is really going to co-operate and if you've got a cooperative patient, then they are more likely to get better."

Students also recognised that there were technical aspects related to the provision of nursing care and that competence in carrying out these procedures was important in gaining the patient's trust.

"It involves a technical side as well, technical care."

"That comes into the trust as well, like if you know what you're doing, then they are going to trust that you're going to look after them properly."

Confidence as well as competence in these 'technical' aspects of nursing care was also viewed as important in ensuring that the patient had confidence in the nurse and was seen as necessary in establishing trust. The importance of being relaxed and acting naturally as well as establishing a mutual understanding was also identified as being important to the development of trust.

"They have to have confidence in you, and they really need to believe that you know what you are doing so they can trust your judgement as well as having an input into it themselves."

"Beneficial to both roles. So the nurses can understand more about the patients' needs, […]. And the patient can obviously trust the nursing staff more."

"The more relaxed we are, and the more natural we act, I think that makes a big difference in terms of getting a genuine relationship with patients. Probably just to trust ourselves, be confident."

4.4.4 Communication

Communication was the second theme that emerged from the data. Students unanimously recognised the key role that communication played in developing the therapeutic relationship and it was seen to be beneficial to the patient. However, they thought that communication alone was not enough. For example, you could communicate information to the patient without necessarily developing a relationship.

> *"Communication is part of the therapeutic relationship but not the whole thing."*

> *"[…] a doctor could communicate to the patient what was going to happen, maybe what was wrong with them, and give details. Or maybe the nurse […]. I think that it has to be more of a two-way thing, […] like they are gaining something from it, rather than being told what's going to happen to them."*

> *"Yes, but I think that in order to have a therapeutic relationship, there has to be good communication, so they do kinda […] cross into each other. If there's no communication there isn't going to be a […] relationship."*

There was recognition that communication was more than the exchange of words. Nurses' behaviours also contributed to how effective the communication was. Although not expressed as empathy, this student is recognising the importance of trying to gain an understanding of what is happening for the patient and recognising the importance of communicating their intention, which is indicative of empathic behaviour.

> *"I think that if you can communicate efficiently, and show you are compassionate, and know where they are coming from, and are able to communicate that through how you act when you are with the patient, it can release stress and anxiety and helps the process for them."*

It was also recognised that communication was a two-way process and that is was important not only to communicate well but to ensure understanding. The students reported that this was better achieved if there was a good relationship between the nurse and the patient and the patient felt comfortable with the nurse.

"I think feeling at ease. If you have a much more relaxed atmosphere between you, then there is more likely to be good communication, especially if you're making sure it's understood on both ways."

"Sometimes the patient doesn't really listen when you are trying to communicate with them, so is that really communication? Because they haven't understood what you've said. You should ask them questions then and give them a chance to tell you."

When asked if questioning the patient to check understanding was important, another student said that it was.

"I would say it is, as [another student] *has just said, so that you can make sure the patient […] and the nurses understand what is being communicated*" [heads nodding in agreement].

Giving clear explanations to the patient was also seen as an important element of communication.

[…]Ask them if they understood what was happening, after they had been to the doctor."

"She took plenty of time to talk things through and asked about understanding."

All the students agreed that the first interaction with the patient was important and that introducing yourself to the patient was a vital first step in establishing rapport.

This was one of the things that they had observed when working with other staff. This student is indicating recognition of behaviours identified with respect.

"She would always introduce herself, which is an important start, rather than just going in and saying here's your breakfast'. It's nice to introduce yourself, and get on a first name basis with a patient, and then they can feel like they can rely on you."

Students also saw the importance of effectively listening to patients and how this would enable them to pick up cues from patients. They also recognised the importance of allowing the patient time to respond.

"I think the listening, like leaving a 90 second pause or was it a 60 second pause? [student paused to think for a moment] *to let the patient have time to say what they have to say; don't think ahead about what your going to say, just listen and take on board what they're saying […] to show that you're listening and you care as well."*

When asked if they had used this technique and whether it had been helpful the student responded that it had.

Yes, there was a lady who was quite weepy […]. She was just venting what she was feeling. I didn't interrupt and let her say what she had to say, and left a pause and she then started to come out with more."

This was referring to theory sessions on the communication skills course regarding allowing the patient time to think. One of the things they are asked to consider is 'are you listening or are you queuing to speak'? Students sometimes felt a bit awkward at first as they were not used to doing this but could see the benefits.

"It still feels a bit awkward! [General laughter.] *Even though you feel awkward you can keep your mouth closed because you know it's the right thing […] for the patient, even though it's a bit strange."*

The importance of listening and spending time with patients was identified as important in building the relationship, using this time to explore any underlying issues the patient might have. Students also reported that this was facilitated by using open questions to explore potential problems.

"[…] but if you show them you have the time to listen, and if you sit down with them, and the way you use your verbal communication, and just show them that you are there for them, and if you think there's anything they need to discuss, or if you think there are any underlying problems, then you can explore maybe what's wrong with them."

"You get a better idea what's wrong with someone if you ask how they are feeling. They might say they have a headache or they're a bit miserable, didn't sleep very well etc. You can find out what's wrong, and address that, rather than find out something's wrong and have to ask more questions."

Body language was also identified as being important. Appearing open and accessible encouraged the patient to confide in the nurse. It was not clear from the transcript whether the student was using accessible in the sense of being physically present or whether she was referring to being emotionally/psychologically accessible. This was explored during member checking and the student confirmed that they had meant the latter.

"It's not just the verbal communication, it's your body language as well, you need to be open, you need to be accessible so that the patient feels like they can confide in you with things that maybe they find difficult to talk about."

"It's good, those five minutes sit down on the bed. I don't like standing up talking to patients. If they're sitting in a chair, it's horrible that you're standing over them, you want to be on their level so you have eye contact, and you're not domineering."

The impact on the patient of what was perceived as negative body language was also recognised.

"[…]The doctor was standing, explaining to the patient his operation and what he would go through, but he was standing above him, arms crossed looking directly at him. You could see he [the patient] *wasn't taking it in, or he was too frightened to ask a question or anything."*

4.4.5 The nature of the relationship

The third theme to emerge was *'The nature of the relationship',* with students trying to find ways of articulating what defines a good quality nurse patient relationship. Most students found difficulty in reaching any firm definition, although they were able to recognise that it was a complex and a different kind of relationship that the nurse developed with the patient.

"It's an extra kind of relationship."

"It's so complex. There are so many things you can integrate into delivering a therapeutic relationship. It's just getting that mix to put everything together […]."

They were also able to describe what they thought contributed to the relationship. These included engagement with the patient, mutual understanding and meeting the patient's needs. There also appeared to be some understanding that the relationship itself could be therapeutic and that there were benefits to the nurse.

"A relationship where a nurse and a patient can engage and have some kind of understanding of what each of their roles are. Be able to understand what the

patient needs from you, and what you can give, and for the patient to understand what you are there to offer."

"I think therapeutic is making someone better. Therapeutic relationships; you are making someone better, maybe even at the same time, you can make yourself feel better, a sort of mutual benefit between the two."

"It's how we interact with our patients, and how they interact with us, with the end goal aiming to improve the condition that they are in hospital with […]. It's how we make […] them comfortable, encouraging in any way we can, for them to become better" [general agreement, heads nodding].

Establishing rapport with the patient was seen as an important element of the therapeutic relationship and closely linked to an ability to provide effective care. It was also seen as important in encouraging patients to talk to the nurse and ask questions.

"I would say it's based on you building up a rapport with the patient, so that you can achieve the most effective care."

"If you don't have that rapport, and you don't have that good communication with the patient, then they are unlikely to talk to you, and ask you any questions."

Recognising and respecting the individuality of each patient was also seen as being important and each patient may have different needs. Students also recognised the importance of seeing the patient as a person and not just focussing on the disease or illness.

"Also individuality, treating a patient for what they are as a person, not treating them for what they are in for specifically but thinking about […] what they're normally like."

"Every patient is different."

"Yeah, that's like holistic care of the patient. Looking at every aspect, treating them as an individual."

"Makes you look at each patient more individually and tailor care to that patient."

"There are the main guidelines that we have, but you won't deliver it in the same way to every patient."

Being open and being yourself were also reported by the students as essential to the relationship and these attributes were seen as important to establishing a good bond with the patient, enabling communication between the nurse and the patient. This appeared to be linked to the increasing familiarity they had with the clinical environment. There was also some indication that students were developing a degree of self awareness.

"The openness that the patients feel they can talk to you and that you are approachable."

"*The more relaxed I am, the more comfortable I am as a student on the ward then the more effective I become interacting with the patients […]. Let yourself be yourself. The more relaxed you are, the more effective you are at communicating as well. It's more genuine, […] becomes a conversation."*

As part of this openness students recognised the importance of being honest with patients and apologising if they made mistakes. There was also recognition that by being open and honest the nurse was demonstrating respect and recognising that respect was mutual.

"Sometimes I have forgotten to do things; like a patient once asked if I could make a cup of tea […] and then you might forget and are tempted to walk past them again! [Lots of laughter from the group.] *Go back and say you forgot, as long as you are open […]. You're a person as well as a nurse so you will make*

mistakes, so apologise. You don't need to beat yourself up about it, and they will respect you more, and there's no need to avoid them for the rest of the shift!" [More laughter from the group and nods of agreement]

Students also identified that empowering the patient was an important characteristic of the relationship and were able to recognise the beneficial effects. Most of the examples they gave were things that they had observed when on clinical placement, rather than the result of any of their own actions. This student was describing the interaction between a physiotherapist and a patient who had undergone orthopaedic surgery.

"Empowering a patient is a really useful thing […]. Although they are in hospital, and they're sick, but they can do something about it as well [....]. They can do the stretches and things like that […]. It improves them, and makes them feel good about themselves. It reduces the feeling of being sick […]. Instead of thinking because they're in hospital they're sick and cannot do anything, they're thinking 'I can walk to the end of the corridor now', they're making themselves have goals."

Some students felt that establishing a relationship with the patient was easier in the community. This was related to the time available and the busyness of the ward environment, which was seen as a potential barrier.

"I find therapeutic relationships are a lot easier in the community, as you're going into their house, and you can get to know them better [murmuring and nods of agreement from the group]. *[… In hospital, sometimes it's a lot harder to get to know your patients, especially if it's a busy ward. It is still possible to have a therapeutic relationship […], but if it's busy you can feel like you don't have a lot of time"* [nods of agreement].

However, one student had been working with a practice nurse in the treatment room and found that even though the nurse only had a short time with each patient she was

still able to establish a good relationship. The student identified that it was the attitude and behaviour of the nurse in establishing the relationship that was key. Again the student recognises respectful and empathic behaviour in the nurse and how it impacts on patient outcomes.

> *"[…] They were letting people come in for five minutes […] having their bloods taken. The mentor would always make conversation, make them feel comfortable, ask them if they understood what was happening […] after they had been to the doctor […]. A lot of them were anxious and didn't seem to know what was happening at first. They were short, but I think were still therapeutic relationships."*

When probed a bit further regarding why she felt that these had been still therapeutic, the student said that she thought the patient had benefited from the interaction and had gone away feeling reassured.

"Yes, I think they [the patients] *left feeling a lot better now that they had information and reassurance, and they could ask questions."*

4.4.6 The benefits to patient and practitioner

The fourth theme was *'The benefits to patient and practitioner'*. Students recognised that a good therapeutic relationship with the patient was beneficial to the patient and could facilitate recovery, with some students seeing this as the main goal of the relationship. There was also recognition of the impact that the nurse could have on patients' well-being.

> *"It's how we interact with our patients and how they interact with us, with the end goal aiming to improve the condition that they are in hospital with."*

Ensuring that the patient was comfortable, both physically and emotionally, recognising and meeting patients' needs, were seen as being important factors in improving patient outcomes.

"[…] but it all comes down to the fact that when the patient is comfortable they get better quicker."

"I think having a therapeutic relationship with a patient adds so much to their time in the hospital."

"A therapeutic relationship for me is that when the patient gets something out of the relationship, in that they are able to communicate their needs, and their needs will be satisfied by the nurse."

Students recognised that having a relationship with the family was also important, especially when the patient had a serious illness. Again, examples were given from clinical placement.

"I think if you're having the therapeutic relationship with the family, it's almost a therapeutic relationship with the patient anyway, because that's their closest people so if you have a relationship with them you have a relationship with the patient."

"My mentor wasn't just there to go see the husband and make sure all his medical needs are alright, she would sit down with both of them [the patient's wife], *talk about other aspects of their lives and if everything else was ok and em […]. I guess that's something else about building up a therapeutic relationship, it's not all medical stuff."*

When prompted about the importance of including the patient's wife the student could see the importance of addressing the needs of the patient's family as well.

"Yeah it was the family as well, my mentor had a really good bond with both, which made them feel a lot more comfortable."

Another student reported that the relationship between the nurse and the family continued to be of benefit to the family even after the patient had died.

> *"[…]My mentor was really good at talking to the relatives and telling them what to expect early on. When the patient passed away, the relatives coped very well. Part of that was because of the way my mentor was, and the communication that went on between them. That was very good communication."*

Students were able to see that when clinical staff did have a good relationship with the patient they were able to motivate them. They could see that this facilitated the patient's recovery and helped the patient to regain independence.

> *"A lot of them* [patients] *didn't want to do what he* [physiotherapist] *was asking, like trying to stand up or walk, but he always managed to get them to in the end; he made it funny, he made it really informal, even though he was always noting down what they could do, maybe his milestones […]. It would have been so easy for him, I think, just to leave them for the day if they didn't want to get out their chair […] but he always managed to coax them around."*

When asked how the student thought he was able to do to that she found it a bit difficult to explain. However the student could clearly identify that it was the approach taken by the clinician that was key to motivating and encouraging the patients.

> *"I don't know […]. It was his whole manner; he was energetic, enthusiastic,* [another student - 'making time for the patients'] *yeah […]* [same student – 'encouraging'] *yeah really encouraging […]. He was really happy, and sometimes when patients are so depressed, it's hard to chivvy them up. I think it's because he was so enthusiastic and funny. He would stand there and say 'Imagine I'm George Clooney, just take that extra step'* [lots of voices] 'it would work for us' [laughter].

If you're making them feel comfortable, communicating in a way that they want you to, just putting them at ease, it helps […] and maybe speeds up […] getting out of hospital, and getting back into their own routine […].Better to get into the home environment, […] better for them."

"Like getting their independence back."

Some students recognised that the relationship could be mutually beneficial, and that by helping the patient they got something from the process themselves.

"Therapeutic relationships; you are making someone better, maybe even at the same time you can make yourself feel better, a sort of mutual benefit between the two."

"To make me feel good, I make them feel good, and hopefully that helps things along."

4.5 Responses to direct prompts

This section will report on the responses students gave to more direct prompting. These are reported as pre-determined themes rather than emergent themes as above.

4.5.1 The role of the mentor and other clinical staff

This section of the interview explored the impact of observing the practice of other clinical staff, including mentors. Students were able to recognise good practice and one student, when discussing an interaction between a nurse and a patient, said that her thoughts at the time had been, *"I'd like to be able to do that."* This was echoed by other students with comments such as *"it makes me want to try harder to achieve", "I strive to be better"* and *"I want to become the best."*

Many of the important aspects of communication and behaviours that contributed to the development of the therapeutic relationship, previously identified, were recognised and admired in other clinical staff. Although this did remind the students

that they still had a lot to learn, they recognised that they were learning skills that they would be able to use in developing their own practice.

"I want to be able to have that rapport with patients because I think it makes life easier for the patient and the nurse."

"It's like having a role model, you want to be just like them when you qualify, because you can see what good they do to the patients, and you try harder and one day you will be able to achieve that after practice."

"I agree with the role model concept, but I also think it makes you realise how much further you've still got to go [general laughter and agreement] *but there's a lot to work towards, and see how many skills you need to build up."*

This student recognised empathic behaviour in the nurse who was able to understand what the patient's wife might need and responded appropriately. The student saw this as something that she would like to emulate.

"The man had went into hospital, and his wife was on her own, so the mentor went in to check on her, which I thought was a really nice touch. I don't know if that was out with her role, but she didn't have to go in […]. It would be nice to be a nurse like that, that really cares for the patients or their families."

Students were also able to recognise when these qualities were not evident in the nurse and the impact this had on patients.

"I'm not saying she was a bad nurse, she was a brilliant nurse, she had a fantastic knowledge base, absolutely everything you could wish for practically as a nurse, but she didn't have that rapport with the patients, they didn't tell her as much, they didn't particularly like her as much."

"A lot of the patients didn't really like her or trust her which was unfair in a way, because she was such a good nurse, but it was just that rapport added so much to the role."

Students recognised that good nurses were able to adapt to the needs of the patient. This student was talking about a staff nurse who was very efficient and always busy, getting things done.

"It was almost as though she slowed down, and went down to the same level as the patient. She took plenty of time to talk things through and asked about understanding, […] in a very approachable and gentle manner, very deliberate. […] By looking at the expressions of the patient and the relatives, you could tell they seemed to become less stressed, and less tense, generally more content because they had been informed in a nice way, generally happier."

Another student was with a nurse who was having a difficult conversation with a patient about his drug taking. The student recognised how the skilful questioning by the nurse enabled the patient to tell their story.

"I was listening to the conversation, and there […]. What I was struck about was how the nurse […] how she asked the questions […]. It's more facilitating the patient to get out what would be his reason why […] they didn't want to tell their doctor about the drugs."

One of the things recognised by students was the importance of not having pre-conceived ideas about patients, the importance of the nurse having a degree of self awareness and not allowing prejudices to influence care.

"What I learned from most of my mentors, and even other nurses […] that […] are really good nurses. They don't have pre-conceived ideas and if they do, they don't seem to display it […]. I think it's very important, especially when you are dealing with difficult patients, difficult behaviours […]."

As well as qualified nursing staff, students also observed good relationships between other members of the health care team and patients.

> *"The health care assistants are really good, in the sense that it's a lot more informal. They have the time […]. It's not like they're not busy but because it's so informal you can see that the patients trust them."*

Another student described the interaction between a radiographer and a patient who was very anxious about having a scan.

> *"She* [radiographer] *was so good, and talked everything through. Every test she explained what she was doing and why she was doing it […]. I know she made the lady feel much better, and afterwards the old lady did say to me, that wasn't that bad was it! No, […] it could have been, but this woman* [radiographer] *really handled the situation well*."

When asked if she could identify what she thought the radiographer had done that made things better for the patient, she found it difficult to articulate but recognised that having an ability to make the patient feel comfortable, be reassuring and explain things was important.

> *"It was her general aura. She was so relaxed, making jokes. When she came in she just chatted to the lady first, she didn't go straight into this is why you're here and this is what we're doing. It was just general chat at first, making the lady comfortable."*

4.5.2 Impact of teaching

All the students felt that it had been really important to have had theoretical teaching prior to going out on clinical placement.

"I think it helps having learned about communication and therapeutic relationships because when you're out on placement, you do have that in the back of your head, and you know what's ok to do, and what's not. It gives you that bit more confidence."

"[…] It's important now that you have the communication knowledge before you go into the clinical placement, […] you can think about what you're doing, apply it, and see how it works, […] evaluate how you communicate with people, and what you can improve on."

It was evident that the teaching that the students had received prior to any clinical placement had already had an impact as students were able to recognise poor practice in relation to communication.

"On my first placement […] I saw really bad communication, and I thought back to class, and was constantly thinking, how can these people be doing that, when they have been taught the same as me? I've been taught all this stuff, and I want to apply it, and it made me think, how can they not do that?"

One of the aspects of communication that students often worry about is what to do when they don't know the answer to a question. This was explored in class and would appear to have helped with this particular anxiety.

"I was quite nervous in case they came out with an awkward question I couldn't answer, and you're put on the spot about it, but then you are given more confidence to be able to say that you don't know but you can find out for them, without coming across as not caring."

Students were asked if there was any aspect of the teaching that they had found particularly helpful. What had evidently been particularly useful was learning about effective listening and how to use silence, giving the patient space and time.

"I think I listen more […] more effective listening […]. Obviously when you are with the patient, obviously you're trying to pick up clues and hints about how they're feeling about treatment."

"[…] I find that silence isn't a big problem, and you can sit there for a second and just let there be a silence. Sometimes it's really beneficial to the patient, although it can feel like a lifetime that you're sitting there, but it's not actually, and sometimes it's needed for people to think about things."

"Yes definitely. Just knowing when not to go on, and use the nervous chat!"

"Knowing if the patient was upset, not trying to explain […] but just to give them that moment to just think about it themselves […]. If they have any questions, they can […] ask, instead of you barging in and not letting them speak."

"Especially with relatives […], because that was one of the things I was most apprehensive about. We've had a couple of lessons on it that I've found beneficial."

Students also found learning about how to use open questions very important and could see how that would be beneficial in exploring how patients might be feeling.

"I didn't know there was types of questions [incredulous tone, laughter and nods of agreement from the rest of the group]. *So it was helpful, […] especially before I went on placement for the first time […]. You are aware of the questions you should be asking, you don't ask are you fine, you ask how you are feeling. It really was helpful, because maybe it improved the relationship with the patient […]."*

When asked what was more important, teaching or clinical placement, in relation to learning about communication skills and the therapeutic relationship, students

reported that both were necessary. Theory supported their learning in clinical practice and provided a base from which they could develop.

"As much as you could do it all on clinical placement, the teaching we get affects how we do it […]. If you didn't have the teaching beforehand, you wouldn't be doing it in the same way, so they both kind of improve each other."

"And each time you have another communication class you think 'in my last placement I did that, so the next time I can do that' and it's a constant kind of improvement."

4.5.3 Personal experience

Students were asked if they had undergone any personal experiences, such as having been in receipt of care themselves, or perhaps seeing a loved one cared for, that had influenced their development or understanding of the therapeutic relationship. No student volunteered any information. They did give some examples of using their skills in other aspects of their lives. This student describes a situation that she now handles differently and demonstrates a developing self awareness and a more respectful approach to customers.

"[…] You start transferring it to other parts of your life […]. I work part time in a shop, in customer services, which is a horrible place to work [general laughter]. *Most people love it up there but it's horrible. You start using communication skills up there and are building better relationships with customers. Although you don't have them as long as you have most patients, you start thinking well, maybe I could say this, you start to think about them […] as a person, rather than someone returning with a naff shirt!"* [General laughter.]

"Sometimes you sit back and think, I've handled that situation differently, because of what I've done over the last fourteen months being on the nursing course'."

However, it is important to note that however tempted one might be to attribute these developments to teaching on the course, it is likely that some of this development in confidence and skill may have occurred as a result of increasing maturity and life experience.

4.5.4 Reflection

Students on the nursing course are expected to maintain a reflective portfolio throughout their training and were asked if using this method of reflection had been helpful in developing the therapeutic relationship. Overall, most students believed that reflection could help them to improve and develop both their skills and their confidence and this was articulated by one student as *"yes […], I can do better next time*". However, most students admitted that they did not do much written reflection, but reported that they did a lot of reflection internally. Lack of time and fatigue were cited as the most common reasons for not maintaining the written portfolio. A couple of students admitted that they felt self conscious writing things down.

> *"I reflect a lot in my head, but when I get home from my 12 hour shift, and you're knackered, want something to eat, and put your feet up in front of the telly, the last thing you want to do is write a reflective, then time goes on."*

> *"[…] Sometimes you feel that something you might think is very reflective, and it comes to the University looking at your portfolio, or the NMC, they could be like, 'She wrote about that?' You sometimes feel a wee bit self conscious."*

> *"You feel like you need something groundbreaking"* [general laughter and nods of agreement]

A number of students mostly recorded the poor practice that they had observed rather than reflecting on things that they may have done well and saw this as a useful way of learning.

"Situations where I've felt, 'Oh what's happened here?' It's not been the good communication. It's not been the good examples; it's always been the bad ones, because they are the ones that have stuck out."

"I think it's easier to reflect on something somebody else has done wrong, rather than something I have done right. […] You write about other people's therapeutic relationships and how you can use that to improve your own therapeutic relationships with patients, if that makes sense."

Students were more inclined to record the practical nursing skills they were learning or used the portfolio as a diary rather than reflecting on their patient interactions. Some of the comments appeared to suggest an anxiety about the perceived relative value of communication vis-á-vis the technical aspects of care provision.

"[…] Sometimes if you say you had a good conversation with a patient, and you reflect on it, people might think is that all you do […]. Sometimes as a student nurse you feel like the bigger things, such as your first catheterisation, that's well in there with the portfolio! [Lots of laughter.] *But your first good conversation with a patient isn't quite as interesting, so you sometimes feel like it's something you can reflect on personally and you don't have to write it up."*

There were a few students who did keep a written portfolio and they found this to be a useful way to record their own progress and develop confidence and self awareness.

"It's a good thing to look back on because comparing myself now to when I started my first placement […], you would notice a big change in your approaches to patients and your confidence."

"Yes, you're developing from situations you've been in; whether you've not done so well, you can do it better the next time."

Most of the students agreed that the most helpful way to reflect was to discuss things with colleagues and friends who were also student nurses. This kind of discussion was often followed by mulling things over later.

"Well, I live with X, and every time I come in from a shift, we literally spend the rest of the night talking about it."

"Then as soon as I go to bed, I'll be thinking, 'Hang on, X said this is what she did, and this is what I did' etc. If X says something I'll be like, 'oh […] maybe I should do that, maybe I should start doing that' […]. I always think that as soon as I go to bed, what I would do the next day […] I would improve."

One student, although they did use the portfolio to record incidents and found that useful, felt that direct feedback from a mentor or other member of staff was more helpful in facilitating learning.

"[…] What would be more useful is if someone else commented on how you have interacted with patients, i.e. getting detailed feedback from your mentor, for example, 'I watched X do this with a patient today; this is what was good about it' […]."

"I was just going to back up X's point, on mentors giving feedback as well. […] .I thought I was being polite by standing, not acting as though it's my own house. […] but my mentor said, 'they know you're human, it's ok if you crumple their cushions'. Obviously that maybe puts them at ease, and thinking back I thought that it's right, so I'm glad I was given that kind of feedback."

4.6 Group interview two

The second group interview was conducted fourteen months after the first. At this stage, the students had experienced another full year of both teaching and clinical experience. As before, the findings represent the views of all study participants as

there was consensus within the group in most areas. Any area where there was disagreement will be clearly identified. The same systematic approach was adopted for the analysis. This time the researcher was not only looking for new emerging themes, but checking to see if the same themes were still present.

4.6.1 Main focus of the discussion

The main focus of the discussion was exploring the students' understanding of the therapeutic relationship and what contributed to its development. In addition, they were asked if they were aware of stages within the relationship. Analysis of the data confirmed that the same four themes were still present, although in some themes there were additional sub-categories. As there were no new sub-categories reported in *'benefits to patient and practitioner'*, this theme is not reported again. One new theme emerged, which was professionalism. This theme and sub-categories, as well as new sub-categories of previous themes, can be seen in table nine. Sub-categories are expressed in single words or phrases and evidenced by direct quotes from participants. Additional paralinguistic language taken from field notes is included where relevant and bracketed in un-italicised text. As before, the themes have been allocated colours to facilitate locating the text in the appendices and are consistent with the colours used previously.

Table nine **Themes - group interview two**	
Core themes (construct)	**Related codes (reality)**
Trust *"I think one of the most fundamental things, is trust"*	Building trust Keeping promises and not letting patients down
Effective communication *"no communication, no relationship"*	Confidence in communicating
The nature of the relationship *"extra kind of relationship*	Building the relationship Purpose of the relationship
Professionalism *"you feel more professional"*	Working within boundaries Insight into own impact Professional knowledge Not taking things personally Self awareness Gaining respect and trust Professional behaviour

4.6.2 Trust

This theme was again the first thing to emerge from the discussion and students appeared to have more understanding that this was something that needed to be developed. It has therefore been identified as a new sub-category. A second new sub-category was the importance of keeping promises and not letting patients down.

It was considered important that the nurse demonstrated a willingness to engage with patients. Students were aware that patients knew who they could and could not trust.

"The patient feels they've got some trust, […] they can maybe ask you some things. It's only certain nurses they feel they can ask, that they feel it would be ok, that it's not an effort to do something."

This had positive benefits as it would enable the patient to open up to the nurse.

"If you build the trust it's more likely that they will open up to you."

"If they can talk to the nurse then they've got a better chance of a successful recovery and getting out of hospital earlier."

Introductions and providing explanations to patients were seen as important first stages in the relationship and necessary to building trust. Again, this is indicative of behaviours associated with respect. This student described the admission of a patient to hospital.

"[…] You don't know who anybody is and they're like moving you on to a bed and what have you, and like no-one stops for a minute and says like listen, 'I'm the staff nurse, I'm the student nurse, like, my name's this […]' sorta like you stop and think about these things and that puts the whole relationship on to a better star. […], just someone taking the time to explain to him."

Students also demonstrated an awareness of respecting patients' privacy and dignity as being important to the development of trust.

" *[…] If you're gonna ask them these personal questions, maybe in a roomful of other people, then they're gonna be less likely to trust you and to tell you things, so try and maintain their privacy and dignity."*

"You might find that they're really embarrassed […] saying things in a four bedded room, […] a bit more private makes it a bit more easier. I don't, to kinda allow them to talk with anyone else hearing."

The importance of keeping promises to patients and not letting them down was also seen as important in the first stage in the relationship. Students also recognised that a failure to keep promises might prevent nurses from getting necessary information from the patient.

"I think it's also doing what you say you're going to do ….]. If you say 'I've got five minutes to do this but I'll come back to you when I've got more time'

and you go back to them […]. That's really important 'cause obviously if you don't then they're […] not gonna tell you other things either, so I think that's quite important for the first stage as well."

This was also seen as the nurse's responsibility in prioritising his/her time. Keeping promises was linked to making the patient feel respected and valued, and was important in establishing trust. This also reflected students' beliefs about a holistic approach expressed in group interview one.

"[…] You need to be able to prioritise your time. Then the patients feel valued and they feel important, they don't just feel they're a task for the day […]. You're making them feel valued, […] making them feel listened to and that their needs are your priority. So they start to trust you, they start to see you as a person that's gonna help them instead of a person who just sees the patient."

