The Transformation of Mental Health Student Nurse Attitudes during their Pre-registration Course

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Thesis submitted to the University of Nottingham.

For the Degree of Doctor of Philosophy, July, 2018.

Acknowledgements.

This thesis would not have been possible without the help and support of a number of people. I would like to extend my sincere thanks to them all.

First I would like to thank the six mental health students who allowed me a ‘snap shot’ of their pre-registration experiences, their openness in discussing their thoughts and supporting my personal aspirations to understand how education can influenced attitudes.

I am indebted to Professor Melanie Walker and Dr Belinda Harris for their encouragement, guidance and support at the initial stages of this long, at times, was stressful (see effects of this in Chapter Six) journey.

I owe my deepest appreciation to my supervisor Professor Monica McLean for her enthusiasm, guidance, knowledge and astute feedback inspiring me to complete this thesis. Thank you.

I would like to thank my ‘study buddy’ Julie, who understood the trials and tribulations of undertaking a PhD, so was able to listen and understand my dilemmas, but also supply much-needed humour.

Lastly, I would like to thank my family: my husband, Roy, for his love and understanding for all the weekends and evenings I was ‘lost’ in my PhD, and my daughter, Karla, and granddaughters, Rhiannon and Holly, for all their kind acceptance when mum/gran had ‘her PhD head on’.

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Abstract

The nurse/patient relationship is seen as central to the heart of mental health nursing and in this thesis I examine how student nurses perceive the concept of therapeutic in regards to these relationships. Contemporary treatment of mental illness is largely based on what are known as 'recovery' principles, which emphasise patients' capacity to regain mental health. This approach is contrasted to forms of treatment and caring underpinned by such attitudes as 'authoritarian', 'benevolent' or 'restrictive' which assume that patients are essentially different from the healthy norm. Recovery principles are embedded in most pre-registration curricula for mental health nurses which aims to develop knowledge about and attitudes congruent with recovery attitudes. While policy and nurse education promote recovery principles, the attitudes of the general public lag behind, tending to 'other' people with mental illnesses.

The issue this thesis addresses is that mental health student nurses begin their courses with attitudes aligned to those of the general public. There has to date been no investigation into whether their educational experiences change their attitudes to a recovery one.

The research was a longitudinal, in-depth case study of a cohort of six mental health nurse students as they progressed through the three years of their pre-registration course (2011-2014). Mixed methods were used to address the research question:

> Does mental health nurse education promote transformative learning which values and respects the diversity of individuals and enables their recovery, if so how and if not why not?

First their attitudes were assessed at the beginning of the course by using the Attitudes to Mental Illness Questionnaire (AMIQ) and then repeated towards the end of the course to compare responses. Four other methods for generating data throughout the course indicated what factors influenced attitudinal change: audio-recorded classroom discussions, recovery assignments, individual semi-structured interviews; and a discussion with the six students about their pictorial representation of their educational experience. Thematic framework analysis was employed drawing on Mezirow (2009) theory of transformative learning and Burnard's (1987) typology of nursing knowledge to explore whether and how different types of knowledges bring about transformation in attitudes.

From a 'benevolent' attitude when commencing the education, all the students made marked movements towards a 'recovery' one. With one exception, the students went through the

transformative phases of learning towards taking on recovery principles, although not all went through all the phases and not all fully incorporated recovery principles into their practice. It is argued that transformative learning is a complex slow process and that it took all forms of knowledge and the full three years for the students to take up attitudes which underpin the recovery principles.

The implications and suggestions for mental health nurse education, policy and practice are explored in light of the findings. Moreover, I argue that, all nurse education should include some knowledge about values of care and different theories of mental illness. If the transformational process is to be smooth consideration should be given to the sequencing of different types of knowledge into the curriculum.

Chapter One: Introduction.

Introduction

My thesis gives an account of an in-depth longitudinal case-study of six mental health nurse students and explores their changing attitudes towards patients with mental illness. These students were studying at a pre-registration level at a university within England and a range of data was gathered during their three years of nurse education at either Diploma or Degree level from 2011 until 2014. My aim was to discover whether their attitudes towards patients[1] changed over time and, if so, what facilitated this transformation. In this introductory chapter, I start by discussing my own positionality within the research and my reasons for conducting the study. This is followed by setting out the context of mental health nurse education at the time the case-study students were studying. I then introduce the debate on the role of the mental health nurse, which is dictated by mental health nurses' beliefs about the causation of mental illness and the type of nurse/patient relationships which they should offer. This debate underpins my investigation of students' attitudes towards the patients they care for. Building on this, I justify the choice to underpin my study with Mezirow's (2009) transformative learning theory and identify how my research questions developed. I end with a summary of all subsequent chapters.

My position in the research

My interest in undertaking this research comes from forty years of being a mental health nurse, including the last ten years as a lecturer in mental health nursing. When I first entered nursing in the 1970s, I thought mental illness was a brain disorder and that patients were hospitalised because they were incapable of living independently in society, so I felt sorry for them in what I now think of as a benevolent and patronising manner. Early in my career in 1978, a chance remark from a colleague of "There but for the grace of God, go I" referring to the patients on the ward we were working on began the process of changing my mind about people with mental health problems. This remark suggested to me that I might see patients as having the same humanity as us, the nurses who looked after them, although at the time I could not express it like this. As an eighteen-year-old on my second ward placement during the state enrolled nurse training I took the comment to mean that patients were 'like me', which I had not previously

[1] A patient is a recipient of health care services, and people with mental illness have used different terms, such as client, service user, survivor, but I used patient throughout this thesis as my focus is on the nurse/patient relationship.

thought. Since this transformatory moment, I have endeavoured to care for patients how I would like to be treated myself.

In 1991, I was offered the chance to undertake the year-long Enrolled Nurse Flexi-Conversion Course[2] which opened up a variety of career opportunities and encouraged my love for learning, leading to my studying a BSc (Hons) and MSc in nursing. The learning environments in higher education I experienced from 1994 until 2006 mirrored the path that nurse education was taking: the ethos changed from the apprenticeship-style training, which I undertook in 1978, to an education-based approach leading to the idea advanced by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC, 1986) that nurses should be 'knowledgeable doers'. These changes will be elaborated on and discussed in the next section on nurse education.

Over twenty-five years later, in 2004 while I was conducting a study with mental health nurses into the effects of life story work on a dementia assessment ward for my MSc, a second comment was critical to the development of my thinking about attitudes. One of the mental health nurse participants admitted that constructing a life story book with a patient made her think of 'patients as people' for the first time. I was genuinely surprised because the student nurse was nearing the end of her three-year nurse education, which despite being underpinned by humanistic principles, had not until this time led her to view patients as human beings like herself.

For me, the two comments, one from a colleague and the other from a student, a quarter of a century apart, have been transformative. The first drew attention to the similarities between myself and patients; and, the second to how other nurses view patients as being different from themselves despite an education designed to counter such an attitude. So, the research problem I was interested in was that, despite the immense changes in the learning content and environment of mental health nurse education between 1978 and 2004, some mental health students, soon to be nurses, still do not grant patients the same personhood as themselves.

After many years practising mental health nursing in many different in-patient settings, in 2006 I became a mental health lecturer. My arrival as a third-year module lead lecturer coincided with the 'Making a Difference' (MaD) curriculum which required students to view 'patients as people', and was underpinned by the Chief Nursing Officer's (CNO) Mental Health Nursing

[2] Enabling the conversation of my enrolled status to that of 'Registered Nurse'

Review (DH, 2006a). These curricula will be discussed in the next section. The MaD curriculum added to the already humanistic content by advancing ‘recovery’ which changed the emphasis from mental illness as a biomedical deficit in need of a cure to a biopsychosocial one which focuses on the person’s strengths and coping strategies. The change in emphasis influences the conceptualisation of the role and function of nurse/patient relationships which has moved from the nurse as the expert directing care options towards the patient as ‘expert-by-experience’ capable of uncovering and discovering what ‘works’ for them to achieve a meaningful life (Slade, 2009).

So as a nurse-educator I wanted to investigate how this new focus of recovery influences mental health student nurses’ attitudes about the nature and role of nurse/patient relationships. The background to this investigation is how policy has shaped mental health nurse education.

Mental health nurse training and education

The curriculum the student nurses who took part in my research were studying under was the ‘Fitness to Practice’ (UKCC, 1999), which was a direct response to the ‘Making a Difference’ (Department of Health (DH), 1999) recommendations after criticism that nurse education was not producing nurses who were ‘fit for purpose’ which meant that newly qualified nurses were not considered to have the knowledge and skills to deliver effective practice (Nursing and Midwifery, 2008).

A historic overview of nurse education reveals the difficulties and politics that characterise the search for appropriate nurse education. Since 1919, nurse training was under the auspices of the General Nursing Council for England and Wales (GNC), which has responsibility for all nurse training. One result of this is that mental health nursing has been weighted towards a general (now known as ‘Adult’) nursing model of care. This tendency was increased by advances in pharmacology during the 1950s, whereby drugs were developed which suppressed distressing symptoms, thereby supporting the theory that mental illness is a medical disorder. This medically-orientated, general framework changed only slowly over time, for instance, the inclusion of psychology in the 1957 syllabus, and then sociology and issues concerning community care in the 1974 syllabus (Burnard and Chapman 1990). For decades, apprenticeship models of education were the accepted mode of preparation for nurses, but due to government policies of relocation of care settings from institutional to community which

meant nurses within mental health would need to be more autonomous in their practice.[3] The new 1982 Syllabus of Training (English and Welsh Broads for Nursing, Midwifery and Health Visiting, 1982) advocated education which promoted self-awareness and advocated the use of experiential teaching techniques such as scenarios, problem-based learning, games and role play.

Following criticism that nurse education lead to poor levels of theoretical knowledge, inappropriate preparation and over-reliance on student nurses being used as part of the workforce (Crotty 1993), significant reform was introduced in 1987 with the development of the Project 2000 curriculum which revolutionised nurse education by moving responsibility from the National Health Service (NHS) to Higher Education Institutions (HEIs). Besides relocation of the taught elements of nurse education, it shifted the focus from training to education, endorsed supernumerary status for students when in practice settings and changed the minimum level of registration entry to Diploma. The theoretical component of the programme was taught within a university setting so much of the experiential learning methods of the 1982 syllabus (ENB, 1982) was replaced by traditional lectures with large groups of students from the various specialities studying together in the first eighteen months of the course, known as the Common Foundation Programme (CFP). Although it was advanced that the CFP included subjects common to all fields (Adult, Mental Health, Child, Learning Disabilities) (UKCC, 1986), it was dominated by the biomedical model of illness and disease which, in White et al's (1998: 46) opinion, was due to 'the sheer weight of [Adult student] numbers having a stronger foothold in higher education'. Project 2000 was criticised by politicians and the media for an emphasis on academic knowledge rather than clinical skills. Such criticism cast the reform as a self-interested move to secure recognition, status and improvement in pay, rather than motivated by a desire to improve standards of patient care. Moreover, hospital managers stated that the newly-educated diploma nurses did not have the skills base for safe practice, while some traditionally trained nurses saw these new Project 2000 nurses as a threat to their own status and career prospects (McNamara, 2005; Macleod Clarke, 2007). This opposition contributed to continuing concerns regarding the capacity of Project 2000 to prepare graduates who were fit for purpose and lead to UKCC to review new education in 1999 (Macleod Clarke, 2007).

[3] Life-long learning was viewed as necessary to provide high quality healthcare in a variety of rapidly changing environments.

Chaired by Sir Leonard Peach, the Peach Commission Report (UKCC, 1999) as it became known, recommended for all fields of nursing a reduction of the CFP to one year, introducing clinical skills earlier and registered nurses' assessment of students' level of competency in placements. This new curriculum, called Making a Difference (MaD), aimed to prepare competent, confident and effective nurses for inclusion on the appropriate part of the NMC register, who were 'Fit for Practice, Fit for Award and Fit for Professional Standing' (English National Board, 2001: 1). This brought nurse education back into a closer relationship with the NHS and its workforce with its skills-based objectives and shifted the focus of nursing away from theory towards competency and skills-based practice (Rokburgh, Watson, Holland et al, 2008). But by reverting to a predominantly competency-based preparation, the MaD curriculum was criticised for being more about technical skill than education for understanding (Watson and Thompson, 2000).

The newly formed Nursing and Midwifery Council (NMC) (2004), which governs the education of pre-registration nursing programmes, supported the changed focus by endorsing that Higher Education Institutions (HEIs) needed to demonstrate practice-centred, evidence-based learning with a range of strategies to assess knowledge, understanding and skills acquisition. The emphasis placed on the development of practical skills upheld the recommendations of the NMC predecessor, the UKCC (1999: 45) that 'interpersonal practice skills should be fostered by the use of experiential and problem-solving learning'. To achieve clinical effectiveness, students now spent fifty per cent of the course in clinical practice and their skills, attitudes and behaviours were assessed by a mentor, a registered nurse who has undertaken additional training. In addition, the programme was tasked with developing students to think critically, problem-solve and have the 'reflective capacities essential to complex professional practice' (NMC, 2004: 17). Now each nursing speciality was taught over two years (rather than eighteen months) and students spent more time on placements; on the mental health syllabus interpersonal skills were emphasised; and, on ways of working with patients were underpinned by Egan (1998), Rogers (1962) and Heron (1989) person-centred interactions (Cutcliffe, Stevenson and Lakeman, 2013). Role-playing patients, nurses and observers, who offered feedback of the 'nurses' performance, using the different interpersonal theories while in university helped students to practice their communication skills for student nurse/patient encounters in clinical settings.

In tandem with the MaD curriculum, when students enter the 'field' specific component in their second year of their education, the Chief Nursing Officer's (CNO) Best Practice Competences

and Capabilities for Pre-Registration Mental Health Nurses in England (DH 2006b) were incorporated. These competences and capabilities reflected the recommendations within the CNO's Mental Health Nursing Review (DH 2006a). These documents recognised that mental health nurses constitute the largest profession working in the field of mental health and make a vital contribution to providing care for people of all age groups and in all settings. These policies saw the shift from paternalistic attitudes of the biomedical model to consideration given to receivers of mental healthcare by asking people in receipt of care what they valued as assisting in their recovery. Both competences and values emphasise holistic practice, viewing the patient as a person; positive patient-focused attitudes of all mental health staff; a therapeutic nurse/patient relationship based on dignity and respect; and, working in partnership to tackle mental health problems. Best practice at registration is seen as mental health nurses who 'Promote a culture that values and respects the diversity of individuals and enables their recovery' (DH 2006b: 5). This requires the mental health nurse to 'integrate a person-centred value base' into their practice ensuring they 'effectively engage with those they care for' (DH 2006c: 4). Repper and Perkins (2009) argue, with respect to supporting and promoting this recovery approach, nurses with positive attitudes to the concept of regaining mental health are more likely to encourage patients to take control of their lives and be proactive in decision making about their own futures. Moreover, they maintain, that such nurses will also be more likely to inspire hope and be willing to consider alternative approaches to care and support. So contemporary mental health policy appears to want nurses to see patients as humans, who have the capacity to recover a meaningful and satisfying life (NIMHE, 2004; DH, 2006a,b).

In 2007 the NMC commissioned a paper outlining its vision of nurse education providing a degree-only programme to meet the demands on healthcare services by 2015 (Longley et al, 2007). Similar to the introduction of Project 2000, this attracted considerable public and professional media attention with critics stating that that such higher education would produce nurses who were less practically skilled and not interested in providing basic nursing care (Scott, 2004). However, supporters viewed this move as an essential prerequisite for the developing nursing roles within modern healthcare with its emphasis on public health and preventive medicine, reduction in hospitalisation and increased primary and community care (Radcliffe, 2009). In 2010, the NMC formally implemented these new standards for pre-registration nurse education with the aim of increasing the minimum academic entry level from Diploma in Higher Education to a Degree by 2013 (NMC, 2010). The students within my study

commenced their nurse education in 2011 so were offered the option of transferring from diploma to the degree pathway dependent on their academic results during the CFP component.

Another debate which is also relevant to this study, and will be explored in Chapter Seven, is the on-going debate in the United Kingdom, since the 1980s, to introduce a generic curriculum for nurse education, where all students study the same curriculum throughout and have placements in adult, child, learning disabilities and mental health settings (Happell, 2001). The specialist model is exclusive to the UK, Republic of Ireland and Belgium and criticism has been levelled that this type of nurse education is not economical due to duplication or overlap of content in the different speciality curriculums; conversely, the restriction in specialist focus is not seen as offering holistic, mental and physical, care in unison (Grant, 2006). However, Robinson and Griffith's (2007) literature review of nurse education from 17 countries, firmly conclude that if the UK moved to generic curricula there would be a minimal focus on clinical and theoretical aspects of mental health and learning disability nursing. This, they state, would lead to students who undertook these programmes not having the knowledge or skills to work in mental health community or hospital settings resulting in difficulties with recruitment and retention of mental health nurses[4]. Nonetheless, the debate and wavering continues: NMC review in 2006 advocated a generic curriculum and the Willis review in 2015 supported a two-year CPF and one-year specialist type education. At the time of my study, the curriculum included the first year as a shared CFP with students of the other specialities and then two years of speciality in mental health nursing, which in the University the students were studying was underpinned by the principles of humanism and recovery.