Apologising to patients when they did fail to meet their needs or keep promises was also seen as important and indicative of respect, even when they had not intended to forget. The following dialogue between two students indicates the difficulties of competing priorities and keeping promises to patients. However, there was also recognition that admitting that you have made a mistake or let someone down takes courage.

"I hate to admit that I've done it but if a patient has asked me maybe for a jug of water I'll say,'Just give me a wee minute I'll go and get that just now, someone else's buzzed they need a commode', you know, it's prioritising patients, you do […] it but I've forgotten about a couple of patients to get them their water then they see that as 'that person broke their promise to me […] am not gonna ask her again, I'll get someone else to do it […]" [interrupted by another student].

"*In that situation I would say that it's important that you go and apologise* [previous student agrees, nods of agreement from the rest of the group] *and*

that you try to minimise the damage that might have been done to that therapeutic relationship. […] the patient might not have seen that you are busy or the next ten minutes, that you're back and forth and some patients will understand that, some don't […]."

"Go back and apologise, 'cause that can make everything ok again […]. It is usually far better for you to admit that you've made a mistake than have somebody else come and say you did that wrong. It takes personal courage to say, 'I made a mistake, I did that wrong'."

4.6.3 Communication

It was evident that the students were more convinced than previously of the important role good communication played in developing the therapeutic relationship.

"It's probably the most important thing" [nods of agreement].

"It's probably the basis of the whole thing [more nods of agreement accompanied by murmuring indicating assent]. [Facilitator: "Ok, I think that's consensus, soft laughter"].

One new sub-category emerged in this theme and was related to the students' increased confidence in their abilities to communicate. They were less self conscious about how they were communicating and could get on with identifying what the patients' needs might be. This included coping with difficulties such as language barriers.

"Language, if somebody can't speak English it's obviously more difficult […]. I think it's one of the most difficult things. I think it's something that's difficult but you get better over the years with practice […]. Try and look at everything, try to grasp some understanding of what they're trying to say, […] trying different options like asking different questions, looking for a yes no response

[…] hand signals" [chuckling from the group, someone says "miming", student nods in agreement].

"[…] You've got more confidence, particularly if the patient can't communicate back with you, you feel more confident goin in and communicating with them, […] thinking of different ways to communicate."

For most students this confidence had been gained by having a successful experience. They had the satisfaction of knowing that the interaction had been of benefit to the patient. They also recognised that their skills in communication meant that they were better able to obtain information from patients and recognise patients' cues.

"[…] Until about halfway through second year I needed quite a lot of support and then I remember I had a difficult conversation with a patient and then I felt that my confidence increased 'cause I felt like I'd made effective communication. I'd made that patient feel better. Since then I've felt that I have had the confidence to build a therapeutic relationship with a patient away from my mentor, you know, just myself […] so."

"You know what you're doing. You feel you can go ahead and do it without having that prompt […]."

"I think you can ask better questions as well [another student agrees, the rest of the group nod in agreement] *you can pick up as well on small things that the patient does as well better and know the significance of it*" [agreement from the group].

4.6.4 The nature of the relationship

There were two new sub-categories that emerged in this theme. These were the recognition that the therapeutic relationship had purpose and that, contrary to what had been suggested in group interview one, "*It just happens, you don't spend that*

much time consciously thinking about it, it just starts developing", it was evident that students were thinking more about how to build and develop the relationship and what strategies would be needed to achieve that.

> *"I think it's important for the nurse to make themselves available, especially when you're initiating something, you want your patients to feel that they can speak to you […]."*

> *"It's so important to build it up kinda slowly. Start off with quite kind of simple questions about their day to day life* [general agreement accompanied by nods] *or more factual based questions then you can go into the more difficult questions, the more sensitive questions until they trust you a little bit more […].*

> *"[…] When you get further on in the relationship I think, as well, reassurance is really important especially if they are really ill. You can see that […] somebody's getting ill and they're starting to withdraw from the other patients you have to try to speak to them and reassure them again […]."*

Students also recognised that how they approached patients was important and required some thought, recognising that each patient was an individual.

> *"You can't approach the patient […] with the same phrase, it's not like you're a robot or anything* [laughter from the group], *it takes a lot of thought walking up to a patient. It doesn't seem like it does, but it does* [everybody agrees verbally and nodding heads]. *You're trying to work out what kind of person they are […]."*

Some students also felt that their own increasing comfort with the clinical environment helped them to feel more confident in developing relationships with patients.

"I think it's also about us being more comfortable in the environment as well [nods and mutterings of agreement]. *I think it was all quite a scary new place* [another student: "*yes"*], *even in second year we still didn't feel that comfortable* [same student: "yes"]. *If you're more relaxed […] then you can then make the patient feel more relaxed* [another student: "mhm"] *then you can build a relationship more easily."*

"The more relaxed we are, and the more natural we act, I think that makes a big difference in terms of getting a genuine relationship with patients. Probably just to trust ourselves, be confident."

"I think […] because you've had a bit more experience, you know kinda how to better communicate things to patients and how to handle things. And not be as […] frightened to, like, talk about some things and ask more questions […] to build that better relationship."

There was also recognition by the students that the relationship, however pleasant, was a relationship with a definite purpose.

"It's about developing a relationship where you can work with the patient, it's not just because you want to be nice to the patient, […] you want to help that patient […] it's about building trust so that you or another member of nursing or medical staff wants to do an intervention […] potentially an unpleasant intervention, that they trust you that it will all be for their good, […] you work together for the betterment of the patient."

"I suppose the next stage is quite factual, you need to then get some basic facts about the patient before you can build any more."

"[…] Getting to know their background, any social aspects like maybe communicating with their family […] learning more about them and asking more questions. […] and you find out more information, […] their progress is better

within the hospital, if there's anything underlying they feel comfortable to tell you."

The students recognised that some patients may be reluctant to communicate but that it was the nurse's responsibility to find a way of eliciting information. Sometimes it may be that the timing is not right or it may be they would respond better to another nurse. They also recognised that there might be important reasons why the patient might not be communicating and that it was important to find these out.

"[…] If the patient is not talking it might be something underlying […], they might have gone through something traumatic, […] they may be just frightened, they maybe don't know […]how to talk to you […] and you're like a stranger to them. […] Is there anything you can do like contact family, bring the family in […] if it makes the situation easier, em, […] it's not always that the patient doesn't want to talk, it could be something behind it that you need to, you maybe need to kinda suss out a wee bit."

"At other times you get the people who just clearly don't want to talk to you so ok fine I'll come back later on, you go and deal with another patient and then come back in half an hour or get another nurse to come and see if they can get a better rapport going."

4.6.5 Professionalism

The new theme that emerged from the second group interview was professionalism. Students were beginning to identify with the idea of becoming a professional nurse.

"You feel more professional."

"Professionalism, [...] I think that's really quite important."

The students were beginning to identify that it was important to recognise that there were boundaries to the relationship. This seemed to be related to the sub category

identified in the previous theme regarding the purpose of the relationship. The difficulty in maintaining boundaries was also identified, especially when there was a good relationship with the nurse.

"I think it's important that it's kept professional. Sometimes you can feel emotionally attached to your patient […] more than you should do so it's kind of important to remind yourself that you're looking after them […]."

"They can seem like a friend some of the time, it's hard to draw that boundary, they ask you so many things about your own life so you think […] they don't ask the other nurses" [lots of laughter and nods of agreement].

The development of professional knowledge was important in helping establish good relationships with patients and enabled the students to feel more confident and more professional.

"They have to think, as well, that you are knowledgeable and know the answers. They have to have faith in you, there's no point in them asking you questions if you don't know the answers. You need to have the ability to answer the question."

"You can just talk to patients because you understand more about their disease processes, you actually feel a bit more professional, 'cause you do have a bit of knowledge."

"I guess you start thinking more about the importance of […] when you're having a conversation […]. Someone says like 'oh, I've had a cough', in first year I might have said 'oh yeah you've got a cough', whereas now I'd be saying, 'you've got a cough, how long have you had that cough for? Have you been producing sputum', then you start thinking about all the theory you've been doing in uni of why do they have the cough, do they smoke?"

"You can […] with what questions you ask and what you take from a conversation rather than it just being a conversation […] that you just walk

away from thinking 'ah that was a nice conversation'. You start thinking 'well, she said this, that means she might need this medication' or 'that's why she's on that medication', you can connect more."

Students demonstrated recognition of their own growth in self awareness and maturity in relation to how they identified and responded to patients' needs. There is evidence here of empathy in the students where they recognise the need and respond in a way that the patient can understand.

"I'd never seen a female catheter being done before so I was quite excited to see what was happening [laughter from the group]. *But then I saw how terrified she* [the patient] *was […]. I went up to her head and started chatting to her, I thought, no, I can't let her sit there all by herself. I was, […] I was quite proud of myself. I thought, stuff my learning, I can see that again later, I want to make sure my patient is ok. I was like, […] I've grown a little bit* [lots of laughter from the group]; *I'm not as selfish anymore. But it's just little things like that that make you realise* [Facilitator: "how far you've come?"]. *Yes, maybe, in first year I would've been 'I want to see this' […] but I thought 'no, no, the patient comes first'. I can learn about this later on […]."*

This was also reflected in how they dealt with patient interactions that were not as positive, learning how not to take things personally and recognising that the patients' conditions may affect how they feel and respond to nurses. This student is describing a patient who was elderly and quite unwell.

"[…] She was almost aggressive with the staff. And it was literally very obvious that if the lady was in that sort of mood then ok, that's fine, I'll come back and see you later. About ten minutes later another member of staff […] and she's very cooperative and I'm thinking 'what did I do?' And sometimes it's not because you've done something wrong, it's because just at that particular moment in time nobody was going to get a positive response out of that patient […] [soft laughter from the group, nods of understanding] *[…]. A degree of*

resilience is required […], most of the time it's not personal it's just 'that nurse that happens to be in front of me right now' […]; it isn't because it's me as a person […]."

Students unanimously identified nurses' attitudes and professional behaviours as being of major importance in developing good relationships with patients. Even though there may be initially an automatic feeling of trust between patients and staff, professional behaviour was essential to maintaining that respect and trust. This included how staff behaved with each other and how they were seen to treat other patients.

"[…] There'll probably be an initial degree where they're expecting all of the staff nurses, health care assistants, medical staff, to be professional […], therefore to continue to get that respect and trust then even things like your appearance, […] your attitude from staff member to staff member and from staff member to patient and to other patients."

"If they see you dealing with another patient then that will probably affect them, how they perceive you are. 'Am I going to listen to this nurse, […] if he tells me to do this is that just because it's going make his life easier or is it because it's good for me?'"

"[…] Then if they hear you 'slagging' off your colleagues then that will potentially bring you down a little bit in their estimation."

There was recognition that patients were able to discern quite quickly who they could trust. Students also realised the impact their own attitude and manner could have on the patient, which demonstrated a degree of self awareness.

"Patients have that they quickly realise who [...] they can trust, who they can ask a question or who, they'll either answer it or tell them they'll get someone [...]. We all learn quickly who we can go and talk to."

"I think it's just always a reminder, to have it in the front of your head. That even, […] obviously everyone has off days, you can't go in being happy every day in life but just to remember that, like, your actions can kinda change someone's day."

4.7 Responses to direct prompts

This section will report on the responses students gave to more direct prompting. These are reported as pre-determined themes rather than emergent themes as above.

4.7.1 Barriers and facilitators

Students were asked if they were aware of specific barriers or facilitators to developing the therapeutic relationship. These were often related to the attitude and behaviour of the nurse. However, there were other barriers and facilitators that the students identified, such as the signals that the nurse sent out through their body language.

"Body language as well is quite a biggie, if you're always charging about with your head down then clearly [...] [laughter from the group] *[…] people don't feel they can ask you for something […]."*

"[...] To be patient [...] just to have a general good attitude [audible agreement from another student, nods from everyone else]. *You know when someone asks you to do something, just be more than happy to do it and not walk out and just say yes [...] and go 'oh for God's sake he's asked me to do that again'* [another student: *"*I know*"*] *and just be happy to help people* [said with emotion and a degree of frustration] *and not hold it against them"* [another student: "no", nods of agreement from the group].

This discussion was around a particular behaviour that the students had noticed and expressed incredulity that nurses demonstrated this type of behaviour. They recognised the effect this might have on patients' willingness to approach staff.

"[...]Tutting and sighing, never good. I wouldn't even pick one nurse I've seen so many nurses and they get asked something and they're like, [student gives a demonstration of tutting and sighing] *right in front of the patient!"* [incredulous tone]. Facilitator: "Do they both go together, the tut and the sigh?"

"*Yes, always* [laughter and nods of agreement from the rest of the group], *obviously the patients feel that they shouldn't have asked, 'I shouldn't have said anything'"* [referring to the patient].

Other students recognised that not only body language but the way the nurse spoke had an impact on patients' willingness to seek help.

"When a patient buzzes and the nurse says 'what do you want this time?' [laughter and knowing nods signifying recognition of this behaviour], *it's like 'you're buzzing too much, stop it now'. That's what she's saying but not in those words. Patients pick up on that and then they're frightened to buzz again*."

Students acknowledged that nurses could actually be busy and that patients recognised that and sometimes didn't ask for things, such as pain medication, when they needed it. These students were discussing how upset they felt when they realised a patient was in pain and did not call for the nurse. This first student is also demonstrating self awareness and is honest about her momentary feelings of dismay.

"It's when patients are in pain or they want something and they don't buzz 'cause they know you're really busy [agreement and sounds of dismay]. *You know so you're always trying to get patients [...] though when you hear a buzzer your heart does sink*." [loud laughter, second voice: "and nobody else gets up", more laughter]. *[...] You'll go round at medicines and you ask them about a pain killer and they say 'I was wanting it earlier but I didn't buzz*

'cause I didn't want to annoy you', [...] you think, they shouldn't have to feel like that" [general agreement].

They did recognise that encouraging patients to ask for things when they needed them could sometimes be frustrating when you have a lot of other things to do. Prioritising and managing your time better was seen as a possible way to overcome this.

"[...] Time constraints are so hard in this job so you are really conscious, especially when you've got like nurses going like [makes a sign like pointing to a watch] *outside the window you're just like 'oh', I mean you can't really keep looking at the clock 'cause that just sends totally the wrong impression but constantly in your mind you're thinking I really need to get this done. So [...] patients pick up on it, [...] they know when you're talking to them that you've got things running through your mind."*

"If they think you're too busy [...] patients will ask you to do something then they'll say 'I know you're busy' but really it's just a bit like how you manage your time […] constructively with the patients. You just try and make the time. If they see that you are running around they might just not want to bother you and not call you at all then."

Although previously students had recognised the importance of families within the therapeutic relationship, they did express the view that families could sometimes pose a barrier. Either the patient would be less than honest or, in some instances, the family member would speak for the patient.

"It's bad to say but sometimes relatives can be an obstacle as well [...]. Sometimes the patient will just say anything just to keep them happy even if it's not what they're feeling. You can tell if you spent any time with them that they don't really mean it but they just wanna say it to keep the whole family happy" [nods of agreement from the group].

"Or the relative speaks for the patient."

"Yeah, the relative speaks for the patient" [the rest of the group agree and nod, followed by laughter].

Students also recognised that the ward culture could be both a barrier and a facilitator depending on the attitude of the staff.

"It's interesting, sometimes it's the culture of the ward, [...] if other nurses, like, think it's important. Like I've been on wards where every, well most of the nurses are making therapeutic relationships and speaking to patients, getting to know them and there's other places where it doesn't happen and it's just kinda the culture of the ward that they're less bothered about it, but other places that's much more of a priority to them and so you'd stand out more if you weren't engaging with patients."

"[...] Sometimes other nurses as well. You might have a good relationship with the patient but the other nurse might not have that relationship with them and, em, […] it makes it difficult for you to talk to the patient when the nurse is there, so the nurse can get in the way" [loud laughter from the group].

Pre-conceived beliefs about the patients and the attitudes of nurses to particular groups of patients were also seen as barriers. Students recognised that this sometimes negatively influenced how they would interact with the patient.

"[...] they'll say 'he's a funny wee man' [everybody agrees verbally and nodding heads, followed by laughter and knowing looks]. *Most of the people they say are funny I find perfectly normal. I don't know if it's a thing you develop when you're a nurse that everyone becomes really odd!"* [More laughter]

"But if enough nurses come and tell you that this patient is a bit strange, you start to kind of [...] if you've not met this patient before you have a pre-conceived idea of what this person is like before you even meet them and that can sometimes, it can make you be a bit cautious about approaching that person."

"[...] If you have kinda been talking to a patient and the nurse goes 'oh, don't believe a word he says, he tells lies'. Well actually I had a really good conversation with him and he told me all of this stuff and I felt that it was completely genuine" [another student: "it casts a wee bit of doubt"]. *"Yeah, and then you start doubting, well is that true? And then that really does affect you* [another student: "the trust is gone"]. Y*es, that really does affect it."*

"I have seen the biases of nurses towards certain patients or groups of patients, say drug addiction or alcohol problems,that nurses are cold […] to this group of patients, so that kind of attitude would not facilitate a good therapeutic relationship."

Age and gender were also seen by students as potential barriers.

"I think their age and their gender compared to yourself might make it difficult, em,[...] male patients may not want to divulge something to a young female nurse for example, or a woman of any age, em [...]."

"[...] Older males and males of any age usually have this pride that they can't, 'oh how are you doing', 'oh, everything's absolutely fine', but it's not all, they have this pride that they have to uphold [another student agrees], *they don't say."*

There followed some discussion as to whether this was more common in men than in women as some felt that some women could also be a bit reticent. However, there was general agreement that it was more common in men except perhaps when female

patients were interacting with male nurses or among elderly women with young nurses.

> *"Female patients do that with male nurses, like they won't want a male nurse to wash them [....]"* [two other students agree].

> *"I find it quite common in elderly women who apologise to you, 'I'm sorry a young thing like you having to take care of me,* [nods and verbal agreement from everyone] *it must be terrible for you'"* [more agreement].

Language and difficulties with communication were also seen as potential barriers. This included where patients, either couldn't speak English or there was some physical or cognitive impairment that compromised communication.

> *"Language ,[…] if somebody can't speak English it's obviously more difficult to follow a conversation and have the same relationship."*

> *"There could be some sort of disease that they can't communicate [...]. I know I've had a couple of patients who […]. I think it was cerebral ataxia that the lady had and she was very very difficult to listen to, em, her words were all jumbled up and she got very frustrated because we couldn't understand what she was asking, and you felt horrible [...]."*

A few students felt that cultural diversity was also a potential barrier.

> *"Cultural diversity as well, it doesn't happen often, it could even happen within our own culture, Scottish culture, particularly with Asian patients. A lot of the female patients don't particularly want a male nurse and on one occasion I've seen an Asian gentleman who didn't want a female nurse [...]."*

Students were able to recognise that the opposite behaviours to those perceived to be barriers were facilitators of a good relationship, such as making time for patients even when busy.

> *"I think making patients feel like the nurse has all the time in the world for them* [audible agreement from another student, nods from everyone else] *even though the nurse doesn't at all, they're under pressure to get stuff done"* [audible agreement from a different student, nods from everyone else].

> *"I think it's important for the nurse to make themselves available, especially when you're initiating something. You want your patients to feel that they can speak to you, like, so I think it's important to make them feel like that in the first place."*

Some students found that if they could establish a connection with the patient through mutual interests, this helped at the beginning of the relationship. Giving patients some degree of choice was also important.

> *"I think something that makes it easier is if you've got, like, mutual interests and they find out that they like something that you're really interested in and that makes it so much easier to have a conversation with them, [...] something […] that you can have a normal conversation about and that builds up a relationship before moving on to the more sort of 'nursey' things."*

> *"I think something that makes it easier is giving the patient choice as well [...]. I think that makes it a lot easier for them to like you. For them to feel like that nurse is genuinely here to help me, is here to make me feel comfortable, make me feel good in the hospital setting."*

When discussing the personal attributes of the nurse, students overwhelmingly identified the importance of not only being compassionate, but communicating this

to the patient. Having patience was seen as being important, even when this was difficult, and being open was identified as an important quality in the nurse.

"You need to be compassionate and you need to be identifiably compassionate because the patients will see who you are and you're not automatically respected. It all comes back to respect and trust and if they think you genuinely want them to get better and you're doing the best you can for them even if it's not […] what your doing isn't great you might go from a nine to an eight on the pain score but they understand that that's as much as you can do."

"Patience, you need to have a lot of patience with patients [soft laughter] *em….they can be very demanding and rightfully so, this is their life […] they're the one that's sick […]. Definitely I think that's something I've adopted over the past couple of years, patience."*

"I think openness is important, […] how you approach someone, the way that you speak to someone on the same level with them. If they ask you something about yourself, you give them a quick response so that they see you're giving something back."

4.7.2 The role of the mentor and other clinical staff

Students were asked about examples they had seen while on clinical placement. In group interview one most of the examples were very positive. In the second group interview there were more examples of poor practice, which may indicate that at this later stage in training, the students were able to view practice with a more critical eye. This student recognises the lack of respect being shown to the patient.

"There was a bank auxiliary nurse and a new patient had come and instead of saying 'oh, hello, I'm blah, blah', she just looked at the bed number and then looked at the patient and said 'oh, you're number four'" [gasps of incredulity and horror all round].

This student described how the qualified staff encourage students to talk to patients but claim that they never have the time, yet they do not utilise the opportunities they do have. The same student also recognises the lack of respect for the patient when their presence is barely acknowledged.

"Another thing that really bugs is that nurses will like to talk to each other when they're washing the patient [loud agreement from the whole group]. I*t really annoys me 'cause there's at least one patient or four or even more if it's a nightingale ward [...], like, you don't really get much chance to talk to patients, but you're on placement, go talk to patients, I don't have the chance to. The first time they have a chance, 'there's a patient sitting right there!'* [sarcastic tone]**,** *they're changing the bed and they talk about their holidays or their man or their kids* [exasperated sigh]."

This student described a nurse who was very vocal in her annoyance at another nurse who had applied the wrong dressing and seemed unaware of the effect this was having on the patient.

"[...] She was just more interested in herself. There was this woman came in she'd [the nurse] *been away on holiday, [...] the woman was allergic to it,* [...] *the nurse said in front of the woman 'look what they've done to your legs, look!'* [exclamations of disbelief from all the group], *look at that, look at that' [...] then the woman got upset and she started to cry [...]. It was just so, like, unprofessional and it was just inappropriate how she was talking [...] and she didn't even notice that the woman was crying."*

Facilitator: "So what did you learn from that that you can take to your practice?"

"[...]. I don't know? Just to be aware of the patients. I don't know, she just didn't impress me at all, just to remember to never ever be like that as a nurse" [soft laughter and nods of agreement].

However, despite reporting the poor examples they had seen, they all had some good examples to report, very similar to those reported in group interview one. Students were able to recognise empathic and respectful behaviour in staff. Although the students still expressed a desire to emulate good practice, they sometimes worried that they would not be able to develop the same skills.

"It just kind of comes naturally, you just kinda hope that it does all come naturally to you, it's just like a second set of hands really that you're able to communicate really well and go and do A, B and C for different patients. You see nurses juggling everything but they still seem calm and it's scary sometimes"[soft laughter and nods of agreement].

"[...] Her confidence and reassuring […]. They had a problem with the medication as well and she was really efficient at getting it altered, she was able to get them medication within half an hour. I just thought it was just kinda fantastic nursing that she was doing [...]."

"I don't know if there's that kind of thing that you can't really learn, that some people just seem to have like, wow they're amazing but I can't put my finger on what it is" [another student: "I know"].

4.7.3 Impact of teaching

Students were asked about the impact of teaching and made similar comments with regard to the skills they had learned, such as listening, using silence and the ability to question. They appeared to be more conscious of making the links between theory and practice. They were also conscious that theory had to be put into practice and that also provided an opportunity for learning and further developing skills and was perhaps now more important than the theory.

"But then you realise, I don't just logically understand the lectures you've received on communication now, you've got the knowledge to back that up, I've been there, I've seen that."

"The only thing is I think you have to have the experience, to actually have the experience. I can think of maybe when a communication has gone wrong or went well and you can reflect on it, so you've actually got an example [...]. So next time you can say 'I'll do this or I would maybe do that again' so the practice maybe is the most important."

"We did a breaking bad news [general agreement as the group remembered] *[…]. I was in ward and we had a patient with dementia but she had a terminal diagnosis and she kept forgetting she had a terminal diagnosis. So you'd have to tell her, and it was very difficult [...]. But it was good that we kinda got the theory behind it, breaking bad news, I can't remember but there was a model* [Researcher: "SPIKE"] *mhm* [nodding in recollection] *but it kinda helped with that [...]."*

Students reported that, although now most of their learning was occurring in the clinical area, it had been important to have the theory initially.

"I know there's been situations that I wouldn't have been able to handle without the theory, difficult conversations with patients and relatives [murmurs of agreement]. *[...] I'm talking about a patient that I nursed and he was palliative and he was coping with his loss of identity and he was really struggling with this and I know that without the theory I wouldn't have been able to talk to him or help him to feel better so you definitely need the theory."*

"You're out there thinking frantically what were we doing that day, what was on the slide, [laughter from the group and nods of agreement] *there was a procedure for that"* [more laughter]. [Another student interrupts with: "But after a while you stop thinking about the slides and it gets easier, but the first time you need to learn what to do"].

"I think it's really important in the earlier years to get a lot of the theory but I think you get to a point where you have to kind of find your own way [agreement]. *Everyone's not the same and you have to be kinda let loose at some point."*

4.7.4 Personal experience

Students were asked again about any personal experience that had influenced their understanding or development in relation to the therapeutic relationship. As in the first group interview, no student had anything to report.

4.7.5 Reflection

Students were again asked about the use of their portfolio in relation to their development and understanding of the therapeutic relationship. As before, there was little evidence of students keeping written accounts of reflection. The portfolio was used more as a record of skills acquisition.

"I've never really used it [loud laughter]. *I use it if there is an incident and [...] it's about learning practical skills. When I was in my last placement I did something about a tracheostomy so I wrote about that in my portfolio but not just about, like, an interaction. I probably should"* [loud laughter].

"I use it more for tasks. Like I might sort of make notes on something that I did or I've learnt like a practical thing, I don't know. I suppose it's because I am more likely to remember the interactions but I am more likely to forget the details of practical things [...]."

Students recognised reflection as important to learning and, although some students did undertake written reflection, most students found it more helpful to talk with other students or to reflect internally on their own.

"You're looking back on it bit by bit almost dissecting it, 'you know what, I done that quite well, I'll try and remember that for the future' or 'I didn't do that so well maybe I should try and adapt, you know, make that situation a wee bit better'. [...] I said that and she shared this with me, do you know what maybe I'll think about doing that again. It helps you build your character."

"Sometimes you just need a good nurse to talk to; you try to talk to your friends but they're completely bamboozled by what you're talking about so you really need a good nursing support network, who know what you do in your day to day life. Some people just can't relate to what you're doing at all."

"I think maybe you remember conversations more in your head maybe [...]. If you'd just had a conversation then maybe you would think about that while you were doing something else. Not actually like physically like write it down and reflect but I think the whole reflection process is something I would do now, whereas I probably wouldn't have done it so much before, now you consciously do it. To try and improve, like, your communication and things like that" [noises of agreement].

4.8 Vignettes

The findings indicated that all students showed evidence of development in empathy and respect over the three data collection points. As would be expected, some students demonstrated a greater degree of development than others. This should not be interpreted as an indication of one student necessarily having developed more than another. This is a self report tool and factors such as writing skills and engagement with the vignette need to be considered. Participant numbers have been

omitted as these were deemed to be irrelevant and risked the anonymity of the participants.

Findings from sections one and two will be presented separately. The findings from section one will be supported with examples from the vignette responses. These will be presented in single quotation marks as they are not direct speech. Evidence of the presence and development of communication skills will also be reported. An example will be presented that illustrates the development over time in selected students. Care has been taken not to manipulate the results, for example showing time point one of one student and matching that with time point three of another student. Section two of the vignette will present the themes that emerged from the data and will be evidenced using excerpts from the students' narrative account.

4.8.1. Vignettes responses - time point one

The narratives of all the students were made up of short, bullet points or very short statements, although a few students did give fuller descriptions of how they would approach the situation. An example of the responses to the vignettes can be seen in appendix ten.

Respect

In the first part of scenario one the nurse has been asked to feed a dependant patient who had suffered a stroke and had mild dementia**.** All the students indicated behaviours associated with respect. No student failed to introduce themselves to the patient and all sought informal consent. Most students indicated that they would engage in some form of conversation although in some students the language was somewhat stilted. This may be more a result of the students' writing skills than how they would actually approach the patient. When describing how they would go about the task there was an impression that this was something that they would be doing to the patient, with the nurse in control.

'Hi there Mr Smith, I'm just going to help you with your lunch. I would sit down next to him […]. I would let him know we were getting started and feed him.'

'Introduce myself and tell him that I will be helping feed him and state I'm a student nurse. Ask him if he enjoys staying at the care home. Begin to feed him, asking if the quantity of food and speed is ok. Ensure that I wipe his face and keep his shirt free from food.'

'Greet Mr Smith and introduce myself. Explain that I'm going to feed him and check that is ok. Tell Mr Smith what food is available and check that he likes it. Be patient and allow him to eat at his own pace. Talk to him and try to get to know him a bit more.'

Some students, even at this early stage, were able to include most of the indicators in their approach to the patient. As well as introductions, consent seeking and conversation, this student indicates not only a respectful approach but also some degree of insight into the patient's situation. The student attempts to engage with him, for example referring to *'feeding him slowly'* and talking about *'assisting him with eating'* rather than feeding him.

'I would explain to him who I was by introducing myself and letting him know that I was going to assist him with eating and would that be alright. I would sit down beside him so he didn't feel intimidated in any way. While slowly feeding him, regularly asking if he would like some more, I would engage in conversation to keep him feeling relaxed and reassured, at a level he could understand.'

When faced with the patient's incontinence, the students again demonstrated a number of the indicators of respect, ensuring that the patient was given an explanation and reassurance. Although most students were not explicit with regard to

privacy, the importance of maintaining the patient's dignity was evident in all the students' responses.

'[…] "ok Mr Smith. We're just going to get you cleaned up." I would put down the food and assist him in getting washed and changed. I would try to make sure his dignity is still intact while carrying out this task'

'Reassure him and calm him down. Get help. Get him cleaned up and out of wet clothes. Once he is cleaned up and dry continue to reassure him.'

Some students were able to achieve most of the indicators and demonstrate sensitivity. The following examples show that the students are careful to explain to the patient what is happening as well as reassure him. There is evidence of the students attempting to empathise with the patient's embarrassment and respond in an effort to minimise this. There is also recognition by the student of the need for discretion to maintain the patient's dignity.

'Try not to make a big fuss as Mr Smith will probably be embarrassed. Put the food aside and explain that you will help him to get cleaned up and get some fresh clothes. Mr Smith might not have eaten enough so offer him some more food when he is clean or offer to keep something he can eat later […].Be efficient and discrete in getting him cleaned up and not over-talk the issue.'

'Although this is a difficult and embarrassing situation for Mr Smith it is important to remain in a professional manner and act as quickly as possible to ensure Mr Smith's dignity is retained. I would explain what has happened and what I am going to do to help him in this situation […]. It is apparent that he may have been eating his dinner in the main communal area, therefore it is important to draw as little attention as possible from others to maintain his dignity.'

In the first part of scenario two, the nurse has been asked to assist Miss Young with her personal hygiene. All the students indicated behaviours associated with respect. In some students this was more developed than in others. No student failed to introduce themselves to the patient and all sought informal consent. Most students indicated that they would engage in conversation with the patient. As before, with some students there was a sense that this was something they would be doing for or to the patient rather than with the patient.

'Introduce myself. Tell her why I'm there. Ask her how much she can manage herself. Explain what I'm doing. Chat to her - let her speak. Ask her if she has any particular beauty treatments she normally does at home and see if I could help her with them.'

'I would smile and say hello, introduce myself. I would then ask her how she was feeling. After listening to her response I would take on board any problems she had. I would then explain that I was going to help her with a little wash before getting her up out of bed.'

However, some students did recognise the importance of allowing the patient some degree of independence.

'Introduce yourself to Miss Young and ask if she would mind if you gave her some assistance to get washed and dressed. Help Miss Young to wash herself but allow her to do the bits she can manage herself so that she still has some independence.'

Some students recognised that the patient might be uncomfortable with being washed and engaged in conversation to try and divert their attention, indicating an attempt at empathising with the patient.

'[…] It is important to introduce myself and gain a sense of rapport to enable her to feel as comfortable as possible and at ease. As this is her first

admission to hospital she may feel frightened or slightly embarrassed, therefore it is important to reinforce that I will not do anything she does not feel comfortable with […] her dignity and confidentiality must be upheld making, her experience within the hospital as easy as possible. This may be through closing the curtain around her bed or taking her to the bathroom.'

'[…] I would introduce myself and ask how she is feeling today, remembering to make her my main focus. […] I would explain what I was going to assist her with and check it was ok with her. By closing her curtain or shutting her door to give her privacy and letting her remain dignified. While washing her I would be gentle and keep checking that she was ok but trying to direct the attention away from the actual process by engaging in conversation with her […].'

Only three students mentioned the need for privacy in this scenario compared to scenario one where most students indicated the need for privacy. This may be because Miss Young was in hospital and in bed and there was an assumption that curtains were there and would be closed automatically.

Empathy

In order to ascertain their ability to empathise with the patient, students were then asked what emotions they thought Mr Smith might be experiencing as a result of the incontinence. Most students came up with similar suggestions and most of the indicators were identified. Most students reported these as a list.

'Embarrassed, frustrated, angry, low self esteem/confidence, low self worth, anxious, stressed, worried, a burden upon the staff, frightened, upset, emotional.'

'Mr Smith may be embarrassed, frustrated with himself.'

This student's mention of a potential aggressive response may have been prompted by the knowledge that aggression is sometimes seen in patients with dementia.

'Mr Smith will be feeling embarrassed and ashamed of his situation. He may also feel a burden and want to be left alone if upset. He will be anxious and stressed and could even turn angry or aggressive due to this.'

Responses from some students showed more of an attempt to understand why he might be experiencing these emotions and how they might respond.

'He won't want other people to know.'

'Take Mr Smith back to his room via shortest/quietest route (he won't want everyone to see).'

'Initially: Helpless, scared, embarrassed, ashamed, depressed, confused.
After he has been cleaned up and finished eating: reassured, respected, but still scared, embarrassed, depressed and confused.'

'I would explain to him what I was doing […], keeping the attention away from the incident as much as possible. I would make the situation as quick and stress free for Mr Smith as possible, keeping the conversation going on between us. Remembering there are other people around, […] keeping it as private as possible to allow him to feel dignified and as relaxed as he can be.'

In scenario two, reasons for Miss Young's reaction were sought as well as the students' responses. Most students identified the majority of the emotions suggested in the indicators. Students' responses varied, with some students perhaps appearing a little dismissive or assuming that, because they could reassure the patient that they did not mind, that would make the patient feel better.

'Embarrassed. Low self esteem.'

Response

'That I enjoy my job. Perhaps ask her a question to get her talking and take her mind off things.'

'Miss Young may feel embarrassed that she needs help with her washing, especially since she is used to doing everything for herself. The fact that she needs such help may be frustrating for her. She could also feel like she is an inconvenience or a burden.'

Response

'I would tell her to stop apologising and that it isn't terrible. Explain to her that I am there to help her and do this for her. I would tell her it's done every day and then maybe ask her why she said this, or feels like this. I would reassure her and re-emphasise that there is no need for her to feel embarrassed or apologise to me.'

'Ashamed of her incapabilities. Aware of her incapabilities. Embarrassed'.

Response

'Is there anything she would like to do herself? State that I am more than happy to help her. Try to lighten the situation.'

'Embarrassed. She may feel because you are young you may be inexperienced. Exposed. She is losing her independence. Frustrated.'

Response

'Assure her that she is not any bother and that she will just need extra help until she has recovered. Tell her you are there to help, that is your job.'

Some students appeared to have some understanding of why Miss Young might be apologising and that led to a more empathic response.

'Miss Young has done this for so long and because of her age she might feel embarrassed that a young person has to wash her. Distressed, uncomfortable.'

Response

'I would respond by saying that "it's fine and I'm only helping you until you can do it for yourself again" and "it's only a quick wash to help you feel better".'

'Embarrassment, shame, irritation that she can't do these tasks for herself anymore, frustrated, anger and helplessness, embarrassment that she may be a nuisance to me and wasting my time, lack of dignity.'

Response

'I would reassure her that everyone needs help with these things at times and maybe give an example of when I've needed help with something like this to reassure her that she's not alone. I would also let her know in a non-verbal way that I am not in any rush and it is no problem at all to help her by being patient and friendly and kind.'

Communication skills

The vignette at time point one was completed prior to any teaching on communication skills or the therapeutic relationship. Nevertheless, some students demonstrated awareness of communication challenges and identified alternative ways of communicating, including the use of body language.

'When I approach him I would have positive body language, i.e. eye contact, not being too serious, smiling if he can't communicate through speaking, try and communicate with him in a way in which he can respond.'

'Make sure body language and behaviours do not show any signs of being tired or not wanting to be with Miss Young.'

'I would have positive body language, i.e. eye contact, not being too serious, smiling.'

4.8.2 Vignette responses - time point two

At time point two the most obvious initial difference was the increased length of the narrative. Most students were incorporating all or most of the indicators of respect and demonstrating an increasing ability to empathise with the patient. As before, this was more developed in some than in others.

Respect

In addition to demonstrating respectful behaviours, most students seemed to be more willing to allow the patient some degree of control and independence. They appeared more comfortable in their role with less of a 'doing to' and more of a 'doing with' attitude. Students were also more conscious of seeking patients' preferences.

'I would explain to Mr Smith that it is tea time and that I was about to help him with his dinner. Throughout the task I would ask him if he would like a drink, keep speaking to him, depending on whether he was able to communicate well or not.'

'Introduce myself to Mr Smith. Inform him that I am going to help him with his meal. Offer him a choice […]. Sit next to him. Feed him at his own pace; do not rush him, until he has had enough. Make sure his face is clean before leaving him. Check food is ok (i.e. hot enough, palatable). Offer drinks. Be polite. Allow Mr Smith to make his own choices. Chat a little if appropriate (he may just want to eat).'

Some students were still presenting a more task orientated approach. Although the indicators of respectful behaviour were present, there appeared to be a lack of

engagement with the patient. Again this may be due to writing skills, or repetition of the task.

'Introduce self and ask for consent for task. Ask him what pace he would like to eat at. Ask him if he would like the food seasoned. Sit at the same level as Mr Smith. Ensure he has a bib or apron on to prevent his clothes from getting dirty. Ask what he wants to eat first.'

'Introduce yourself. Ask Mr Smith's permission before you start. Explain what you are going to do. Start to feed him. Wait for him to finish each mouthful before asking him if he is ready for another.'

Students were also developing more knowledge regarding the patient's condition and this was evident in how they responded to the vignette. This also indicated that students were increasingly secure in their role as professional nurses.

'Introduce yourself. Smile and look friendly. Ask Mr Smith if he is hungry and wants lunch. Give him a choice. Don't hurry him. Be at his level.'

'Always watching his swallowing and chewing whilst chatting to him.'

'Observe him closely to ensure that he wouldn't be in danger of choking on his food. I would talk to Mr Smith whilst feeding him but always observing that he isn't having difficulties swallowing.'

In scenario two all the students indicated that they would use behaviours associated with respect. No student failed to introduce themselves to the patient and all sought informal consent. Most students indicated that they would engage in some form of conversation with the patient. The need for privacy and dignity was better articulated and the student appeared more willing to allow the patient a degree of control and the student indicating a willingness to promote independence in the patient. This may be

as a result of the student feeling more comfortable in their professional role and, again, there was evidence of the student's increasing nursing knowledge.

'[…] Introduce myself, pull curtains round and explain why I'm there. Ask if this is ok. […] Try to establish a rapport with her to make her feel at ease. See how much she can do herself, e. g. hands, face. Watch for difficulties moving, shortness of breath or anything out of the ordinary. Assist her with washing, drying, dressing, […] ask if anything else is needed / wanted. Record in nursing plans.'

Some students were also able to negotiate with the patient in a gentle way if she seemed reluctant to be helped, trying to reassure the patient. They were also able to recognise the potential discomfort the patient might be experiencing and take steps to ease the situation.

'[…] Introduce myself and ask how she is feeling. I would explain what I am about to do. If she was reluctant for me to help I would try to explain that if she's feeling unwell then she may need a little bit of assistance with some things she would normally do for herself. If she was still reluctant then I would try and talk her into letting me just start to wash her hands and see how she feels from there. I would ensure that she has complete privacy and ensure that her dignity was maintained by covering any parts of her body I wasn't washing and ensure that I have her consent.'

'[…] Introduce myself and try also to get to know Miss Young a bit. […] I'd get the basin, soap, towel, cloths and any fresh clothes. I'd encourage her to do as much as possible, […] making sure the rest of her body remained covered […]. During the wash I'd chat as much as she felt comfortable with and try to get to know her, but also so she wasn't focussed on the fact that I was washing her. I'd check she didn't have any wounds […].'

Empathy

When asked how Mr Smith might be feeling most students identified a broader range of possible emotions, with some students recognising the role of the nurse in alleviating the patient's distress.

'Upset, annoyed at self, embarrassed, low, feel useless, hopeless, low self esteem, anxious, silly, old, loss of independence, loss of confidence.'

'I think that Mr Smith might be feeling embarrassed, distressed and even quite angry with himself. Anxious, confused, frightened, inadequate, burden.'

'Mr Smith would probably be feeling embarrassed, maybe ashamed but it is our job to reassure him and comfort him as much as possible.'

Similarly, students were asked how Miss Young might be feeling when she started to apologise and how they would respond. Students identified most of the pre-determined indicators. Some students still appeared to assume that because they could reassure the patient that they didn't mind, that would make the patient feel better. There was no evidence of the dismissiveness that had appeared in time point one. Most students at this stage seemed to be trying to understand why the patient might be feeling this way, which allowed them to respond empathically to ease the patient's discomfort.

'She may be feeling embarrassed, guilty, like a child, body-conscious, vulnerable, frustrated.'

Response

'Give her reassurance. Explain that she may need a little help while she recovers from serious illness but hopefully once she regains her strength she will be able to become independent again.'

'She'll be feeling like a burden, as she's living by herself and used to doing things for herself and may not like depending on other people. She may be feeling a lot older as she'd just been admitted to hospital […].'

Response

I'd reassure Miss Young, firstly that 75 isn't that old, but also that I am more than happy to help her in any way possible to make her more comfortable.'

'Embarrassment. She may be feeling a loss of control and her self esteem/worth may be low. She may feel as though she's not worth the bother.'

Response

'Tell her it's my job and I enjoy it. Tell her more about the job and ask what she used to do – thus changing topic to make her feel more at ease.'

'Miss Young might be feeling embarrassed that a young person is having to wash her. She may also be feeling that her independence is being stripped away from her. This could make her feel worried and scared about her independence in the future. She may also feel that she is losing part of her self image as she normally manages herself and independence is a big part of her life.'

Response

'I would tell her that she didn't have to apologise to me and try to reassure her that it's your job and try to explain to her that whilst she is unwell it might be better for her to have some assistance until she recovers.'

Communication

There was evidence of development in communication skills in most students. Some students sought alternative ways of communicating with the patient if verbal communication was difficult and recognising the importance of body language and interpreting patients' cues.

'Although Mr Smith may not be able to communicate effectively I will still ask permission […] and thereby look for some indication that he consents.'

'I would sit down/get to Miss Young's level […].'

'[…] It is important to observe his facial expression and body language.'

4.8.3 Vignette responses - time point three

Most students were providing much lengthier responses and there was no student who did not demonstrate some evidence of growth in both empathy and respect. It was evident that those students who had not demonstrated a great deal of growth development between time points one and two demonstrated more growth between time points two and three. Those students who had demonstrated evidence of a great deal of development between time point one and time point two demonstrated less evidence of growth between time point two and time point three.

Most students were more willing to let patients do things for themselves. This may indicate a greater degree of confidence in relation to their professional roles as nurses and did not have the same need to 'be the nurse' as opposed to, for example, in time points one and two where there was still a feeling of *"it's my job I don't mind doing it"*.

In scenario one all the students indicated respectful behaviour with the responses demonstrating more engagement with patients and less focus on tasks. There was evidence of letting the patient set the pace. The only identified indicator that was not present was related to keeping the patient's clothing and face clean. This was only omitted by three students and may be because these activities were now part of what the student would now automatically do.

'[…] I would approach Mr Smith, introduce myself and ask him if he would be happy for me to assist him with his lunch […]. I would ensure he was sat upright in an appropriate and safe way to eat […]. I would make sure I had a drink for

Mr Smith, one of his preferences […]. I would ensure I was giving him at an appropriate speed, and offering drinks in between […]. I would encourage conversation, aim to make him feel comfortable, whilst making him hopefully feel he has some independence. I'd ensure he was left in a comfortable, satisfied and clean state.'

'I would approach Mr Smith with a smile and ensure that I held eye contact with him while I introduced myself […]. I would speak clearly using short sentences which can be easily understood. I would then ask Mr Smith how he likes to be addressed (i.e. James or Mr Smith) […]. I would use the questions with yes or no answers until I gauged the severity of his condition. […] I would encourage him using non-verbal cues but would encourage him to speak, if appropriate, when he had a break from eating or after he had finished.'

Some students still appeared to be a little disengaged from the patient and there was less indication of establishing rapport in their responses. This may be as a result of the difference in students' writing skills or reflect either familiarity or boredom with the vignette.

'Introduce yourself and explain what you are about to do. Ask consent. Ensure the correct equipment […] is available. Ask him if there is a specific order he wants to eat his food in. When feeding him ensure he has an apron on to prevent his clothes getting dirty. Check that the food isn't too hot and that I'm going at a speed that Mr Smith is happy with.'

'Introduce myself and explain that I will help him with his lunch. Find out what he would like and get his meal. Sit down at Mr Smith's level/beside him. Feed at his pace and as he likes. Offer drinks. Ensure he is kept clean. Stop when he says he has had enough (but encourage eating). Ensure he is left comfortable. […]Make some small talk, ensure everything is ok, but do not talk too much whilst Mr Smith is trying to eat. Make him feel safe and relaxed.'

Responses to how students would cope with the patient's incontinence also demonstrated evidence of growth in all students. The indicators of respectful behaviour were all present and there was some attempt by all students to empathise with what the patient might be feeling and respond appropriately.

'I would first of all reassure Mr Smith […]. If Mr Smith was able to walk I would walk him to the bathroom […] and change his clothes. However if he has had a stroke […] it would probably be better to wheel him to his room to change him […]. Throughout this entire time I would be talking to Mr Smith to make sure he isn't frightened and to let him keep his dignity.'

'I reassure him. I may fetch a wheelchair and blanket quickly so he can discreetly slip from the dining chair into a wheelchair and be covered to maintain dignity and so he does not need to walk with a wet patch showing. I would take him to his room and get him freshened up and changed […].'

All of the students identified the range of emotions that the patient might be feeling. For some students this was still expressed in single words or phrases.

'Angry, upset, embarrassed, loss of control, vulnerable, exposed, dependent.'

'Possibly embarrassed, helpless, upset, frustrated, angry, fed up, confused.'

'Embarrassed, upset, anxious/worried, put off his meal (offer to return later), a burden, angry with himself.'

However, some students demonstrated more insight into why the patient might be experiencing these emotions.

'Mr Smith might be feeling embarrassed, particularly in front of other people in the dining room and possible at the fact a young woman's helping him wash and

change. He may also be frightened from the confusion of eating lunch to being whisked away to be washed.'

'Depending on level of dementia, Mr Smith may be feeling confused which would heighten his anxiety. Mr. Smith may be feeling frustrated that he is so dependent. Embarrassed that he is no longer able to control his bladder function and that other residents may have seen, angry that there is little that he can do.'

One student, while recognising the emotions the patient might be experiencing, also commented on the importance of not making assumptions and trying to find out what the patient is feeling.

'Everyone is different though, and he may feel none of these things. This is why it is important to encourage him to disclose his concerns.'

Again in scenario two most students reported all the behaviours indicative of respect to a high level by time point two. There was more evidence of the students adopting a more holistic approach to care.

'[…] and introduce myself […] assess Miss Young's response to get an understanding of her hearing and alertness. […] Ask her what she likes to be called. […] Ask her what kind of wash she usually has […]. I would pull the curtains around Miss Young's bedside, […] use her toiletries. […] Make sure that Miss Young's dignity and privacy is respected throughout, asking if she would prefer […] to manage herself or asking what I can do for her […]. I would also take the chance to assess Miss Young's skin. I would try and keep the atmosphere happy […] and keep a light level of conversation throughout […] if I felt it appropriate to do so.'

'[…]Introduce myself to Miss Young […]. I would help prepare everything and then seek her permission […]. I would let Miss Young manage what she can (i.e. washing her face) and help with anything she couldn't manage. […] I could talk

with Miss Young and try to relieve any anxieties. I would be inspecting her skin for any pressure areas while assisting her.'

'[…] I would introduce myself; explain why I was there and if this was ok with her. I would establish her ability in washing herself, her mobility, is she on oxygen therapy? […] I would speak with Miss Young, hoping to make her comfortable before I began to assist her […]. I would also ensure her privacy was maintained by keeping the door/curtains closed at all times. […] I would encourage oral hygiene and hair care offering assistance if required. Before leaving Miss Young I would ensure she was comfortable, check her oxygen and she had a drink and nurse call system to hand.'

One student demonstrated fewer of the indicators of respectful behaviour than at time point two and at time point one. This was the only student in whom this was evident. This may be as a result of lack of interest in the vignette rather than deterioration in performance.

When asked about how Miss Young might be feeling, all the students identified a range of possible emotions, with most students trying to understand the underlying cause and making attempts at an appropriate response. Some students demonstrated the use of good communication skills in trying to ascertain potential problems.

'Incapable of looking after herself. Embarrassed, frustrated that she is no longer able. She may actually feel that I am doing too much, and usually manages fine by herself but is too polite to ask me to leave. Old, fearing what is to come, i.e. she may recognise that she is deteriorating and is worried about the future.'

Response

'Encourage her to do as much as possible, to give her a feeling of independence […]. Put an emphasis on 'team-work', she can help me out by doing the things she can, and I will help her out by doing what she can't. Ask "what makes you

say that?" to see if she does have any further anxieties or other issues she would like to address. I would then hope to relieve any anxieties […].'

'It could be […] that she has been used to being independent […] and isn't used to help. She could also be scared of losing her independence and could be worried about how she will cope after she is discharged. She might also feel embarrassed that someone a lot younger than her is helping her with something that is very personal and private. She might also feel upset and frustrated about being in hospital and that this is happening to her. She also might be feeling very vulnerable and frightened.'

Response

'I would try and reassure her anxieties by talking to her and letting her know that she has nothing to apologise for. I would try and let her know that sometimes when people are unwell that it's ok to let someone help, although it's not very pleasant, but it might help her feel better to feel nice and fresh. I would also find out if there is anything else troubling her and try to help relieve/reassure any other worries she is having.'

'Embarrassment, feelings of not being in control, vulnerability.'

Response

'Encourage her to be more positive. Discuss why she's in hospital and physiotherapy - how is she finding it. Make a joke, lighten the mood, however in a sensitive way. Tell her I don't know how it feels for her but I can try to imagine and it's all part of a job that I enjoy and have time to talk. Find out if anything else is upsetting her.'

One of the male students considered that his youth and gender may be a factor.

'Due to the fact that I am male and young she may feel embarrassed that I would have to clean her, because of this she may feel that her independence is

being taken away. This is why it's important to allow her to help herself as much as she can.'

Response

'I would reassure her that I didn't mind doing it and try to spark conversation that would retract from the situation and would make Miss Young feel more comfortable.'

Communication skills

There was increased evidence of the students utilising their communication skills in both scenarios - for example in the use of open questions, prompting and body language.

'I would reassure Mr Smith and use open questions such as "how are you feeling?" to encourage him to disclose his worries if he wants to. He may require the use of a pen and paper or pictures to indicate his feelings, depending on the severity of his condition.'

'I may use open questions to explore Miss Young's concerns, such as "what makes you say that?"

'I would use the questions with yes or no answers until I gauged the severity of his condition.'

'As the nurse I'd be sitting at eye level and provide encouragement, prompting and directing, while at the same time communicating in order for the patient to feel comfortable.'

4.8.4 Examples of growth in empathy and respect

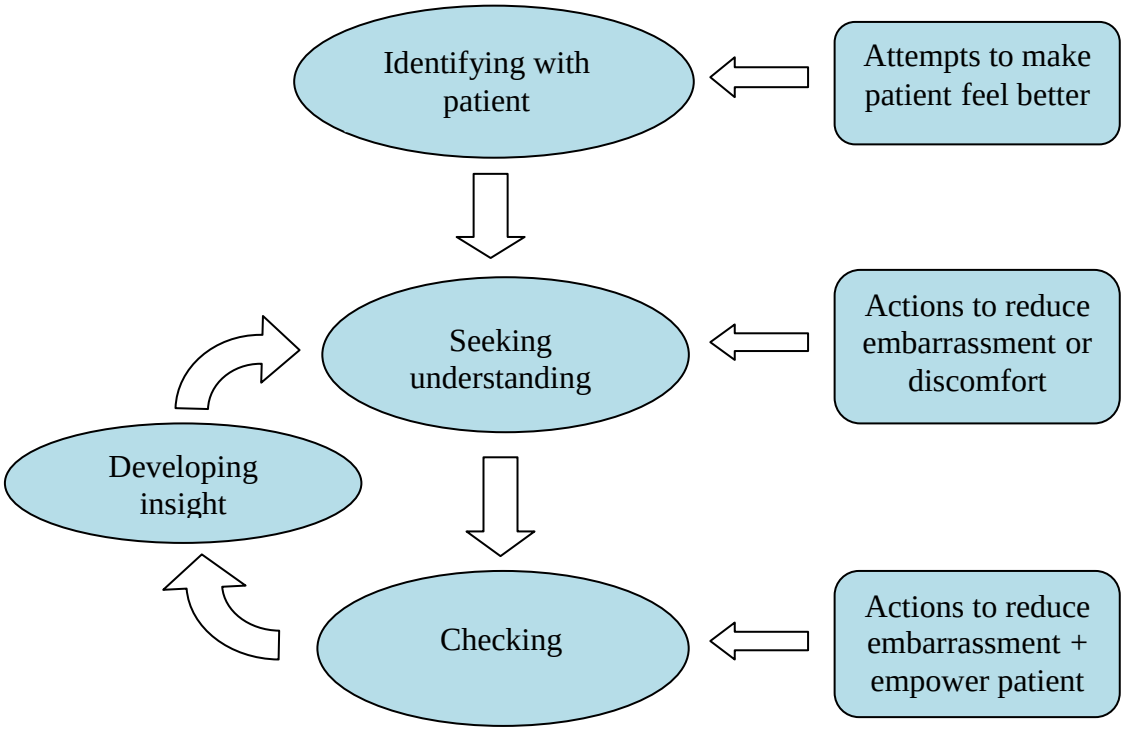
The aim of the study was to observe potential growth in the cohort over time in the development of the skills related to empathy, respect and self awareness, rather than growth in individual students. Equally, the study did not observe the development of

students' relationships with particular patients, but rather their growth in the ability to engage in the therapeutic relationship over time. In relation to the evidence linked to potential growth in the ability to empathise over the three time points, the emerging pattern suggested that over time students were not only able to recognise how patients might be feeling, but were able to begin to try and understand why patients might be feeling that way. This greater understanding then led them to put in place interventions that might make patients feel better. This is reflective of Rogers' (1959, 2000, pp. 1-5) view that empathy is a process whereby an attempt is made to understand what the patient/client is experiencing, checking that this view is correct and enabling the patient to take the lead. By checking out their perceptions with patients nurses are able to signal to patients that they are attempting to understand their situation. As demonstrated by the preceding examples, this was evident in students by time point three.

The example below (table ten) is presented as an illustration of this pattern of growth over the three time points. This example is from the second scenario related to Miss Young. How the student demonstrates empathy is depicted in Fig. 4.

Table ten **Illustration of growth in empathy over time**	
Time point one	**Some attempt to identify what patient might be feeling expressed in short phrases or single words** *'Ashamed of her incapability'* *'Aware of her incapability'.* *'Embarrassed.'* **Although there was no evidence of the student's understanding of why the patient might be feeling that way, there was an attempt to make the patient feel better.** *'Is there anything she would like to do herself? State that I am more than happy to help her. Try to lighten the situation.'*
Time point two	**The student is trying to understand what the patient is feeling but appears less definite - *'may not like depending on other people'*.** *'She'll be feeling like a burden, as she's living by herself and used to doing things for herself and may not like depending on other people.'* **There is also an attempt to try and understand why the patient may be feeling that way.'** *'She may be feeling a lot older as she'd just been admitted to hospital - so that may be impacting her.* **The student attempts some action to try and lessen the patient's embarrassment or discomfort.** *'During the wash I'd chat as much as she felt comfortable with and try to get to know her, but also so she wasn't focussed on the fact that I was washing her.'*
Time point three	**Again the student is attempting to understand what the patient may be feeling but now she is 'checking out' to see if her if her assumptions are correct** **'***Embarrassed. Frustrated that she is no longer able, she may recognise that she is deteriorating and is worried about the future.'* **Student's response** **'***Ask "what makes you say that?" to see if she does have any further anxieties or other issues she would like to address. I would then hope to relieve any anxieties - highlight there will always be help if she requires it.'* **The student now takes action to lessen the patient's anxieties and aims to empower the patient in the situation.** *'Encourage her to do as much as possible, to give her feeling of independence, capability and if I am doing too much, to let her do it.'*

Fig. 4 Empathic Process



The following example, from a different student (table eleven), shows the potential growth in respect over time and is taken from the first section of scenario one related to feeding Mr Smith. The student appears to have moved from demonstrating knowledge of the indicators of respect and reporting them, to demonstrating more recognition of the patient as an individual - more of doing than knowing what to do.

Table eleven **Illustration of growth in respect over time**	
Time point one	**The indicators related to introductions and seeking consent are present and the student does attempt to seek preferences and recognises the importance of not rushing the patient.** *'Greet Mr Smith with a smile and eye contact. I would then ask Mr Smith what he would like for his lunch. I would ask Mr Smith if he would like a wee hand with eating his lunch. I would then take my time in helping him so he has proper time to eat his food to prevent choking.'*
Time point two	**The student, as well as the consent seeking and introductions indicates the importance of keeping the patient's clothing etc. clean. There is also more evidence of engagement with the patient and increased emphasis on patient preferences.** *'Introduce myself and ask Mr Smith if he would like some help (consent). Ask if he would like an apron to protect his clothes. Ask what he would like to eat and drink. Ask if a straw may be helpful with his drinking. Take a seat next to Mr Smith (level with him). Ask him to tell me if I am going too fast/slow, or too much on fork or too little or a signal to stop. Ask if he would like a drink in between, clean his mouth if it becomes smudged. Always watching his swallowing and chewing whilst chatting to him.'*
Time point three	**All of the indicators of respect are present. Not only does the student introduce herself but checks out how the patient would like to be addressed. There is also increased recognition of the patient as an individual; the importance of involving the patient and the importance of maintaining the patient's dignity are more evident.** *'Introduce myself stating I'm a student nurse and how would Mr Smith like me to address him; allow him the chance to wash his hands; gain consent. Give Mr Smith the options he can have on a soft diet allowing him to choose which one he would like to eat and drink. Offer Mr Smith an apron to cover his clothes which he can accept or decline. Set up a signal with Mr Smith as to when he needs a rest, has had enough or needs a drink of he cannot verbally say so. Go at a pace that suits him and always offer drinks in between mouthfuls. Keep Mr Smith tidy and wipe away any food on his face, not like a baby but to keep his dignity intact. Also have a conversation with him, involve him.'*

4.9 Vignettes - section two

Section two of the vignette aimed to capture students' awareness of their own feelings and responses while interacting with the patients. The findings are reported for each of the three time points. As before, the findings presented represent all seventeen study participants. Codes related to each theme are expressed in single words or phrases. Themes have been allocated colours to facilitate locating the text in the appendices (appendix eleven).