Good pre-registration education is seen as key for equipping mental health nurses with the knowledge, skills and attitudes appropriate for caring for people with mental health problems (DH, 2006a). To this end, the CNO (DH, 2006b: 4) states that pre-registration mental health nurse education should emphasis:

> [T]he need to build these competencies through programmes of professional development, enabling the student of mental health nursing to develop and promote positive attitudes towards people with mental health problems; engage with service users, carers and

[4] Australian nurse education has adopted a generic/comprehensive programme and is often used as an example of the difficulties faced with recruitment in mental health nursing see Edward, Warelow and Hemingway, et al (2015)

families through the therapeutic use of self; and, understand the central role of interpersonal relationships and empathy in mental health nursing.

This study aims to explore students' attitudes because they underpin their understanding of the 'therapeutic use of self' in the 'interpersonal relationships' between nurses and patients. However, it must be acknowledged that for many decades the role and function of the mental health nurse has been highly contested within its own speciality. I explore the two key opposing views next.

The role of the mental health nurse

In recent times then, the nurse/patient relationship is seen as central to the heart of mental health nursing (Dowling 2006; Lafferty & Davidson 2006; Silverstein 2006; Yamashita *et al.* 2005). However, the proper focus of mental health care has been hotly debated in the UK for many years. By the early 21st century, this debate focused on two broad and opposed approaches: the 'science' or 'art' of nursing. The 'science' approach favours biological and genetic theories as the cause of mental illness, while supporters of the 'art' of nursing see mental health problems as predominately personal, interpersonal and social problems in living, which diagnosis and medication does not fix (Gournay, 1995; Newell and Gournay, 2009: Barker et al, 1995; Barker and Buchanan-Barker, 2006).

In Cutcliffe's (2008) opinion nurses' beliefs and attitudes about the causes of mental illness will impact on the type of nurse/patient relationships they engage in. If the causation and aetiology of mental health problems is believed to have biological or genetic origins, the nurse's attitude is that mental illness resides within the patient, so consequently patients as people are invisible and are viewed as standardised 'cases' requiring the application of uniformed care and treatments. Viewing mental illness simply as a chemical imbalance of the brain results in nursing practice being reduced to dispensing medication, controlling behaviour associated with mental distress until the medication takes effect and then helping patients adapt to a life of disability. With this approach to care, nurses see their role in the therapeutic relationship as a route to monitor symptoms, assess the risk to self and others, and, promote medication compliance. Because mental illness is perceived as biological, medication and risk aversion dominate care, and nurses feel morally obliged to enforce treatment and containment practices for the patient's 'own good' (Cutcliffe, 2008: 90).

However, if the nurse views mental health problems as crises of human life, relationships and self-existence experiences, they view the nurse/patient relationship as an equal partnership, believing themselves to be the most useful 'therapeutic tool at their disposal' in helping patients cope with and find meaning in their life experiences (Cutcliffe, 2008: 91). The nurse explicitly disputes the ideology of the medical model that conveys that the patient is virtually powerless to do anything about their circumstances. So, the nurse/patient engagement, while offering emotional support, also fosters empowerment because the patient's personal meaning of life experiences is recognised and personal growth strategies promoted. Working alongside patients helps them ascribe individual meaning to their experiences and find ways of coping with their mental health problems by exploring opportunities for recovery and personal growth, through the medium of the therapeutic relationship (Cutcliffe, 2008). This approach upholds the view of patients as 'expert by experience' within a helping relationship where nurses are 'on tap, not on top' (Shepherd et al, 2008: 2) to inspire hope and encourage control over their lives and futures and is in line with contemporary mental health policy (DH, 2006 a,b).

Contemporary mental health care and mental health nurse education tends to recognise that nursing is both a science and an art that utilises a biopsychosocial paradigm, however, conflict between the schools of thought remain. Critics of the biopsychosocial model argue that rather than being holistic, it artificially promotes distinctions between the three factors; it causes confusion with assessment and educational need; and, it has done little to destigmatise mental health (Tavakoli, 2009). Nonetheless, the 'art' approach to nurse/patient relationships is relevant to my study because the mental health nurse curriculum that the six case-study students were studying was underpinned by this recovery philosophy, which I align with art, and I wanted to find out whether the programme produced students with the knowledge, skills and, most importantly, attitudes to practice as recovery principled nurses. So, the primary purpose of my research was to explore whether the recovery curriculum taught by the university supported students' practising in ways underpinned by conceptualising patients as having the abilities for recovery, personal growth and establishing a meaningful life.

The research problems and questions.

The students' attitudes towards their future role as a mental health nurse were under investigation within my study. Jack Mezirow's (2009) theory of transformative learning emerged as a generative way of exploring changes during their three-year nurse education. I first heard about transformative learning when I became a mental health lecturer during

discussions about different learning theories used in nurse education. Prior to this, I had studied different theories of learning while studying for a BSc (Hons) and MSc: behaviourism (Pavlov 1927; Skinner 1938), cognitivism (associated with Gestalt psychologists such as Kohler 1925 and Lewin 1948), humanistic approaches embedded in the work of Maslow (1970) and Rogers (1962); Knowles' (1980) andragogy and social learning theory (Bandura (1977). While Mezirow's (2009) transformative theory incorporates some of the features of these other major theories, it goes further by detailing how learners undergo fundamental change in the way they view themselves and the world. I also identified with his phases of 'alienation', 'reframing' and 'consolidation' in my own 40-year experience of developing and changing as a mental health nurse. I will now briefly discuss Mezirow's (2009) learning theory and explain how it influenced my research questions (the theory will be expanded on in Chapters Two and Three).

As noted above, a nurse's attitude towards people with mental illness influences how the function and purpose of the nurse/patient relationship is conceptualised and has been found to impact on patient outcomes/recovery. Using Mezirow's (2009) transformative learning as the theoretical perspective for my study was aimed at examining whether students' attitudes changed during their nurse education and, if so, what influenced these changes. In this section I briefly review Mezirow's theory and begin with his definition of transformative learning:

> Transformative learning refers to the process by which we transform our taken-for-granted frames of reference (meaning perspectives, habits of mind, mind-sets) to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove more true or justified to guide action. Transformative learning involves participation in constructive discourse to use the experience of others to assess reasons for justifying these assumptions, and making an action decision based on the resulting insight (Mezirow 2000: 7-8).

This definition of transformative learning guides my study. Mezirow's (1978a) theory was devised following his observations of USA students, returning to higher education following a long interruption in studying, who underwent personal transformations following a 'disorienting dilemma' when they questioned their own attitudes and beliefs. He concluded that transformative learning and action to integrate this new worldview into one's life was advanced by critical self-reflection and critical discourse after the disorientating dilemma. Although Mezirow's transformative theory is the overarching theory I use in my thesis, I also draw on other theories: Burnard's (1987) typology of nursing knowledge and Todres et al's

(2009) values framework, to explain, explore and discuss the students' education journey. I will discuss these theories in Chapters Two and Three respectively. Having explained my interests; sketched the history of mental health nurse education; drawn attention to contestation about the role of the mental health nurse; and, made brief case for framing my research by transformative learning, I am in a position to set out my research problems and research questions.

The first problem, already introduced, which ignited my interest in the subject of students' attitudes was that I was unsure whether the student who participated in my life story study on the dementia ward and had not previously thought of mental health patients as a person like herself was a 'one-off' or whether other students did not grant patients they met the same humanitarian status as themselves. The second problem was what theoretical, practical or experiential components of nurse education help or hinder transformation to help students towards a recovery frame of reference. The aim of my research was to explore mental health nurse students' 'frames of reference' (to use Mezirow's term) when learning from a curriculum underpinned by humanistic recovery principles. A longitudinal case-study methodology, which will be discussed in-depth in Chapter Four, was used to chart whether a cohort of six participants, who were student nurses from 2011 until 2014, changed their 'habits of mind' about people with mental health problems during their Pre-Registration Mental Health Nurse education. Therefore, my main, overarching question is:

- Does mental health nurse education promote transformative learning which values and respects the diversity of individuals and enables their recovery, if so how and if not why not?

To achieve this, sub-questions guided the study and will be addressed in the thesis:

- What were the students' frames of reference about people experiencing mental health problems, at the start of their three-year nurse education? What appeared to have shaped these attitudes?
- Did these students change their frames of reference over their three-year education? If so, how did they change?
- If students have negative unhelpful frames of reference which do not change, what appeared to be the barriers to change?

Structure of the thesis

In this introductory chapter I discussed my own positionality and reasons for conducting this study. I then set out the context of mental health nurse education at the time the students were studying and introduced the debate on the role of the mental health nurse, which is dictated by beliefs about the causation of mental illness and the type of nurse/patient relationships within mental health nursing. Lastly, I justify my choice to underpin my study with Mezirow's (1978) transformative learning theory and identify my research questions. The final part of this chapter will offer a summary of all subsequent chapters.

Chapter Two: Developing a Conceptual Framework: Knowledge and Transformation

This chapter explains the two main conceptual frameworks in the thesis. First I expand and critique the key concepts of Mezirow's (2009) transformative learning theory, encompassed in three phases of 'alienation', 're-framing' and 'consolidation', which leads students to transform their frames of reference and therefore attitudes. In Chapter Six, the findings relate to the three phases of transformative learning. Secondly, I discuss Burnard's (1987) three-fold typology of 'propositional', 'practical' and 'experiential' nursing knowledge theorises how students learn the art and science of nursing from multi-dimensional influences. These three forms of knowledge will be explored in Chapter Five, through audio recorded classroom discussions, to identify the effects different forms of knowledge have on the students' frames of reference.

Chapter Three: Public and Mental Health Nurses' Attitudes towards the Mentally Ill- The Literature Review

This chapter begin by exploring Goffman's (1963) and Link and Phelan's (2001) theories of stigmatisation and then I explore the British public's attitudes towards people with mental health problems using the responses to the Attitudes to Mental Illness Questionnaire (AMIQ) from 1994 until 2015. A brief discussion of Todres et al's (2009) concept of humanization and dehumanization in healthcare, will assist the review of research into mental health nurses' attitudes, mainly from the UK, but also offering an international perspective. I use the research reviewed in this chapter to argue that attitudes held by mental health nurses and student nurses are close to those of the general public and direct their views about the causes of mental illness, which in turn, influence what is seen as appropriate behaviour within nurse/patient relationships.

Chapter Four: Methodology and Methods of Data Generation

I describe and justify the use of a longitudinal case-study of six student nurses to explore their frames of reference during their three-year nurse education. I first offer reasons for employing the Attitude to Mental Illness Questionnaire (AMIQ) (usually a quantitative method) as a heuristic tool to gain a baseline of the students' frames of reference and knowledge upon commencing the course and again in their third year of study. I then describe the qualitative methods used to gather data throughout the education of the six students. These methods included: classroom discussions; written assignments, individual interviews and pictorial representation of their journeys during their education, which were subsequently examined using thematic network analysis. Through these methods, I explored the students' attitudes, reasons for any changes and effects this change on their nursing practice, which is discussed in Chapters Five and Six. Lastly, I identify my limitations in choice of data collection methods while conducting this case study and discuss ethical implications of the research processes throughout the chapter.

Chapter Five: The Impact on Attitudes of Propositional, Practice and Experimental Learning

In this chapter I explore the students' verbal descriptions of propositional, practical and experiential knowledges as described by Burnard (1987) during their three-year study. First, I offer some background by introducing each student and discussing their reasons for choosing to study mental health nurse education. Each of the students had a 'benevolent' frame of reference when they commenced their education which, in the first year, appeared to be supported by propositional knowledge taught in the shared modules at the university. At the start of their field specific course in the second year, despite being introduced to the recovery principles, which underpin contemporary mental health care, the students appeared to struggle to fully incorporate the recovery attitude into their practical knowledge. However, experiential knowledge in the form of inspiring role models in practice, challenging of their viewpoints by their peers in classroom discussions and identifying themselves with patients' reactions to life situations and circumstances appeared to develop transformative learning as four of the students scored a recovery frame of reference when they retook the AMIQ six months before the end of their education. The remaining two students AMIQ scores indicated a marked movement towards the recovery frame of reference.

Chapter Six: How Transformative Learning Changed Attitudes towards Patients

Drawing on the analysis of the students' reflections captured in their interviews and pictorial representations, I discuss their experiences of transformative learning, in terms of Mezirow's (2009) phases of alienation, re-framing and consolidation. Five of the students appeared to experience a disorientating dilemma; one had a dramatic experience, while the other four students experienced incremental dilemmas which altered their frames of reference. Five students realised that given the right circumstances or life events they too could experience mental health problems, so they were able to empathise with patients and this empathy led to them wanting to practice in a recovery principled way. However, transferring this re-framing into practice took a considerable time: in the last six months of their education students began to incorporate the recovery values into their practice. The sixth student did not speak about a dilemma provoking event or events, but her frame of reference did change to a recovery attitude. The findings of the data from the students' individual interviews and pictorial representation of their nurse education journey, analysed through Mezirow's (2000) transformative learning lens, confirmed that the propositional knowledge (Burnard 1987) taught in the first year upheld their initial benevolent frames of reference. Additionally and critically relevant to my study, I found that the students did not incorporate the recovery principles into their practice until they underwent their own stressful experiences and met patients who they related to.

Chapter Seven: Conclusion.

The findings from Chapters Five and Six are used to answer the main research question: 'Does mental health nurse education promote transformative learning which values and respects the diversity of individuals and enables their recovery?'. Three issues were identified: (1) the dominance of the biomedical model of care and treatment in the students' first year of study (2) the practice-theory gap where the propositional knowledge taught in the university did not reflect the practical and experiential knowledges the students encountered in placement and, lastly (3) the stress students experienced during the course. I then deliberate on the implications of these issues and offer suggestions for future mental health nurse education. Finally, I discuss the contributions to knowledge the findings from my study offers.

Chapter 2: Developing a Conceptual Framework: Knowledge and Transformation

Introduction

In this Chapter, I establish a framework of concepts drawn from Mezirow and Burnard which will allow me to explore questions about the student learning experiences during their three-year nurse education. First, I discuss Mezirow's (2009) transformative learning to explore the different phases which forms full transformation. The relevance to my study is that I am investigating whether the student nurses change their attitudes towards people with mental illness during their education so the transformative phases of Mezirow's theory offered a structure to identify transformation. Next I explain Burnard's (1987) three-fold typology of nursing knowledge. As discussed in Chapter One, nursing is a practice profession and Pre-Registration Nurse Education is split between 50% of the course in theory, which equals to 3,200 hours and the same in practice. So Burnard's theory offered a framework for understanding the different learning environments and experiences the students encountered as they learned to become members of the nursing profession.

Jack Mezirow's Theory of Transformative Learning: How attitudes change

Mezirow's (1978a, 1978b, 1981, 1991, 2000, 2009) emphasises that attitude, or as he terms it 'frames of reference', change is the goal of transformative learning. 'Frames of reference', in Mezirow (2009) opinion, are ingrained and shape and define expectations, perception, reasoning and feelings so changing one's attitude, although difficult, may be enlightening and transformative, but challenge to the validity of one's values and the assumptions that underpin them may cause conflict and distress. Mezirow now acknowledges both the cognitive and emotional aspects of changes to frames of reference within a ten stage, embodied in three phases, model, which is useful for analysing any changes in attitude the students in my study may have. I will now explore Mezirow's transformative theory, the development, criticisms and how I wanted to employ the phases to assist analysis of the data gathered in this study.

As noted in Chapter one, from Mezirow's (1997: 5) perspective, a person's taken-for-granted 'frames of reference' are 'structures of assumptions through which we understand our experiences. They selectively shape and delimit expectations, perceptions, cognition and feelings. They set our line of action'.

Mezirow (2000) explains that frames of reference encompass cognitive (thinking), affective (emotions) and conative (expressed endeavour) dimensions and are comprised of 'habits of mind' and resulting 'points of view', which result largely from cultural and familial influences. A habit of mind is a set of assumptions or broad generalized and habitual ways of thinking or 'predispositions that act as a filter for interpretation the meaning of experience' (Mezirow 2000: 17). He (2000) suggested some varieties of habits of mind that influence a person's perspective including the sociolinguistic such as social norms, customs and secondary socialization; moral-ethical (conscience, moral norms); epistemic, such as learning styles; philosophical, for example, religious doctrine or transcendental world view: psychological, such as self-concept, personality type or emotional response patterns: aesthetic, for example, values, tastes and judgements about what is beautiful, ugly or humorous. Stigma is an example of a habit of mind, where, for instance people who have not experienced mental health problems may view those who have, as different to themselves or inferior. Similar examples can be found in relation to homosexuals, people of different races, colour, religion and/or gender.

A habit of mind is expressed as a point of view which expresses 'immediate specific expectations, feelings and judgements, that tacitly direct and shape a specific interpretation and determine how we judge, typify objects, and attribute causality' (Mezirow 2000: 18). These points of view can be positive or negative depending on previous experience, cause-effect relationships, other people's viewpoints and one's own idealised self-image. So the point of view of people who have not experienced mental health problems might be that they consider those who have, as different or inferior may due to defects of the brain or that they are in some way responsible for their mental illness.

In summary, Mezirow (2000) thinks of attitudes as frames of reference which are shaped by society, culture and family influences, cause and effect experiences and own idyllic image of oneself. This explanation of how frames of reference are constructed is a helpful lens for exploring how people with mental illness have been perceived by the general public and mental health nurses. But my study wanted to explore whether and how the students' attitudes were changed by the Pre-Registration Mental Health Nurse Education so I now discuss Mezirow's three phases of transformation.

Mezirow's first insight into transformative learning was empirical (1978). He conducted a qualitative study to identify factors that impeded or facilitated the learning of 83 USA women

who returned to college. Based on his findings, he concluded that some students had undergone personal transformations and the major elements conducive to this were critical self-reflection and critical discourse which underpins his ten stages, which are arranged in three phases: 'alienation', 're-framing' and consolidation'. I have constructed a table to illustrate this linkage (Table 2.1).

Table 2.1: Mezirow's (2009) transformative learning phases

Stage 1	Alienation phase	Experience a disorienting dilemma
Stage 2	Alienation phase	Self-examination with feelings of shame, fear, guilt or anger
Stage 3	Alienation phase	A critical assessment of assumptions or beliefs
Stage 4	Re-framing phase	Recognition that one's discontent and process of transformation are shared
Stage 5	Re-framing phase	Exploration of options for new roles, relationships and actions
Stage 6	Re-framing phase	Planning a course of action
Stage 7	Re-framing phase	Acquiring knowledge and skills for implementing the plan
Stage 8	Consolidation phase	Provisional trying of new roles
Stage 9	Consolidation phase	Building self-confidence and competence in new roles and relationships
Stage 10	Consolidation phase	Reintegrating into one's life on the basis of conditions dictated by one's new perspective

The shaping of Mezirow's transformative learning

Although Mezirow was influenced by Freire's (1970) conscientization or consciousness-raising, which was guided by the desire for political liberation and freedom from oppression, he grounded his theory in cognitive and developmental psychology. This is evident when he identifies how adults absorb habits of mind and points of view from the process of socialisation in their families and the culture in which they were brought up. Individuals and families make meaning of the world through experience so what happens once, re-enforces an expectation that it will happen again (frames of reference). Once this frame of reference has been formed, individuals view and interpret other people, groups, events and experiences through these lens. However, Mezirow maintains that given the right circumstances these can change so I will now discuss how he says this happens.

Disorientating dilemmas

In Mezirow's view, transformative learning can occur when something different happens, which is often a personal crisis, or a diverse opinion is voiced resulting in a disorientating dilemma, challenging internalised frames of reference, codes and categories. He claimed that learners who experience a disorientating dilemma and engage in critical reflection can change their 'meaning schemes' and 'meaning perspectives' (specific beliefs, attitudes and emotional reactions). This may result in 'perspective transformation' when the learner becomes critically aware of how and why their own assumptions have come to constrain the way they view the world. So when a learner is confronted by a situation which does not fit with their current frame of reference they may undergo 'a conscious recognition of the difference between the old viewpoint and the new one and make a decision to appropriate the newer perspective as being of more value' (Mezirow, 1978b: 105).

Critique of Mezirow's theory

His earlier (1978, 1978b, 1981, 1991) key terms, such as meaning perspective and meaning schemes have been criticised as they tended to cause confusion due to their unfamiliarity (Cranton, 1997; Wiessner and Mezirow, 2000). However, it could be argued using accessible language can lead to indiscriminate use with loss of precision. Even though Mezirow (1997, 2000, 2009) took care to provide as much clarity as possible, Taylor (2000: 292) has discussed the 'illusive nature of frames of reference', arguing that the conceptual construction of a frame of reference, though grounded theoretically 'lacks a strong empirical foundation'. Other criticism of Mezirow's theory has been that it stresses individual agency, rather than the cultural, social and historical context (Clark and Wilson, 1991; Tennant, 1993). Despite Habermas's influence, which is discussed below; it does not distinguish between normal life-cycle stages and perspective transformation, and it is agreed Mezirow's work is overly rational and analytical thus minimising the role of feelings (Taylor, 1998; Taylor, 2001). In his later work Mezirow (2000: 30) appears to acknowledge the social context by arguing that the 'goal of adult education is to help adult realise their potential for becoming more liberated, socially responsible and autonomous learners' to make informed choices by critical reflection and engagement in the social context. Mezirow (1978) initially maintained that transformational learning was exclusively an adult learning theory, because children tend to seek evidence to support or expand their frames of reference without critically questioning their values, but he later conceded that adolescents may learn to think hypothetically and become critical of what

they read, see or hear (Mezirow, 1997). Finally, he admitted that a disorientating dilemma which occurs due to a personal crisis is 'often an intensely threatening' experiences because 'we have to become aware of both the assumptions undergirding our ideas and our emotional responses to the need for change' (Mezirow, 2000: 6–7).

Over the preceding years since his formulation of transformative learning, Mezirow has responded to criticism by acknowledging his version of transformative learning as a 'theory in progress' (Mezirow, 1991a: xi). Although the phases have never changed it has led to him clarifying, refining and developing the model: acknowledging the influence of societal context, developmental and emotional aspects within transformative learning and changing some of his terms, such as meaning schemes became habits of mind and meaning perspective points of view (see Appendix 1 for an overview of the many changes). Aside from changes in terminology and refining his theory, Mezirow maintains that transformative learning is initiated by a disorientating dilemma. If the new experience is similar enough to earlier orientations, it can be accommodated within current habits of mind, produce an incremental shift or be dismissed as a one-off event. However, if vastly different, it can cause feelings of intense uncertainty leading to questioning (critical reflection) of habits of mind and points of view. In an attempt to analyse these problematic perspectives, discussion (critical discourse) with other people will be undertaken. Transformative learning depends on acknowledging that previous beliefs and assumptions do not sit well in these insightful dialogues (communicative learning) and mean that they need to be altered (re-framing). However, Mezirow (2009) conceded that the validation or justification of contested beliefs and assumptions will be dependent on the person's opinion of the other people as informed, objective and rational individuals. If this is the case, learning occurs by: expanding on assumptions, world-view or mindset (frames of reference); by learning new frames of reference; by altering opinions formed through experience (objective points of view); or, by adapting the sense of self, belief system or interpretations (subjective habits of mind) resulting in new self-knowledge. For the learning to be truly transformative, the person then works to integrate the implications of different beliefs and assumptions into their worldview thereby enlarging it.

Theoretically, Mezirow (1991; 1997; 2000; 2009) has drawn on the work of the German philosopher and sociologist Jürgen Habermas to discuss two domains of learning. 'Instrumental learning' involves learning to manipulate or control the environment or other people to improve practice, while the counter to it is 'communicative learning' which is derived from Habermas's (1971) theory of 'communicative action', the purpose of which is to come to agreements with

others in truthful and authentic ways about what is right and just. Mezirow (2000) argued that significant learning in adulthood falls into the domain of 'communicative learning' because it requires:

> [A]ssessing and understanding the meaning behind a person's words; the coherence, truth, and appropriateness of what is being communicated; the truthfulness and qualifications of the speaker. We become critically reflective of the assumptions of the person communicating (Mezirow, 2000: 9).

In mental health nursing, instrumental learning can be seen as task-oriented problem solving by determining 'cause and effect' relationships based on observation, practicing the task and analysing the consequences, which appears to reside within Burnard's (1987) practical knowledge. Whereas, communicative learning can be seen as informed and thought-provoking dialogue, consideration of evidence and assessing arguments and opinions objectively, which resides within propositional and experiential knowledges. Because of the significant value of 'communicative learning' for transformation Mezirow has offered teaching staff seven ideal conditions for advancing rationale discourse so learners need to have:

> [A]ccurate and complete information, be free from coercion and distorting self-perception, be able to weigh evidence and assess arguments objectively, be open to alternative perspectives, be able to reflect critically on presuppositions and their consequences, have equal opportunity to participate (including the chance to challenge, question, refute, and reflect, and to hear others do the same), and be able to accept an informed, objective, and rational consensus as a legitimate test of validity (Mezirow, 1991: 77)

He maintains that the full transformation cycle involves three phases: alienation, reframing and contractual solidarity (1978b). Alienation occurs when a dilemma is experienced, the feelings this induces and examination of existing assumptions. Reframing consists of becoming aware of taken for granted assumptions, exploring others' views and behaviours. While, contractual solidarity or consolidation is the crucial decision to adopt this new perspective and incorporate it into one's worldview.

The first two of the three phases are evident in the university's curriculum as during many classroom discussions students often talk about incidents from placements, ethical issues or their role in supporting patients, which either uphold or refute the subject being taught so could be construed as disorientating dilemmas. Additionally, in group clinical supervision students

actively seek their peers and lecturers' advice on issues they are struggling with in an attempt to find consensus of views and discussion of ways forward. Within these discussions Mezirow's (1991) seven ideal conditions for advancing rationale discourse are observed to offer a safe and supported environment for students to discuss, listen, challenge, question and reflect on their own and their peers' experiences and attitudes. So, alienation and reframing appeared to be already happening when students attended the university, but unless the student revisits the issue they were struggling with in later supervisions, the consolidation phase is not evident. Also communicative learning conducted in placements, which might advance transformative learning, is not known. Transformative learning is relevant to my study as I wanted to investigate if the students changed their frames of reference towards patients and the role of the mental health nurse during the three-year course, so I intended to establish if they spoke about any disorientation dilemmas and whether this lead to contractual solidarity.

Mezirow's transformative learning offers a theory of how learners undergo fundamental change in the way they view themselves and the world, which is relevant to my study as student nurses begin their nurse education with certain frames of reference about patients and the role of the mental health nurse, which may reflect the public view as discussed earlier which does not reflect contemporary recovery policy. My research question asks if the pedagogical experience they are studying advances recovery and, if so, do the students undergo the phases of transformative learning to achieve this.

Philip Burnard Typology of Nursing Knowledge: Linking theory to practice

I first learnt about Burnard's (1987) typology of nursing knowledge while I was studying my MSc and thought that it was helpful in explaining the different ways nurses accumulate, review and reflect on the knowledge gained from different sources. As will be explained below, these different types of knowledge encompass the need for nurses to use evidence-based knowledge and skills to ensure person-centred care. However, I could not find any literature discussing Burnard's framework in any depth except briefly mentioning it in passing. But for many years there has been discussions and research regarding the theory-practice gap, when students find a discrepancy between what is taught in the university and found on clinical settings, and I believe Burnard's framework helps to link these knowledges together (Corlett, 2000; Hewison and Wildman, 1996; Rafferty et al, 1996; Landers, 2000; Rolfe, 2003). Additionally, this framework acknowledges the influence of interactions with others such as patients, their relatives and care teams, which I believe can have either a positive or negative impact on

attitudes towards people with mental illness. So now I will offer an overview of this framework and identify how it linked to the curriculum the students in my study were undertaking.

As discussed in Chapter One, the Chief Nursing Officer (CNO) (DH 2006b) maintains that good pre-registration education should equip mental health nurses with the knowledge, skills and attitudes appropriate for caring for people with mental health problems. The emphasis within programmes is to build these competences through professional development, promoting positive attitudes towards people with mental health problems. In Burnard's (1987), a lecturer and author on nurse education, view, nursing knowledge is divided into a three-fold typology: 'propositional', 'practical' and 'experiential' knowledge. Propositional knowledge is abstract theoretical concepts or facts about a subject, person or thing. Student nurses are exposed to propositional knowledge in taught lessons in university, from textbooks, journals and on-line resources. However, Burnard (1987) points out that learners can amass considerable propositional knowledge without having direct experience of the subject, person or thing, In agreement, many other education scholars have also identified how propositional knowledge alone can lead to surface, mundane learning by acquiring a collection of disjointed facts and figures without comprehending the meaning and structure of what is stated, and taking the research findings or experts' opinions at face-value (Anderson and Krathwohl, 2001; Marton and Saljo, 1976 cited in Biggs, 2003).

In the University that this study was conducted, in the first year, known as the Common Foundation Programme (CFP), the students (60 in total), included the four fields of nursing: Adult, Mental Health, Learning Disabilities and Child, attended the same lectures which had been designed to introduce them to biological sciences, social sciences, evidence-based practice and nursing theory. The CNO (DH 2006b) recommendations were embedded into the mental health field's core philosophy, which started in the second year of their nurse education, by promoting a recovery-focused culture of learning effective communication, holistic and safe care, and working collaboratively with patients. Within the mental health branch there were smaller groups of students, about 20 per cohort. Flexibility of teaching methods was possible so alongside formal lectures, discussion groups, skills workshops, demonstrations and simulations, enquiry-based learning, student-led seminars and self-directed learning were used to explore different perspectives of recovery, the role of the mental health nurse and 'the therapeutic use of self' (DH 2006b: 4). As explained in Chapter Three, the principles of hope, empowerment and opportunity was embedded in the nurse education under study within this

thesis, reflecting the Chief Nursing Officer's Best Practice Competences and Capabilities for Pre-Registration Mental health Nurses in England (DH 2006b).

The second type of knowledge in Burnard's framework is practical and is developed through the acquisition of either psychomotor or interpersonal skills, undertaken in placement settings or simulated in the classroom (Burnard 1987). As nursing is a practice-based profession, Burnard acknowledges that many nursing activities reside within this domain but the smooth performance of the task without the underlying propositional knowledge does not allow understanding the reason for the intervention or its possible consequences. As noted previously students on pre-registration courses spend 50% of the curricula on placements in varied clinical placements with experienced nurses throughout their three-year education, this entails direct patient care which allows the students practice what they have learnt in the university.

Students in the university experienced diverse placements within mental health care settings: older adult, acute admission, rehabilitation and forensic in-patients wards and child and adolescent, crisis and home resolution, assertive outreach, and recovery community teams. The local mental healthcare trust policies are underpinned by the principles of recovery and person-centred care reflecting the CNO (DH 2006a) review of mental health nursing. This exposure to different types of placement begins in the first year with two, eight-week placements within the student's chosen field of nursing and one, four-week placement in another field. During the branch programme, starting in the second year, there were four, twelve-week placement which are field specific. Students were actively encouraged to participate in all aspects of patient care and develop recovery-focused student/patient relationships.

The final type of knowledge in Burnard's framework is experiential, which is subjective and gained through direct personal encounters with the subject, thing or person. These real-life experiences are subjective, often emotional, so can either confirm or refute previously held beliefs, assumptions or attitudes. Although experiential knowledge can be mere assessment of the usefulness of a theoretical model (propositional knowledge) or a clinical skill (practical knowledge), Burnard (1987) insists it is synonymous with personal relationships with other people. As nursing is a practice profession, other people could include patients, their relatives, the teams of professionals they are in practice with and the lecturers in the university. These encounters can facilitate learning about one's own belief system and it is only 'when we are so detached from others that we treat them as objects that no new experiential knowledge can

occur' (Burnard, 1987, p191). He stresses that reflection on these direct experiences is the key to validating, transforming and giving personal meaning to different forms of knowing. Since the introduction of Project 2000 (UKCC 1986) curricula, reflection has been emphasised as an expected learning component of all nurse education.

In the mental health course featured in this study, besides written portfolio evidence, reflection is required in some academic assignments and students have reflective discussions with their mentors and personal tutors on one-to-one basis. Additionally, group tutorials in the first year explore aspects of placement encounters and during the field specific component clinical supervision is a regular feature of the mental health course to promote self-awareness, reflection, expression of emotions, insight and problem solving skills.

In this section, I have explained Burnard's (1987) typology of nursing knowledge and identify how the different knowledges fit within the curriculum the students I was studying. The different knowledges are important for my study as I was researching whether the curriculum promoted recovery attitudes. Each of the knowledges have the potential to either confirm or refute previously held attitudes about the causes of mental illness which, I argue in Chapter Three, informs appropriate nursing practice. Alternatively, the three knowledges might be seen as contradicting each other and led to the theory-practice gap mentioned above, leaving students confused as to the fitting view of patients and the role of the mental health nurse. Although in Burnard (1987) experiential knowledge he maintains encounters with other people can facilitate learning about one's own belief system, he does not explicitly discuss attitudes so his theory was useful as a framework for identifying which knowledges (propositional, practical and experiential), or which combination of the knowledges, advances or inhibits recovery attitudes was paramount to answering my research question. In Chapter Five I will discuss the data gathered from 2011 until 2014, in a chronological order, to ascertain which of Burnard's knowledges influenced the students' attitudes throughout their nurse education.