4.9.1 Time point one

All students were able to articulate how they might feel hypothetically in relation to each scenario, with some students demonstrating a degree of self awareness by being able to analyse why they might be feeling that way. Three themes emerged from time point one (table twelve). These themes will be evidenced by direct quotes from the participants.

Table twelve
Emerging themes - time point one

Themes	Related codes
Anxiety	Uncertainty about what to do Worried about what the patient thinks
Embarrassment	Feeling embarrassed and uncomfortable Feeling embarrassed for the patient Frustration
Sympathy	Feel sorry for him Compassion Maintain patient's dignity and respect

Anxiety

A degree of anxiety was evident in most students in relation to both scenarios and was related to a number of different factors. For most students this was the fear of doing something wrong and uncertainty about what to do and was related to their awareness of their own inexperience.

'Uneasy, worried that I am not doing it correct.'

'Nervous. It's my job to give him the care he needs. Probably fear because of my inexperience.'

'Worry, in case I do something wrong.'

'I would feel nervous as I have never had to deal with this before. I would probably panic but tell myself to keep control of the situation.'

'Not sure how to approach Mr Smith. Sad, helpless. I don't know what to do, not knowing what and how to help Mr Smith or support him.'

For some students there were also feelings of worry and anxiety regarding what the patient might be thinking or feeling or the effect they may be having on the patient.

'Worried that I'm doing it wrong and concentrating on feeding him too much, drawing attention to the fact that I am feeding him. Oh no[…] what do I do!'

'Worry about how she's feeling now she needs to rely on somebody else.'

'Slightly panicky as I would not really know how to tell her not to worry about it without being patronising.'

'I think I would feel helpful, but that I might be an annoyance to her as she is used to being so independent.'

Embarrassment

The second theme to emerge was embarrassment. Students expressed feelings of embarrassment and discomfort in both scenarios. This sometimes manifested itself in not knowing how to respond.

'Uneasy/uncomfortable. Confused of how to act accordingly.'

'Uncomfortable/slightly embarrassed as she may not want me to do it.'

'I may feel slightly embarrassed myself when he urinates.'

'Embarrassment because I might be making her uncomfortable.'

Some students were embarrassed and also felt ashamed that the patient was feeling embarrassed. One student wondered if the embarrassment was triggered by a previous experience.

'Embarrassed that she feels she has to apologise for something she has no control over.'

'Shame - she should not have to apologise, has any colleague made her feel that she should?'

'I would feel embarrassed that she feels the need to apologise. I would also feel bad that she is apologising as that is my job and she shouldn't have to feel like that.'

Some students also felt embarrassed on the patient's behalf and were attempting to empathise with the patient's situation.

'Would stay calm, but would empathise with his potential embarrassment.'

'You might feel bad that he is unable to do things for himself. Feel that he will be embarrassed by the situation.'

'Sad for him, knowing that he will likely be embarrassed at doing this in front of me.'

Some students were embarrassed by their own feelings of annoyance and frustration. During member checking, one student in particular was horrified that she had expressed annoyance at the patient being incontinent.

'Annoyed – she doesn't need to apologise. Try to be compassionate.'

'Frustration that I will now have to clean and change him before continuing. Shame at being frustrated.'

'Only human to be annoyed - but I would never let him know that. Would feel bad that he had to go through the experience in the middle of a dining room.'

Sympathy

All students expressed sympathy for the patients in each of the scenarios and expressed feelings of compassion, wanting to make the patient feel better, although some students seemed to express a wish to try and empathise with the patients.

'I may feel a bit sorry for him, but want to help him eat as much and as carefully as possible. I'd want to make him feel a bit brighter.'

'Upset and compassionate, try to empathise, stay positive.'

'Empathise with her and realise she may be feeling embarrassed and exposed and try to make her feel as comfortable as possible.'

'I would think that I would feel sorry for him and try to imagine what it would be like if I was in his situation.'

Some students recognised that although they felt sorry for the patient, the patient might not appreciate this.

'Sympathy, although try not to show pity too much.'

'[…] Compassion, again I would feel sorry for him (I don't know if this is right as I would not want people feeling sorry for me). I would feel keen to make him feel better. I would hope to be empathic.'

'Pity - feel sorry that he is unable to do it himself - but cannot let it show! Relieved that he is accepting help.'

As well as feeling sorry for the patient, the importance of maintaining the patient's dignity and promoting independence was also recognised.

'I may feel a bit sorry for her, but want to maintain her dignity and ability to do things for herself as much as possible.'

'I would keep it fresh in my mind that she has been independent for so long and would also do my best to maintain her dignity.'

4.9.2 Time point 2

Analysis of the data confirmed that two of the previous themes, 'Anxiety' and 'Sympathy', were still present. No new related codes were identified from the previous time point in relation to sympathy. There was one new related code identified in the theme 'anxiety' and two new themes emerged (table thirteen).

Table thirteen
Emerging themes - time point two

Themes	Related codes
Anxiety	Patient's well-being
Developing awareness	Trying to empathise Seeking understanding Feeling good and helpful Comfort and reassurance
Frustration	Questioning own performance Annoyance at the situation

Anxiety

Anxiety reported at time point two was related to the patient's well-being and concern regarding the patient's physical and mental condition, rather than uncertainty about what to do.

'Worried that he may choke on his food, and maybe a bit nervous about communicating with a dementia patient, as you have to be careful what to say so as to not upset them.'

'Anxious in case he chokes or I am feeding him too fast.'

'Worried if I am feeding him the correct amount or if he is satisfied or not. I would feel concern as I do not want Mr Smith to feel embarrassed.'

'Concerned at her feelings, anxious that I was making her more embarrassed.'

There was one student who seemed to still report feelings of great anxiety in relation to both scenarios and the language suggested an increase rather than a decrease in feelings of anxiety.

'Anxious, frightened of doing something wrong, worried. Anxious, confused, panicked, not knowing what to do next, flustered, trying to remain professional and positive that I can help this man.'

'Panicky, slightly embarrassed, shaky, afraid of doing something wrong, afraid of not respecting her needs.'

Developing awareness

The first new theme to emerge was developing awareness. Students seemed more aware of the patients' situations and although much of what was reported still suggests feelings of sympathy, there was evidence of the students attempting to empathise and seek understanding.

'I'd be concentrating on finding out who Miss Young is, what she is like and how she likes things done, so that next time I help her she would feel more comfortable.'

'I would want to make her feel as in control and capable as possible as I would worry about taking that away from her.'

'That it must be difficult for someone else to feed you, so you must try your best to make the patient feel independent and comfortable.'

'I would feel a bit awkward at first but then after a while would feel ok. I would try and imagine how it feels having to be fed.'

Some students were trying to relate the patient's experience to how they might feel themselves in the same situation.

'I would feel very powerless and anxious particularly if I am used to doing things on my own.'

'Fear - might be me one day.'

'I would feel that I would want my independence maintained if I was in her situation.'

There was also increasing evidence of the students' awareness of the importance of reassuring the patient and a realisation that they could experience a feeling of well being and contentment at being able to provide care.

'A desire to make him feel good (or as good as possible) about himself.'

'I would want to make her feel as in control and capable as possible as I would worry about taking that away from her. I would feel that I wanted to reassure her as much as possible.'

'Proud to help. Concerned that I do a good job and make him feel comfortable and enjoy his meal.'

'Joy - it is good to help someone, especially if they are feeling good about what you are doing.'

Frustration

The second new theme to emerge was frustration. This was related to either annoyance that some omission on their part had caused the situation to arise or annoyance at the inconvenience. Students were conscious of not letting this annoyance show to the patient. A couple of students expressed feelings of guilt.

'Slightly annoyed. Upset that I never asked him before lunch if he needed.'

'Guilty, maybe you didn't realise he was needing to go to the toilet.'

'Possibly frustration - was he not toileted before? Have I forgotten to do something? Embarrassment on his behalf.'

'Frustrated, not at Mr Smith, but at the time it takes. Would try not to let this show.'

'Slight frustration because now you have to change him but also compassion because you realise how upset his situation makes him.'

4.9.3 Time point three

There was very little evidence of anxiety. Those who did report it related it to the patient's physical condition or causing the patient embarrassment or distress.

'I would feel concerned in case he choked and also in case he was unable to communicate with me adequately.'

'I would feel anxious that Mr Smith might not be able to chew his food properly or choke himself. Anxious that hopefully I would not add more embarrassment to Mr Smith.'

One student was conscious and anxious about the fact that he was a male nurse. This was the first time a gender issue was mentioned in the vignettes and perhaps indicates an increased level of awareness in the student of how factors, such as gender, may have an impact on how the patients might respond to who is providing care.

'*Probably worried if she was not comfortable with me as a nurse.'*

One student did report a high level of anxiety and lack of confidence, although seemed to be making an effort to appear confident. This is the same student who reported high levels of anxiety at time point two.

'Feelings of nervousness and uncertainty as to how he is normally fed. However, I would address the task in a confident manner, reassuring myself that I am capable of doing this and should not worry.'

'I think at first until a rapport is developed […] I would feel slightly awkward or uncomfortable. As well as feelings of anxiety and apprehension due to worrying if I am doing it correctly in a way that is satisfactory for them.'

Two new themes emerged at time point three and these with related codes are illustrated in table fourteen.

Table fourteen **Emerging themes - time point three**	
Themes	**Related codes**
Professional role	Confidence in own abilities Focus on patient
Empathy	Understanding the patient's situation Dignity and respect Role satisfaction

Professional role

Most students demonstrated a greater degree of confidence in their abilities to manage the situations and demonstrated a professional approach.

'I would feel confident that it is a situation I can handle.'

'Chatty (not really a 'feeling', I know). Relaxed […]. Nice time to get to know patients.'

'Want to make him feel comfortable as soon as possible. Get organised to make it as straightforward and problem free for him as possible.'

'I would feel empathy, nobody likes to feel humiliated in front of others, and compassion as he was distressed. This would make me deal with the situation promptly and confidently to make him feel better.'

One student is very honest in her reflection and is thinking practically, but is also aware that this is not something that should be evident to the patient.

'Unfortunately probably ticking off to-do list mentally, while reviewing his ability to eat and drink and keep up a rapport […]. Exasperated slightly (although not shown hopefully).'

Whereas students did still report on their own feelings, these were mostly overshadowed by adopting a professional role and focusing on the patient's needs. For example, this student still reports that they believe they would still experience some embarrassment. However, the student's response indicated that the aimwould still be to focus on caring for the patient.

'Initially I think I would feel a little embarrassed on his behalf, however that would quickly disappear as I would want to concentrate on moving him and maintaining his privacy and dignity as much as I could.'

Empathy

Overwhelmingly, the students were trying to understand what these situations might be like for the patient. Some did this by trying to imagine how they would feel in a similar situation. Others thought about how they would like their own family treated.

'I would also put myself in his position and think how isolated I could feel and how vulnerable if I had to rely on other people for basic things such as eating.'

'I would feel good that I am helping her, and trying to maintain her dignity as much as possible. However, if I was in her position it would probably be difficult having someone three times your age washing you' [on member checking student clarified this to say they meant three times younger than you].

'I would probably try and put myself in his shoes and make sure he keeps his dignity and pride.'

'I would constantly think to myself 'how would you act if this was your grandma' and try to make it a casual and light hearted situation, whilst feeling satisfied that I was making sure all her needs were met to a high standard.'

'I would think of a member of my family who is very much like Miss Young and try to care for her in the way that I know that person would want to be treated. I would want her to feel as in control as possible.'

Students were still very conscious of the need to respect the dignity of the patient in relation to both scenarios, and attempted to put themselves in each patient's situation.

'When I realised Mr Smith has been incontinent […] I would always maintain a professional manner in front of him. However, I would probably try and put myself in his shoes and make sure he keeps his dignity and pride.'

'At first, I think I would have a moment of panic at what to do but I would gather my thoughts and energy into ensuring the patient is not exposed in an undignified manner.'

'I would feel that if I was in Mr Smith's position, someone would try to maintain my dignity, so I would like to make him feel comfortable.'

Students reported a sense of role satisfaction and demonstrated pride in their ability to help the patient.

'[…] I think I would feel really pleased if he is eating his food and proud that he would allow me to do so. It is a nice feeling when someone trusts you enough to let you feed them, particularly if they have dementia and can maybe get frightened easily.'

'Eager to help her regain her independence. Want to make her feel relaxed and safe - spend time with her where possible.'

'Feels good when you can make them happy and understand that it is not a burden on you. Once they believe that it is ok for them to receive your help, then everything is smiles.'

'I think I would feel satisfied and good once I have finished helping her that she is happy and in a comfortable environment.'

Chapter 5 Discussion

5.1 Introduction

The aim of the study was to contextualise undergraduate student nurses' understanding of the therapeutic relationship, and their abilities to develop this with patients in the context of providing essential nursing care. The study also aimed to explore the pedagogical design elements which influenced this. The conceptual framework was developed from the literature and informed the research questions. One overarching research question supported the aim of the research and was operationalised by two specific research questions. A naturalistic paradigm was adopted as the broad methodological approach, which permitted the selection of case study methodology. A single case holistic approach was the research design of choice, where the 'case' constituted the cohort of students (Yin, 2009, p. 51).

A purposive sampling strategy was adopted and qualitative methods of data collection were employed, congruent with the naturalistic paradigm and epistemological stance of the research. These consisted of group interviews at two time intervals and addressed research question one. Question two was addressed by completion of self report vignettes at the beginning to establish a baseline and then at two further intervals. This chapter will discuss the research findings in three sections, firstly in relation to the research questions, secondly in relation to the contribution to the field and, finally, the strengths and weaknesses of the methodological approach.

5.2 Research Question one - group interviews

Overarching question

What is student nurses' understanding of the therapeutic relationship, and what influences the growth in their ability to develop this relationship?

- **How do student nurses reflect on their experience of working with the patients?**

It was evident from the initial group interview that the students had some understanding of the therapeutic relationship and its importance in nursing and this addressed the overarching research question. At this time point the students had some difficulty in defining the relationship but were clear that this was a different kind of

relationship to those they formed in their personal lives. This uniqueness of the therapeutic relationship was identified by Peplau (1952, p. 11, 1997) and has been attested to by a number of authors since (Travelbee, 1966, 1999; Forchuck, 1992; Forchuck & Reynolds, 1998; Roach, 1992, 2002; Moore, 2005). Although the students experienced some difficulty with definition, they had no difficulty in identifying the key components of the relationship. These components emerged in the themes identified in group interview one. Even at this early stage in their nurse education (students had completed 12 months) the students identified *'Trust'* as a fundamental building block of the relationship and recognised that without this the relationship would not be possible. This supports Peplau's view that there is an orientation or beginning stage in which the establishment of trust and respect are fundamental.

The importance of trust in the therapeutic relationship is reported in the literature by a number of authors (Peplau, 1952, p. 9; Benner and Wrubel, 1989 p. 9; Wendt, 1996; Forchuck, 1992; Wilson et al., 1998; Hupecy et al., 2001; Moore, 2005; OCN, 2006). The students were able to identify a number of factors that they considered to be essential in developing trust. Competence and confidence were seen as important in gaining patients' trust. These attributes have been identified in the literature as necessary for establishing the therapeutic relationship (Williams, 2001; Wilkes & Wallace, 1998; Forchuck, 1992; Roach, 1992, 2002). The students also saw trust as necessary in gaining the co-operation of patients, which in turn led to benefits for the patient and the nurse and linked to the fourth theme (*Benefits to the patient and practitioner*) that emerged from the analysis of the data from group interview one. The development of trust is identified in the literature as an important first step in establishing the relationship and as a key element of the first, or 'orientation', phase of the relationship (Peplau, 1952, p. 9; Forchuck, 1992; Wendt, 1996; Arnold and Underman Boggs, 2007, p. 120).

Empowerment was identified by students as a key component of the therapeutic relationship and this correlates with the work of both Peplau (1952 pp. 19-32 and

Rogers, (2007 p. 15). Empowerment, as described by the students, mirrors the activity in the 'working phase' of the relationship as described by Peplau (1952, p. 28). Students identified that empowerment was an important element in enabling the patient to get well and regain independence. Taylor (1998) suggested that empowering the patient was an essential factor in gaining treatment compliance, enabling health goals to be achieved. The findings of the study under discussion would appear to support Peplau's (1952, pp. 18-42) description of the first two stages of the therapeutic relationship and suggest that these stages are still recognisable in contemporary nursing.

Peplau (1952, p. 37, 1988) identified the working phase as the stage in the relationship where the nurse and the patient had already established mutual trust and respect which, as previously discussed, the literature suggests occurs in the first or 'orientation' phase of the relationship (Taylor, 1998, Arnold & Undermann Boggs, 2007, p. 120**).** It is in the working phase of the relationship where the nurse and the patient work towards mutually agreed health care goals (Peplau, 1952, p. 9; Forchuck 1992). Taylor (1998) also identifies the importance of empowering patients in order to achieve mutually agreed health goals as a key aspect of the therapeutic relationship. Taylor further suggests that this can only be achieved effectively after the establishment of trust and respect between the patient and the nurse. This would appear, therefore, to support the premise that the relationship occurs in stages, with the development of trust and respect occurring in the 'orientation stage' and the second stage of the relationship, described as the 'working phase', focussing on working towards the achievement of mutually agreed health goals (Peplau, 1952, p. 28; Wendt, 1996; Taylor, 1998; Forchuck, 1992; Arnold & Undermann Boggs, 2007, p. 120)

Similarly, Rogers (1957, 2007, pp. 1-5) also viewed the establishment of trust and respect, which he described as unconditional positive regard, as key components in developing the therapeutic relationship. Trust and respect were the foundations or the first stage of the relationship. Following this, the goal of the relationship was to work with the individual, empowering them to achieve therapeutic goals. This

suggests that, although applied to different fields, there is congruence between the two theorists in relation to the therapeutic relationship, with both theorists recognising the need to establish a foundation followed by working towards achieving therapeutic/health goals. The findings of this study suggest that these concepts are still fundamental to the therapeutic relationship in contemporary adult general nursing and therefore have application in the context of contemporary nursing. The findings would therefore also suggest that the work of these theorists should be more overtly included in nursing curricula. As utilised within the communication skills course that was developed, the work of these theorists can still provide a sound underpinning to the development of a therapeutic patient nurse relationship. Therefore, there is a role for these theories to underpin key curriculum content such as communication skills, the nurse patient relationship and the role of the professional nurse.

By the second group interview students had completed a further fourteen months of their nurse education and were in the third year of their degree. The students were much clearer in their understanding of the nature of the relationship and were better able to articulate this. Again, trust emerged as an important factor in the relationship. Students seemed to be increasingly aware that this was something that needed to be developed and that the actions of the nurse were the catalyst. There was a realisation that this was perhaps not just something that happened but something that the nurse needed to actively build over time. Stepping stones to building trust were identified by students such as introducing yourself and providing explanations to the patient. The importance of respecting patients' privacy and dignity as part of developing trust was also recognised and students were able to give examples of how that could be achieved. This correlates with what patients are reported to have identified as important factors in feeling respected (Haddock, 1996; The Essence of Care, NHS 2003; Price, 2004; NMC, 2007; Audit Scotland, 2007; Delivering Dignity, 2010; The Francis Report, 2010). The importance of respect for the patient as a core component of the therapeutic relationship was identified by Rogers (2007, p. 1-5) and by Peplau (1959). This is further supported by the work of Chochinov et al. (2006) and Chochinov (2007), who also identified the importance of respect for dignity in the

provision of health care. It appears, therefore, that the study findings support the literature in that the students viewed respect for the patient and maintaining dignity as an important first step in building trust in the therapeutic relationship. The students' realisation of the need to earn trust at this later stage in their nurse education indicates their greater perception and understanding of their own professional roles and their responsibility in developing the relationship.

In the second group interview, students recognised that trust could be lost by letting patients down and not keeping promises. This was not identified in group interview one and again is an indication that the students were more perceptive to patients' needs and more aware of their own professional roles in maintaining trusting relationships with the patient. The fragility of the trust in the nurse patient relationship has been recognised in the literature by previous authors (Wendt, 1996; Hupecy et al., 2001; Moore, 2005; OCN, 2006; Chochinov, 2007). Students acknowledged that this sometimes happened unintentionally and cited factors such as competing priorities or being busy. Other factors included attitudes of other staff, who perhaps perceived time spent with patients as unproductive (Bach & Grant, p. 62). Students felt that the loss of trust could be prevented by better prioritising their time and making a timely apology. They believed that most patients understood that they were busy and that an apology could prevent the loss of trust and could engender respect for the nurse. However, it was evident that students were distressed and felt guilty when they let patients down.

The importance of communication in the therapeutic relationship was reported by all students in both group interviews one and two. The important role of communication in the development of the therapeutic relationship has been consistently identified in the literature (Faulkner, 1998; Wilkes & Wallace, 1998; Chant et al., 2002; Moore 2005; Marchese, 2006; Arnold and Underman Boggs, 2007, pp. 99-100; Lewin et al., 2009; The Health Care Quality Strategy, 2010; Time to Care?, 2011; Care & Compassion?, 2011). In the first group interview students were able to distinguish between information giving and the type of communication that contributed to the development of the relationship. Students recognised that the effectiveness of the

communication was influenced by nurses' behaviour. The importance of the nurse's attitude and behaviour and what that communicates to the patient is identified in work by Chochinov et al. (2006), Chochinov (2007) and McLuskey et al., 2011), and supports work by earlier authors (Benner & Wrubel, 1989 p. 9; Taylor, 1998; Forchuck, 1992; Bowles 2001). Price (2004) and Chochinov (2006) both stated that the way the nurse communicates with the patient is instrumental in whether or not the patient feels respected.

Although not using the word empathy, it is clear from the examples given that students were describing empathic communication, letting the patient know that they were trying to understand and that they were willing to help. This suggests that the students were able to distinguish between sympathy, which is more feeling sorry for the individual, and empathy, which is more related to understanding, as their responses made it evident that they understood the importance of trying to understand what the patient was feeling. This distinction between the two concepts and the importance of empathy in the therapeutic relationship is recognised in the literature (Kunyk & Olsen, 2001; Kristjánsdóttir, 1992; Taylor, 1998; Arnold and Undermann Boggs, 2007, p. 98). The students recognised that understanding was important so that appropriate interventions could be offered. This correlates with Rogers' third core condition for an effective therapeutic relationship and incorporates conditions five and six in relation to ensuring empathic intentions are understood by the patient (Rogers, 1959, cited in Wyatt, 2002, p. 3; Rogers, 2007, pp. 1-5). Students also recognised the importance of ensuring that the patient understood what was being communicated and could give examples of how they had seen this in practice with other nurses. This checking out of patients' understanding has been identified as a core skill in patient/nurse communication (Hargie, 2006. p. 11).

Students expressed some surprise on finding that giving patients time to respond, and making it evident to them that they were being listened to was helpful in their communication with patients. This was something that they had not considered prior to the theory sessions. The importance of what is referred to in the literature as 'active listening' is another important communication skill. Active or attentive

listening is indicative of respectful behaviour and students also found that it enabled them to pick up cues from the patient. This was something that they had remembered from theory sessions in class and, although feeling awkward, were prepared to *"stick it out"*, as it allowed them to find out more about the patient, which then assisted in care planning (Moore, 2005; Hargie, 2006. p. 11; Chochinov, 2007). The students were also very aware of the importance of body language and other non-verbal ways of communication and recognised that these could impact either positively or negatively on the patient. Positive body language could be a means of signalling to the patient that the nurse was accessible not just physically but psychologically and signalled a willingness to spend time with the patient. This accessibility is important in encouraging patients to disclose concerns so that potential problems can be recognised (Thorne et al., 2005).

At the second group interview the students were even more emphatic in their belief in the importance of good communication in developing the therapeutic relationship and saw it as *"the most important thing".* What was evident at this time was students' increase in skills and confidence. They were able to give descriptions of some difficult communication situations they had encountered in practice. When asked what had helped them develop confidence, the students all attributed this to having a successful experience with patients, where they had tested out their skills and had either positive feedback from a patient or the outcome had been successful. This supported findings by Suikkala et al., (2008) who reported on the important role patient interaction played in student learning.

Students also tentatively suggested that the nature of the relationship itself could be therapeutic if the nurse was prepared to be open and *"be there"* for the patient. This echoed the view of Moore (2005), who observed that for some patients this was all that could be offered. Other important aspects of the relationship that the students identified included establishing rapport, which they saw as an important first step and a stepping stone to developing trust. Students also recognised that there were intrinsic benefits to be gained by having a good relationship with the patient and, in addition to making the patient feel better, they could feel good themselves. This was

mirrored in what was reported in section two of the vignettes. This mutuality of the relationship is reflected in the literature (Peplau, 1997).

Respect for individuality was deemed important and there was consensus that a *"one size fits all"* approach wasn't appropriate. Students highlighted that being yourself and being genuine were key. This, coupled with their increasing familiarity with the role and clinical environment, resulted in them feeling more at ease. This supports the findings of Suikkala et al., (2008) and Rogers (2007, pp. 1-5). Genuineness and being 'a real person' was the first of Rogers' core conditions. To achieve this Rogers suggested that the clinician needs to develop a degree of self awareness (Rogers, 2007, pp. 1-5). There was some evidence of self awareness as students were prepared to admit that they could make mistakes and had enough insight to know that they might consider not facing up to their mistake by *"walking past the patient"*.

There was some discussion regarding the amount of time needed to develop the relationship, with some students expressing a view that it was easier in the community. However, one nurse had worked in a very busy clinic where short interactions were perceived to be therapeutic. This student felt that it was the attitude and approach of the nurse that was important, not the length of time available. This supports work by Erci et al. (2008), who found significant reductions in anxiety levels when applying Peplau's model, even though the length of the relationship was relatively short. At the second group interview there was a realisation that the relationship, like trust, was something that needed to be developed and didn't just happen, as had been suggested at the first group interview. The group acknowledged that it was the nurse that needed to put in place the strategies that would help develop the relationship. Again, there was evidence of thinking very consciously about what they were trying to achieve, seeing each patient as an individual - *"it takes a lot of thought walking up to a patient […], you're trying to work out what kind of person they are".* Another development was a firmer understanding of the purpose of the relationship. This was a professional relationship and, although it could be friendly, there were clear goals for the patient. However, some students reported that they sometimes found maintaining professional boundaries difficult, particularly if they

had a friendly relationship with the patient - "*They can seem like a friend some of the time, it's hard to draw that boundary*." This emphasises the importance of ensuring that this important aspect of the professional relationship is adequately discussed in class and students taught strategies to develop appropriate boundaries so as not to lose their sense of self (OCN, 2006; Arnold & Underman Boggs, 2007, p. 98).

In the second group interview, students were asked if they were aware of different stages in the relationship. Students could clearly identify that there was a beginning stage where the nurse was getting to know the patient and establishing trust, what Peplau (1952, p. 17, 1998, p. 28) referred to as the 'orientation phase'. The students were also aware that the next phase was where they were able to work with the patient to help them get better, which would correlate with the 'working phase'. However, the students made no mention of ending the relationship or the termination phase. There are a number of reasons why this may be the case. Firstly, students are in a clinical area for relatively short periods of time and work twelve hours shifts so it is possible that they do not see the continuity of care that may include a termination phase of the relationship. Although, in acute care, there is discharge planning, students evidently did not relate this to closing the relationship. However, although not identified specifically, the importance of the end goal for the patient being independence and early discharge suggests that the students were aware of the 'termination phase'. The stages of the therapeutic relationship described by Peplau (1952, pp. 17-42) related to psychiatric care where patients might be in care for prolonged periods of time. Shatell (2005) argued that the model was difficult to apply in contemporary health care, though this was disputed by other authors who had applied it successfully to general care (Jones, 1995; Fowler, 1995; Erci et al., 2008; Mcnaughton, 2005). This may be a more obvious part of the relationship for nurses who carry an independent case load and have patients with more long term conditions such as palliative care. Nevertheless, in order for patients to regain as much independence as possible, a 'termination phase' of the relationship must be planned and may include instruction and advice on self management and the setting up of support mechanisms where appropriate. Therefore, the researcher would suggest that the model is applicable in modern health care, but perhaps requires some

re-definition applicable to the contemporary health care setting in general nursing. As students come to recognise the importance of empowerment and regaining independence, the rehabilitative aspects and achievement of patient goals could be more clearly emphasised as the conclusion or 'termination' phase of the relationship (Jones, 1995; Peplau, 1997).

- **How do student nurses reflect on their experience of working with mentors and clinical staff in the field?**

In group interview one the students reported mostly positive experiences and gave examples of excellent care that they had witnessed both from nursing staff and other members of the multi disciplinary team. In some cases, they seemed almost overwhelmed and felt that they would never be able to achieve this level of practice themselves, although they would strive to reach it. One student summed this up by saying *"I want to be able to do that"*. The attributes that they observed mirrored what they had said previously regarding their understanding of the therapeutic relationship and reflected what has been reported in the literature in regard to the attributes of the nurse that facilitate the development of the therapeutic relationship (Taylor, 1998; Forchuck, 1992; Bowles, 2001; Chochinov et al., 2006; Chochinov, 2007; McLuskey et al., 2011).

The clinical staff were able to establish trust and rapport with the patients and this extended to families. The students also recognised that the staff treated patients with respect and students were able to recognise empathic behaviour. The ability of the staff to motivate and empower patients was also recognised and the students could identify that this was beneficial. Students were also aware of the good communication skills demonstrated by the clinical staff and were able to learn from them. This confirms the findings in the literature regarding the positive impact of role models in enabling students to develop skills in communication (Spouse, 2001; Hockley, 2008; NMC, 2010). Students were able to see that when clinical staff were not able to establish rapport with patients they did not get as good a response from the patient, even though from a competency point of view the nurse did nothing

wrong. Students also recognised those nurses who were able to demonstrate 'unconditional positive regard' and did not allow any pre-conceived feelings they might have about the patient to interfere with the quality of care provided, and referred to them as *"really good nurses*". This reflects what is reported in the literature regarding the important role communication plays in whether or not the patient feels respected (Price, 2004; Chochinov et al., 2006).