Conclusion

This chapter offered a brief overview of the recovery principles that underpin mental health nursing curriculum the students were studying. I then linked both Mezirow's (2009) transformative learning and Burnard's (1987) typology of nursing knowledges to discuss the usefulness of both theories to my study. Mezirow offers an understanding of how frames of reference are lens to view and make meaning of the world, however these can change as a consequence of disorienting dilemmas when new or different information challenge these

ingrained frames of reference. Self-reflection, meaningful discussions, plans of action, gaining new knowledge and skills, trying out new roles and integrating this new perspective into one's life is seen as transformative learning. But this does not explain what knowledge or experiences causes a dilemma so Burnard's theory will be used in conjunction with Mezirow's transformative learning to explore the effects of different experiences during their pre-registration nurse education.

In the following chapter I will explore, using Goffman' (1963) and Link and Phelan's (2001) theories, the stigmatisation of people with mental illness and this is followed by discussing the attitudes of United Kingdom public and mental health nurses.

Chapter Three: Attitudes towards the Mentally Ill: Situating the Research

Introduction

In this chapter, I explore public and mental health nurses' attitudes towards people with mental health problems. As the students in this study were born and brought up within the United Kingdom, views of the public and society are pertinent to understand how people, including the students, see the mentally ill. Additionally, as the students work alongside mental health nurses their views and behaviours will have an influence of the students' attitudes. I follow this by reviewing two theories of stigmatisation that of Goffman's (1963) and Link and Phelan's (2001) to show that people with mental illness are viewed by the general public as different to others. I turn then to grey literature to explore the British public's attitudes to the mentally ill through the Attitude to Mental Illness Questionnaire (AMIQ) which has been commissioned by the government since 1994 to monitor the British public's opinions (TNS BMRB, 2015). The questionnaire was introduced following community care initiatives by former United Kingdom (UK) governments and the introduction of the NHS and Community Care Act (DH 1990), which resulted in the closure of many mental hospitals. Following the exploration of the public's attitude, I will discuss research into mental health nurses' attitudes, mainly from the UK, but also offering an international perspective. The differing attitudes of mental health nurses will be explored using Todres et al's (2009) concept of humanization and dehumanization in healthcare.

The mad, bad and tortured: stigmatisation

In every society, there are attitudes about and actions and behaviours towards others that are culturally sanctioned or disapproved and maintained by economic, educational, religious and political groups which 'bear the social definition of being either good or bad, normal or abnormal' (Burgess 1962; 389). A category of people often seen outside of society's 'normal' groups is the mentally ill. Positive attitudes can lead to the mentally ill being seen as human beings with emotional problems who need to be treated with respect and dignity (Kitwood, 1997). Negative attitudes, however, can lead to stereotyping, prejudice and discrimination. Stereotypes are cognitive perceptions or images attached to members of a social group, whereas prejudices are the feelings these stereotypes evoke in individuals and societies towards the different social group, and discrimination is the behaviour that results from prejudice (Stier and Hinshaw, 2007). Negative stereotyping, prejudice and discrimination can lead to stigmatization

when treatment of one group by another results in the limitation of human rights or life opportunities.

Erving Goffman (1963), an American sociologist, presented his social theory of stigma as a 'spoiled identity', enlightening an understanding of attitudes towards the mentally ill. For Goffman (1963), spoiled identity means individuals are aware of societal norms and standards and are acutely sensitive to what others see as a 'failing' causing them to agree that they fall short of what they ought to be. The focus of his work was the organization of observable, everyday behaviours and he developed classifications of the different elements of social interaction. According to Goffman's (1963: 3) theory of social stigmatization, people are placed into categories by society based on what is considered socially normal, and those not meeting this 'normality' are reduced 'from a whole and usual person to a tainted, discounted one'. In fact, Goffman (1963: 5) maintained that individuals were differentiated between those considered 'normal' of society and those who had deviated from the standard of perfection and thus were 'not quite human'. In Goffman's (1963) opinion, there are three forms of stigma associated with perceived negative attributes: tribal, abomination of the body and blemishes of character. 'Tribal stigma' sees people from different races, nationalities or who hold different religious beliefs as radically different. The 'abomination of the body stigma' is often forced upon people with physical disabilities or deformities. The 'blemishes of character stigma' sees some people as weak-willed, domineering or dishonest and Goffman (1963) located people experiencing mental health problems within this category.

Link and Phelan (2001) using Goffman's theory focused on the contemporary stigma faced by people with mental health problems and state that there is an interrelationship between four components, which are relevant to my study which examines mental health student nurses' attitudes towards patients. The first component is that people distinguish and label human differences. In the UK people with mental illness are diagnosed and arguably labelled by psychiatrists so could be classed psychiatric 'cases', acts of law, the latest being the Mental Health Act (2007), prohibit their freedoms and enforce compulsory treatment reducing personhood and status within society. The second component, is that dominant cultural beliefs link labelled people with perceived undesirable characteristics to negative stereotypes. All too often, media portrayals of the mentally ill reflect our culture's fear and misunderstanding about mental illness, the most prevalent stereotype being that the mentally ill are dangerous and unpredictable. The third component, once labelled people are placed in distinct categories to

accomplish some degree of separation of ‘us’ from ‘them’. Historically, at the time Goffman developed his theory, this separation was done physically by putting the mentally ill into mental hospitals built away from towns and cities. There remains a dichotomy within society of ‘them and us’, or what Pilgrim (2005, p.123) refers to as ‘two groups of humanity’, people with mental illness are viewed as ‘other’. In the fourth component, labelled people experience status loss and discrimination that lead to unequal outcomes. Link and Phelan (2001) state that this process of stigmatisation, leading to disapproval, rejection and exclusion, develops early in life as part of cultural socialisation. Further, this stigma is a matter of degree and depends on who is being stigmatised. From a mental illness perspective, individuals who present a greater degree of symptomology are likely to seen as being linked to more undesirable characteristics, whereas, those with minimal symptomology, may be less rejected by the public. The loss of status can impact on life chances such as employment, social relationships, housing and psychological well-being (Link and Phelan, 2001).

In their literature review of the stigma faced by the mentally ill, Rusch, Angermeyer and Corrigan (2005) suggest that the general public hold three common views of people with mental illness: they are dangerous, have a character weakness or are incompetent. Such views influence how people think the mentally ill should be treated. If in the public’s view a person with mental illness is a homicidal maniac, s/he is feared and treatment should be exclusion from the general public. If they are rebellious free spirits they must be controlled. And, if they are perceived to have childlike perceptions, life decisions need to be taken for them (Rusch et al, 2005).

Having now discussed how attitudes are constructed and maintained by the culture we live in, I will examine the lay beliefs of people within Britain. I decided to limit my examination to Britain as the six students in this study grew up here and, it can be suggested, experienced the same cultural influences and similar backgrounds to others living in Britain. To do this I will review the findings from the Attitude to Mental Illness Questionnaire which has been commissioned by the United Kingdom (UK) government on an annual basis since 1994 to monitor changes in public attitudes towards mental illness in Britain. Additional background information will be offered to contextualize the debates and government policies regarding the care and treatment of mentally ill people over the past two decades.

Capturing the UK public's views on the mentally ill

Community care initiatives, underpinned by the development of internal market approach, which have been promoted by successive governments in the UK during the 1980s were amalgamated in the NHS and Community Care Act (DH 1990). The Act advanced domiciliary and day care to enable people with mental health problems to live as independently as possible in their own homes. Large mental hospitals were closed and replaced by day centres, out-patient clinics and community teams who visited people with mental illness in their own homes or, if the person was acutely ill, small units attached to general hospitals. These changes, however, did not automatically change the public's attitudes towards people with mental health problems.

Since 1994 the United Kingdom (UK) government has commissioned a survey to monitor changes in public attitudes towards mental illness in England. The Attitude to Mental Illness Questionnaire (AMIQ) has been undertaken mostly on an annual basis with approximately 1,700 adults individually interviewed face-to-face each year. These participants have been selected to be representative of the English population, using a random location sampling methodology. The core of the questionnaire has remained largely unchanged over the last twenty years, except for questions about personal experience and descriptions of people with mental illness being included in 2009 and 2010 respectively. Also, the first question uses an adapted version of Taylor and Dear's (1981) Community Attitudes to Mental Illness (CAMI) but instead of stressing a 'community mental health ideology', the emphasis throughout the AMIQ is 'recovery'. In Chapter Four I will explain these changes in more detail but briefly the questionnaire is used to determine four attitudes towards people with mental illness: 'authoritarian', 'benevolence', 'social restrictiveness' and 'recovery'. As the students within my case study commenced their nurse education in January 2011, I employed the 2010 version of this questionnaire (again this will be discussed further in Chapter Four).

I will now examine the changes in public opinion towards people with mental illness using each of the attitudes used in the AMIQ from 1994 until 2014. Besides an annual report, there have been three collated reports of the AMIQ: 1994-2003 (Mehta et al, 2009); 2009-2012 (Evans-Lacko et al, 2013); 1994-2014 (TNS BMRB, 2015), I will use these resources to offer a longitudinal overview of similarities and changes in the public's attitudes since the questionnaire began. I also include some background information to explain why changes in attitudes might have occurred. Additionally, as all of the students in my study lived in the

United Kingdom during the time the public opinions were being surveyed, they would have been exposed to society's views, the media portrayal and debates concerning the care of people with mental illness, so it could be expected their attitudes would be similar to those found in the AMIQs. I now use the four attitudes outlined in the questionnaire to frame the following section.

Authoritarian attitude

An authoritarian attitude views people with mental illness as an inferior class requiring coercive handling, so they are different to 'normal' people. However, there are a wide variety of mental illnesses and mental health problems to which the level of normality attributed is different for example, schizophrenia is often understood to have a biological cause and is seen as an incurable life-long condition, while depression is perceived as a human reaction to life's stresses thus more curable (Mann and Himelein, 2004). The less normal the person is perceived as, the more they need to be hospitalised for their own good as they require control and discipline (Taylor et al, 1981). A high agreement score in this category reflects a belief in a biological or genetic cause for mental illness where lack of self-control and rationality on the part of the mentally ill person implies permanency of the condition so complete cure is impossible (Read and Harre, 2001; Phelan, 2002).

Reduction in people wanting the mentally ill hospitalised in 2014 tended to fall in the younger 16-34 and 35-54 age groups who, unlike the over 55s, might not be aware of previous mental health services such as large hospitals so had nothing with which to compare contemporary community care and small in-patient unit facilities to. Although the marked decrease is made from 29% in 1994 to 18% in 2014 of respondents agreeing that 'there is something about people with mental illness that makes it easy to tell them from normal people', some of the other responses conflicted with this. The agreement of the statement 'mental illness is an illness like any other' increased from 71% in 1994 to 77% in 2013. Equating mental illnesses to other medical disorders became a popular strategy to combat the stigma of 'othering' in the 1990s as it was meant to stop blaming the person with mental illness for the condition (Maddux, 2012). Advancement of biomedical reasons for mental illness gained prominence in the 1950s with the development of psychoactive drugs. The calming effects on psychotic behaviour of people, usually diagnosed as schizophrenic, advanced the dominant theory of chemical imbalances within the brain for causes of mental illness (Whitaker, 2010). By the 1990s genetic disposition was advanced as the reason for these neurotransmission chemical abnormalities (Corrigan and

Watson, 2004). Although there appears to be growing agreement that mental illness is like any other illness, a consistently small number of respondents agree with the statement 'virtually anyone can become mentally ill' (9% in 1994 and 8% in 2014). But equating mental illnesses to other medical disorders locates the abnormality 'inside' the individual, which in turn promotes a view of the mentally ill as physically distinct from the mentally well (Maddux, 2012; Mehta and Farina, 1997). What has been more apparent is that since the AMIQ was first commissioned in 1994 the general public in Britain has become more able to identify the names of different mental illnesses thus supporting the authoritarian attitude. This might be explained by more media interest in mental illness. In Goulden et al's (2008) critical analysis of five British, mainly broad sheets, newspapers from 1992 to 2003 and Thornicroft et al's (2013) content analysis on 27 local and national newspapers between 2008 and 2011 found that since 2000 there was an increase in stories promoting an understanding on mental illness. Both studies conclude that overtime newspaper coverage has become less stigmatizing but in Goulden et al's (2008) review this was not true for all mental health diagnoses, with depression perceived more positively than schizophrenia, while Thornicroft et al's (2013) put this down to guidance to journalists and editors from mental health charities.

So, the authoritarian attitude towards mental illness and people experiencing it appears to be influenced by the dominant biomedical knowledge and media presentations. Moreover, the majority of the general public did not agree that 'virtually anyone can become mentally ill' which might suggest people believe their own 'brain chemistry' is not vulnerable to abnormalities. Having explored the AMIQ authoritarian attitude and offered some rationale for its adoption I will now consider benevolent attitudes, which appear to be closely linked to authoritarian attitudes but are more kindly in nature.

Benevolent attitude

A benevolent attitude is a paternalistic, sympathetic and kindly view of people with mental illnesses. This means they are seen as having childlike, naive characteristics, so life decisions need to be taken for them and this is the responsibility of society (Taylor et al, 1981). So a high agreement score in this category appears to indicate the mentally ill are incompetent, helpless and incapable of reason, therefore in need of protection (Rusch et al, 2005). This sympathetic attitude was seen as positively supporting the mentally ill in 1981 when the CAMI questionnaire, the forerunner of the AMIQ, was first developed, soon after the closure of the

large mental hospitals. Indeed, benevolence can be a catalyst for advocating and endorsing more funding for mental health services (Corrigan et al, 2004).

The benevolent responses to the AMIQ has remained mainly high and static from 1994 until 2014 with the exception of two major changes. A significant difference was seen between the levels of agreement of the statement 'There are sufficient existing services for people with mental illness' (increasing from 11% in 1994 to 23% in 2014) and a decrease in agreement of 10% (1994) to 6% (2014) to the statement: 'People with mental illness are a burden on society'. The youngest group of respondents (16-34) were consistently more in agreement with these statements, closely followed by the 35-54 and then the over 55 age group. Agreement with the first statement might reflect younger participants' knowledge, similar to the reasons for not wanting the mentally ill hospitalized: they have only known the present care in the community services. While the older age groups might remember the public outcry about the lack of resources for the mentally ill, following closure of many large hospitals. As Coid (1994) reports, the provision of community services has been, at times, inadequate and many people discharged from the hospitals became homeless and did not have the support needed from dedicated mental health teams. Additionally, the younger respondents disagreement with the mentally ill 'being a burden on society' might be due to their heightened awareness of campaigns to combat discrimination, such as Time to Change strategies, who are supported by Comic Relief. The campaign uses social media to get their message across so are seen by younger people who might not read newspapers. The campaign's aim is to inform, reduce stigma and injustice and promote compassion for people with mental health problems (Time to Change, 2010).

Many people like to consider themselves compassionate, kind and sympathetic about the plight of the mentally ill. But as Taylor et al (1981) concede, this sympathy can also turn to pity for the 'unfortunates'. In Read et al's (2001) opinion, pity leads to infantile treatment and is a consequence of campaigns to promote mental illness as a biomedical disorder. Benevolent pity can produce negative effects known as 'benevolence stigma', when the mentally ill are seen as unable to competently handle life's demands, so require benevolent authority to make decisions for them (Corrigan et al, 2001). Viewing the mental ill as infantile while discouraging blame, is patronising because it justifies controlling people, showing them how to do things and where they are going wrong (Mehta and Farina, 1997). So, while people with mental illness are not held responsible for their problems and should be treated with compassion, if they object to treatment they are nevertheless given it 'for their own good' reflecting an authoritarian attitude.

This attitude disempowers and undermines the person with mental illness, reduces self-determination and perusal of life goals (Corrigan, Rafacz and Rusch, 2011). Nonetheless, the caring benevolent attitude remained relatively high in the AMIQ over the past two decades, indicating tolerance for people with mental illness.

So, while well intentioned, the benevolent attitude, influenced by the biomedical model of permanency, is a type of stigma because it can be disempowering, leading to the view that people with mental illness are different from other members of society, less competent to live an independent life and less acceptable. Having discussed the benevolent attitude I will now consider the social restrictiveness attitude, which again appears to be closely linked to the authoritarian attitude.

Social restrictiveness attitude

A social restrictiveness attitude views people with mental illness as a threat to society because they are deemed dangerous and unpredictable, so they should not have the same rights as 'normal' people and should be avoided (Taylor et al, 1981). A high agreement score in this category indicates a perception that the mentally ill are viewed as dangerous and lack self-control.

Although many of the responses to the AMIQ social restrictiveness statements are similar in both the 1994 and 2014 surveys, there was a sharp rise in agreement with this attitude in the late 1990s and early 2000s. For example, agreement with the statement for 'It is frightening to think of people with mental illness living in residential neighbourhoods' started at 15% in 1994 and fell to 12% in 2014 but in 1997 this peaked at 26%. The high levels of social restrictiveness during this timescale was reflected in all the statements pertaining to this attitude. It would appear that this rise in the perceived need for social distancing and responsibility limiting among the general public during the 1990s and early 2000s was due to the high-profile media exposure of the risk posed by people who had accessed mental health services and was re-enforced by government policies.

In Read and Law's (1999) opinion, the unpredictable and violent 'madman' stereotype is a result of the biological explanation for mental illness. They also contend that it is the most predominant stereotype of the mentally ill, but the increased level of dangerousness is not based on objective facts. Despite only 8% of all homicides being committed by people with mental illness and a decrease since the deinstitutionalization in the 1980s (DH, 1999), in the period

between 1990-2000 government policy development appeared to be preoccupied with risk and the need to prevent violence (Paterson and Stark, 2001). Fear of people experiencing mental illness increased with several high-profile murders committed by people who had previously had or were experiencing on-going mental health issues[5]. In McKeown and Clancy's (1995) view, media representations of the mentally ill has had a significant effect on the public's attitudes as they depict people with mental health problems as dangerous, unpredictable and volatile. During the 1990s and early 2000s the British tabloid press gave, and in some instances still does, widespread coverage to the perceived 'dangers' posed by ex-patients living in the community (Allsop et al, 2004). But as Mullen (1997) points out, anyone who has come into contact with the mental health services is labelled an ex-patient and any future undesirable actions are attributed to mental illness.

The growing concern by the general public about safety led Frank Dobson, Secretary of Health to proclaim that many vulnerable people were being left uncared for and posed a danger to themselves and a nuisance to others. This has been reflected in Government policy, for instance the Mental Health Bill (DH, 2002) which accentuates the risk posed to the general public by a small number of people experiencing mental health problems. This policy resulted in radical new extensions of Community Treatment Orders (CTO)[6] to the Mental Health Act (MHA 1983) for people who were deemed dangerous or with severe personality disorder (MHA 2007). These supervised CTOs can be imposed on the new category of 'community patient' if they are deemed to be at risk of non-compliance with their treatment plan forcing them to return to hospital for treatment (Taylor, 2010).

The slow decrease in the social restrictiveness attitude from 2003 onwards suggests the general public were reassured by government policy. Additionally there was a significant decrease in articles in newspapers containing the element of 'danger to others' and pejorative language (Thornicroft et al, 2013). But this social distancing and responsibility-limiting stigma remains the most dominant attitude expressed with 40% of people believing the mentally ill are dangerous and unpredictable, which is still perpetuated by some negative media coverage. I

[5] The unprovoked attack and murder of Jonathon Zito on the London Underground in 1992 by Christopher Clunis, who had a diagnosis of schizophrenia, led to the forming of the Zito Trust. One of the most vocal charities, while never blaming people with mental illness, the trust highlighted that once discharged from hospital some ex-patients' did not receive adequate care and tended to have transitory lifestyles and maintained that the system had failed to protecting the public.

[6] Interestingly, once CTOs had been introduced the Zito trust disbanded as it felt it had achieved its goal in helping to protect the public.

will now move on to the final attitude which initially was called the 'community mental health ideology' by Taylor and Dear (1981) but the emphasis within the contemporary AMIQs is on recovery. As will be discussed in the next section, the CNO (DH 2006a,b) considers recovery to be the ideal attitude to hold about people who have experienced mental health problems and underpins the nursing curriculum the students in this thesis studied.

Recovery attitude

Finally, the recovery attitude acknowledges that anyone can experience mental health problems and it accepts the principle of deinstitutionalized care, going further to ensure people with mental illness are afforded the same status and rights as other members of society.

A high agreement score in this category differs greatly from the last three attitudes, which views people with mental illness as different due to brain disorders (authoritarian), incompetence (benevolent) or dangerousness (social restrictiveness). While recognising that some people may need hospitalisation, recovery responses indicate that the respondent thinks that a community is the best place to care for people with mental health problems.

Although many of the responses to the statements from 1994 to 2013 positively adopt a rise in community care, there is a notable negativity between 1997 and the early 2000s. The reason for this might be that people with mental health problems were viewed as dangerous and unpredictable as discussed in the previous section. Indicating that people with a recovery attitude are not immune to worries about the closure of many large mental institutions, media representation of the mentally ill and government policies during the late 1990s and early 2000s. Since 2010 the older age group of people (55 plus) tend to express more positive attitudes towards recovery from mental health problems than their younger counterparts (Evans-Lacko et al, 2013; TNS BMRB, 2015) which might reflect life experiences such as their own mental health issues, stressful periods in their lives or contact with people who have mental illness.

The steady increase in the recovery attitude might also be explained by the rise of user movements within the UK. Although started during the 1970s and 1980s, in 1985 there were only a dozen of these pressure groups, but by 2005 there were at least 500, fostered by the consumerism policies of the Conservative government (Campbell, 2005). These groups not only promoted individual and collective rights, but challenged mental health care and policy as a right under the National Health Service (NHS) and Community Care Act (DH 1990), which

made consultation with patients and former users of the service a requirement for community care planning (Wallcraft et al, 2003). User groups demanded social inclusion as a right and a new vocabulary of ‘recovery’ rather than ‘cure’ was being advanced, which challenges the pessimism of previous decades of care where mental illness was seen as a lifelong condition (Watkins, 2007). Additionally, public education campaigns such as ‘Time to Change’, ‘Respect’, ‘Mad Pride’, the annual ‘World Mental Health Day’ and celebrities ‘coming out’ about their mental health problems might have had a positive impact on the public’s attitude. These collective voices offered insights into the experience of having a mental illness, their treatment by the mental health services and the public at large and demonstrated that ‘recovery’ was possible.

Critically, the concept of recovery was devised by people based on their experience of mental illness to emphasise their individual journeys to a meaningful life (Anthony, 1993). However ‘recovery’ is confusing, difficult to define and open to interpretation. It has been likened to an approach, a model, a paradigm, a movement and a vision (Wallcraft, et al 2003; Shanley and Jubb-Shanley 2007). It differs from the traditional biomedical meaning of recovery as ‘cure’ from biological illness, rather it refers to a process of change and personal development, that considers recovery, the reclaiming of personhood, roles, responsibilities and self-knowledge (Slade, 2009; Shanley and Jubb-Shanley 2007).

Deegan (1988), who had first-hand experience of mental health problems, was the first to propose this definition of non-medical recovery. She believes that recovery is the process of people accepting their mental illness as a social disability and gaining a new sense of self. Repper and Perkins (2009) identifies recovery as rebuilding a satisfying and meaningful life with or without the eradication of symptoms. This deeply personal process offers ‘a way of living a satisfying, hopeful and contributing life even with the limitations caused by the illness’ and developing new meaning and purpose beyond the catastrophic effects of the mental illness (Anthony, 1993, 527). Deegan (1996) acknowledges she was devastated by her diagnosis of schizophrenia and remained ‘stuck’ in this label for many years, so she maintains that recovery cannot either be forced on people or rushed, rather there needs to be an environment of trust and partnership to help people become ‘unstuck’ and regaining self-agency. The core dynamics of this environment is ‘hope’ that recovery is possible, ‘empowerment’ to be actively involved in care decisions and ‘opportunity’ to lead a rewarding and meaningful life (Shepherd, Broadman and Slade, 2008). Deegan (1996, 92) states ‘The goal of recovery is not to become

normal. The goal is to embrace the human vocation of becoming more deeply, more fully human'. This definition of recovery and the principles of hope, empowerment and opportunity was embedded in the nurse education under study within this thesis as discussed in Chapter One, which incorporated the Chief Nursing Officer's Best Practice Competences and Capabilities for Pre-Registration Mental health Nurses in England (DH 2006b).

So, the recovery attitude is more humanistic in nature, and it can be influenced either positively or negatively by life experiences and political and media representations of the mentally ill. This attitude more than the other three appears to be promoted by the person's own mental distress experiences by life events, recognition of a relationship between cause and effect stressors and influenced by significant others' viewpoints.

To sum up, different attitudes about people with mental illness influences beliefs about how they should be treated. The authoritarian view is that people with mental illness are inferior and require a coercive approach. Benevolence offers a sympathetic view but is disempowering as all decision-making is removed from the mentally ill. Social restrictiveness views the mentally ill as a threat to society so constraints are placed upon them. Recovery accepts that anyone can experience mental health problems, so they should be afforded the same status, self-agency and life chances as everyone else. Green (2010), a medical sociologist, discussed the stigma experienced by people with long-term illnesses and found that most of the British public reactions to the mentally ill appears to lie along the continuum between authoritarianism and benevolence, resulting indirectly in the reduction of the self-agency of people with mental health problems. In my study the students might commence their nurse education with similar attitudes to the public's authoritarian or benevolence ones, but are undertaking a curriculum which is underpinned by recovery principles so my aim was to establish whether this education transforms their attitudes to advancing patient self-agency. Now that I have offered a brief history of how people with mental illness have been viewed and some of the reasons for this over the past twenty years, next I will explore how attitudes can influence patient care.

Mental health nurses are part of the culture too

As mental health nurses in UK were mainly born and brought up in and remain part of the UK society, it might be expected that they hold the same attitudes about people with mental health problems as those members of the public who undertook the AMIQ. This, in turn, could influence their frames of reference in regard to the causes of mental illness and how the mentally ill should be treated. Although British nurses were not included, this influence was

illustrated in Chambers et al (2009) study of mental health nurses' attitudes in five European countries when the socio-political climate and culture of the country of origin was the most influential factor in predicting levels of tolerance and stigma. The chief finding to emerge was that nurses' attitudes differed depending on the culture of the country they lived in, with most positive views evident in Portugal and least positive in Lithuania. Nurses from Lithuania displayed the most social restrictive and authoritarian attitudes and were most concerned about risks posed by people with mental health problems. The researchers concluded that the socio-economic and cultural environment toward mental illness influences the attitude of nurses as the key attribute to their clinical behaviour. In Portugal community services are well established, while in Lithuania most mental health care continued to be provided in mental hospitals, similar to the provision in the UK before the 1990s, and this segregation classifies the mentally ill as incapable of decision-making and living independently.

As noted previously in Chapter One the role and function of mental health nurse has been debated over the past two decades from opposing standpoints of science and art (Gournay 1995; Newell and Gournay 2009: Barker 1995; Barker and Buchanan-Barker 2006; Cutcliffe 2008). Supports of mental health nursing as a science tend to view mental illness as biological dysfunction or of genetic origin therefore the patient is defective in some way and so requires management, direction or control, which mirrors the authoritarian, benevolent or social restrictiveness attitudes discussed previously. While supports of mental health nursing as an art see mental health problems as predominately personal, interpersonal and social problems in living so the patient is viewed as a person who has the freedom and ability to make choices about her/his own life reflecting the recovery attitude. Also discussed in Chapter One, the mental health nurse's belief about the causation of mental illness influences the type of nurse/patient relationship she/he employ. I use Todres et al (2009) humanization and dehumanization of healthcare to frame the next part of the literature review of seven studies found which included United Kingdom mental health nurses and student nurses attitudes.

The humanization and dehumanisation of nursing care

Although not specifically referring to mental health care but to all fields of nursing Todres et al (2009) values-based framework is relevant to my study because it identifies how attitudes towards patients can have a positive or negative influence on the care they receive. In Todres et al's (2009) opinion, there are eight principles of humanisation in healthcare systems and interactions, but there are also eight opposing dehumanisations elements. Their framework is

expressed as a continuum stretching from positive to conflicting negative values of seeing patients as 'human' or consequences of their diagnosis.

Todres et al (2009: 69) stress these values are not either/or humanisation or dehumanisation moments, but a spectrum of 'touchstones for awareness when considering the complexity of lived situations'. They acknowledge their perspective on 'what it means to be a human' is influenced by the phenomenological philosophy of Husserl (1970), Heidegger (1962) and Merleau Ponty (1964). Although these philosophers differ in their focus of phenomenology, they agree that all human experience takes place within space/world, the body, time and relationships with others. These humanisation and dehumanisation dimensions correspond to AMIQ attitudes with humanisation paralleling recovery and dehumanisation resembling authoritarian, benevolent or social restrictiveness (see table 3.1).

Table 3.1: Relationship between the AMIQ attitudes and humanisation and dehumanization healthcare.

Humanisation		**Dehumanisation**	
Recovery principles	**Insiderness** Recognising patients' subjective interpretation of their experiences, skills, knowledge and motivation	**Objectification** Ignoring patient's subjective interpretations and treating them as standardised objects, problems or diagnosis.	**Authoritarian attitude**
Recovery principles	**Agency** Respecting the patients' ability to make choices and the freedom to act on these decisions.	**Passivity** Placing patients in a disempowered, submissive position.	**Benevolent attitude**
Recovery principles	**Uniqueness** Honouring each patient as a distinct person.	**Homogenisation** Treating patients as a member of a collective diagnostic group.	**Authoritarian attitude**
Recovery principles	**Togetherness** Identifying patients' social and relationships and with their community.	**Isolation** Seeing patients as alienated from companionship and commonality.	**Social restrictiveness**
Recovery principles	**Sense-making** Valuing patients' desire to understand the significance of things, events and experiences.	**Loss of meaning** Considering patients as unable to comprehend concepts and relationships between them.	**Benevolent attitude**
Recovery principles	**Personal journey** Appreciating patients' need to move through time in a meaningful way.	**Loss of personal journey** Patients being seen as either stuck or fixed in their diagnosis.	**Benevolent attitude**
Recovery principles	**Sense of place** Acknowledging patients' need for the feeling of being in a comfortable, familiar place.	**Dislocation** Attributing patients' feelings of strangeness and alienation to their diagnosis.	**Authoritarian attitude**
Recovery principles	**Embodiment** Respecting patients' wholeness as an individual human being.	**Reductionist view** Viewing patients' as bio-chemical bodies without feelings, values or emotions.	**Social restrictiveness**

The only study within a mental health setting, employing Todres et al's (2009) values framework offers insight into how dehumansing and humanising care is demonstrated. This is an important study and relevant to my study as it demonstrates how the attitudes of mental health care staff reflect authoritarian, benevolent, social restrictiveness and recovery, and how these can led to dehumanisation or humanisation of care. I identify the value-base in my discussion of Borbasi et al's study to illustrate how authoritarian, benevolent and social restrictiveness attitudes dehumanise patients, while the recovery attitude enshrines humanisation (as Table 2.1 illustrates).

In Borbasi et al (2012) Australian research, they used the reflective journals of the Dementia Outreach Service (DEMOS), who assisted Residential Aged Care Facilities' (RACF) staff ability in managing residents who display difficult behavioural and psychological symptoms of dementia. The DEMOS teams helped the RACF staff by: assessment of the resident with identification of possible triggers for their behaviour; spending time 'on the floor' with staff, observing the residents' behaviour, and, the staff's responses and offering supportive training.

The data within these reflective journals was used to illustrate how some residential staff 'dehumanised' residents, while the DEMOS team promoted 'humanising' care which reduced residents' difficult behavioural and psychological symptoms. Some staff 'were seemingly unable to see beyond the disease or a sum of tasks to the person behind the disease', which lead to residents' feelings not being taken into account (objectification). This could be countered by the DEMOS team asking the residents' their preferences, listening to their responses and considering their feelings (insiderness). There were examples of task-orientated practice when residents were expected to comply (passivity), when they tried to make choices but could not articulate in a way that was understood by care staff, this was misinterpreted as being difficult. Finding out the residents' preferences and offering choices was demonstrated to reduce this 'difficult' behaviour (agency). Sometimes the residents were treated as a collective (homogenization), which the researchers suggested, could be due in part, to the heavy workloads and staff shortages, but concluded could easily become the norm. To combat this and promote dignity, the residential staff were encouraged to view each resident as an individual personality with individual needs (uniqueness). There was an assumption that residents were incapable of forming relationships with other residents and, on the odd occasion this did happen, it was seen as inappropriate and actively discouraged (isolation). However, the DEMOS team stressed that companionship is fundamental to personal well-being and can have positive effect of reducing loneliness for both parties (togetherness).

Also observed were tasks carried out without explanation on residents who were confused or disorientated resulting in resistance (loss of meaning) but by explaining what was happening in language the resident could comprehend increased their understanding and reduced their fear (sense making). Many of the residents' past lives were not known to the staff or acknowledged in the care (loss of personal journey), but by getting to know residents' past enabled them to connect with their sense of self and helped staff see the person not the disease (personal journey). Some residents were unsure where or why they were in the residential homes so became uncooperative to care (dislocation) but facilitating a sense of 'homeliness' by altering routines and the coldly clinical environments to lead significant improvements in residents' quality of life (sense of place). Some staff reduced the residents to physical bodies or objects requiring tasks (reductionist view of the body) but by seeing the whole person meaningfully interacting with the world and situations impacted positively on the residents' quality of life (embodiment).