When asked to reflect on the impact of other clinical staff in group interview two, students tended to report more negative experiences. Students had observed a lack of respect and empathy and poor communication in some staff. They recognised the negative effect this had on patients, with some patients not seeking help when they needed it. A number of authors have reported on the importance of effective communication in promoting the well being of patients (Stewart, 1996; Fallowfield & Jenkins, 1999; Fellowes et al., 2004; Thorne et al, 2005; Collins, 2005, 2009). Although viewed as negative, students were able to use these observations to confirm that this was not how they would want to practise themselves. This would appear to support the approach taken by the researcher by developing the communications skills course to reflect the important underpinning concepts of empathy, respect and communication skills early in the programme, as suggested by previous authors (Chant et al., 2002; McCarthy et al., 2008; McMillan & Shannon, 2011; Brown et al., 2011).

Students had identified attitudes and behaviours of staff as potential barriers to the therapeutic relationship but were aware of others. Families were, in the main, viewed positively, although they were seen as a potential barrier, particularly if they prevented the patient from communicating with the nurse. Ward culture was also seen as a potential barrier and this alluded to whether nurse patient interactions were perceived as being of value (Bowles et al., 2001). Pre-conceived beliefs about the patient or 'labelling' were seen as barriers to developing a relationship with the patient and students were conscious that they were sometimes influenced by things they heard at the report before they met the patient. This finding supports earlier work that also identified these barriers (Forchuck, 1998; Collins, 2005, 2009). It

could be argued that this may lead to a lack of respect for the patient and an inability to give 'unconditional positive regard', considered a core component of the therapeutic relationship.

Cultural differences, such as age and gender, were also identified as potential barriers and students recognised that being sensitive to these was a way of demonstrating respect for the individual and, arguably, the students' ability to recognise these barriers demonstrated a degree of empathy. Facilitators to the relationship mirrored much of what had been reported while discussing working with patients and mentors and reflected what has previously been acknowledged in the literature (Spouse, 2001; Hockley, 2008; Suikkala et al., 2008; NMC, 2010). However, students were clear that it was not enough to demonstrate to the patient that the nurse was endeavouring to be compassionate but that the patients needed to know that that was what the nurse was attempting to do, again echoing Rogers' condition five, related to the patient perceiving the intention of the clinician (Rogers, 1959, cited in Wyatt, 2002, p. 3).

- **How do student nurses reflect on the contribution of the academic input to their learning?**

It was clear from both group interviews that the development of skills and acquisition of confidence resulted largely from interacting with patients and getting feedback from patients and mentors. However, students did acknowledge in the group interviews that the underpinning theory had been invaluable, particularly in the beginning. In group interview one a student reported that having had some basic communication skills prior to her first placement allowed her to recognise poor practice at that early stage. This approach to embedding basic skills and teaching related to empathy and communication early in nurse education is supported by the literature (Nerdrum & Lundquist, 1995; McMillan & Shannon, 2011; Brown et al., 2011). In group interview one the students were still using theoretical language to describe the skills that they were using, such as open questioning and reflecting. In some cases they would reflect back on lectures to try and structure how to approach a particular situation. In particular, learning about active listening and the use of

silence seemed to have a big impact. Students were pleased and sometimes surprised when they had success when applying theory to practice. In group interview two it was evident that confidence had grown and the skills had become more embedded in their practice. There was still the belief that the underpinning theory had been invaluable and that theory in third year, related to more complex communication situations, had been timely. This would support the incremental approach taken in the development and delivery of the communications skills course, undertaken as part of this study, where students were able to build on skills and knowledge relative to their stage in training and what might be expected of them in clinical practice. This is also consistent with the literature (Chant et al., 2002; McCarthy et al., 2008; Farrell et al., 2008).

As part of their training, students are asked to develop a reflective portfolio. Most of the students did not use this as means of reflection, even though reflective writing is considered an important aspect of professional learning by a number of authors (Howatson-Jones, 2010, p. 8; Rolfe, Freshwater & Jasper, 2010, p. 41; NMC, 2010. Portfolios were used to record practical skills they had learned and interesting things they had observed. Reasons why students did not use the portfolio included fatigue, being too busy and fear that someone would ask to read it. The majority of students found discussions with other students most helpful in assisting them to reflect on their practice (Roberts, 2008). They found it difficult to discuss this with other non-nursing friends as they felt that only their peers would understand. Students found reflecting on poor practice helpful and tended to focus more on this than on positive things they had either seen or done. They reported that reflecting on poor practice helped to reinforce what good practice was. Whilst looking at things that can go wrong can be a useful learning experience, so too can engaging in reflection on the positive and on occurrences from everyday practice (Howatson-Jones, 2010, p. 8; Rolfe, Freshwater & Jasper, 2010, p. 41). This is something that students should be encouraged to engage in, a possible mechanism for which could be facilitated reflective sessions. Supervised reflective practice has been identified in the literature as an effective mechanism for facilitating reflection on practice in student nurses (Cunningham, 2006; Suikala et al., 2008).

Portfolios and reflective diaries are promoted in nurse education as a means of encouraging reflective practice (Green & Holloway, 1997; Harding, 2002; NMC, 2004, 2010). However, it is evident in this student cohort that this was not a useful way to encourage reflection and that facilitated reflection may be more beneficial (Cunningham et al., 2006; Suikala et al., 2008). This has just been included in the communications course and the informal feedback from students so far supports this view. The literature had suggested that students' own life experience could be influential in how they develop relationships with patients but the students had no experiences to report in either group interview (Cunningham et al., 2006). They were, however, able to comment on how the skills they were learning as part of the course were being utilised in other aspects of their lives. This has not previously been reported in the literature reviewed.

5.2.1 Summary - research question one

The researcher believes that all elements of research question one were answered. Students were able to articulate the key components and building blocks of the therapeutic relationship as identified in the literature. As they gained experience, they were better able to articulate this and developed a greater understanding of their own roles in developing the relationship. They had an understanding of the reciprocal nature of the relationship and were able to reflect on the benefits to both the patient and the nurse. They also recognised the importance of effective communication in establishing the relationship and were developing key skills in this area. Students reflected positively on the importance of patient interaction in their development. Although they found the theoretical input beneficial in providing a starting point, it was positive experiences with patients and feedback from mentors that allowed them to develop confidence in their communication skills and relationships with patients.

Mentors and other clinical staff had a significant impact on students' learning. Examples of good nursing and good interaction with patients stimulated students to emulate this behaviour and strive to improve. Examples of poor interactions were identified by the students and confirmed for them the type of nurse they did not want

to be. The author would suggest that the early input of education and discussion related to empathy and respect and that learning effective skills in communication minimised the potential impact of observing poor practice. Confidence was enhanced by a combination of solid grounding in theory and positive feedback from mentors and role models as well as from patients. The timing of educational input related to empathy is important and has been found to be significant both prior to this study and since (Nerdrum & Lundquist, 1995; Brown et al., 2011; McMillan & Shannon, 2011). This supports the researcher's decision to incorporate this at the beginning of the communication course.

5.3 Research question two - vignettes

Overarching question - What is student nurses' understanding of the therapeutic relationship, and what influences their growth in their ability to develop this relationship?

- **How would students respond to potentially awkward, embarrassing or sensitive patient nurse interactions, both by reporting what they would do and by trying to identify the feelings and potential responses of the patient? Are students able to identify their own potential feelings in relation to each of the scenarios?**

The first section of the vignette sought to identify indicators of empathic behaviour and respectful behaviour in the students' responses. Students at time point one had only completed two weeks of the course and no specific communication skills teaching or clinical experience had been undertaken. Other than the two students who had worked as auxiliary nurses, it is unlikely that the other students would have found themselves in these situations previously. Therefore, most of the students were required to imagine how they would respond at time point one.

5.3.1 Time point one

All students demonstrated evidence of behaviour that patients have reported as important in making them feel respected (Audit Scotland, 2007; Chochinov et al., 2006; The Francis Report, 2010; Delivering Dignity, 2010). Responses included

essential indicators such as introducing themselves, seeking consent and attempting to establish rapport. Some students achieved all of the indicators including protecting the patient's clothing and drawing the screens. When confronted with the patient's incontinence, most of the students put concern for the patient ahead of other considerations. They also stressed the importance of respecting and maintaining the patient's dignity and providing reassurance. Empathy is the third of Rogers' core conditions and, although it was evident that students were attempting to understand what the patient might be feeling, what they expressed was more akin to sympathy. Although both sympathy and empathy have compassion for the individual in common, sympathy focuses more on the sharing of an experience and feeling sorry for the individual as opposed to empathy, which is typified by an attempt to understand others' experiences (Kunyk & Olsen, 2001; Rogers, 2007, p. 1-5; Davies, 2011). Arguably, it is this understanding of the individual's situation that facilitates the development of appropriate interventions.

Most of the students were able to identify the range of emotions that might be experienced but expressed these as single words. Some students were able to articulate this better and demonstrated more understanding, not only of what the patient might be feeling, but why. All students made attempts to alleviate the patient's distress and expressed compassion. Some students did seem to be trying to empathise and made suggestions as to how they would alleviate embarrassment. This desire to provide compassionate care would support findings by Burhans and Alligood (2010), who suggested that the provision of compassionate care was important to nurses. The importance of the nurse patient relationship to student nurses has also been reported (Johnson, 1994; Wilkes & Wallace, 1998; Siukkala et al., 2008)

It was encouraging to see that, at this early stage, students demonstrated awareness of respectful behaviour. Kunyk and Olsen (2001) suggest that respect can be conveyed through behaviours even if there are no feelings of respect. The evidence in the literature suggests that respect is essential in developing the trust necessary to establish a therapeutic relationship and is the second of Rogers' core conditions

(Milton, 2005; Moore, 2005; Chochinov et al., 2006; Rogers, 2007 p. 1-5). When looking at the language students used to describe what they would do in each of the scenarios, there was a sense that this was something they would be doing *to* the patient rather than doing *with* the patent. Only a few students mentioned allowing the patient some input or talked about independence. This may have been because they were very conscious of their roles as nurses and were not confident enough to relinquish control, which supports the findings of Suikkala et al (2008).

When analysing section two of the vignette narratives it was concerning to see the high levels of anxiety recorded. In both scenarios, the students' anxiety was related to competence and the patients' reactions. Students were afraid of getting things wrong and not knowing what to do and this was particularly evident when dealing with the patient who was incontinent. This reinforces the importance of simulated learning prior to clinical experience (Skelton, 2009, p. 58; NMC, 2004, 2010). Students do have clinical skills practice prior to placement but these findings have prompted a review of this provision and in particular the need for debriefing (Skelton, 2008, p. 58). There is evidence in the literature that suggests that fear of not being able to deal with situations can create a barrier that inhibits the development of the therapeutic relationship (Spouse, 2001). It is also reasonable to suppose that, when on clinical placement, the relative unfamiliarity of the task will inhibit his or her ability to fully engage with the patient as their focus will be on carrying out the task correctly (Munnukka, 1996). They were also anxious about what the patient might think about how they were dealing with the situation. It may not be surprising that students are anxious at this stage in their training. However, as educators, we may have a tendency to forget how anxious we may have been at the outset and, to some degree, this may be true of mentors. While it would be impossible to eliminate all anxiety, students need to be offered an opportunity to discuss fears and anxieties prior to placement and perhaps simulated vignette scenarios in small facilitated groups would enable students to articulate fears and concerns (Skelton, 2008, p. 59). As previously discussed this could be facilitated by structured reflection as suggested in the literature (Cunningham et al., 2006; Suikala et al., 2008).

Embarrassment was also reported by the students and this was both their own embarrassment at the situation and feeling embarrassed for the patient, although this did not seem to prevent them from doing their best to minimise the impact on the patient. Some students seemed to think that reassurance from them should be enough, which suggests perhaps more of a focus on self than on the patient and an inability to empathise and understand why the patient might be feeling that way. A couple of students also expressed frustration and irritation both with the patient who was incontinent and Miss Young who was apologising. They were embarrassed and ashamed at these reactions, even though they made it clear that they would not let these feelings become evident to the patient. This was mentioned in group interview one, which was conducted a year after the vignettes, and suggests that feelings of guilt regarding what the students see as negative feelings and emotions persist. The problems that arise from nurses not being able to manage their emotions is documented in the literature (Salmon, 2000; Byrne et al., 2001; King's Fund Report, 2008; Gray & Smith, 2009; Sawbridge & Hewison, 2011). These findings suggest that nurse educators need to identify mechanisms for enabling students to explore and manage their emotions.

Although there was little evidence of empathy there was a great deal of sympathy expressed for the patients in both scenarios. Students felt very sorry for the patients in the vignettes, although a couple of students recognised that this might not be helpful. It was clear, however, that students felt compassion and recognised the importance of respect and of maintaining the patients' dignity.

5.3.2 Time point two

By time point two, most students were reporting all or most of the indicators of respect. Most students were also writing fuller accounts and appeared to engage with the vignettes. What appeared to be different was students' increasing willingness to allow the patient more control. This is consistent with the findings of Suikkala et al. (2008), who found that as students gained in experience they were more willing to work in partnership with patients. There was more a sense of a 'doing with' rather

than a ‘doing to’ and this was true for both scenarios There was evidence of students engaging with the patient in a more relaxed way and much more evidence of trying to understand not just what the patients were feeling but why.

The students were able to identify a broader range of emotions that the patient might be experiencing and some students were developing an ability to empathise and were attempting strategies to ease the patients’ feelings of embarrassment. Most students were attempting to understand what the patients were feeling and trying to respond in a way that they thought might alleviate this. It would be reasonable to presume that this improvement was in part related to clinical experience of working with patients and observing how other staff members dealt with difficult situations, supporting the important role of the mentor/role model (Spouse, 2001; Hockley, 2008; NMC, 2010). This vignette was completed in the same time frame as group interview one, where students discussed the positive impact good role models had on their own practice. However, some students still appeared to feel that reassurance from them should be enough to allay embarrassment (with Miss Young), although they were not as dismissive as they appeared at time point one. This suggests that these students were not yet able to empathise with the patient, although they did report that it was their role to alleviate distress and mak attempts to do this.

There were two students (P10, P12) whose responses were almost identical to those in time point one and the researcher suspected that this may be due to lack of engagement with the vignette or that the student remembered the vignette and gave a similar response. This is a documented disadvantage of using the same vignette (Chau et al., 2001). There is, of course, the possibility that neither of these students had moved on. However, the researcher had no means to explore this as part of the study. It was also evident at this time that students were beginning to develop their communication skills and referred to this in their responses to the vignettes. There was reference to positive body language and making eye contact as well as seeking alternative ways of communication with Mr Smith if his ability to communicate was impaired. This development of communication skills was also reported by students in group interview one.

When comparing the findings of the vignette at this time point with the findings of group interview one, there would seem to be a correlation between what students were discussing and how they responded in the vignettes. In the group interview students demonstrated an understanding of the key components of the therapeutic relationship such as respect, compassion, recognition of empathy, effective communication and establishing rapport and reflected what is reported in the literature in relation to factors necessary for the establishment of the therapeutic relationship (Rogers, 1957; Forchuck, 1992; Taylor, 1998; Bowles, 2001; Chochinov et al., 2006; Chochinov, 2007; McLuskey et al., 2011). The vignette responses suggested that most students had an understanding of these skills and behaviours and hypothetically put them into practice.

On reviewing the feelings that the students reported in section two of the vignette, it was clear that a number of students still experienced quite a lot of anxiety. For most students, anxiety was related to the patients' well-being. As their nursing knowledge increased they were more aware of the potential risks to the patient if they did something wrong, such as the danger of choking in a patient who has suffered a stroke. Students also worried that they might be causing the patient more embarrassment. A couple of students were still anxious regarding their competence but one student in particular still seemed to lack any confidence and reported what appeared to be high anxiety. What was also evident was a growing awareness of the patient's situation. The students were reporting in their responses that they were not only recognising what the patient might be feeling but trying to understand what the patient might be experiencing. Although sympathy was still being reported, this trying to understand and subsequently suggesting what might be an appropriate response is indicative of a growing ability in the students to empathise with the patient. Understanding what an individual may be feeling is a key component of empathy and is one of the factors that distinguish it from sympathy (Kunyk & Olsen 2001; Davies, 2011).

Students were also beginning to be aware of how good it made them feel when they could help the patient and provide comfort and reassurance. This was also evident in group interview one where the students reported on the benefits to both the patient and the nurse and the mutuality of the relationship (Pepalu, 1997). Feelings of frustration were much more evident at time point two and were related to annoyance at the situation, although students were at pains not to show this to the patient. This attitude reflects Peplau's (1997) maxim that the nurse should endeavour to 'struggle with the problem and not with the patient'. Students were also anxious that the situation had been caused by an omission on their part. This reinforces the need to ensure that students have an opportunity to reflect on incidents occurring in practice.

5.3.3 Time point three

At time point three there was little further development in relation to respect as most students were demonstrating respectful behaviours by time point two and this was fully developed by time point three. Respect for the patient is the second of Rogers' core conditions essential to the therapeutic relationship (Rogers, 2007 pp. 1-5). Interestingly, the same two participants (P10, P12), discussed previously, again demonstrated little change and one student arguably demonstrated some regression, although the hypothetical nature of the vignette does not mean that the student actually regressed and is a limitation of the vignette. Knowing that both students actually perform well in the clinical area and have received positive feedback from mentors, the researcher is persuaded that familiarity and or boredom with the vignette are probable reasons. Most students appeared fully engaged with the vignettes and some wrote rather lengthy narratives. Those who had shown less development at time point two had developed more at time point three. The pace of development may also have been influenced by the quality of the clinical placements and the feedback from mentors.

Students were more willing to work with the patient and positively encouraged independence. This is possibly due to their own increasing confidence in their abilities and feeling comfortable in the clinical environment, again mirroring the findings of Suikkala et al. (2008). This was also reflected in group interview two

which was conducted within the same time frame as the time point three vignettes. Most students were reporting empathic responses and had much better understanding of not only what the patient might be feeling but why. This allowed them to attempt to respond in ways that they thought might be helpful. This indicates a move from feeling sympathy, recognition of what the patient might be feeling, to empathy, where there is more of an understanding of what the patient is feeling (Kunyk & Olsen, 2001; Davies, 2011). This development of empathy is the third of Rogers' core conditions essential for a therapeutic relationship. As these students were also demonstrating respect, they were also fulfilling the second of Rogers' core conditions (Rogers, 2007, pp. 1-5). However, Rogers suggests that empathy is not a state of being but a process, whereby the clinician is checking out that their perceptions are correct, taking their lead from the patient. Those students who appeared to develop most in relation to empathy were students who were able to do this. By the process of checking out their perceptions, they were conveying to the patient that they were trying to understand, which fulfilled Rogers' fifth and sixth conditions where he emphasises the importance of the patients knowing they are respected and sensing the clinicians' desire to understand (Rogers, 1959, cited in Wyatt, 2002, p. 3). There was again increasing evidence of the students' development in communication skills and they were now using quite sophisticated approaches such as open questions, prompting and silence. There was also an increased awareness of how their body language could impact on the patient and they were also more able to read the cues in the patient's body language (Hargie, 2006, p.11; Bach & Grant, 2009, p. 54).

In section two of the vignette, with the exception of a few students, there was little evidence of students reporting their own feelings. Most students reported feelings in relation to the patient. Although on the surface this may seem admirable, there is evidence to suggest that nurses do suppress their own feelings and emotions which, in the longer term, may lead to emotional distancing from the patient and burnout (Gray & Smith, 2009; Kings Fund Report, 2008). There was evidence of empathy rather than the sympathy reported previously and related to this the importance of dignity and respect was very evident. This progression to demonstrating empathy

rather than sympathy indicates that the students were willing to try and understand what the patient was feeling. These findings are consistent with the literature, where the understanding associated with empathy is viewed as taking sympathy a step further in order to facilitate the appropriate interventions (Rogers, 2007, pp. 1-5; Kunyk & Olsen 2001; Davies, 2011).

Students also reported a great deal of role satisfaction in being able to help the patient, even more so than at time point two. There was also a real sense of being professional nurses and seeing themselves in that professional role. There was a definite increase in confidence except in one student who still reported a great deal of anxiety. During member checking this was discussed with the student and strategies put in place to help the student manage this.

When comparing the findings of the vignette at time point three with the findings of group interview two, they would again appear to mirror each other. The increasing confidence that the students reported in the group interview was reflected in how they responded to the vignettes. The behaviours and attributes identified by the students as being important in developing the therapeutic relationship were 'acted out' in how students responded to the scenarios. The students were reporting in the scenarios how they were using the essential communication skills they had discussed in the group interview.

5.3.4 Summary - research question two

The researcher believes that research question two was answered. With the possible exception of two students, the group appeared to engage with the vignettes and was able to report how they would respond in the simulated situations. The responses to the vignettes demonstrated development in empathy and respect over time with students also demonstrating an increase in skill and confidence related to communication and other aspects of the therapeutic relationship such as establishing rapport. This increasing confidence and competence enabled the student to consider more of a partnership approach to care and the promotion of independence. Reassuringly, from the earliest time point, students were conscious of the importance

of respect and dignity and this was a recurring theme at all three time points. Students were aware of their own feelings, and there was evidence that they were able to reflect on these in relation to the care they would provide. However, by time point three there was less evidence of students identifying their own feelings with much more focus on patients' feelings. Levels of anxiety were high at time points one and two but as students became more confident and experienced, this allowed for a more collaborative relationship with the patient by time point three.

There appeared to be a correlation between group interview one and vignette two and group interview two and vignette three in relation to understanding and development of the therapeutic relationship and communication and how this was actualised in practice via the medium of the vignette. This suggests that students could not only discuss what good practice was but could demonstrate this in the simulated situation.

5.3.5 Comparison of findings over time

Between group interview one and group interview two, the attitudes of the students to the key role played by communication skills had changed. Although, in group interview one, students recognised that communication skills were important, by group interview two the students were more emphatic in their belief that good communication was essential to developing a good therapeutic relationship. This recognition that good communication is essential in developing a good therapeutic relationship supports what is found in the literature (Faulkner, 1998; Chant et al., 2002; Moore, 2005; Marchese, 2006; Arnold and Underman Boggs, 2007, pp. 99-100; Lewin et al., 2009; The Health Care Quality Strategy, 2010; Time to Care?, 2011; Care & Compassion? 2011; Brown et al., 2011). It was also evident by the examples given by the students that they had developed their communication skills and were more confident in using them.

In group interview one the students had expressed the view that the therapeutic relationship was something that 'just happened'. However, by group interview two, this belief had changed and there was a realisation by the students that the therapeutic relationship was something that did not 'just happen', but had to be

developed. They realised that the behaviour and attitude of the nurse played a role in the successful development of the relationship. This is again consistent with the findings in the literature in relation to the impact of the attitudes and behaviours of nurses on developing an effective relationship between the nurse and the patient (Forchuck, 1998; Bowles et al., 2001; Collins, 2005, 2009; Chochinov et al., 2006; Chochinov, 2007). Another development between group interview one and group interview two was that the students appeared to have a firmer understanding of the purpose of the relationship, which was to work with the patient to achieve identified health goals.

Between the two time points there was also an increase in the reporting of negative interactions the students had observed while working in the clinical area. Although the experiences were negative, students were able to use these observations positively as a means of confirming for them how they would wish to practise. Students were also more aware of how much of their learning was attributable to good role modelling and the learning gained from working with patients (Spouse, 2001; Suikkala et al., 2008; Hockley, 2008; NMC, 2010).

In the vignette findings, key differences between time point one and time point two were that students' responses indicated a willingness to allow patients more control and a willingness to work in partnership. This partnership approach was even more evident in the time point three responses, with students indicating increasing attempts to work in partnership with patients and positively encouraging patients to be independent. Students' responses also indicated an increase in their confidence in their roles as professional nurses. This is consistent with the findings of Suikkala et al. (2008), who found that partnership working with the patient became more evident as the student gained experience. This increase in confidence is mirrored in the findings of group interview two, which was undertaken within two weeks of the completion of the time point three vignette, meaning that the students were therefore at the same stage in their learning.

Students were also able to identify a broader range of emotions that patients might be experiencing and demonstrated in their responses how they were attempting to not just recognise, but understand, what the patient might be feeling. The ability to understand what someone might be feeling is an important aspect of empathy and is one of the factors that differentiate between empathy and sympathy (Rogers, 2007, pp. 1-5; Kunyk & Olsen 2001; Davies, 2011). Students' responses in relation to demonstrating respect showed the greatest increase between time point one and time point two. By time point two, students' responses indicated an awareness of the importance of respecting patients' dignity and how important this was in developing their relationships with the patients and the provision of good care. The students also indicated how this could be achieved and made references to the importance of addressing patients appropriately, ensuring privacy and maintaining confidentiality. These findings reflect what is reported in the literature in relation to the importance of respect for dignity in developing effective relationships with patients and the delivery of good care (Haddock, 1996; The Essence of Care, NHS, 2003; Price, 2004; Chochinov et al., 2006; NMC, 2007; Chochinov, 2007; Delivering Dignity, 2010).

5.4. Relationship of findings to demographic data

There were insufficient numbers to draw any meaningful correlations from the findings. There was no evidence that the student who had undertaken a psychology degree performed either worse or better than other students and this confirmed that it had been appropriate to include her in the study. Interestingly, the student who appeared to demonstrate most development in empathy had had no previous experience in any of the fields asked for in the demographic questionnaire. Although work by Siukkala et al. (2008) suggests that more mature students are better able to enter into a partnership relationship with patients, this was not found in this study. Although there were only three students in the over 25 age group, there was no indication that they performed better or worse than younger students. Previous experience in communication skills did not appear to correlate with performance in this group.

5.5 Comments on the communication skills course

Although the study was by no means a formal evaluation of the communication skills course, it would appear that the course structure has facilitated the development of the underlying concepts of empathy, respect and self awareness as well as core communication skills. However, it is acknowledged that the course was not measured against the previous course, which may also have facilitated these developments. The author is also conscious that some of this development may have occurred as the students increased in maturity and life experience. The inclusion of teaching on the theoretical aspects of communication and the therapeutic relationship such as understanding empathy, developing self awareness and respect for dignity, as well as core communication skills such as reflecting, paraphrasing and interpreting cues, appears to have been helpful early in the students' nurse education. This is supported by the findings of both group interviews and the vignettes and reflects what is reported in the literature (Nerdrum & Lundquist, 1995; McMillan & Shannon, 2011; Brown et al., 2011). Students recognised that the theoretical underpinnings provided a firm foundation on which to build these skills when working with patients and mentors in the clinical area. This again supports what is reported in the literature regarding the importance of practice and theory in skills development (Hargie, 2006, pp. 1-3).

The Johari window, which was used as part of the course to encourage development in self awareness, received mixed reviews. This may have been as a result of how it was utilised and the researcher intends to explore the work of Jack and Miller (2008) in relation to utilising it as a means of developing reflection and experiential learning. The advanced skills element of the course using simulated patients, video recording and feedback was undertaken after completion of the study so could not be reported formally. However, this is reported in the literature as being an important part of communications skills rehearsal **(**Gysels et al., 2005; Lane & Rollnick, 2007; Ramsey et al., 2008). Feedback from the students was very positive and they all agreed that undertaking this level of simulation would not have been helpful earlier. This would support the view of McCarthy et al (2008) who suggested that this level of simulation was most useful in the final year of training. Feedback from the

simulated patients was also extremely positive and they were impressed by the level of skill demonstrated by the students.

5.6 Contribution to the field

In the literature reviewed, no studies were identified that explored students' experiences of developing therapeutic relationships. It is therefore believed that this study offers a unique insight into that experience. The findings highlight a number of areas not previously identified in the literature. The levels of anxiety and guilt that students reported in relation to the simulated situations should be of concern to nurse educators. Although it is acknowledged that the vignettes may not necessarily reflect what students might feel in actual situations, the researcher's own experience of working with students supports the premise that many students do experience these emotions. Students need permission to acknowledge negative emotions and to develop strategies to manage these powerful emotions whilst developing realistic expectations of themselves. An inability to deal with emotions and feelings of guilt is associated with burnout, which may inhibit a nurse's ability to provide compassionate care (McMillan & Shannon, 2011).

The study also identified which aspects of the communication skills training course were most useful when communicating with patients. These were active listening, the use of silence and knowing when to ask different types of questions such as open questions. Although these skills are identified in the literature as important, they have not been previously reported in the literature in the context of undergraduate nurse education. In particular, the effectiveness of silence and listening was found by students to be most helpful. The findings also highlight the importance of embedding education and discussion related to empathy and respect early in the curriculum and are consistent with the literature (Nerdrum & Lundquist, 1995; McMillan & Shannon, 2011; Brown et al., 2011). However, the author believes that this study offers insight into students' experiences not hitherto reported in the literature.

The study also highlights the important role that mentors and other clinical staff had on the students' development. Although the important role of mentors is well

documented, the author is not aware of any other study that highlights the amount of detail students observe about how nursing staff and other clinical staff interact with patients.

5.7 Methodological approach

A naturalistic paradigm was adopted for the study, which was congruent with the ontological and epistemological beliefs of the researcher. A case study methodology was deemed an appropriate choice as the researcher was seeking to answer a *how* question and had little control over elements of the students' learning events and how the phenomenon under study occurred in a real life context (Yin, 2009, pp. 2-7). The researcher believes the research aims were met and the research questions answered, which further supports the methodological approach, the selected research design and the data collection methods.

Within the case study methodology, a single case holistic approach was the research design of choice and was consistent with Yin's fifth rationale where the study is longitudinal, observing the same 'case' and, looking for differences at points in time where the desired or expected changes would be expected to occur and there is a single unit of analysis (Yin, 2009, p. 51). The researcher believes that the study under discussion meets the above criteria as the cohort was considered to be a single case. The aim of the study was to explore the understanding and growth of the therapeutic relationship in undergraduate student nurses and the factors that influenced this growth. The time intervals were chosen to represent milestones in the students' learning both from an academic and a clinical perspective. Furthermore, the study utilised more than one method of data collection, which is also consistent with a case study methodology.