Although many of the residential staff were underqualified, I am not claiming their disrespectful attitudes and behaviours were held following formal mental health education, but this study is useful in identifying dehumanising and humanising behaviours. And as Borbasi et al (2012) state, the dehumanising behaviours tended 'not to be through any wilful intent, but through lack of understanding' when the residents' diagnosis overshadowed their individuality and advanced disrespect and disempowering care.

Now that I have identified humanising and dehumanising values of care, the following section will discuss the seven studies found following a literature review which included United Kingdom mental health nurses and student nurses to explore if Todres et al (2009) values uphold my assumption that authoritarian, benevolent and social restrictiveness attitudes result in dehumanising care and that recovery attitudes promotes humanising care.

What is known about the humanising and dehumanising attitudes of mental health nurses

Morant (1995) interviewed thirty British and thirty French mental health professionals to ascertain their attitudes towards patients. The participants, mental health professionals, tended to describe people with mental illness in terms of psychiatric symptoms (objectification) and the inability to cope or function. Typically, people with psychosis, which traditional psychiatry describes as losing touch with external reality, were considered as 'different' (isolation) because the health professionals found it difficult to understand the patients' experiences. British nurses in particular were more likely to express themes of 'difference', which Morant

(ibid.) suggested was a psychological distancing strategy to alleviate high levels of stress experienced through daily contact with severely mentally ill. This distance fosters ‘a sense of alienation and an inability to imagine what the experience of mental illness is like’ (Morant 1995: 9). ‘Sameness’(togetherness) was felt for people who had the diagnosis of neurosis, such as depression or anxiety, which was perceived as an exaggerated form of normal experience eliciting empathy and compassion for the distressed person. Some participants in this study appeared to practice in Todres et al’s (2009) dehumanising isolation values base due to the perceived severity of the patients’ diagnosis and used distancing strategies which reflects social restrictiveness attitudes.

In Breeze and Repper’s (1998) British study similar themes of psychotic diagnosis and enduring mental health problems, in addition to not responding to treatment and disruptive behaviours were identified as attributes of ‘difficult’ patients who tended to be avoided or needed to be controlled (passivity). A focus group of nine experienced acute mental health nurses were asked what, in their view, were the characteristics of ‘difficult’ patients and why they are ‘difficult’ to nurse. Although nurses are seen as compassionate people who want to help, the reasons the focus group participants gave for the need to control ‘difficult’ patients were that these individuals threatened the nurses’ competence by rejecting help and not getting better (loss of personal journey), so required control for their own and other patients’ safety (Breeze et al 1998). Additionally, avoidance was used as the nurses felt more challenged by these ‘difficult’ patients when staffing levels were low because they demanded time resulting in more ‘deserving’ patients’ needs not being met. Seeing patients as ‘difficult’ when they did not response positively to treatment, thus stuck in their diagnosis; when they acted in a passive manner appeared to reflect a benevolent attitude when the patient is seen as incapable of self-agency so Todres et al’s (2009) passivity value of dehumanisation was employed by nurses.

The effects of this ‘care’ was also explored in Breeze et al’s (1998) research when they asked the same participants to identify ‘difficult’ patients and six of the patients identified agreed to be interviewed to discuss their experiences of care. They all acknowledged empowering relationships (agency) with some nurses but also described feelings of being controlled by other staff with restrictions being placed on their movements, having to change their behaviour if seen as ‘maladaptive’ and being forced to comply with treatment (passivity). Additionally, they complained of not having a say in their own plans of care, and when they disagreed, or offered an alternative plan they were ignored or their views dismissed restricting the patients’ ‘voice’.

These ‘difficult’ patients felt that there was no negotiation in their plan of care. This endorses the concept of benevolence stigma because some nurses viewed patients as ‘difficult’ when they tried to assert their agency. What was notable within this study was the researchers’ frustration when these ‘difficult’ patients either missed agreed interviews or changed their minds about participating. As both Breeze and Repper are advocates for recovery this offers insight into some of the difficulties experienced by nurses which appeared to promote non-recovery attitudes. So, in this study, while patients stated they had encountered some nurses who practiced in a humanising recovery focused manner, others describe the effects of being controlled and not having a say in their own care which reflects Todres et al (2009) dehumanisation passivity reflecting benevolent stigma.

Both, Morant (1995) and Breeze and Repper (1998) studies are relevant to my study as they identify that the diagnosis patients are labelled with has an influence on some nurses attitudes, suggesting these nurses consider mental illness to be a biomedical disorder and treat patients in a dehumanisation manner. Although these first two studies were undertaken before the publication of the CNO (DH 2006a,b) as discussed in Chapter One, the shared vision of partnership working between nurses and patients, these values have long been the philosophy of the skilled interventions in mental health nursing (Barker et al, 1997). Nonetheless, similar findings have been identified in more recent studies which will be discussed below.

The link with diagnosis and distancing was found in Lammie et al’s (2010) research when they explored the attitudes of nurses in low and medium secure forensic wards in two hospitals with people who had a diagnosis of psychosis. They used a mixed-method approach of two questionnaires, one asking two open questions and the other Corrigan et al’s (2003) Attribution Questionnaire 27. The two open questions posed probed anti-discriminatory/ discriminatory practice and positive/negative attitudes towards patients. The results showed that overall nurses in these wards promoted positive relationships, supportive environments and the rights of the patients; but nearly half were pessimistic in relation to recovery and the majority alluded to the patients as ‘dangerous criminals’. The patients’ diagnostic label appears to encourage either a benevolent or social restrictiveness attitude. Seeing the patients as stuck in their diagnosis (loss of personal journey) may account for the pessimism of ‘recovery’ and viewing them as biochemical bodies without feelings, values or emotions (reductionist view) through the implied tag of ‘dangerous criminals’. In the second part of this study, the findings from the Attribution Questionnaire 27 (Corrigan et al 2003), which involved a vignette of ‘*Harry*’ who

'hears voices' and has a recent history of violent behaviour, raised questions about feelings of pity, anger, responsibility, dangerousness, fear, help and avoidance. The forensic nurses' answers identified views that '*Harry*' should be avoided and upheld the previous theme of dangerousness. However, the researchers suggest that a perception of danger is not an unreasonable perception in the context of forensic services. Nevertheless, the consequence is that participants opted for avoidance and segregating strategies from '*Harry*', contributing to social distance (social restrictiveness) and placed staff 'on a different and higher level than patients' (Lammie et al 2010: 712). Once again, the patients' diagnosis appeared to advance dehumanisation by some of the nurses in the form of either benevolent attitudes when the patients were seen as fixed in their diagnosis so pitied or social restrictiveness attitudes when interactions were avoided.

In Howard and Holmshaw's (2010) study more humanisation values were afforded to people experiencing mental health problems but not when co-existing substance use was involved. Using a mixed method approach of questionnaires and interviews, Howard et al aimed to elicit mental health in-patient staff (including nurses, doctors and other members of the multi-disciplinary team's (MDT)) attitudes and experiences of caring for people with mental health problems and co-occurring substance misuse. 84 staff from nine mental health units completed the questionnaire, which incorporated the Drug and Drugs Problems Perceptions Questionnaire (DDPPQ) (Watson, Maclaren and Kerr, 2006), then 10 of these staff agreed to participate in semi-structured interviews. All of the staff held more positive attitudes about people who solely had mental health problems, than patients who also used illicit substances as they could not understand the patients' reasons for this behaviour. However, staff who had received training about working with people who had a dual diagnosis were found to have more positive attitudes towards this client group, than those who did not. In addition, clinical supervision, clear and directional trust policies and team communication to ensure consistent approaches from all team members around problem-solving were seen as strategies to promote less negative attitudes and more recovery focused interventions. But many staff did not have the opportunity for specialised training or access to clinical supervisors with knowledge of working with people who had a dual diagnosis of mental illness and drug use, there was a lack of clarity in local trust policies and lack of consistency within the multi-disciplinary team in regard to therapeutic approaches. Not receiving training or supervision and the inconsistency of approach within the MDT meant many staff could not see any commonality between themselves and the patients who took illicit substances. Without working in partnership with patients to understand the

reasons for this behaviour, these members of staff appeared to dehumanise patients as different to themselves which appeared to reflect social restrictiveness attitudes. This study also identified the positive benefits of relevant education and clinical supervision on the staff's attitudes towards patients who had both mental health problems and took illicit substances.

Both Lammie et al's (2010) and Howard and Holmshaw's (2010) was published four years after the Chief Nursing Officers 'Values to Action' (DH 2006a) so it would have been expected that mental health staff were aware of the principles of recovery and actively practicing within these guidelines, but as their findings show this is not always the case. Additionally, the importance of education and supervision for upholding recovery attitudes was evident in Howard and Holmshaw (2010) research. Education is also found to be encourage partnership working between nurses and patients in Munro and Baker's (2007) study.

The dehumanisation values discussed in the previous studies are not supported in Munro and Baker's (2007) study, which investigated the influence of education on attitudes of 140 qualified and unqualified nurses working in acute in-patient wards in the north west of England. Using the Attitude Towards Acute Mental Health scale (ATAMH) (Baker, Richards and Campbell, 2005) to gather data they found a wide range of attitudes between staff but in comparison to their unqualified colleagues, 80% of the qualified mental health nurses held positive attitudes towards the patients. They tended to work in partnership with each patient to plan individualized care (uniqueness and embodiment), but remained pessimistic about their recovery (loss of personal journey). So, although the qualified nurses saw patients as individuals, they also viewed them as stuck in their diagnosis (loss of personal journey) equating to a benevolent attitude. Munro et al (2007) attribute this benevolence to acute nurses caring for the most vulnerable people who are predominately in crisis, a period of relapse or chronically ill, without experiencing working with people who are in recovery. Once again, education appears to advance patients being seen as individuals and reduces some of dehumanising healthcare values identified by Todres et al (2009). But because of the nature of the service which caters for people who need to be hospitalised due to their mental health problems, the nurses appear to see the patients as 'stuck' in their diagnosis reflecting dehumanisation attitudes.

The previous studies were conducted with ward-based staff whereas Linden and Kavanagh's (2012) study was undertaken with both in-patient and community nurses. 121 qualified and 66 student mental health nurses who were enrolled on the four-year bachelor of mental health

nursing degree, in the Republic of Ireland, participated in this study to investigate their attitudes towards people with a diagnosis of schizophrenia. Data was collected by the CAMI scale and Social Interaction Scale (SIS). As noted previously, an abridged version of the CAMI is used in the first question of the AMIQ (TNS BMRB 2015). The SIS, which was originally designed to assess attitudes towards people with AIDS, has seven items with categories ranging from 'strongly agree' to 'strongly disagree' indicating the desire to be associated with people with mental health problems (Kelly et al 1987). Their findings demonstrated that ward-based nurses expressed a more social restrictiveness attitudes than community nurses, as they 'did not want to live next door to people with schizophrenia' and 'I would not want to marry a person who had a diagnosis of schizophrenia' (isolation). The researchers attributed this to these nurses' direct experience of patients in crisis and acutely unwell thus seeing them as dangerous. They also stated that nurses needed to make decisions for patients reflecting a benevolent attitude. The more positive recovery attitudes were held by community nurses suggesting they did not view patients with a diagnosis of schizophrenia as dangerous, would encourage patients to make decisions regarding their lives (agency) and would be willing to maintain friendships with them (togetherness). Nurses with more years of experience, from both in-patient and community settings, held more positive attitudes than those of newly qualified staff which Linden et al (2012) suggests upholds the 'exposure effect'. So, seeing patients in their own communities and having been a nurse for longer appeared to advance seeing patients as less dangerous, having the capability for decision-making and promoted more humanising recovery attitudes. Although this research aims were to study if there were differences between qualified and student nurses' attitudes, no significant differences were found but disappointingly after stating this no details were offered making it impossible to gauge if students' attitudes reflected either in-patient or community nurses as they have placements during their education in both settings. It is also impossible from this study to ascertain whether students commence the nurse education with either humanisation or dehumanisation values or whether these change and, if so, what influences these changes.

The only other UK study including mental health students which investigated attitudes towards people with mental health problems is Schafer et al's (2010). Again using Taylor et al (1981) CAMI they surveyed 288 pre-registration first year students in the second week of their education, 53 of whom were on the mental health branch and had the most positive attitudes. The strongest influence on attitudes was knowing someone who had experienced mental illness, again reflecting the 'exposure effect' found in Linden et al's (2012) study, followed by

the student's ethnicity. Only 42 students were Black and Black British, 18 of which were studying mental health nursing but they displayed less positive attitudes across all fields of nursing. Besides ethnicity, having experienced mental illness or knowing someone who had been discriminated against all prompted more positive attitudes. What is not explained in this study is if a benevolent attitude is deemed positive, as it was in Taylor et al's (1981) original study, but as discussed previously benevolence disrespects the agency of the person with a mental health problem leading to disempowering dehumanisation and does not support contemporary recovery focused care. Nonetheless, capturing the students' attitudes as they commence their education, prior to starting in placements, is useful as a baseline measure but it does not study the effect of the nurse education on their attitudes.

Taken together the seven studies offer useful insights into the reasons for dehumanisation values in mental healthcare which reflect authoritarian, social restrictiveness and benevolent attitudes. The perceived severity of the patient's diagnosis; misuse of illicit substances; supposed dangerousness; and, patients who do not accept treatment appear to provoke dehumanisation behaviours in some mental health nurses (Breeze and Repper, 1998; Howard and Holmshaw, 2010; Lammie et al, 2010; Linden et al, 2012; Morant, 1995; Munro and Baker, 2007; Schafer et al, 2010). While length of experience, mental health nurse education, clinical supervision and working within community teams appears to foster humanisation values reflecting a recovery attitude. The relevance of these studies to my own research was that the students might have encountered some or all of these attitudes and behaviours towards patients when they were undertaking the practice element of their Pre-Registration Mental Health Nurse education. This might result in either contest or confirm the taught element of their education which was underpinned by recovery principles, and influence on their own attitudes. But what was most evident in my literature review was the gap in research about students' attitudes about mental health patients and whether these changed during their education, so my study attempted to research this neglected area.

The studies also suggested examples of ways of measuring attitudes and Todres et al's (2009) values framework offered examples of humanising and dehumanising behaviours and expressions. So, to investigate the students' baseline attitudes upon commencing their nurse education I used the AMIQ to capture their attitudes towards people with mental illness and this was undertaken a second time, as a comparison, later in their third year. Observing students' behaviours in practice would be difficult due to patient confidentiality so the

influences which advance students' humanisation and dehumanisation practice was examined through their own narratives in classroom discussions and their individual interviews. This will be explained in-depth in Chapter Four.

What the seven studies identify is that mental health student nurses' attitudes and the effects of nurse education has not been researched in any great depth, so my study makes a contribution to this area and in doing so adds new knowledge to the field of pre-registration nurse education.

Conclusion

This chapter discussed the four attitudes towards people with mental health problems documented through the findings of the AMIQ from 1994 until 2014 and explained the changing landscape of mental health services, public and expert opinion and government policy over the last twenty years. The reason for this was that the student nurses in my study were born and brought up in the United Kingdom during this period so were exposed to the similar influences of society's views, media representations and government policy that the respondents of the AMIQ were.

Todres et al's (2009) dimensions of humanisation and dehumanisation values were described and applied to an appraisal of seven published research studies into UK mental health nurses and student nurses' attitudes towards patients. Factors which appeared to promote dehumanisation in the form of authoritarian, social restrictiveness and benevolent attitudes included the perceived seriousness of patients' mental health problems, if this was combined with substance misuse, if they were seen as dangerous and their unwillingness to have care decision dictated by staff, which mainly fostered by in-patient nurses. While humanising recovery attitudes were advanced by education, clinical supervision, personal contact and experience of nursing patients with mental health problems and working with patients in their own homes. The relevance to my study is that the students might be exposed to any of these attitudes and behaviours during the practice element of their nurse education and this could either dispute or endorse the taught component of their specialise nursing field of mental health education, which is underpinned by the principles of recovery.

In the following chapter I will discuss the research methodology I employed to study a cohort of nursing students to explore if they underwent transformative learning.

Chapter 4: Methodology and Methods of Data Generation.

Introduction

This chapter offers my rationale for the use of a longitudinal case study of a cohort of six mental health nurse students. The overall aim of my study was to explore whether and how mental health nurse education, underpinned by the recovery principles, produces nurses who value and respect the diversity of people they care for and enable their recovery. I chose to achieve this aim by way of a longitudinal case study, over three years, of six students and gathered data from the students via questionnaires, recorded classroom discussions, individual interviews and pictorial representations of their pedagogical journey.

First I will discuss the context and setting in which my study was conducted, including the ethical considerations of being a lecturer and researcher. Secondly, I offer reasons for selecting a cohort of mental health nursing students. I then discuss my rationale for choosing Stake's (2000) 'collective' case study methodology, the different methods of gathering data and how I analysed this data.

Context of the study

I have previously discussed that the mental health curriculum the university, in which I was a mental health lecturer and where the case study was conducted, was underpinned by the recommendations of the Chief Nursing Officer's (DH 2006b) Best Practice Competences and Capabilities for Pre-Registration Mental Nurse in England in Chapter One. Now I will discuss the setting. The university had five education centres spread over two counties in England. The two education centres within the county I worked in traditionally had two intakes of nursing students per year (January and September), each providing education for all of the four specialties of nursing: Adult was the largest number of students, with Learning Disability, Child and Mental Health students having places for approximately ten students each. At the start of the second year these smaller groups join their peers in one designated education centre for their specialist education to form larger cohorts. Dependent on commissioned places and attrition rates, these joint cohorts in mental health nursing programme ranged from twenty to thirty students. This meant at any one time, six cohorts of students were studying to become mental health nurses and could have been included in this study: third-year students in their final year of the pre-registration programme; second-year students half way through their

course; and, first-year students who had recently commenced their education. This offered many different options for meeting this study's aim of investigating if the recovery principled mental health nurse education produced nurses who valued and respected the diversity of individuals with mental health problems and enabled their recovery:

- Students in their final year of study could have been asked to reflect on their 'frames of reference' (beliefs and assumptions) (Mezirow et al, 2009) prior to commencing the course, if these had changed or not, and the reasons for this. Although this would have been an intensive period of data collection, it would be a one-off exercise so achievable within this study. However, this would have been a retrospective study so the students might have had difficulty in remembering their initial beliefs after three years, may not be aware of any changes or be unable to identify when and why a change happened.

- Another option would have been to ask a selection of students from each year about their current 'frames of reference' and look for differences and similarities between the cohorts. Again, this would mean an achievable, intensive, one-off period of data collection, but would offer only a snapshot of different students' current 'frames of reference' and may not identify if they had changed during their education so would not answer all the research question.

Neither of these options appeared to fulfil the aim of this research as I needed to know whether the students changed their 'frames of reference' during their three year education, and if so, what influenced this change. In Holloway and Wheeler's (2002) opinion, selecting appropriate participants for a research project depends on purposeful sampling in which individuals are chosen because they fit certain criteria to produce information rich data. By deliberating on these sub-questions I decided the most appropriate way to investigate the influence of the recovery focused nurse education on students' 'frames of reference' was to choose a purposeful sample of a few students, each a case, commencing the course and gather data over their three year course.

However, I need to mention the many local changes in nurse education provision that occurred during this study which had an impact on my study. First, due to reconfiguration of programmes, student intakes in the two education centres within the county reduced to once a year (September) instead of twice a year (January and September) but this was implemented in a phased approach resulting in only one education centre having a January intake in 2011. This

worked to my advantage because instead of 25, only ten mental health students commenced the programme in January 2011, which felt like a suitable number for a longitudinal case study. So the cohort of ten students became my ten case studies, but as explained later this reduced to six.

But, unknown to me and many of my colleagues, this was the start of the university withdrawing their nurse education from the county to consolidate all their resources in the main campus which was situated in a neighbouring county. So a year into my study we were informed that nurse education would be provided by another university after the last registered intake had completed their education. This resulted in three options for staff: apply for posts within the university main campus, apply to different universities, transfer to the new nurse education provider in three year-on-year phase dependant on teaching/responsibilities in each academic year or leave education. Three of the six mental health lecturers transferred to the university which had won the tender and the lecturer who was the students' Personal Tutor in this study retired. Although I considered the different options I decided to transfer to the new provider, and as a third module lead I transferred in the third wave of transfers (2014). This left another lecturer and myself to provide the mental health theory and support for practice for five cohorts of students (approximately 110) before we would be transferred to the new provider two years in the future. These developments ensured I could continue my research, but my workload and responsibilities increased significantly and caused many of the students' anxiety over the educational content and support they would receive. So by negotiation, my colleague and I decided our roles and responsibilities to ensure that the students' education was not compromised and that we provided support for our remaining students. How this reconfiguration influenced my research will be discussed later within this chapter.

Selecting and accessing the purposeful sample.

Ethical approval and permission to undertake this case study had been agreed from the Education Ethics Committee at the University's School of Education and Ethics Officer of the School of Nursing, Midwifery and Physiotherapy (Appendix 2). The Ethics Committee had been assured that all data would be stored in a lockable drawer until the end of the project, when they would be wiped clean and destroyed and computer data would be stored in a password-protected Word file. Additionally, they were assured that students would be offered information about the study in the form of an Information Sheet (Appendix 3) and meeting

with me prior to deciding if they would like to participate. With ethical agreement secured, I asked the cohort's Personal Tutor if she would approach the ten January 2011 students via an email to ask them if I could meet them to discuss my study and they all agreed.

In this meeting following an explanation of my study and some of the data collection methods which would be used, all ten of the students agreed to participate. Although this appears to imply that I simply asked students to participate in my study, I was mindful of Bradbury-Jones and Alcock's (2010) ethical issue 'research contribution'. This relates to how the research will add to a body of knowledge so prospective participants needed to understand that they were contributing to a study which may not provide any immediate benefit to themselves, but may benefit others in the future. They also needed to have sufficient information about the aims of the research in readily-understood, but not patronising, language to make an informed choice to participate or not. Additionally, Bradbury-Jones et al (2010) explain that researchers themselves need to be mindful that they might inadvertently try to persuade students to participate due to time-restraints or deadlines because I accessed them through their Personal Tutor, an experienced qualitative researcher, who had completed a PhD in nurse education four years previously and was in a senior position to me, so would not have allowed me to access to any student who did not want to meet me, I felt the students were not manipulated into agreeing to discuss my research. Additionally, I reiterated verbally and in the Information Sheet that taking part in the study was entirely voluntary and would have no effect, positive or otherwise, on their assessment or any other aspect of their course.

Following to this meeting I emailed the cohort to explain the aims of my research and attaching an Information Sheet and asked students whether they would like to meet me individually to discuss the study. Only one of the students met with me prior to the group meeting when I reiterated the aims, answered their questions as best I could, due to the flexibility of data collection strategies, and explained that it would be a three-year study but students were free to withdraw from the study at any time without detriment to their progress on the course. When meeting all ten of the students I restated this and ten (original) students agreed to be participants and signed the Consent Form (Appendix 4). Although I was unaware that my time at the university was coming to an end, and ultimately contact into with new cohorts of mental health nursing students who could have been participants if this cohorts refused, I still did not feel l pressurized the students into participating. Even though consent was gained from all the students at the start of this longitudinal study, I felt that a one-off consent would not suffice, so

ensured these participants consented on an on-going basis by emailing them the date and time of each session that was to be recorded two weeks beforehand and asking them to email me if they did not want to continue participating in the study. I also continually reiterated that participation was voluntary and withdrawing would not detrimental to their progress on the nursing programme. Additionally, the lecturer undertaking the recorded session was reminded to ask at the start of every data gathering session if students consented to being recorded. This is referred to as informed consent process which encourages participants to play a collaborative role in the decisions regarding on-going participation (Polit and Beck, 2006).

Bradford-Jones et al's (2010) third ethical issue is 'research impact' which means I had to consider any potential harm the students might face through involvement in the study. I did not envisage any physical harm to the students but were aware that the discussions concerning their experiences throughout their nurse education might invoke reliving stressful situations. Nonetheless, the majority of sessions, when data was collected, was incorporated within the pre-existing timetable, so all students had the opportunity to be involved in these discussions (or opt out if they choosing not to speak). This was the case for all discussions, the only exceptions were the completing the Attitude to Mental Illness Questionnaire (AMIQ) for the second time, individual interviews and the pictorial representation, these were organised at times convenient to the students and will all be classroom discussed later in the chapter. The Information Sheet (Appendix 3) given to the students prior to any agreement to participate identified different strategies for seeking support if required by either myself or the university counselling services. What I had not foreseen was the reaction of one of the students to some of her own comments about patients which I had included in her pen portrait. She was dismayed at 'seeing it in black and white, it sounds so politically incorrect, sounds awful' so we discussed her feelings and she stated that this had made her reflect on how her attitude had changed during her nurse education.

By the end of the first year the number of students in the cohort had reduce to six in number: one left the programme to pursue a career as a travel agent; one became pregnant and commenced maternity leave; one transferred to the Adult branch; and, one had failed his assignments due to personal problems and took a nine month interruption from his studies. Although only one student actually left the course citing a 'wrong career choice', attrition rates for pre-registration nurse education has been identified as a problem and misconceptions of the role of a nurse has been documented as among the top five reasons for attrition for nurse

education (Glossop, 2002). 'Wrong career choice' also appeared to contribute to the student wanting to change to Adult branch of nursing, who stated she had enjoyed the fast pace and employing technical skills that her four-week placement on an adult medical emergency ward provided, compared to the slower-paced community mental health placements during mental health placements. The two students who interrupted their studies, resumed their nurse education by joining the next cohort, but as they missed many of the group discussions when data was collected were excluded from this study. The remaining six students in my study were aged between 18-45 years old and five were female and one was a male. I will now discuss my reasons for employing case study methodology to research the effectiveness of the students' recovery principled curriculum on their attitudes towards patients with mental health problems.

Critique of Singular Collective Case Study

Categorizing case studies is difficult and the method itself has come under scrutiny, they are often labour intensive and more time consuming than survey methods (Daniels and Cannice 2004; Voss et al 2002) and individual cases are difficult to generalise (Jensen and Rodgers 2001; Patton and Applebaum 2003). Traditional criticisms of case study have also reflected those levelled at most forms of interpretative research; that there is a lack of rigour, poor systematic procedures and an inability to provide generalisations. For example, Argyle, (1978) infamously associated interpretative researchers with journalists; whereas Burns and Grove, (2008), while not taking such an extreme view, are critical of the type and volume of data collected because these restrain the size of the samples that can be used. In turn this leads to criticisms of unrepresentativeness, and consequently, unsafe generalisations; the gold standard of positivist research, even though this is not the intent of interpretative research (Bassey, 1998). However, case study research tends to focus on the underlying meanings and is not concerned with statistical correlations, it can help to discover causal relationships and help to understand how and why things have happened in a certain way (Hillebrand, Kok and Biemans 2001; Jensen and Rodgers 2001).

While mindful of these criticisms the small cohort of students lent itself to case-study methodology which Stake (2000) argues is a useful method for practice-related research because it can provide an in-depth analysis that focuses on real-life cases. Through an in-depth approach case-studies can identify interactive processes for example relationships, politics, or any pattern of influence. This suggested to me that a longitudinal case-study of a cohort would be an appropriate approach to investigate students' frames of reference upon commencing,

during and at the end of their course and whether or not their pedagogical experiences of nurse education promotes transformative learning which values and respects the diversity of individuals and enables their recovery.

Stake (2000: 436) defines case studies as: 'both a process of inquiry about the case and the product of that enquiry' and identifies three types of case study: 'intrinsic', 'instrumental' and 'collective'. Intrinsic case studies are undertaken not because they illustrate a specific trait or problem but to gain a better understanding of a particular case. The purpose is not theory building it is rather to tease out the stories of those living the case. In my study I wanted to investigate, through the students' accounts of their experiences, their views about people with mental health problems so intrinsic case-study appeared relevant to my study as I also wanted to gain a better understanding of what influenced any changes in attitude. An instrumental case study is undertaken because it is typical of other cases so could provide an identification of an issue or forward a generalisation. This changed the focus of the study from the case being dominant, as in the intrinsic category, to a specific trait or problem being dominant. The overall aim of this research was to study whether the students' pedagogic experiences promoted transformative learning, which values and respects the diversity of individuals and enables their recovery. The dominant focus is on nursing education of both theory and practice on the students' experiences so the instrumental category also appeared relevant to my present study, in that I hoped the findings would relate to nurse education beyond the case. Finally, collective case studies are undertaken with a number of cases simultaneously to explore similarities and differences between cases to investigate a phenomena, population or general condition. In my study each student, who can be conceptualised as an individual case within a collective cohort case, was studying the same mental health nursing programme at the same time so their propositional knowledge content was similar. They also experienced comparable clinical placements within settings and teams of nurses and other multidisciplinary practitioners for people experiencing mental health problems so comparable practical and experiential knowledge would be encountered (Burnard, 1987). As my research views each student as an individual case within a group case study of a cohort, Stake's (2000) collective category, underpinned by both intrinsic and instrumental principles, appears to be the best description of what I was trying to do.

A mixed-methods approach was used. I again draw on Stake (2000) who is an advocate for qualitative data gathering tools to tease out participants' stories, identify issues and explore similarities and differences between cases offered relevant and constructive data collection and

analysis methodology. For meaningful data, he suggests qualitative case studies that employ interviews, focus groups, observation and document reviews and acknowledges some quantitative tools can be useful to support or establish background. As will be discussed later in this chapter, classroom discussions between the students facilitated by a lecturer were the main data gathering tool for my study, and a quantitative questionnaire was employed to gain baseline understanding of the students' attitudes commencing the programme and then again in their third year of study to compare against the baseline.

Stake (1995) also encourages four strategies of triangulation to support of findings: data source, investigator, theory and methodology. Combining different types of data sources can increase the validation of the study (data source triangulation), teaming up with different investigators offers broader and deeper understanding of the analysis process (investigator triangulation), working together with professionals from different disciplines to interpret a single set of data (theory triangulation) and using of many qualitative and/or quantitative methods to study the case (methodological triangulation). Data source triangulation was achieved in my study using as noted previously, classroom discussion, a questionnaire, the recovery assignment the students wrote at the end of their second year, individual interviews and their pictorial representations of their nurse education journey. Investigator triangulation was reached first by the need for help to analyse the first question of the questionnaire as the four attitude types were not equally distributed throughout the statements, so I asked a quantitative research colleague for his help and three academic supervisors who assisted me throughout this study, none of whom were nurses, offered diverse insights into my, sometimes narrow, mental health nurse and educator view. Theory triangulation was again attained by my academic supervisors challenging my views and offering constructive feedback, and also, by my asking the students for their own opinion of my interpretation of their nurse education story written as a pen-portrait. Finally, methodological triangulation was achieved by examining the students' data through Burnard's (1987) typology of nursing knowledge, then the three phases of Mezirow's (2000) transformative learning while always conscious of Todres et al's (2009) humanisation and dehumanisation of healthcare.

Moreover, Stake (2000) is flexible about the timescale of collection and analysis of data because adjustments or modifications may be needed as the study progresses to give meaning to first impressions and final findings. He suggests 'progressive focusing' for collecting data which permits researchers to explore issues as they emerge under direct observation without the necessity of a rigid study plan. This is relevant to my study because module modification

sometimes occurs due to different facilitators or following lectures many lecturers reflect on their lessons and change the content of lessons so by asking my colleagues which lessons would be pertinent to my study I needed to change my date gathering sessions to reflect this.

Methods of Data Collection

Stake's (1995) case-study methodology was chosen to underpin this study due to his qualitative position fitting more with the aim of this study into the students' frames of reference and the different types of data sources assisting in teasing out their stories. Table 4.1 illustrates the timeline of when and how the data was collected and each will now be discussed in chronological order with explanations of how and why I chose each method.

Table 4.1: Timeline of data gathering

Year of study	Date of data collection	Data collection method	Description of data collection method
1st	January 2011	AMIQ 1 30 minutes duration.	Students completed the survey to gain a baseline of their attitudes at the start of their nurse education.
1st	May 2011	Practice discussion in the university. Audio-recorded observation. 2 hours duration	During their first clinical placements, the students returned to the university to discuss their practice experience, gain support for any concerns and clarify any issues with practice documentation.
1st	December 2011	Transition to specialised field session. Audio-recorded observation. 2 hour duration.	At the end of the students' first year of nurse education they reviewed their experiences gained in university, practice and meeting patients. They also discussed their personal concerns and ambitions for the future.
2nd	January 2012	Recovery session. Audio-recorded observation. 3 hour duration.	The students were introduced to the concept of recovery and how this changed 'care' from disempowering to empowering. They were encouraged to reflect on their previous practice experiences and consider whether this upheld recovery.
2nd	May 2012	Group clinical supervision. Audio-recorded observation. 2 hour duration.	During placement the students returned to the university to discuss their practice and gain support if required.
2nd	November 2012	Analysis of reflective recovery assignments.	This assignment was the assessment component of their recovery module, in which they reflected on their knowledge and skills of working in partnership with one patient.
3rd	January 2013	Group work facilitation session Audio-recorded observation. 3 hour duration.	The students practised the skills of facilitating a group session, using pre-planned questions.
3rd	May 2013	AMIQ 2 30 minutes duration.	The students undertook the survey they completed at the start of their nurse education.
3rd	October 2013	Individual interviews. Audio-recorded. 45 minutes - one hour and 15 minutes duration.	Each student was interviewed individually using a semi-structured approach.
3rd	December 2013	Pictorial representation. Audio-recorded. 1 hour duration.	The students were asked to draw and discuss their education journey over the past three years.