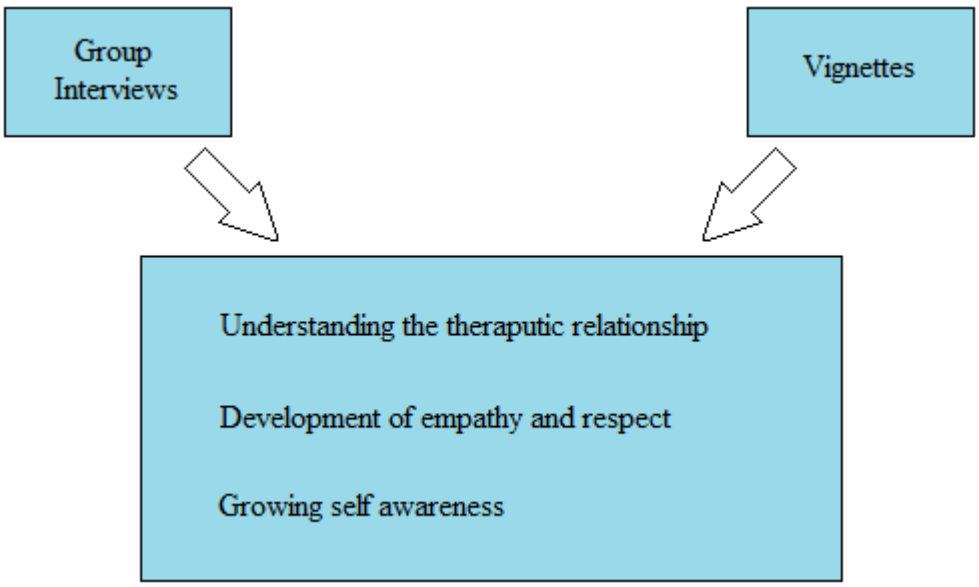
The longitudinal nature of the study posed some difficulties in relation to data collection. The researcher had little formal contact with the students after first year so coordinating times for the group interviews and completing the vignettes was sometimes difficult. The researcher was also concerned that the longitudinal nature of the study would result in some students either leaving the study or failing to come

to group interviews or complete vignettes. This proved not to be the case, with only one student leaving the study after it commenced.

5.7.1 Triangulation

Data were collected from two different sources with the aim of answering the overarching research question. Each method of data collection sought to answer different aspects of the question. The researcher is cautious in claiming that triangulation was achieved according to the criteria suggested by Yin (2009, pp. 116-118). Certainly there were no contradictions between the two sets of findings and in most aspects there was agreement. The 'facts' of the case study that are supported by both methods of data collection would appear to be that: (1) student nurses do have an understanding of the therapeutic relationship; (2) student nurses did demonstrate growth in empathy and respect over time; (3) student nurses did demonstrate self awareness. In light of this, the researcher believes that triangulation was achieved in respect of these three 'facts'.

Fig. 5. Converging data - adapted from Yin (2009, p. 117)



5.7.2 Data collection instruments - group interviews

Although considered by some to be inferior to individual interviews (Bloor et al., 2002, p. 43), the researcher believes that for the purposes of this study it was the correct approach. The participants were a homogenous group, in that they were all student nurses, had chosen to study at the institution where the study was conducted and all aimed to be registered nurses. A group interview was therefore appropriate (Noaks & Wincoup, 2004, p. 78). Individual interviews in this situation would not have stimulated the discussion that resulted in the rich data that emerged from the group. It is a consideration that, in any group setting, one individual may dominate or a group member may not participate. There was no evidence of this as each group member contributed to the discussion and the facilitator managed the interview to prevent any individual from dominating. It was beneficial to have an experienced facilitator conducting group interviews, who was unknown to the students. This allowed the researcher to take field notes, which were invaluable during data transcription and analysis. The topic guide proved flexible enough to allow free discussion but ensured the participants stayed with the topic.

5.7.3 Data collection instruments - vignettes

The vignettes did appear to elicit real responses from the students and most students appeared to engage with them. Two students did not appear to engage. One student may have been bored with the vignette and the other student appeared to have remembered previous responses. The strengths of the vignette as a data collection method for this study were: (1) that they allowed participants to respond to the stimuli on their own terms; (2) they compensated for the student nurses' lack of experience of dealing with awkwardness; (3) they facilitate some insight into students' conceptual understandings. The researcher would suggest that these are robust reasons for the use of this data-gathering technique.

There are methodological limitations in the use of vignettes. Students' reported responses may not reflect actual behaviour while in a clinical situation. Direct observation would have been a possible method of triangulation but, as this would have involved patients in the research study, it was not a feasible option at this time.

However, it is believed that what the students reported in the focus groups supported the responses in the vignettes. Member checking with both the vignettes and the focus group transcripts further enhanced understanding and accuracy.

Vignette 'fatigue', or remembering the scenario is another potential problem of vignettes (Chau et al., 2001). This has to be balanced with the problems of comparability associated with using different, albeit similar vignettes. Only two students appeared to not fully engage with the vignette, which suggests that the use of the same vignette was appropriate. Whilst the researcher would consider using vignettes again, the vignettes used in this study were perhaps too long and possibly one scenario would have been sufficient.

5.7.4 Trustworthiness

The issue of rigour, or trustworthiness, in qualitative research is well documented and there is much debate over which terminology should be used. The researcher has aimed to establish rigour using the criteria proposed by Lincoln and Guba (1985, p. 290). The researcher believes dependability has been established by ensuring that there is an audit trail that has made clear the research design, the data collection methods and the steps to analysis and findings.

Credibility was established by regular peer-debriefing and the use of member checking with both the group interview transcripts and the vignettes. The researcher also used verbatim transcription and an appropriate sampling strategy. In addition, both the group interview topic guides and the vignettes were reviewed by a panel of experts and piloted prior to use. Confirmability was established using the aforementioned techniques and inter coder checking for both the group interviews and the vignettes.

It is difficult to claim that transferability was fully achieved and Lincoln and Guba (1985, p. 316) suggest that the researcher must provide an in-depth account of the setting, the participants and the findings so that other practitioners in the field can consider the relevance of the work to their own situations. The researcher has

endeavoured to achieve this by providing demographic details of the participants, ensuring the rigour of the study, and reporting the findings honestly.

The researcher aimed to achieve authenticity by ensuring that the participants were fairly represented and believes this was achieved by member checking and inter coder checking. A degree of ontological authenticity was achieved as the study contributed to the knowledge in the field of study. Educative authenticity is more difficult to claim. Based on student feedback, it would appear that students benefited from participating and claimed that it stimulated them to think more about the therapeutic relationship and they valued the opportunity to interact with one another. However, this is informal self report and is not claimed as evidence. Catalytic authenticity has been achieved to some degree as the research has already prompted curricular change in relation to simulated learning and reflective practice within the researcher's own HEI. Its ability to stimulate change in the wider nursing community and tactical authenticity has not yet been tested.

Reflexivity is an important aspect in establishing trustworthiness. This was achieved by documenting in a research diary pre-conceptions and suppositions prior to data collection and analysis. This was kept under review during the data analysis process. The researcher also sought regular peer-debriefing and discussions with the academic supervisor.

Chapter 6 Conclusion and recommendations

6.1 Conclusion

The aim of the study was to contextualise undergraduate student nurses' understanding of the therapeutic relationship and their ability to develop this with patients, in the context of providing essential nursing care. The study also aimed to explore the pedagogical design elements which influenced this. This aim was underpinned by one overarching research question and operationalised by two specific research questions. The researcher believes that the aims of the study were met and the research questions answered. The key findings of the study were that student nurses had an understanding of the therapeutic relationship from an early stage in their learning. This understanding developed over time, with students demonstrating an increasing ability and desire to enter into this relationship. Students recognised that key components of the relationship included establishing trust and good communication. Encouraging students to consider the underlying principles of communication and the therapeutic relationship at the outset allowed them to consider the nature of the relationship they wanted to develop with patients.

Although a formal evaluation of the communication skills course was not the main focus of this study, it was evident that the communications skills course had had a positive impact on the students' abilities to establish therapeutic relationships. This confirms the important principle of embedding communications skills training throughout the curriculum. Communication skills, together with development of the underpinning concepts of empathy, respect and self awareness, are key skills and attributes of professional nursing practice. Therefore, the need for undergraduate nursing curricula to be designed to ensure that these aspects of education are firmly embedded and assessed is fundamental to the development of the nursing profession.

Students demonstrated an awareness of the barriers and facilitators that impact on the therapeutic relationship and identified factors such as pre-conceived beliefs about patients, nurses' behaviour and ward culture. Students also recognised that there were unavoidable factors, such as the busyness of the clinical area, that may impact

on patient care, but identified that trust could be maintained by giving apology where appropriate.

An incremental approach to communications skills teaching gave the students a base from which they could further develop their skills and enabled them to identify poor practice when they encountered it. However, developing confidence and competence in these skills was gained from positive interactions with patients, feedback from mentors and observing good practice in other clinical staff. Students engaged in reflective practice but found this most helpful when they were able to discuss practice issues with peers. Portfolios were under-utilised as a mechanism for reflection, although they were utilised as a means of documenting learning related to the acquisition of practical nursing skills and monitoring their progress.

Students demonstrated a willingness to treat patients with dignity and respect from the outset. They also demonstrated willingness to enter into an empathic relationship with patients. This was evident from the findings from the group interviews and was indicated in the vignette responses. Students demonstrated growth in both empathy and respect over time, with all students demonstrating a willingness and ability, hypothetically, to engage with the empathic process by the end of the study. The move from feeling sympathy for the patient in the early part of their nurse education to empathy was something the students were able to reflect on as part of their development as professional nurses. It is clear, therefore, that Rogers' work on empathy can inform nursing curricula in clarifying the difference between empathy and sympathy and deepening student nurses' understanding of the importance of empathy in developing meaningful and therapeutic relationships with patients. Students did demonstrate some degree of self awareness and were able to report their own feelings. However, they did report feelings of anxiety and guilt if they perceived these feelings to be inappropriate. Over time, students tended to report their own feelings less and tended to focus more on patients' feelings. These findings led to the recommendations for practice outlined below.

6.2 Recommendations for practice

- Post-placement experiences should be explored in reflective practice sessions that allow the students to discuss their feelings and develop management strategies. This could reduce the anxiety, guilt and frustrations experienced by students and allow them to explore the normality of these and other emotions to prevent unnecessary feelings of guilt that were reported in this study.
- Opportunities for simulated learning should be core elements of the curriculum with a greater emphasis on emphasis on debriefing.
- Both Peplau's and Rogers' theories emphasise the importance of empathy, respect and self awareness as concepts fundamental to development of the therapeutic relationship and therefore teaching related to these concepts must be incorporated into the nursing curricula at an early stage.
- Communication skills training in the undergraduate curriculum must include the teaching of, and opportunity for rehearsal of, the fundamental communication skills such as active listening, questioning, use of silence, reflection and summarising. In addition, teaching should also include awareness of non-verbal communication, body language and proxemics.
- Development of the essential communication skills should be incremental, culminating in videotaped role play with simulated patients in the final stages of training, as suggested in the literature. This should be accompanied by timely and sensitive feedback.
- Constructive feedback on communication skills and the ability to engage with the patient should be given by mentors while the student is on clinical placement.
- Assessment methods should reflect achievement of key learning outcomes previously identified in chapter one and include assessment of the theoretical component, which could be achieved either by a reflective essay or carefully crafted exam questions.

- The skills component could be assessed using videotaped observed structured clinical examination (OSCE), which would allow the student to critically reflect on their own performance and identify areas for improvement.
- There should be more robust evaluation of approaches to communication skills training in undergraduate curricula in order to determine the best approach.
- Clinical mentors should be facilitated to continue to maintain and develop their own communication skills.
- More opportunities for structured reflective practice with peers need to be incorporated into the curriculum. These should be facilitated by an experienced clinician or member of staff with clear ground rules to ensure safety.
- Clinical staff need to be more aware of the impact their attitudes, behaviour, and the ward culture have on student nurses and this should be incorporated into mentor preparation.
- New ways must be explored to engage students in portfolio activity and reflection. This is a requirement of the NMC (NMC, 2004, 2010). However, it is evident from this study that, from an early stage, students do not utilise them effectively to develop reflective practice.
- The findings suggest that nurse educators need to identify mechanisms for enabling students to develop strategies for managing their emotions and developing professional boundaries.

6.3 Limitations of the study

- This was a small study, which of course limits the generalisability of the findings.
- The self report nature of the data collection methods may not report the actual performance of the students. Students' individual writing styles may also enhance or inhibit their abilities to self report. However, it is believed that member checking did go some way to mitigate this.
- It is acknowledged that there are limitations to using vignettes as opposed to real life situations. In the vignette the student is being asked to hypothesise

about how they would respond in a given situation and there is no guarantee that they would respond in the same way when faced with the situation in real life.

- A quantitative approach to measuring the growth in empathy and respect, by applying values to the indicators, may have demonstrated more explicitly where and how much growth had occurred. However, the author has presented reasons why this was considered but rejected in chapter three.
- The students in this study chose an Honours degree nursing course that has one of the highest entry requirements of all HEIs in Scotland. This perhaps indicates that these students are not typical of nursing course students on other Ordinary degree programmes.
- The study was conducted in a small school of nursing with an average intake of 45 students, whereas the majority of schools of nursing have intakes in excess of 200. The small class size may make it easier to facilitate small group reflection and discussion.

6.4 Direction of future research

- Further studies are needed to evaluate the effectiveness of incorporating the underpinning concepts of empathy, respect and self awareness in the nursing curricula.
- Further research is required into the mechanisms student nurses find most useful for developing reflective practice.
- It would appear from this study that students are willing and able to develop good nurse patient relationships. Longitudinal studies following students from training into their roles as registered nurses may identify work place issues that impact on nurses' abilities to maintain this over time.
- Further studies exploring the impact of role models and clinical mentors could inform mentor preparation.
- Exploration of Peplau's model as a tool for research related to aspects of the nurse patient relationship.
- Further exploration of the applicability of Peplau's model in the context of contemporary health care in general nursing.

6.5 And finally

In relation to students' understanding of the therapeutic relationship and its central role in nursing, it is appropriate to give the final words to the students.

> *"Yeah, like you can be good at the practical things but I think having a good therapeutic relationship with someone is what makes you a good nurse and that's what affects the patient most. I've definitely learnt the importance of it and it's something that you sort of strive for*."

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Appendix

Existing Provision			
BN1 Related topic	**Hours**	**Section of the curriculum**	**Teaching strategy**
Communication	3.5	Nursing 1	Lectures
Nurse- patient relationship	1	Nursing 1	Lecture / small group discussion
Concepts of caring (empathy explored in this session)	1.5	Nursing 1	Lecture
Developing Self Awareness	2	Psychology, sociology and health promotion	Lecture
Communication with individuals with learning disabilities	2	Psychology, sociology and health promotion	Lecture
BN2 Related topic	**Hours**	**Location**	
Communication	4	Palliative care week	Lecture / communication 'games'
BN3 Related topic	**Hours**	**Location**	
Communication skills and breaking bad news (with a cancer focus)	2	Nursing 3	Lecture
Communication issues	2	Cancer week	Lecture

New Course Outline

Year 1 -Indicative content

- What is communication?
- Basic communication skills
- Exploring self awareness
- What is empathy?
- Understanding the therapeutic relationship
- Respect in nursing
- Communicating with individuals with impaired communication
- Facilitated reflective practice following clinical a period of clinical experience

Examples of learning outcomes

At the end of year 1 communications the student will be able to:

- demonstrate their understanding of the concept of communication (K)
- use their knowledge of basic communication skills in the clinical setting (S)
- reflect on and challenge their own attitudes and beliefs (A)

In addition the simulated learning in the clinical skills suite will be enhanced to ensure rehearsal of skills and knowledge with an emphasis on rehearsing basic communication related to nursing activity e.g. feeding & personal hygiene.

Year 2 - Indicative content

- Facilitated reflective practice following a period of clinical experience
- Barriers to developing the therapeutic relationship
- Challenging communication situations

Examples of learning outcomes

At the end of year 2 communications the student will be able to:

- apply theoretical knowledge of communication skills to challenging communication situations (K & S)
- apply communication skills to clinical practice in order to develop the therapeutic relationship (K&S)
- critically discuss attitudes and values that create barriers to effective communication (A)

In addition the simulated learning in the clinical skills suite will be enhanced to ensure rehearsal of skills and knowledge with an emphasis on rehearsing communication related to carrying out more complex procedures e.g. passing naso-gastric tubes.

Year 3 - Indicative content

- Giving complex information
- Giving significant news
- Dealing with complex communication situations
- Communicating with the angry patient/relative
- The role of communication in health care

Examples of learning outcomes

At the end of year communications the student will be able to:

- select and use appropriate communication skills to challenging communication situations (K & S)
- critically analyse and discuss the key role of communication in the context of health care delivery (K& A)
- critically analyse and discuss the relationship between communication and the therapeutic relationship (K)

In addition the simulated learning in the clinical skills suite will be enhanced to ensure real rehearsal of skills and knowledge with an emphasis on rehearsing communication related to caring for patients with complex and acute care needs e.g. care of the critically ill patient, care of the patient admitted to A&E. Students in third year will also undertake an intensive 3 day communications skills course involving video-taped role play with simulated patients (actors). The student will receive a copy of their DVD and be asked to write a critical reflection on their performance.

Appendix 2

Reg. No:

I.D.

Demographic Questionnaire

Title of the Study

The therapeutic relationship: an exploration of its understanding and growth in undergraduate student nurses

Thank you for agreeing to complete the following questionnaire. You are just about to commence on a 3 / 4 year nursing degree of which communication and the therapeutic relationship play an integral part. The questionnaire is seeking information on your biographical data and information related to your previous experience in relation to communication skills and the therapeutic relationship.

The contents of the questionnaire will be treated in the strictest confidence.

Please complete the following:-

Today's Date: ☐

1. Sex M ☐ F ☐

2. Have you had any previous nursing or caring experience?
   (Please tick) **(√)**

   Yes ☐

   No ☐

If you answered no please go to question 4

3. Where did you gain your previous nursing / caring experience?
(please tick all that apply) **(√)**

Nursing Home	☐
Hospital	☐
Caring for family member	☐
G.P. Practice	☐
Other	☐

If you answered other please give details here

4. In what capacity did you undertake you previous nursing / caring experience/
(please tick all that apply) **(√)**

Carer	☐
Health care assistant	☐
Volunteer	☐
Work experience	☐
Other	☐

If you answered other please give details here

5. Have you yourself been in receipt of nursing care?

Yes ☐

No ☐

If you answered no please go to question 6

Please comment on your experience if you wish

6. Have you had any education or training in communication?
(please tick) **(√)**

Yes ☐

No ☐

If you answered no please go to question 7

If you answered yes to question 6 what form did this education / training take?

At school ☐

Work orientation ☐

Designated communication skills course ☐

Other ☐

If you answered other please give details

7. Have you had any education or training in psychology?
   (please tick) **(√)**

   Yes ☐

   No ☐

If you answered no please go to question 8

If you answered yes to question 7 what form did this education / training take?

School qualification ☐

Degree ☐

Diploma ☐

Certificate

Other ☐

If you answered other please give details

8. Have you had any education or training in counselling?
(please tick) **(√)**

Yes ☐

No ☐

If you answered yes to question 8 what form did this education / training take?

Counselling certificate ☐

P.G. Diploma in counselling ☐

Other ☐

If you answered other please give details

Thank you for taking time to complete this questionnaire

Appendix 3

Study Title:
The therapeutic relationship: an exploration of understanding and growth in undergraduate student nurses

Group interview one - topic guide

Interview topic	**Example prompts**
General introductions	• Introduce Lorna • Setting ground rules • How are you getting on in year 2?
Understanding of the therapeutic relationship	• What do you understand by the therapeutic relationship? • Is there a difference between that and good communication?
Information about the role of the mentor	• Have you seen good examples of the therapeutic relationship in your mentors? • Can you describe an example? • How did you recognise it, what stood out? • Were you aware of the impact it had on the patient? • What effect did it have on you in relation to your own nursing practice?
Information about the influence of other nursing / clinical staff	• Have you seen good examples of the therapeutic relationship in any other staff e.g. other nurses, auxiliaries, doctors or AHPs • Can you describe an example? • How did you recognise it? • What effect did it have on you in relation to your own nursing practice?
Information about the impact of teaching	• Did the teaching you had on the communication course help you understand the therapeutic relationship and in what way? • What elements of the teaching were most helpful • Where do you think you have learned most about good communication or the therapeutic relationship – school or placement? • Why is that - can you explain your answer?

Personal experience that may have had an influence	• Have you had any personal experience that has influenced your understanding of the value of the therapeutic relationship (only if you are comfortable about sharing it with the group)?
Information about the use of reflection	• Do you use your portfolio for reflection on experience or just to record things you have done? • Has any of this been about communication or the therapeutic relationship? • Do you think using reflection, for example in your portfolio, has ever helped you to understand the therapeutic relationship or changed the way you practice and can you give an example?
Winding up and thanks	• Is there anything else you would like to mention? • Thank you for agreeing to share your experience with me

Appendix 4 - Group interview 2 - topic guide

Title: The therapeutic relationship: an exploration of understanding and growth in undergraduate student nurses

Interview topic	**Example prompts - Prompts in italics indicate new prompts**
General introductions	• Introductions • Setting ground rules • How are you enjoying year 3?
Understanding of the therapeutic relationship	• The last time we met we discussed your understanding of the therapeutic relationship. Do you think your understanding of this relationship has changed in any way? • *Are you aware of different stages in the development of the therapeutic relationship?* • *If yes, how would you describe these stages?*
The therapeutic relationship and communication	• *What role does communication play in the development of the therapeutic relationship*
Facilitators and Barriers to developing the therapeutic relationship.	• *From the HCPs perspective what factors or circumstances facilitate the development of the therapeutic relationship* • *From the HCPs perspective what factors or circumstances present a barrier to the development of the therapeutic relationship* • *From the patients perspective what factors or circumstances might prevent the patient from engaging with the nurse to develop the therapeutic relationship* • *What personal attributes in the HCP are essential to developing and maintaining the relationship*
Information about the role of the mentor	• Have you seen good examples of the therapeutic relationship in your mentors? • Can you describe an example? • How did you recognise it, what stood out? • Were you aware of the impact it had on the patient? Can you describe this impact? • What effect did it have in you in relation to your own nursing practice?

Information about the influence of other nursing / clinical staff	• Have you seen good examples of the therapeutic relationship in any other staff e.g. other nurses, auxiliaries, doctors or AHPs • Can you describe an example? • How did you recognise it? • What effect did it have on you in relation to your own nursing practice?
Information about the impact of teaching	• Did the teaching you had on the communication course help you understand the therapeutic relationship and in what way? • What elements of the teaching were most helpful • Where do you think you have learned most about good communication or the therapeutic relationship – school or placement? • Why is that - can you explain your answer?
Personal experience that may have had an influence	• Have you had any personal experience that has influenced your understanding of the value of the therapeutic relationship (only if you are comfortable about sharing it with the group)?
Information about the use of reflection	• Do you use your portfolio for reflection on experience or just to record things you have done? • Has any of this been about communication or the therapeutic relationship? • Do you think using reflection, for example in your portfolio, has ever helped you to understand the therapeutic relationship or changed the way you practice and can you give an example?
Winding up and thanks	• Is there anything else you would like to mention? • Thank you for agreeing to share your experience with me
Winding up and thanks	• Is there anything else you would like to mention? • Thank you for agreeing to share your experience with me

Appendix 5

University of Strathclyde Glasgow

Study Number

BN 1 Communication Pre course Vignette	Reg. No.

Section 1
Please read the short scenarios below and answer each of the questions. If you do not have enough room in the box please use the additional sheets of paper at the back, ensuring that you number the answer e.g., 1c continued.

Scenario 1
Mr. James Smith is a 75 year old man who has suffered a stroke and has mild dementia. He has been in the care home for 6 years. Staff nurse has asked you to go and assist Mr. Smith with his lunch. Staff nurse has advised you that although Mr. Smith can manage a soft diet, he is unable to feed himself. After washing your hands and donning an apron you approach Mr. Smith in the dining room.

1a). How would you carry out this task, including how you would engage with Mr. Smith?

This question addresses the area of respect. There are ten key behaviours that would demonstrate that the nurse was showing respect for the patient in this situation. These have been drawn from what is identified in the nursing literature and from the clinical experience of the researcher and the 'panel of experts'. The students' responses will be analysed for language that suggests these behaviours are present

- Introducing yourself and asking what the patient would like to be called
- Seeking permission to carry out the task
- Ensuring that the patient is comfortable
- Make sure the patients clothes are protected
- Make sure you are on the same level
- Give the patient time to chew and swallow – do not rush
- Engaging in conversation
- Ensuring mouth/chin are wiped clean as necessary
- Asking if he likes the taste and if the temperature is ok
- Giving the patient your full attention

Additional relevant indicators will be noted

1b). While you are helping Mr. Smith eat his main course he becomes distressed and starts crying, you realise that he has been incontinent of urine. What do you do now?

This question also addresses the area of respect. Answers may also indicate a degree of empathy. There are six key behaviours that would demonstrate that the nurse was showing respect in this situation. These have been drawn from what is identified in the nursing literature and from the clinical experience of the researcher and the 'panel of experts'. The answer will be analysed for language that suggests these behaviours are present.

- Stop feeding the patient
- Discreetly take the patient to a quiet private space
- Help him to wash and change
- Provide reassurance
- Ask if he would like to go back to the dining room
- Remain calm & patient

Additional relevant indicators will be noted

1c). How do you think Mr. Smith might be feeling?

This question addresses the area of empathy and aims to ascertain if the nurse is able to empathise with what the patient might be feeling in this situation. Below are a number of possible emotions that the patient may experience in this situation. These have been drawn from what is known in the literature about the emotions experienced many patients in this situation and from the clinical experience of the researcher and the 'panel of experts'. The students' responses will be analysed for language that indicates recognition of any of these emotions.

- Embarrassed
- Ashamed
- Angry
- Frustrated
- Helpless
- Worthless
- Loss of dignity
- Humiliated
- Confused

Additional relevant indicators will be noted

Scenario 2
Miss. Alice Young is a 72 year old woman who was been admitted to the medical ward with pneumonia. Miss Young lives alone and has been managing on her own until this hospital admission. You have not yet met Miss. Young but Sister has asked you to go and assist her with her personal hygiene prior to her getting out of bed. After washing your hands and donning an apron.

2a). How would you carry out this task, including how you would engage with Miss Young?

This question addresses the area of respect. There are seven key behaviours that would demonstrate that the nurse was showing respect for the patient in this situation. These have been drawn from what is identified in the nursing literature and from the clinical experience of the researcher and the 'panel of experts'. The students' responses will be analysed for language that suggests these behaviours are present.

- Introduce yourself and ask what the patient would like to be called
- Ask permission to carry out the procedure
- Ask if she has her own toilet things
- Ensure screens are drawn to ensure privacy
- Ask if she is able to carry out any aspects herself e.g. hands and face
- Ensure that dignity is maintained by ensuring that patient is adequately covered
- Engage in conversation

Additional relevant indicators will be noted

2b). While you are washing Miss Young she keeps apologising to you and saying that it is terrible that a young person like you should have to do this for an old woman. What might Miss Young be feeling that prompts her to say that?

This question addresses the area of empathy and aims to ascertain if the nurse is able to empathise with what the patient might be feeling in this situation. Below are a number of possible emotions that the patient may experience in this situation. These have been drawn from what is known in the literature about the emotions experienced many patients in this situation and from the clinical experience of the researcher and the 'panel of experts'. The students' responses will be analysed for language that indicates recognition of any of these emotions.

- Embarrassed
- Frustrated
- Helpless
- Loss of dignity
- Humiliated

Additional relevant indicators will be noted

2c). How would you respond to Miss Young?

This question addresses the area of empathy and aims to ascertain if the nurse is able to empathise with what the patient might be feeling in this situation. Below are some possible ways the nurse might respond to the patient. These have been drawn from the literature and from the clinical experience of the researcher and the 'panel of experts'. The students' responses will be analysed for language that indicates any of these behaviours.

- Not being dismissive of patients anxieties
- Reassure the patient that you do not find it distasteful
- Try to change the topic by asking the patient about family etc
- Check for underlying problems

Additional relevant indicators will be noted

End of Section 1

Section 2

1. **What feelings do you think you would experience when you are feeding Mr Smith?**

2. **What feelings do you think you would experience when you realise Mr Smith has been incontinent?**

3. **What feelings do you think you would experience when you are helping Miss Young with her personal hygiene?**

4. **What feelings do you think you would experience when Miss Young starts to apologise to you**

Thank you

Appendix 6

Copy. A M Rice.

University of Strathclyde
Education

Notice of Departmental Ethics Committee Decision

Date:	6th October 2009
Applicant:	**Prof E Maclellan (Anne Marie Rice)**
Title:	An exploration of how student nurses develop the capacity to engage in a therapeutic relationship with the patient.

Approval Of Investigation

The Departmental Ethics Committee confirm ethics approval for the above investigation strictly within the terms as advised on the application.

When your investigation is completed we would welcome a short note indicating completion and advising of any ethical matters that may have arisen but which were not anticipated within your application.

The committee wishes you success in your investigation.

For the Departmental Ethics Committee

David Wallace (Chair)

Department of Educational and Professional Studies
Sir Henry Wood Building
76 Southbrae Drive
Glasgow G13 1PP

t: 0141 950 3183/3368
f: 0141 950 3367
www.strath.ac.uk/eps

Mr Clive Rowlands
Head of Department

Margaret Keoghan
Administrator
HASS Research and Knowledge Exchange Support Team
L418 Livingstone Tower
University of Strathclyde
Tel 0141 548 3965

From: Helen Marwick
Sent: 02 March 2011 17:17
To: Jean McCallum
Cc: Margaret Keoghan
Subject: ethics application Effie Maclellan and EdD student Anne-Marie Rice

Dear Jean

Please find attached the ethics application for a project extension from Effie Maclellan and EdD student Anne-Marie Rice, which has been approved by the School of Education Ethics Committee, and has been forwarded for full approval. The original application for the main project was approved in 2005 and has been included in the zip file.

kind regards

Helen

Dr. Helen Marwick
Postgraduate Research Coordinator
Ethics Convener
School of Education
Faculty of Humanities and Social Sciences
University of Strathclyde
76, Southbrae Drive
Glasgow G13 1PP
T. +44 (0)141 950 3592

Appendix 7

University Logo

Date 8th October 2009

Dear Ann Marie

Thank you for letting me know that you now have full ethical approval from Strathclyde to proceed with your research project. I also note that you have checked this with the [redacted] ethics committee and no further approval as necessary. As your research has been approved by the undergraduate programme director I am happy to give you permission to access the undergraduate students.

I would like to take this opportunity to wish you well with your research. Please keep me informed of your progress.

Yours sincerely

[redacted]

[redacted]
Head of Department
Nursing & Health Care School
[redacted]

[redacted]

Appendix 8

Participant Information Sheet

Study Title
The therapeutic relationship: an exploration of understanding and growth in undergraduate student nurses.

You are being invited to take part in a research study. Before you decide it is important for you to 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. Ask if there is anything that is not clear or if you would like more information and then decide whether you wish to take part or not.

Thank you for reading this

What is the purpose of the study?

The purpose of the study is to explore the factors that influence the development of a therapeutic relationship and how student nurses develop such a relationship with patients in their care. The study is based on the assumption that the professional relationship the nurse has with the patient is a therapeutic intervention and therfore fundamental to the provision of good nusing care. The evidence suggests that the ability to communicate effectively is important in developing this relationship (Moore, 2005) and that the key factors influencing the ability to communicate effectively are respect, empathy and self awareness. Similarly, Rogerian theory related to the therapeutic relationship suggests that these 3 factors are also essential for the development of the therapuetic relationship (Rogers, 1984). Most of the literature on both communication and the therapeutic relationship within care provision is based on qualified staff and there is very little information related to the development of these skills in undergraduate student nurses. This study is trying to find out more information related to both communiucation skills and the therapeutic relationship and how they develop in student nurses. It is anticipted that the study will be conducted over a period of 3 years.

Why have I been chosen?

You have been chosen because you are commencing your student nurse training for the first time, at the University of Glasgow. It is intended to invite all new first year students to participate in the study.

Do I have to take part?

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. Even if you do decide to take part you are still free to withdraw at any time, without giving a reason. A decision to withdraw at any time, or a decision not to take part, will be respected and there will be no further contact made with regards to the research study. A decision not to take part will have no impact on the quality of teaching, support and supervision you would receive as a normal part of the course and will have no bearing on your grades.

What will happen to me if I take part?

You will be undertaking a communications skills course as a core part of your education on the nursing course. As part of the course evaluation, you will be asked to answer questions on a vignette (this is a short story or scenario designed to establish your understanding related to respect and empathy). You will also be asked to complete a self assessment exercise related to self awareness. These exercises will be undertaken at the beginning of year one and at the end of each academic year over the 3 years of your nursing degree (4 times in total).

If you agree to take part, your course evaluations will become part of the study and you will be asked to complete a demographic questionnaire that will establish your previous experience or training in relation to communication and the therapeutic relationship.

As a part of your learning on the nursing course you will be expected to participate in role play related to some of the skills that you need to develop, for example feeding a patient. This allows you to practice both the practical skills and the communication skills necessary to successfully carry out the task. If you agree to take part in the study you may be asked if the role play can be videotaped and form part of the study, this would only be once in the academic year. If you agree to this, the video tape will only be viewed by you, the one other student you are doing the role play with and the researcher.

You can agree to take part in one part of the study e.g. allowing your course evaluation to become part of the study and decline to be videotaped while participating in role play.

By taking part in the study you will not be asked to do anything in addition to what you would be expected to do as a normal part of the course.

What are the possible disadvantages and risks of taking part?

Although role play is an integral part of the teaching and learning strategy within the nursing course, you may feel vulnerable being videotaped. In order to minimise this, ground rules will be established at the beginning of the scenario and you are assured that the contents of the tape will be confidential and will only be seen by you, the other particpant and the researcher. All data will be handled in strict adherence with the Data Protection Act (1998)

What are the possible benefits of taking part?

Those who participate in the study may find that their participation affirms their development in communication and the therapeutic relationship. Participation in the videotaped role play, with an opportunity to review your own performance may contribute to the development of both skill and confidence in relation to communication and the therapeutic relationship. Some participants may welcome the opportunity to contribute to the ongoing development of this element of the nursing course for future students.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be anonymised and kept strictly confidential. Data will be encoded and anonymised at the outset. All names and places of work along with any other identifying features will be removed. Data will be stored on a secure drive on a computer housed in the University of Glasgow, password protected, with access only to the researcher. Manual files will be stored in a designated locked filing cabinet, accessible only to the researcher. The filing cabinet will be in a locked room. All data will be handled in strict adherence with the Data Protection Act (1998)

What will happen to the results of the research study?

You will be given an update on the research each year. On publication of the finished work you will be sent a summary of the results if you express a wish to receive them. You will not be identified in any published reports.

Who is organising and funding the research?

The research is being undertaken as part of a research degree leading to the award of Doctor of Education. There is no funding attached to this research

Who has reviewed the study?

This study has been reviewed and approved by Department of Education and Professional Studies, University of Strathclyde Research Ethics Committee, and also has the approval of the University of Glasgow Ethics Committee. Permission has been granted by the Head of Department, Nursing & Health Care, University of Glasgow.

Contact for Further Information

Should you require any further information please contact

Ann Marie Rice
Lecturer
Nursing & Health Care
University of Glasgow
59 Oakfield Ave
Glasgow G12 8LL.
0141 330 3605
Email: ann.rice@strath.ac.uk
amr8y@glasgow.ac.uk

You will be given a copy of the information sheet and a signed consent form to keep
Version 2 October 2009

Participant Information Sheet

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The therapeutic relationship: an exploration of understanding and growth in undergraduate student nurses.

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If you agree to take part, your course evaluations will become part of the study and you will be asked to complete a demographic questionnaire that will establish your previous experience or training in relation to communication and the therapeutic relationship.

As a part of your learning on the nursing course you will be expected to participate in role play related to some of the skills that you need to develop, for example feeding a patient. This allows you to practice both the practical skills and the communication skills necessary to successfully carry out the task. If you agree to take part in the study you may be asked if the role play can be videotaped and form part of the study, this would only be once in the academic year. If you agree to this, the video tape will only be viewed by you, the one other student you are doing the role play with and the researcher.

You can agree to take part in one part of the study e.g. allowing your course evaluation to become part of the study and decline to be videotaped while participating in role play.

By taking part in the study you will not be asked to do anything in addition to what you would be expected to do as a normal part of the course.

You may also be asked to take part in a focus group, which is an interview within a group of similar people as yourself (normally between 6-10 people per group). The purpose of this is to ascertain the role your clinical experience and your mentor has had in your learning and development in relation to communication skills and the therapeutic relationship. The group interview will take place in the School of Nursing. As a group interview is more complex to manage than with just one person, the interview will be digitally recorded to help us to accurately recall what was actually said. The importance of maintaining confidentiality within the group setting will be highlighted to all participants prior to the group discussion. You will have an opportunity to read a transcript of the interview before it is used in the study.

What are the possible disadvantages and risks of taking part?

Although role play is an integral part of the teaching and learning strategy within the nursing course, you may feel vulnerable being videotaped. In order to minimise this, ground rules will be established at the beginning of the scenario and you are assured that the contents of the tape will be confidential and will only be seen by you, the other particpant and the researcher. All data will be handled in strict adherence with the Data Protection Act (1998)

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Email: ann.rice@strath.ac.uk
amr8y@glasgow.ac.uk

You will be given a copy of the information sheet and a signed consent form to keep
Addendum: Version 2 October 2010

CONSENT FORM – Use of vignette evaluations and self awareness assessment as part of a research study

Title of Research
The therapeutic relationship: an exploration of understanding and growth in undergraduate student nurses.

Name of Researcher: **Ann Marie Rice**

1. I confirm that I have read and understand the information sheet Version 2 for the above study and have had any questions satisfactorily answered

2. I have been made aware of what my participation will involve and any potential risks.

3. I understand that I am under no obligation to respond to all aspects of the study and am free to refrain from answering certain questions if I wish.

4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my rights or my learning and support on the course being affected.

5. I agree that the researcher may maintain records of the study to enable a follow up study to be carried out in the future.

6. I understand that all information will be anonymised and kept confidential in strict adherence to the Data Protection Act (1998).

7. I agree to take part in the above study.

_____	_____	
Name of Participant	Date	Signature
_____	_____	
Researcher	Date	Signature

I would like to take this opportunity to thank you for taking part in this research study

1 for subject; 1 for researcher

Ann Marie Rice, Lecturer
Nursing & Health Care, University of Glasgow
59 Oakfield Ave
Glasgow G12 8LL.
0141 330 3605 - Email: amrice@strath.ac.uk, amr8y@glasgow.ac.uk

CONSENT FORM – Participation in a group interview as part of a research study

Title of Research
The therapeutic relationship: an exploration of understanding and growth in undergraduate student nurses.

Name of Researcher: **Ann Marie Rice**

8. I confirm that I have read and understand the information sheet Version 2 for the above study and have had any questions satisfactorily answered

9. I have been made aware of what my participation will involve and any potential risks.

10. I understand that I am under no obligation to respond to all aspects of the study and am free to refrain from answering certain questions if I wish.

11. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my rights or my learning and support on the course being affected.

12. I agree that the researcher may maintain records of the study to enable a follow up study to be carried out in the future.

13. I understand that all information will be anonymised and kept confidential in strict adherence to the Data Protection Act (1998).

14. I agree to take part in the above study.

_____	_____	
Name of Participant	Date	Signature
_____	_____	
Researcher	Date	Signature

I would like to take this opportunity to thank you for taking part in this research study

1 for subject; 1 for researcher

Ann Marie Rice, Lecturer
Nursing & Health Care,
University of Glasgow
59 Oakfield Ave
Glasgow G12 8LL.
0141 330 3605
Email: amrice@strath.ac.uk, amr8y@glasgow.ac.uk

Appendix 9

Transcript of Group Interview (1)
Nursing & Health Care School
Tuesday 26th October 2010

Speaker		Comments / Themes
Facilitator:	**Thanks very much everyone, for coming in this afternoon. A couple of things before we start. Obviously I'm independent to this study, but what is important is that you give an honest view. You'll be asked questions and to give examples as we go along. If you use examples can I ask you to please not identify people or clinical sites or anything so that that's anonymysed. We would take it out of the transcript any way but just so that people or not necessarily identified. So I think that's the only sort of rule. That and the confidentiality of this group. Anything said in the group remains in the group. And you will all be anonymysed when the data is presented**	
Facilitator:	**So you've had some information about what were going to do. The title of the study as you'll know is "An exploration of how student nurses develop the capacity to engage in a therapeutic relationship with the patient". So it's really all about therapeutic relationships. Obviously I don't know any of you around the table, you are all in BN2 Nursing? How is that going?**	
Voice 2	It's good	Second year positive
Voice 4	Yes, it's just flew in	Good and going quickly
Facilitator	**Is second year different from first year?**	
Voice 5	A lot different	Very different +ve tone of voice
Voice 3:	And a lot more science.	

Voice 5:	You have to think a lot more about things as well, rather than being factual, you've got to think more in depth.	**In depth thinking** **Challenging** +ve tone of voice
Voice 2:	A lot more problem solving, having to link everything together to get an answer.	**Integrating knowledge**
Voice 1	We've linked everything from first year, and it all seems to be coming together now. And when we go to placement we feel we have more of an idea about what's going on	**Integrating knowledge** **Relating theory to practice**
Facilitator	You done something similar to this last year?	
AMR	No, this is the first focus group	
Facilitator	**The first thing really is for me to ask you what you understand by the term therapeutic relationship, because that's key to this session. What does that mean to you?**	
Voice 2	A therapeutic relationship for me is that when the patient gets something out of the relationship, in that they are able to communicate their needs, and their needs will be satisfied by the nurse.	**Beneficial to patient** **Communicating needs** **Needs met**
Facilitator	**Everybody agree, or would like to add anything?**	
Voice 5	I would say it's based on you building up a rapport with the patient, so that you can achieve the most effective care. I think, because if you don't have that rapport, and you don't have that good communication, with the patient then they are unlikely to talk to you, and ask you any questions. YEAH I think it's really important in the communication process	**Building Rapport** **Achieving effective care** **Rapport important** **Communication important**
Voice 1	I think one of the most fundamental things, is probably trust as well. A patient, who trusts you, is really going to cooperate and if you've got a cooperative patient, then they are more likely to get better.	**Trust is fundamental** **Trust necessary for Cooperation** **Trust & cooperation aids recovery**

Facilitator	**Trust is a big part of a therapeutic relationship**	
Voice 4	I suppose how you communicate with them as well; spending time with them, and showing patients that it might take them a bit longer to open up and tell you about something, but if you show them you have the time to listen, and if you sit down with them, and the way you use your verbal communication, and just show them that you are there for them, and if you think there's anything they need to discuss, or if there you think there are any underlying problems, then you can explore maybe what's wrong with them.	**Communication** **Being present** **Listening** **Verbal communication** **Communication aids assessment**
Facilitator	**So a lot about communication then. Do you think the two; a therapeutic relationship and communication are the same, or are they different?**	
Voice 3	I think communication is a big part of the therapeutic relationship. It's not just the verbal communication, it's your body language as well, you need to be open, you need to be accessible so that the patient feels like they can confide in you with things that maybe they find difficult to talk about. I don't think its all communication, must be something else. There must be a difference.	**Communication Key** **Use of body language** **Conveying openness** **Accessibility - not just physical** **Therapeutic relationship complex**
Voice 5	I agree with you, but not sure what the other thing is!	**Therapeutic relationship complex**
Voice 3	Yes, something missing	**Therapeutic relationship complex**
Voice 5	Involves a technical side as well, technical care.	**Practical nursing skills**
Voice 3	Yes, competency.	**Competence**
Voice 2	the 5cs (general Laughter)	**Professional caring This refers to Roach's 5 Cs taught in 1st & 2nd year**
Voice 1	That comes into the trust as well, like if you know what you're doing, then they are going to trust that you're going to look after them properly.	**Competence** **Trust related to practical skills** **Caring**

Voice 4	And that might help the recovery rate as well; if they're feeling more comfortable within their environment, and are more like compliant with the staff and yourself, they will want to get better quicker.	**Facilitates recovery** **Trust related to compliance** **Compliance related to recovery**
Voice 2	It helps because if they're more comfortable then they'll want to sleep, and sleep helps with their recovery process. Doing all these things, people say its all talk and no walk, but it all comes down to the fact that when the patient is comfortable, they get better quicker.	**Trust** **Feeling at ease** **Facilitates recovery**
Facilitator	**Anyone want to add anything to that? (shaking heads indicating no)**	
Facilitator	**When you've been out on placement, have you seen examples of a good therapeutic relationship, maybe from your mentors?**	
Voice 3	When I was in my fourth placement, my mentor would always go into the patient's room with me, and say, "Hi my name is X, and this is my student nurse, X, she's working with me today". She would always introduce herself, which is an important start, rather than just going in and saying here's your breakfast. It's nice to introduce yourself, and get on a first name basis with a patient, and then they can feel like they can rely on you.	**Demonstrating respect** **Establishing rapport**
Facilitator	**So that introduction is a key part of that?**	

Voice 1	In district nursing; there was one patient we were looking after. He was in bed, and as soon as he went in the house, my mentor would give the wife a hug, and made the wife feel comfortable first and then like ….. My mentor wasn't just there to go see the husband, and make sure all his medical needs are alright, she would sit down with both of them, talk about other aspects of their lives and if everything else was ok and em I guess that's something else's about building up a therapeutic relationship, its not all medical stuff	**Use of touch** **Families important** **Holistic approach**
Facilitator	**I guess in that example, that wasn't just the patient?**	
Voice 1	Yeah it was the family as well, my mentor had a really good bond with both, which made them feel a lot more comfortable.	**Families important**
Facilitator	**Tell me about the hug?**	
Voice 1	I think it was really good; it was definitely what the wife needed.	**Touch appropriate**
Facilitator	**So was the right thing at the right time then?**	
Voice 1	yeah Definitely.	

Facilitator	**Any other examples?**	
Voice 2	When I was on my health visiting placement, my mentor would always suggest to me that I take the kids up to their room or something, and they would show me the toys, while she was talking to the mother about any issues she had that they didn't want to discuss in front of me or the children. My mentor had said, that a few times, parents were a bit anxious about their children whether they are developing properly, or if they were guilty that they resented their children because they cannot go out anymore things like that. It was really interesting to see that's all it needed, was for me to take the child up to the room and show me their toys…. to enable her to have a more private conversation, because nine out of ten times the health visitor is there for the child, whereas she was there looking out for the mother as well.	**Privacy** **Respect** **Empathy- understanding** **Role modelling** **Families** **Holistic**
Facilitator	**So you got to play with the toys ?**	
Voice 2	Yes (laughter from the group)	
Facilitator	**So those of you that have given examples, do you think that has helped the patient, did it have an impact?**	
Voice 3	Yes (nods of agreement from the group)	**All of the above professional behaviours had positive impact on outcomes**

Facilitator	**A positive impact do you think?**	
Voice 3	Yes, because in my example it wasn't just a nurse with no name that's coming in doing this and that; it's someone you can relate to and see as a person and not just an authority figure.	**Relationship** **Openness** **Accessibility**
Voice 4	And in that, because the patient is in a ward, in an unfamiliar environment, everything's different; different routines, different people; its just a lot more busy than they are maybe not used to. If you're making them feel comfortable, communicating in a way that they want you to, just putting them at ease, it helps in the process within the hospital and maybe speeds up their time getting out of hospital, and getting back into their own routine, what works for them if they do go home, and extra support they might need at home, rather than being in, always in especially if it is a chronic condition ….in a hospital setting. Better to get into the home environment….better for them	**Good communication** **Establishing rapport** **Empathy** **Assessing** **Facilitates recovery** **Rehabilitation** **Making life easier**
Facilitator	**Again, do you think the things you have described and seen, did that affect your own nursing practice?**	
Voice 2	it did because it made you strive towards being a better nurse. You would maybe say, when I graduate and I become a registered nurse, I'd like to be able to do that because it improved my relationship with the patient and the child, and it did help with all those things, because it made your patient more comfortable, which is your goal so there is no point in rejecting them for it.	**Role modelling** **Professional goals** **Improve practice** **Improve patient outcomes**
Voice 3	It's like having a role model; you want to be just like them when you qualify, because you can see what good they do to the patients, and you try harder and one day you will be able to achieve that after practice.	**Role modelling** **Professional goals**

Voice 4	It's like your foundation, and you develop from that.	**Professional goals**
Voice 2	Its like you've got all the superheroes and you become the best! It's all the little things and you pick them up	**Professional goals** **Role modelling**
Facilitator	**You've said when you graduate; does it wait until then?**	
Everyone	It's an ongoing thing	**Ongoing development**
Voice 5	I think after you graduate you won't ever stop progressing in that way.	**Ongoing development**
Voice 4	Every patient is different as well, and you're going to be faced with different situations, and you just need to deal with every patient as they are. You might deal with a patient you've never dealt with before, so that will be a whole new learning curve, and so you just have to, you need to go with it your instincts and deal with the situation as it is there and then, and not just follow the routine of how you've cared for like other patients, just kind a deal with their…. deal with their circumstances.	**Respect individuality** **Patient centred** **Using instincts** **Going with instincts**
Voice 5	Makes you look at each patient more individually, and tailor care to that patient.	**Respect individuality** **Patient centred**
Voice 4	It's not like a collective way of delivering care; there are the main guidelines that we have, but you won't deliver it in the same way to every patient	**Individualised care**
Voice 5	I agree with the role model concept, but I also think it makes you realise how much further you've still got to go, (general **laughter and**	**Role modelling** **Highlights development needs**

	agreement) but there's a lot to work towards, and see how many skills you need to build up.	
Facilitator	**What about other professionals that aren't nurses that you may have worked with? Have you seen any examples from them of how they establish a therapeutic relationship**	
Voice 1	I went with a woman to get respiratory tests; she was a little frail old lady. She was so scared about going, and she didn't know what was going to happen. She was asking me all the time what was going to happen, but I hadn't been so I hadn't a clue. I went down with her, and she had to sit in this respiratory room, and sit in a box with the door shut. Once she had that explained to her that made her even more scared because she's claustrophobic. But the woman who was there, was so good, and talked everything through; every test she done she explained what she was doing it and why she was doing it….told her it was not going to be that bad she would only have to hold her breath for like 10 seconds. She made me feel really comfortable being in the same room, and I know she made the lady feel much better, and afterwards the old lady did say to me, that wasn't that bad was it! No it could have been But this woman really handled the situation well, because it was scary situation being sat in a room and told to breathe in all these different ways. This lady she really handled the situation well	**Patient anxiety** **Information giving** **Explaining** **Reassurance** **Communication**
Facilitator	**Do you think it was the explanation that she gave?**	
Voice 1	It was her general aura. She was so relaxed, making jokes. When she came in she just chatted to the lady first, she didn't go straight into this is why you're here and this is what were doing. It was just general chat at first making the lady comfortable	**Rapport building** **Pacing** **Openness** **Accessibility** **Body language**

Facilitator	**What did you learn from that?**	
Voice 1	hem….I guess that, it's important to stay relaxed and calm with anxious patients, and that it's important not to be really task orientated. Yes you have to do the medical procedure that has to be done, but at the same time you gotta look after the patient and make them comfortable with what you're doing	**Professional** **Calm** **Patient focussed** **Not task focussed**
Facilitator	**Any other examples of other professional groups?**	
Voice 4	On my last placement I was on an eye surgery ward, and this woman was getting a nucleation of her eye; so they were removing her eyeball. Which was quite extreme for this lady, as she had a normal job, she had children, and it was amazing all the professionals that came up and talked to her ; the nurses, the surgeon, the anaesthetist who came up and explained everything involved. Afterwards, she didn't show how she was really feeling about it, and the surgeon came up and sat with her, and em….explained, from she went into the surgery until she left that there were no problems or anything, what she was going to be faced with now. She felt so much more comfortable, because he was the person that done it, and she was reassured that everything went fine, and afterwards he came up to reassure her. She actually said to me after the conversation that it must be ok, because he's told me and explained everything; it just made her have a bit more confidence. It was good the way he came up and done that, it was amazing because sometimes you think when the surgeon has done the surgery, that's their job finished, they have that task and the next patient comes along. It was so sweet because when she was leaving, she gave him chocolates, said she kinda him fancied him!	**Explaining** **Empathy** **Reassurance** **Communication** **Not task focussed** **Patient focussed** **Beneficial** **Confidence** **Trust**

	General laughter from the group She got him a big card It was so good to see, and after such a big surgery being done, she saw the positive side of everything, and that everything was going to be ok and could get her life back to normal again.	
Facilitator	**So it seems from what you said, about reassurance, and given the patient confidence; are these key factors do you think?**	
Voice 4	Definitely. She came back up and she wouldn't really talk to anyone …. I think she just needed that boost of self awareness, that it wasn't the end of it, and there is things that can be done, and explained procedures you can get, like artificial eyes and everything, and I don't think she considered the aftermath about what the surgery was going to be. She just considered the actual surgery in her head. Afterwards it was like where do we go from here but when he came . As well as the nurses, they work together to boost her confidence back up again, and you can definitely see it in here when she left. And she had to come back in to get re dressings and you could see the progress that she was making, step by step it was good to see.	**Information giving** **Reassurance** **Confidence** **Facilitated recovery**
Voice 2	It's a slightly different story I have. It was a physiotherapist, she was being very reassuring, and empowering the patient, saying "The only thing that's holding you back is you". And she was really helpful to the patient. It was very cheesy the way she was doing it. By the end of the time she had spent with the patient, the patient wanted to spend time trying to walk around the room, trying to improve her mobility after having heart surgery. She was just constantly walking round her room hold on to the furniture and see how far she would get without the furniture. It was really good to see her improve like that because she was	**Empowerment** **Facilitated recovery** **Helpful** **Reassurance** **Rapport** **Motivation**

	then really appreciative of what the physiotherapist done, and it improved the relationship, because it meant she's no longer getting on at the physiotherapist to get her to do things she thought she couldn't do. She got a bit box of chocolates as well!	
Facilitator	**There seems to be a theme with these chocolates, if it goes well you get the chocolates!**	
Voice 4	We just do it for the rewards really!	
AMR	**It's all about the chocolates!**	
Facilitator	**Do you think you learned anything from that that you can use?**	
Voice 2	Empowering a patient is a really useful thing. As soon as they realise that although they are in hospital, and they're sick; but they can do something about it as well; they can walk around the room, they can take their medicines when it's put in front of them. If they've got orthopaedic surgery, they can do the stretches and things like that … they're supposed to be doing. It improves them, and makes them feel good about themselves. It reduces the feeling of being sick, like instead of thinking because they're in hospital they're sick and cannot do anything, they're thinking Ican walk to the end of the corridor now; they're making themselves have goals.	**Empowerment** **Motivation** **Facilitates recovery**
Facilitator	**So empowerment?**	
Voice 4	It's like motivating them to want to do better, to rebuild how they were before maybe, even if they had massive surgery; it's getting back to a normal life for them.	**Motivation** **Rehabilitation** **Independence**
Voice 3	Like getting their independence back.	**Independence**

Facilitator	**That was the clinical aspect. In your course here, in the communication aspect of the course, was there anything about that teaching you may have had in first year that helped you establish your therapeutic relationship with patients?**	
Voice 1	I think it's hard to pinpoint things, because we get taught so much, that it kind of gets drilled into you **general laughter and agreement** and you kinda just know….. You just know you've been taught so much and you're **general laughter and agreement** constantly thinking about it, because we've discussed it so much in class. I think it's good, the clinical skills time that we have, has given us that bit more practice you could say; we have practised being the patient, administration, like how to drink and brush their teeth and everything. Before, we had done that clinical skills station; I had never done that, except maybe feeding a baby, but its totally different feeding an adult. It gave you a real insight in maybe how to go about it, and not to be uneasy or look uncomfortable, you shouldn't really be uncomfortable and if you are uncomfortable, but try and overcome that. It really did help to have that bit of practice, because if I was to go out, and someone asked me to go out and feed someone, I don't know…it was just all new …. it would have been very new. But it did help getting that bit of help before going out.	**A lot of teaching** **Think about it a lot** **Simulation - good** **Rehearsal**
Facilitator	**So the clinical skills aspects were important?**	
Group	**All but one nodding in agreement**	
Voice 3	I think it' more difficult in clinical skills, because you're feeding your friend, and they're pulling faces at you! You feel really quite awkward, but when you go and do it in the ward, it's quite serious, and easier not to feel uncomfortable. Whereas in clinical skills, people are laughing and	**Simulation – not helpful**

	joking, and you feel awkward doing it in front of your peers. It s very different if you can do it in clinical skills you can do it in the ward.	
Facilitator	**Did you do actual taught communication class room based?**	
All voices	Yes, a lot. **General laughter**	**A lot of teaching**
Facilitator	This is where the drilling came in!	
Voice 4	yes ……**followed by general laughter and agreement**	**A lot of teaching**
Facilitator	**What aspects of the actual taught sessions then?**	
Voice 2	With the open questions, I wasn't entirely sure until I started the course, the difference between open questions! I didn't know there was types of questions. So it was helpful understanding, especially before I went on placement for the first time; since I had no clinical experience before then. You are aware of the questions you should be asking; you don't ask are you fine, you ask how you are feeling. It really was helpful, because maybe it improved the relationship with the patient because they weren't just giving you yes and no, you are able to have a conversation with them	**Open questions** **No prior knowledge** **Improved relationship** **Helps with rapport**
Voice 3	You get a better idea what's wrong with someone if you ask how they are feeling; they might say they have a headache or they're a bit miserable, didn't sleep very well etc. You can find out what's wrong, and address that, rather than find out something's wrong, and have to ask more questions. It would take less time as well to ask how are you feeling? to get the answer in one paragraph rather than ask a lot of questions ….. it really was helpful, and improved the relationship with the patient, instead	**Open questions** **Facilitates assessment** **Improved relationship**

	of a lot of separate questions.	
Facilitator	**So they way you ask the questions, and the opening line, they are important?**	
Voice 2	Yes, they help you get the information from the patient.	**Assessment**
Facilitator	**Anything else from the course?**	
Voice 5	I personally found that when I learnt more about communication theories in class, you start to really analyse how you do things, and you pick up on things you do; I didn't realise I did that …… good or bad …it really highlights things and makes it easier to work on them.	**Self analyses** **Increased self awareness** **Facilitates development**
Voice 2	It gave you room for improvement, you're thinking you shouldn't have asked a closed questions, and it makes you realise you ask closed questions a lot.	**Self analyses** **Increased self awareness** **Facilitates development**
Voice 3	You wouldn't think about it, unless you were taught it. You were saying silence is good, and it's ok to get a patient to talk to you, and then not say anything when they're finished. Before I found that out, I had always felt awkward thinking, 'What do I say to fill this silence?' But it's ok to give them time, but it's not awkward for them, they're just trying to digest what's going on around them, and work out how they feel.	**Teaching important** **Use of silence +ve** **Silence feels awkward** **Empathy** **Pacing**
Facilitator	**And did you use that on placement? How did you find it?**	
Voice 3	it still feels a bit awkward! **General laughter** Even though you feel awkward you can keep your mouth closed because you know it's the right thing, it's the right thing for the patient, even though it's a bit strange.	**Use of silence +ve** **Silence feels awkward**

Facilitator	**Do you think your therapeutic relationship, What helps you really to build, university based study, or clinical?**	
Voice 1	I think it's definitely both. On my first placement, it was care of the elderly. And there was a lot of things and I saw really bad communication, and I thought back to class, and was constantly thinking, "How can these people be doing that, when they have been taught the same as me?" I've been taught all this stuff, and I want to apply it, and it made me think, how can they not do that? In every situation I was in, you have all your class stuff coming in one side, and you gotta act on it.	**Combination of teaching & clinical** **Able to recognise poor practice** **Teaching informs**
Facilitator	**So both?**	
Voice 1	Definitely, yes.	**Both important**
Facilitator	**That a unanimous decision?**	
Everyone	Yes	**Both important**
Voice 2	As much as you could do it all on clinical placement, the teaching we get, affects how we do it. So I think if you didn't have the teaching beforehand, you wouldn't be doing it in the same way; so they both kind of improve each other. And each time you have another communication class; you think in my last placement I did that that, so the next time I can do that and it's a constant kind of improvement. And when you are learning things, for example the silence; I tried doing a silence with a patient, but they weren't having it at all! It's not like going on clinical placement its not like putting your theories into practice because you can already practice some of them. It's not like you're	**Teaching needs to come first** **Theory into practice** **Doesn't always work**

	purposely going in to do that, it's one of those things, for example, this patient is having a problem; if I stay silent now maybe I can get something else from her, but I didn't!	
Facilitator	**Outwith the university clinical side, do you think your own experiences influence how you deal with patients in terms of a therapeutic relationship?**	
Voice 1	I always think when I am in hospital, I try and treat all patients like they were my own granddad, for example this is how I would want my granddad tret, so this is how I'm going to treat this patient. If I start feeling uncomfortable in a situation I think, hang on; 'Why am I uncomfortable now? If I was sat with my granddad, it would be fine' it sounds stupid, but that's the way I'm constantly thinking.	**Identify with patient** **Respect** **Empathy** **Self awareness**
Voice 5	I'm the Same	
Voice 2	It's kind of unfair, you want your granddad to have the best care, but you're not giving other peoples granddads the best care; so it's only fair, if that makes sense! **(General laughter)**	**??????????**
Facilitator	**All these granddads that are being given good care . Coming back then, into the academic side; you've got portfolios yes? Do you use your portfolio to reflect on these experiences that we've spoken about?**	
Voice 5	Yes I do, but to be honest, probably not as much as I should. I reflect by myself at the end of something, and sometimes think I don't want to write it down because I've already done it. I don't feel you need to write absolutely everything down, because otherwise you'll just be writing forever about reflection. I think it's an automatic thing that people do anyway.	**Reflection not written**
Voice 3	**:** I reflect a lot in my head, but when I get home from my 12 hour shift,	**Reflection not written**

	and you're knackered, want something to eat, and put your feet up in front of the telly, the last thing you want to do is write a reflective, then time goes on.	**Time constraints** **Fatigue**
Voice 2	And sometimes you feel that something you might think is very reflective, and it comes to the University looking at your portfolio, or the NMC, they could be like, "She wrote about that?!" You sometimes feel a wee bit self conscious, even though it is your portfolio. At some point the NMC or University will have to look at it.	**Self conscious**
Voice 3	You feel like you need something groundbreaking! **(General laughter)**	**Self conscious**
Facilitator	**Do you think that the mechanistic things that you might reflect on, would be seen as more important then, than the therapeutic relationships?**	
Voice 2	I'm not saying it like that, just sometimes if you say you had a good conversation with a patient, and you reflect on it, people might think is that all you do? Sometimes I think…. Sometimes as a student nurse, you feel like the bigger things, such as your first catheterisation, that's well in there with the portfolio**!** **Lots of laughter** But your first good conversation with a patient isn't quite as interesting, so you sometimes feel like it's something you can reflect on personally, and you don't have to write it up.	**Reflection written more practical skills**
Voice 3	I think it's easier to reflect on something somebody else has done wrong, rather than something I have done right. One of my essays was about a doctor who wasn't very nice to a patient, I wrote about that rather than how he was nice to a different patient as…… I was to a patient**. Facilitator; so that was about the therapeutic relationship?** It is about therapeutic relationships, so you still write about it, just maybe in	**Reflection on others poor practice** **Improving form others errors**

	a different way, maybe you write about other people's therapeutic relationships, and how you can use that to improve your own therapeutic relationships with patients. If that makes sense!	
Facilitator	**Most of you had said that even though you're not writing in the portfolio, you are thinking and reflecting about your relationships with patients. Are you aware then, having reflected, of then how you change or influence your practice, following that reflection?**	
Voice 1	Well, I live with Steph, and every time I come in from a shift, we literally spend the rest of the night, talking about it.	**Reflection – peer debriefing**
Voice 4	It's crazy, That's all we talk about!	**Reflection – peer debriefing**
Voice 1	**:** Then as soon as I go to bed, I'll be thinking "hang on, Steph said this is what she did, and this is what I did" etc. if Steph says something I'll be like oh…maybe I should do that, maybe I should start doing that… I always think that as soon as I go to bed, what I'm would do the next day… I would improve	**Reflection – peer debriefing** **Reflection – tool for learning**
Facilitator	**Would that be the relationship with the patients, or actual duties?**	
Voice 1	It's probably more so, the relationship with the patient I think	**Reflection on relationship not tasks**
Voice 3	You do that every day though, communicating with your patients. So I think you reflect on therapeutic relationships more, but that's partly because you're doing it all the time, and you need to do that al the time. In other parts the technical care may be quite limited in when you do it.	**Reflection on relationship not tasks**
Voice 5	The amount you reflect on the certain areas depends on your personal interests in the area as well. If you are really keen and interested to improve your communication skills, then you will be thinking about that more and more, so it influences how much you reflect.	**Reflection - Depends on focus**

Facilitator	**Is there anything else; we have already touched on clinical aspects and academic aspects of how we help to develop therapeutic relationships, is there anything else that you want to add, or examples that you've seen that would help?**	
Voice 2	When we were taught about communication, we started thinking about it all the time, so you start transferring it to other parts of your life. For example, I work part time in a shop, in customer services, which is a horrible place to work. **General laughter** most people love it up there but it's horrible You start using communication skills up there, and are building better relationships with customers. Although you don't have them as long as you have most patients, you start thinking well maybe I could say this, you start to think about them not as a patient, but as a person, rather than someone returning with a naff shirt! **General laughter** It's a better way for communication, because I think about it more, and it's not like I don't need to think about it because I'm not on placement, I'm not in University .	**Communication skills – impact on personal life** **Respect individuality**
Facilitator	**so it spills over in to other areas of life?**	
Voice 3	You use it with your friends and family. I argue with my boyfriend less now because I know how to communicate! **(General laughter)**	**Communication skills – impact on personal life**
Facilitator	**If I went back to that first question, what do you understand about therapeutic relationships? Having had that discussion, would you be clearer now? Or would you give a different answer?**	
Voice 5	I think personally, it's fairly similar. Apart from maybe in a broader sense	**Broader understanding**
Voice 3	I think so too.	**Broader understanding**
Voice 5	That it's massively based around communication.	**Communication key**
Voice 4	It's so complex. There are so many things you can integrate into delivering a therapeutic relationship. It's just getting that mix to put	**Complex relationship** **Patient centred**

	everything together to try and make it with the patient.	
Facilitator	**The bits that you've thrown in during the discussion, was the empowerment and the confidence, and assurance, and all those things.**	
Voice 4	you probably don't really think about it. When you initially asked us what a therapeutic relationship was, and we all thought there were so many things you could say. But when you start talking about it after talking, you realise what things are integrated into it, and you do know what's involved, but when you are reflecting back on your own experience, you can see what it really involves	**Complex** **Multifaceted** **Empowerment** **Reassurance** **Trust** **Respect** **Empathy** **Self awareness** **Confidence**
Voice 3	When you're with a patient, you don't consciously think, "I'm going to go in there and build an awesome therapeutic relationship!" ….**much general laughter**…. It just happens; you don't spend that much time consciously thinking about it, it just starts developing.	**Unconscious**
Voice 4	it just builds up from all your experiences and class and what you've done	**Builds from experience and teaching**
Voice 2	although it's fantastic it is really difficult to describe …**general agreement** … You do it… you unconsciously do it because it's been drilled into us! **General laughter**	**Complex** **Multifaceted** **Rewarding** **teaching**
Facilitator	**drilling's a theme isn't it**	
Voice 2	It's not bad drilling! It's good	**teaching**

Facilitator	**Anything else anyone wants to add? Or say**	
Voice 5	The only thing that I would say from my own personal reflection, on communication and that sort of thing, is I sometimes wonder if it's almost a bad thing to have too much communication skills taught to you, because sometimes I think you can over think situations, and I think that's, that's unnatural. If you are going to build a relationship with a patient, then you have to be yourself. I think there can be a tendency to think too much about it.	**Can become introspective** **Over thinking**
Facilitator	**Do you think that happens personally, and you have over analysed a lot?**	
Voice 5	Yes, and I think that because I have done a lot of communication skills in the past. The more and more you think about it, and the more things you get taught, although it is good to keep thinking about it, sometimes I do feel I over think it	**Can become introspective** **Over thinking**
AMR	thank you all for taking part	

Stage 1 **Core themes (construct)**	**Sub themes (reality)**	**Stage 2** **Core themes** **(construct)**	**Sub themes (reality)**
Trust *"I think one of the most fundamental things, is trust"*	Competence Confidence Cooperation Mutual understanding Trust	**Trust** *"I think one of the most fundamental things, is trust"*	Competence Confidence Cooperation Mutual understanding
Effective Communication *"No communication, no relationship"*	Introductions Establishing Rapport Picking up cues Listening& using silence Exploring problems Body language Explaining & Ensuring understanding clarification	**Effective Communication** *"No communication, no relationship"*	Introductions Establishing Rapport Listening & picking up cues Exploring problems and other aspects of their lives Body language Explaining & Ensuring understanding Respecting Individuality
Establishing the therapeutic relationship *"extra kind of relationship"*	Empowering Patients can talk to you Good bond Being there Spending time Being open & being yourself Enabling Getting well & gaining independence Motivation	**The nature of the relationship** *"extra kind of relationship*	Establishing Rapport Empowering Being there, patients can talk to you Good bond Being open & being yourself Inclusion of family important Respecting Individuality

	Understanding & meeting needs Mutually beneficial	**Benefits for patient and practitioner** *"they get better quicker*	Patient is comfortable and less anxious Mutually beneficial Understanding & meeting needs Inclusion of family important Getting well and gaining independence
Benefits for patient *"they get better quicker"*	Patient is comfortable and less anxious Patient is comfortable Facilitates recovery Mutually beneficial Understanding & meeting needs Inclusion of family Gaining independence Motivation Less anxiety Encouraging		

Role modelling *"I'd like to be able to do that"*	Become the best Strive to be better Try harder to achieve Role modelling	To be discussed as responses to questions rather than a theme as many of the sub categories in the relationship section are drawn from this part of the interview e.g. motivation etc so I don't think anything will be lost	
Applying theory to practice *"You wouldn't think about it, unless you were taught it."*	Using silence Open questions Not afraid of not knowing answers Need theory & practice to establish T R	Discussed as responses to questions rather than a theme. I have been over the transcripts again and students only really discuss the theory in response to the prompt it doesn't really come up in any other section.	

Appendix 10

Participant No			
Section	Time point 1	Time point 2	Time point 3
1a	Introduce myself and state that I understand he needs some help eating. General chat, sit next to him. Get the food, ask if he can do it himself or would he like some help. See how hungry he is.	I would take a seat next to Mr smith and introduce myself, ask him how he's feeling and whether he would like some dinner and if there is an option what would he like. I'd then ask if he'd like a hand with his dinner and assuming he is used to people feeding him, he would probably say yes. As I feed him and after he'd clearly finished each mouthful I'd ask him what he would like next, is it an ok temperature, would he like some more and would he like a drink. I'd try to make the experience as casual as possible and engage in as much conversation as he felt comfortable with.	On my approach to Mr. Smith I would try to get his attention, perhaps just with a 'Hello, Mr Smith' in order to assess his alertness, hearing and so I don't give him too much of a shock as I get nearer. If he replied promptly I would know he is fully alert and could hear me so I would continue to introduce myself. If I got no response I would go closer, perhaps even wake him up with a touch to his hand or a hand on his shoulder, and ensure that he could hear me by assessing the level of his response. I would continue to introduce myself, e.g. 'Hello Mr Smith, I'm Catherine a student nurse. What name do you prefer to be called by?' I would then go on to explain that I was coming to help him with dinner. I would do all this while sitting by his side, so that I am at his eye level and to ensure that he can hear. As he has suffered a stroke and has dementia his communication and understanding may be affected so I would assess his understanding by the level of response and would change my technique of communication accordingly so perhaps using more hand signals and facial expression more. If there was a choice in menu I would ask if he had any preferences, or if no choice ask if he thought he could manage what is available. Before starting feeding him, I would make sure I had tissues near by to catch any food that falls, so as not to disrupt the meal if it happens. I would then offer him small amounts of food, checking the

			temperature is ok, ensuring he is swallowing properly, no evidence of him struggling with swallowing and stop at any signs that he didn't want any more (hand gestures, turning his head, not opening his mouth) The whole time I would try and maintain light conversation and a good level of communication.
1b	Ask if he wants to go to the toilet, or to his room. Take him there and ask if someone else could clean up the chair, just so he didn't get too embarrassed sitting and watching it being done in front of him. Clean him up. Ask if he would like to continue with his dinner. And if he wants to go back into the dining room or would he prefers to stay in his room.	I'd try to calm him down and reassure him, telling him its ok, we'll just go and get him cleaned up. If he requires 2 nurses to mobilise, or any walking aids I'd quickly and quietly get the appropriate help so as not to draw attention to the situation. I'd take him to the bathroom and ask another member of staff to clean up any mess at the table and perhaps try to keep his food warm. After taking Mr Smith to the toilet, getting him cleaned up and hopefully calmed down, I'd ask if he'd like the rest of his dinner, or if he'd rather just leave it and maybe have a little chat	Stop feeding Mr Smith, put his meal somewhere to keep warm if possible. I would then reassure him that everything is ok, we will just pop to the bathroom. If it is clear that he is able to walk, perhaps with a zimmer, then I would take him to his room (if it is en suite) or just to a nearby bathroom while asking somebody else to bring a fresh pair of pants and trousers, so that I could stay with Mr. Smith. If Mr. Smith was unable to walk, I would ask a member of staff how he transfers and get the appropriate equipment and help. The whole time I would try to relieve Mr. Smith's anxieties and cause as little disruption to the other residents as possible.

		with him to see if he's ok	
1c	Embarrassed. Angry that he is losing control over his body and is becoming more dependant on others. He will probably still want to do as much as possible by himself. **He won't want other people to know.** Ashamed.	Mr Smith will probably be feeling very embarrassed that he was incontinent around other people, but also angry that he is losing control of his body and will not want a lot of fuss made about it, but clearly he was upset that it happened. He may also be feeling confused as to what happened (due to the mild dementia), possibly making him more angry that he is not functioning the way he used to	Depending on level of dementia, Mr. Smith may be feeling confused which would heighten his anxiety. Mr. Smith may be feeling frustrated that he is so dependant. Embarrassed that he is no longer able to control his bladder function and that other residents may have seen. Angry that there is little that he can do.
2a	Introduce myself, ask how she's feeling and if she had a nice sleep. Talk about the approaching day – is there anything she would like to do, has she had breakfast yet, etc. But first it would be a good idea to have a wash. Go and get a cloth or whatever and start with her hands – if she takes the cloth and wants to wash herself. If not, whilst washing her I'd ask more about her and what brought her to hospital to try and divert attention away from the fact I am	As I entered the room I'd say hello and that we hadn't met yet so introduce myself and try also to get to know Miss Young a bit. I'd ask if she fancied a was, and as she'd been managing by herself at home I'd assume she could manage quite a lot – nevertheless I'd help her in any way. If there was an available shower, and she wanted one, I'd ask id she'd want assistance in the shower. However if she just want a basin of water, I'd get the basin, soap, towel, cloths and any fresh clothes. I'd encourage her to do as much as possible, starting with	I would approach Miss Young and introduce myself, and again I would assess Miss Young's response to get an understanding of her hearing and alertness. Once I am sure Miss Young can hear me, I would introduce myself: 'I'm Catherine, a student nurse' and ask her what she likes to be called. I would then highlight that it is time to get up out of bed and get ready for breakfast, and ask her what kind of wash she usually has and what she would like today. As she had been previously independent I would encourage her to have a shower, or whatever she would have done at home. A lot of patients really appreciate a shower, however if Miss Young would prefer a bedside wash then I would pull the curtains around Miss Young's bedside area and get a basin of water, and either use her toiletries or get hospital ones. With either shower or bed side wash I would make sure that Miss Young's dignity and privacy is respected throughout, asking if she would prefer me to leave for her to manage

	washing her **and also to find out what is wrong with her.**	washing her face, then main body arms and armpits, making sure the rest of her body remained covered. I'd offer to was her back, then get her dried , top half dressed and then wash her bottom half. During the was I'd chat as much as she felt comfortable with and try to get to know her, but also so she wasn't focussed on the fact that I was washing her. I'd check she didn't have any wounds or places for cream, I'd then encourage oral hygiene.	herself or asking what I can do for her (wash back for example). I would ensure if I did leave Miss Young unaccompanied for any amount of time that it was safe to do so and her buzzer was near by. I would also take the chance to assess Miss Young's skin. I would try and keep the atmosphere happy throughout my time with Miss Young, and keep a light level of conversation throughout carrying out any activities; is she expecting any visitors today, does she have any family, or general things about the weather or her nice slippers, etc. only if I felt it appropriate to do so. If I get the impression that Miss Young would rather not converse, I would act appropriately. I would ensure she was washed properly, given appropriate oral hygiene, hair combed, glasses and hearing aid if necessary.
2b	Ashamed of her incapability. Aware of her incapability. Embarrassed.	She'll be feeling like a burden, as she's living by herself and used to doing things for herself and may not like depending on other people. She may be feeling a lot older as she'd just been admitted to hospital – so that may be impacting her	Incapable of looking after herself. Embarrassed. Frustrated that she is no longer able. She may actually feel that I am doing too much, and usually manages fine by herself but is too polite to ask me to leave. Old Fearing what is to come, i.e. she may recognise that she is deteriorating and is worried about the future.

2c	Is there anything she would like to do herself? State that I am more than happy to help her. Try to lighten the situation.	I'd reassure Miss Young, firstly that 75 isn't that old, but also that I am more than happy to help her in any way possible to make her more comfortable	Encourage her to do as much as possible, to give her feeling of independence, capability and if I am doing too much, to let her do it. Put an emphasis on 'team-work', she can help me out by doing the things she can, and I will help her out by doing what she can't. Ask 'what makes you say that?' to see if she does have any further anxieties or other issues she would like to address. I would then hope to relieve any anxieties – highlight there will always be help if she requires it.
Section 2			
Question 1	Worried that he might think that I'm being a little bit patronising, like 'you can't feed yourself so I'm feeding you'. Worried that I'm doing it wrong and concentrating on feeding him too much, drawing attention to the fact that I am feeding him.	Worried that he may choke on his food, and maybe a bit nervous about communicating with a dementia patient, as you have to be careful what to say as to not upset them.	Confident that it is something I can do; Glad that he is receiving nourishment; willing to spend time to understand his individual needs to make it an enjoyable experience for him.
Question 2	Oh no… what do I do! Would stay calm, but would empathise with his potential embarrassment.	I would just try and stay calm, and handle the situation as best as possible to ensure Mr Smith doesn't get any more upset	Again I would feel confident that it is a situation I can handle. I would empathise with his potential distress however that it is not something I would like to happen to myself and I would appreciate someone who took care of the situation in a caring yet confident manner, which is what I would try to do.
Question 3	Worried that she thinks I could be embarrassed.	I'd be concentrating on finding out who miss young is, what she is like and how she likes things done, so that next time I help her she would feel more comfortable.	I would look forward to meeting a new patient and finding out about her. I would constantly think to myself 'how would you act if this was your grandma' and try to make it a casual and light hearted situation, whilst feeling satisfied that I was making sure all her needs were met to a high standard.

Question 4	I would want to apologise back for making her feel that way, but would understand that it's understandable to feel like that.	I'd feel a bit bad that maybe I'd done something to make her feel that way I'd also feel a bit put on the spot and not know what to say. However again I'd stay calm – not to make her feel any worse	I would want her to stop apologising as I actually enjoy helping her. However I would empathise with any feelings she had about not being able to do things herself, as I know how much I take it for granted that I can do all those things myself and will one day be in her situation.

Appendix 11

Red = Respect
Pink = empathy
Green = communication

Participant No			
Section	Time point 1	Time point 2	Time point 3
1a	Firstly I would begin by introducing myself and what task I am about to do, and ask him if he is happy for me to carry on and is in a comfortable position to enjoy his lunch. Sitting with him at his level and engaging in conversation as I feed him. It is important to ask relevant questions such as is this meal ok for you or make gestures to enable him to respond in a way that I can understand how he is feeling	Approach Mr Smith and introduce myself, telling him who I am and the purpose of me being there. Although Mr smith may not be able to communicate effectively I will still ask permission and whether he is comfortable with me feeding him and thereby look for some indication that he consents. Following this I would ell Mr smith what there was for lunch that day and make sure he was happy with that option. As he is a stroke patient he may not be able to eat + drinks as well as other patients therefore it may be appropriate to cover him with something that keeps him clean + tidy, however if he appears uncomfortable with being covered, try to the best of my ability to keep him tidy. I would then begin by putting small or appropriate amounts that are manageable onto the fork or spoon and leave appropriate time	On approach to mr smith I would introduce myself and ask consent in order to assist with his feeding. As well as asking if there is anything else he would like done before commencing feeding such as going to the toilet ensure also they are in an upright position for feeding. Once this was achieved I would sit at eye level with the patient at a comfortable distance that is not invasive for the patient. it may be appropriate to ask the patient if he would like an apron to prevent any spillages, however this is the patients own decision. It is important to have the meal ready and a drink in order to aid the process. I would then begin feeding the patient altering the amount of food on the fork or spoon to meet the patients requirements. It is also important t ensure to give adequate spacing in between spoonfuls and drinks

		intervals in between each mouthful and ensure he does not feel rushed. Also giving drinks in between when needed. Following this I would ensure he was and at ease and that he had enough to eat + and drink before I left.	give regularly in order to aid digestion. It is vital to go at a pace that is satisfactory for the patient they are uncomfortable and in a position to eat comfortably. Once the patients shows signs of not wanting any more it is vital not to force any more food upon him. Ensure when finished feeding that they are left in a comfortable position and are at ease. Ensure that patient is clean and remove apron if necessary
1b	Although this is a difficult and embarrassing situation for Mr Smith it is important to remain in a professional manner and act as quickly as possible to ensure Mr Smith's dignity is retained. I would explain what has happened and what I am going to do to help him in this situation. I would then ask for assistance if required and try quickly as possible to clean him up so he feels comfortable again. It is apparent that he may have been eating his dinner in the in the main communal area therefore it is important to draw as little attention as possible from others to maintain his dignity	Firstly, it would be important to try and calm Mr Smith down, reassuring him that it was not a problem and I would clean him up in a quick and dignified manner as soon as possible. I would set the dinner aside, pull the curtains around his bed or if in a public communal area I would discretely remove him to a suitable place where I could help him get cleaned and changed before returning to his dinner. Also if required I would ask for extra assistance. As Mr Smith is a stroke patient and may be slightly confused this may make him even more distressed for himself as well as me. However, I realise it is important to remain calm and professional, adopting a caring and respectful role. Following getting him cleaned up and changed if appropriate I would bring him back to his dinner and continue as	It is important in this case not to draw attention from other residents at the care home of what has happened if anyone is in the surrounding area. It is then my responsibility to reassure Mr Smith that everything is alright and that I was there to help him. It is important at this point to take him away from the dining area to his bedroom and bathroom in order to get him changed and cleaned in order for him to return to his dinner as promptly as possible. During this incident it is my role to act in a dignified, respectful manner in order to keep the patient as calm as possible. Once the incident is resolved it is important to bring Mr Smith back to where he was and continue with his dinner if he wants or if it has become cold it may be relevant to give him something alternative such as a

		before, ensuring that he does not feel embarrassed or uncomfortable.	**sandwich.**
1c	**Embarrassed, frustrated, angry, low self esteem /confidence, low self worth, anxious, stressed, worried, a burden upon the staff frightened, upset, emotional**	**It is clear he may be feeling embarrassed, anxious, stressful, tearful, loss of dignity and simply overwhelmed with the situation. In turn, he may present distressed, angry, upset, shameful and even disappointed in himself. As he is a stroke patient with mild dementia, this may cause further confusion and bewilderment, as he may not know why it just happened and what was going to happen next.**	**It is clear Mr Smith may be feeling embarrassed, withdrawn, upset, irritable and quite anxious. This is due to feeling exposed within his own environment in an undignified manner. He may be experiencing feelings of low self esteem and worth and primarily hindered independence. It is clear this is a very private and personal area and to be exposed to others in a way that reveals his incompetencies would be demoralising. Ultimately he may be feeling fearful for what other people may think and create negative thought processes in his head that people may have changed or altered opinions of him. Mr Smith may in turn withdraw himself from everyone in the care home which may in turn lead to psychological issues such as lack of confidence, self esteem and feelings of worth. Primarily, this can alter his general health and well-being.**
2a	**It is clear that miss young as not yet met me and that it is important to introduce myself and gain a sense of rapport to enable her to feel as comfortable as possible and at ease. As this is her first admission to hospital she may feel frightened or slightly embarrassed, therefore it is important to reinforce that**	**Firstly, I would quickly look at Miss Young's medical notes to identify if there is anything important that I should know before I introduce myself such as how she mobilizes, how independent she is and if she has any medical conditions that need to be rectified. Following this, I would go and introduce myself to Miss**	**It is clear, as the patient and myself have not yet been introduced it is my permanent role o make myself known to the patient and communicate effectively in an attempt to build a rapport. It is clear this is a sensitive area to address as Miss Young has otherwise been independent until her admission**

	I will not do anything she does not feel comfortable with and if there is any concerns she would like to express that would make the procedure as easy as possible . it is apparent that her dignity and confidentiality must be upheld making her experience within the hospital as easy as possible. This may be through closing the curtain around her bed or taking her to the bathroom.	**Young, telling her who I am, what I was coming to do and was it permitted by her for me to help her give her a wash. If consent was granted, I would ask her what kind of wash would she like such as a shower, bath or a bed bath and thereby do the appropriate preparations to do that. When assisting with washing, I would ensure that she feels comfortable while maintaining her dignity and demonstrating respect towards her. Following giving her a wash, I would ensure she is comfortable and at ease before leaving her.**	**therefore it could be very hard for her to come to terms with someone offering assistance. It is important to address the question of would she allow me to assist her in a caring and compassionate way that the patient feels comfortable in your presence, hopefully allowing her to come to terms with the fact that she may require a little help with her personal cleansing and dressing. If the patient then confirms consent it is then our role to allow the patient to be as independent as possible, allowing them to do what they can, ensuring that they feel part of their own care and independence is not taken away from them.** **It is also important to offer the patient options of how they would like to get washed such as taking a shower, bath or if the just feel like a quick wash with a basin at the side of the bed. Once clarifying this I would ask the patient if the have any of their own products that they would like to use therefore enabling them to still feel like their own person and comfortable with where they are. When assisting the patient a vital component is to maintain and respect the patients dignity as much as possible, offering them towels to cover up, as well as pulling the curtain at the bedside, closing the door of the bathroom and**

			primarily giving them time and patience so they do not feel rushed. The patient should always be given the choice of what they would like to wear that day and if they require anything else such as washing and brushing their dentures, giving them a comb to brush their hair and ensuring primarily that they feel comfortable and at ease within themselves.
2b	**Embarrassed, a burden anxious, inferior lack of confidence/ self esteem, sad frustrated**	**Embarrassment, undignified, a burden, feeling that she should be independent and able to do things for herself as she may be comparing herself to others of her own age.**	**Miss Young may be feeling like she has lost her independence as she was used to caring for herself until admitted to hospital. Feelings of being a burden and useless may contribute as well as loss of self confidence and esteem. Feelings of embarrassment or being a hindrance as she may feel it was time wasted and a nuisance on the staff. She also may be feeling emotional such as upset, tearful, confused, irritated that she has been admitted to hospital meaning her independence has been compromised and the fact that she is in an unfamiliar environment may be quite frightening. It is clear she will be experiencing mixed emotions as this has been quite an ordeal for her and it is difficult to come to terms with the fact we are there to help her.**
2c	**Reassure her that it is a normal everyday activity and that her needs are my priority. By saying there is no need to**	**Tell her that she is still doing well for her age and condition and that it is important to stay positive and live life to**	**It is important to point out to Miss Young that it is our role to take care of patients admitted to the ward in order to**

	apologise that she is not a burden, that it is my job to cater for her needs	**her full capacity. Offer reassurance and positive comments.**	**maintain and safeguard health and well-being. I would reassure Miss Young that it is not a problem to help her and that she should be confident in herself and maintain as much independence as possible. Reassurance should be offered and a caring and compassionate manner used to make her feel as comfortable and at ease as possible with her unfamiliar setting.**

Appendix 12

Demographic Data

Participant No	Gender	Age	Previous nursing /caring experience	Where?	In what capacity?	Have you received nursing care	Previous education/training in communication	Previous education/training in psychology	Previous education /training in counselling
1	F		No			No	No	No	No
2	F		No			No	No	No	No
3	F		Yes	Hospital g.p practice community	Work experience And as a 1st & 2nd year medical student	Yes As a child	Yes Medical school	Yes Medical school	No
4	F		Yes	Volunteer with the sick to Lourdes	Helper	No	No	No	No
5	F		Yes	Hospital	Health Care Assistant	No	Yes – part of team work training	Yes – at school	No
7	M		yes	Day care centre for people with	Volunteer Work experience	No	Yes At school Work orientation	No	No

				mental health problems					
8	**F**		**No**	**No**		**Yes – student has not commented on experience**	**Yes St Johns ambulance**	**No**	**No**
9	**F**		**Yes**	**Hospital**	**Volunteer**	**No**	**No**	**No**	**No**
10	**F**		**Yes**	**Hospital**	**Health care assistant**	**No**	**No**	**No**	**No**
11	**F**		**Yes**	**Community**	**Worked with district nurse for work experience**	**Yes – student has not commented on experience**	**No**	**No**	**No**
12	**F**								
13	**F**		**No**			**Yes – student has not commented on experience**	**No**	**No**	**No**
14	**M**		**Yes**	**Nursing home**	**Health care assistant**	**No**	**Yes Work orientation**	**No**	**Yes officer training in the navy for provision of pastoral care + alcohol problems**

15	**F**		**yes**	**Hospital Caring for family member Orphanage Centre for elderly Hospital day care centre**	**Carer volunteer**	**Yes**	**Yes At school Work orientation Comms skills course**	**Yes Part of first degree**	**No**
16	**F**		**No**			**No**	**Yes Work orientation**	**Yes Degree in psychology**	**No**
17	**F**		**Yes**	**At home**	**Helping mother, who is a nurse + carers to care for grandparents**	**No**	**No**	**No**	**No**
18	**F**		**No**			**Yes – tonsils out as a child**	**No**	**Yes took a course as part of a previous degree**	**No**