Survey Questions: Attitudes to Mental Illness questionnaire 1 (AMIQ 1), 30 minute duration

Despite wanting to engage the students in 'communicative learning', which, as discussed in Chapter Two, underpins transformative learning (Mezirow 2000), when I first met with the ten students in January 2011, I was aware that they had commenced their nurse education only three weeks beforehand and this was only the second time they had met as a group with their personal tutor. Their propositional learning had been in shared classes with students from other fields and they had not been in placement as yet, so practical and experiential knowledge had not been experienced (Burnard, 1987). Although this offered an excellent time for collecting a baseline of their frames of reference, it also proved a stumbling block for meaningful discourse. Asking to engage in conversations about their personal attitudes and beliefs with other strangers, including myself, may not have resulted in meaningful or truthful responses as they may have felt apprehensive about expressing themselves openly. In Holtgraves' (2004) opinion, some participants may respond in a manner which they think will be viewed favourably by others leading to social desirability bias answers.

I had used the Community Attitude to Mental Illness (CAMI) questionnaire as a heuristic tool (Taylor et al, 1981) previously in my third year module to encourage students to become self-aware of negative attitudes. Using a Likert scale to score 'strongly agree' to 'strongly disagree' criteria for the positive statements (and vice versa for negative statements) yielded a rudimentary score of authoritarian, benevolent, social restrictiveness or community mental health ideation. Through my literature review (Chapter Three) I found that the UK government employ the Attitude to Mental Illness questionnaire (AMIQ) (DH 2010) as an annual evaluation of the public's attitudes, knowledge and uptake of mental health services included the CAMI questionnaire (Taylor et al, 1981) in its first question. So I decided that a paper form of the AMIQ would be the most straight forward method of identifying the students' attitudes. Additionally, this questionnaire gathered information on the students' knowledge about mental illness and their willingness to seek help if experiencing mental health problems, which was useful for identifying their knowledgebase regarding mental illness, treatment options and the perceived stigma of accessing mental health services. The only supplement to this questionnaire was that I asked for the students' reasons for why they wanted to be mental health nurses (Appendix 5). All of the students completed the questionnaire and when these were analysed (to be discussed below) they all exhibited a benevolent frame of reference.

Pen-portraits

After the first questionnaire I constructed a table identifying data from each student, this evolved into an individual pen-portrait (see Appendices for 6 and 7 for examples of pen-portraits) and following each data collection this was added to. The six pen-portraits spanned the timeline of the findings from the first questionnaire and the second one, and included the intervening data gathered from each student. This helped organize the unwieldy sum of many hours of recorded and thousands of transcribed words of data into individual experiences and viewpoints. It also tentatively offered some insights into the reasons for these attitudinal movements. However, the main use of the pen-portraits was to ensure that the students were aware of the data collected about them so to facilitate this, each student was given their own pen-portrait to read prior to their individual interview.

When I discuss each student's verbal contributions in the group discussions in Chapter Five I use direct quotacy to illustrate my points. To gain feedback on my interpretations each student was given their pen portrait prior to their individual semi-structured interview. Discussion of these assisted the structure of the interviews, as clarification or dispute of any aspect of the pen portrait was encouraged. I was mindful not to make assumptions, miss potentially important information or misinterpret the data (Kvale, 1999). My dual roles of lecturer and researcher could 'steal the voice' of the students, as bell hooks (1990: 151-2) suggests:

> I can talk about you better than you can speak about yourself. No need to hear your voice.... I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you. I am still author, authority.

This member checking did result in one pen portrait being amended because a student had misread one of the AMIQ statements ticking the opposite to what she meant. All the other pen portraits remained the same and all students agreed that their views were reflected.

The majority of the other data gathering methods were audio-recorded observations of the six students' classroom group discussions. These sessions were chosen on the advice of the module leaders and the students' personal tutor who, after I had discussed my study's aims, were able to identify the relevant sessions. The usual lecturer for the session facilitated it which meant I was only present for one session, the Group Work Facilitation. The audio-recording was undertaken by placing a tape-recorder on the desk near to the students. The decision to use an audio-recorder to capture the students' discussions was taken to ensure data was not missed

and allowed me to review the data in its entirety (Atkins and Wallace, 2012). Prior to each session the students were informed, by email, that I wanted to record the specific discussion and on each occasion I gained their permission to do so. I will offer overviews of resulting findings from each of the data gathering discussions, and these will be discussed in more detail in Chapter Five where I use Burnard's (1987) typology of nursing knowledge to explore how these knowledges influence students' attitudes towards patients and the role of the mental health nurse. The first audio-recorded discussion happened during the students' first placement and will now be described.

Practice discussion: audio-recorded observation, two hour duration.

By May 2011, the students had completed the initial 12 weeks of theory in the university and had commenced their 8-week placements in different mental health settings. These placements were either ward-based or in the community and they had a designated mentor (a registered nurse who has undertaken a teaching and assessing course) to guide and support their learning. Halfway through this first placement students were afforded the opportunity for clinical supervision as a group with their personal tutor, to discuss their placement, any concerns and identify if they require any extra support. This session was recorded as initially I aimed to gain data about the influence of practice experience had on students' frame of reference.

However, the majority of the time was used to answer the students' queries regarding placement documentation and how they could gather portfolio evidence. Only two students discussed their placements: one who was on a dementia assessment ward, described the patients as 'naughty' and 'mischievous', while the other, who was also on a ward, described patients as 'interesting' and 'pleasant'.

Transition to specialised field session: audio-recorded observation, two hour duration.

The clinical supervision session revealed that at this point during the course students were struggling with the paperwork and focused on meeting their learning outcomes. To identify fora where the students would talk at length about their experiences in both theory and practice, which I hoped would offer communicative learning and a glimpse of their frames of reference, I discussed my research with my mental health colleagues. The Transition to Specialised Field session at the end of the students' first year was noted to encourage students to reflect on their learning, encounters and future goals. So in December 2011, this session was recorded but nothing was said about the theory taught in university. However all of the students spoke about their experiences in practice, and two described patients as 'unpredictable', several voiced

concerns over ‘personal safety’ and most labelled patients as ‘cases’. When discussing their goals for the future, they wanted to remain on the course and achieve a good degree.

Recovery session: audio-recorded observation, three hour duration.

At the start of the students’ second year of mental health nurse education in January 2012 they were formally introduced to the concept of personal ‘recovery’. Again, I was guided by my colleagues as I was a third year module lead, so did not have a working knowledge of the content or teaching styles used in this module. Although there was a taught component to this session, it mostly consisted of discussion-based learning with students encouraged to explore the meaning of ‘recovery’ in relation to themselves and the patients they had met in practice. Despite conceding that having a mental health problems could lead to ‘stigma’, once more labelling patients occurred, although this time not as ‘cases’, but by their diagnosis and several students discussed the frustration they had witnessed from staff in practice when patients did not adhere to their planned care.

Group clinical supervision: audio-recorded observation, two hours duration.

During their third 12 week placement in May 2012, the students returned to the university to attend group clinical supervision. Previously, they had been introduced to the principles of clinical supervision during theory sessions and were expected to engage in regular individual supervision in practice with their mentors, but this was the first time that as a group they were able to talk about their placement. Although this was facilitated by the module leader, he encouraged the students to respond to each other and actively drew all the students into the discussion. This led to one student, who tended to sit quietly listening to the others, to question and challenge her peer’s viewpoint. Another student appeared to be starting to weigh up different alternatives for patients’ actions, while two students spoke about inspiring mentors who advanced recovery focused practice.

Analysis of the students’ reflective recovery assignment.

The assessment component of the second year was a written reflective assignment discussing the use of recovery principled care the students had engaged in with a patient and was submitted in November 2012. This was chosen to be included in my data because it offered a glimpse into how the students linked theory to their practice and what they had learnt from this experience. Although all of the students wrote about the different notions of recovery: clinical and personal, so their knowledge base was evident, none of the assignments yielded any

meaningful insights into their frames of reference towards patients. They wrote about their involvement in a patient's care and that they were able to practice interpersonal skills, but unfortunately reflecting on their own practice was limited. This became evident when one student, in her individual interview, identified that the man she had written about in this assignment was the source of her 'disorientating dilemma'.

Group work facilitation session: audio-recorded observation, three hour duration.

During the third year my module on health promotion and management skills included a session on group development, different leadership styles and the skills needed to facilitate effective groups. Following the theoretical component of this session, each student facilitated a group discussion with their peers using pre-planned questions, used previously with former students.

1) What made you want to become a mental health nurse?
2) What do you think causes mental health problems?
3) Can people with mental health problems recover?
4) Have your views of people with mental health problems been challenged over the last two years and if so, how?
5) Have the attitudes of other people influenced your beliefs/values about people with mental health problems. If so how?
6) What does the therapeutic relationship mean to you?
7) Has your view of the MH nurse changed during your course? If so, how and why?

When the students attended this session in January 2013 in their third year, each student asked their peers one of the questions. As there were six students I asked the last question. This generated a lot of data as the students questioned, challenged and agreed with each other. What was apparent during these discussions was that the students appeared to struggle to define the causes of mental illness and that positive and negative placement experiences had a large impact on their frames of reference about patients and the role of the mental health nurse.

Survey Questions: Attitudes to Mental Illness questionnaire 2 (AMIQ 2) 30 minute duration

In May 2013 the students were asked to complete the AMIQ for the second time to assess if their frames of reference had changed. It was also a guide to their knowledge base about mental illness and their willingness to seek help if experiencing mental health problems. Again this was in paper form and was identical to the first questionnaire they completed in January 2011 so offered comparisons between a timeline of twenty-nine months. What was noted was that

there was movement away from a benevolent attitude by each student. As expected their knowledge base of mental illness and treatment options had increased. Following this second AMIQ each student was given their pen-portrait prior to their individual interview to able them to review the data I had collected about them.

Individual interviews: audio-recorded, 45 minutes to one hour and 15 minutes duration.

The aim of this research was to ascertain whether the nurse education the students were studying changed their attitudes towards patients and the role of the mental health nurse. The previous data collected using the AMIQs identified that all of the students had moved from a benevolent attitude towards a recovery one. In Chapter Five I explore the data gathered between these two AMIQs through the framework of Burnard's (1987) typology of nursing knowledge, but I needed to establish whether each student felt they had changed their attitude and, if so, how and why. So I needed to explore the students' views with them individually and decided the best way to do this was by interviewing them. Interviews can vary from structured, semi-structured and unstructured and each has advantages and disadvantages (Holloway and Wheeler, 1996). Structured interviews, with sequential and defined order in the questioning, can offer all participants identical questions, but they have all the restrictive elements associated with questionnaires. Unstructured interviews, where the interviewer has broad areas of interest which can be used as a prompt, allows participants the freedom to raise issues they feel are important providing richness of data, they also producing data that is of no value to the research being undertaken. Between these two polar extremes lies semi-structured interviews, which offer more flexibility than structured interviews and are more focused that unstructured interviews due to the researcher having an interview guide of probing questions as guidance but also encouraging the participants to elaborate on their answers. In agreement, Mack et al (2005) maintain that semi-structured interviews with open-ended and probing questions offer participants the opportunity to respond in a rich and explanatory nature and the interviewer to ask the how and why questions. So I chose semi-structured interviews to conduct with the students and constructed five questions which I ensured aligned with my research questions:

- Do you think your pen-portrait is a true reflection of your experience over the past three years or is there anything you want changing or disagree with?
- What have been some of the highlights of the course?
- What have been some of the challenges?

- Is there anything you'd do differently on this course at all?
- Is there anything you think could be included in the course that would be helpful for students?

Each student agreed to be interviewed and these semi-structured interviews were conducted in a tutorial room in the education centre in an attempt to produce a more relaxed environment than if they were held in my office. My questions were used as a guide to stimulate conversation but were also flexible enough to encourage the students to raise issues that were important to them (Holloway and Wheeler 1996). Although all the students appeared apprehensive to begin with, they all started to relax when talking about their pen-portrait. The data gathering during these interviews and the pictorial representation of their nurse education, which will be explained next, is explored in Chapter Six using Mezirow's (2000) three phases of transformative learning.

Pictorial representation of their education journey, audio-recorded, one hour duration.

The final method of data collection was a result of a conversation with one of my PhD supervisors regarding the students' interpretation of their experience of being a mental health nursing student. My supervisor suggested that she come and ask the students to draw a picture of their journey to aid recollection (a technique she had previously used) for discussion and offered to facilitate this. Pictorial representation, a visual expression, can offer an arena for reflection on conceptions, experiences and feelings, which might be difficult to formulate in words (Weber and Mitchell, 1999).

I accepted my supervisor's offer because she had the expertise in this method of data collection and I thought that she might be seen as an impartial 'outsider' so the students would not feel obliged to 'say the right thing' and could complain more easily if they had felt pressurised into participating. The audio recording and feedback from my supervisor identified that initially the students were bemused about drawing a picture as this was the first time in many years they had been asked to do this. Nevertheless all but one drew a timeline with identified significant events. One by one each student discussed their drawing and what each event meant to them. They were also asked how they felt about being in this study and if they had felt compelled to participate, to which they stated they did not feel coerced into taking part. Now that I have explained how my data was collected I will, in the next section, discuss how I analysed the different data.

Data organization, categorization and analysis

AMIQs analysis

The AMIQ (DH 2010) is a well-tested method for surveying the general public's attitudes to mental illness which has been used since 1994 in the UK (Schafer, Wood and Williams 2010; Chambers et al 2009). My use of this questionnaire was to capture the six students' attitudes to people with mental health problems and knowledge of mental illness at the beginning of their course and then again near the end. So their responses were not used to compare against the results of the general public but as a baseline for me to compare with their responses in the third-year of their nurse education.

As discussed in Chapter Three, the first question of this questionnaire is an adapted version of Taylor et al's (1981) Community Attitudes to Mental Illness (CAMI) and the remaining questions solicit respondents to agree or disagree with various statements about people with mental health problems, tests their knowledge about mental illness and asks about their willingness to disclose their own mental health issues. So the questionnaire was a straightforward way of analysing each of the student's frames of reference about people with mental health problems and to offer an insight into their viewpoint about the best and most appropriate forms of care. However, a problem became apparent once detailed analysis was undertaken. The first question of the AMIQ does not include all of Taylor et al's (1981) 40 statements, preferring to use only 27 of these. This resulted in seven authoritarian, eight benevolent, seven social restrictiveness and five recovery attitudes. These were worded, as in the original, either in positive or negative sentiments. Unfortunately there was no indication of the weighting of each statement within the given attitude category, and my attempts to gain this information by contacting the research firm met with no response, this had to be estimated and tested. To this end, and with guidance from a colleague who was a quantitative researcher, I coded the statement: Strongly agreeing with a positive sentiment was given a score of 4, strongly disagreeing a score of 1, while neither agreeing or disagreeing, which may indicate an unsure answer, was scored as 0. When the sentiment of the statement was negatively worded these scores were reversed. An example of the scoring for positive and negative worded social restrictiveness attitude can be seen in Table 4.2 below.

Table 4.2: Example of scoring for AMIQs

Do you agree or disagree with the statements below?	**Strongly agree**	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**
People with mental illness should not be given responsibility.	4	3	0	2	1
People with mental health problems should have the same rights to a job as anyone else.	1	2	0	3	4

All the attitude categories were then grouped together on a spreadsheet but as the categories were of unequal measure they required standardising by expressing the score as a percentage. In turn, this enabled comparisons between categories to be made: number of statements ('authoritarian' 7) x maximum score for each statement (4) = total score for category (28), participants' score for each category (X) divided by total score for category (28) X by 100 to obtain a percentage.

- Score: =SUM(B1:B7)
- Percentage: =B8/(7*4)*100

As I am a novice researcher this was a crude calculation, therefore needed it to be tested. In an attempt to ensure vigour in the weighting and standardising of statements, six PhD students were asked to complete the first question, which underwent analysis and returned to them for their response to the ascribed attitude. All the PhD students agreed with their attitude profile and as most were not nurses, their responses appeared to reflect the general public's attitudes, which I suggest in Chapter Three is heavily influenced by media interpretations of people who have mental health problems. The overwhelming attitude noted was the sympathetic benevolent, closely followed by the social restriction. The exception was the only mental health PhD student who was a mental health nurse scored highly in the recovery attitude. All the PhD students agreed with their attitude profile and as most were not nurses, their responses appeared to reflect the general public's attitudes, which I suggest in Chapter Three is heavily influenced by media interpretations of people who have mental health problems. This brief process appeared to support that the first question used was able to accurately reflect student's attitudes towards mental health.

The second question asked the respondent to describe people with mental illness and as illustrated in Table 4.3 answering 'yes' to the statements towards helped to confirm responses in question one.

Table 4.3: Question 2 of the AMIQ.

Which of these statements do you feel usually describes a person who is mentally ill.	**Yes**	**No**
Someone who has serious bouts of depression. **(Authoritarian attitude)**		
Someone who is incapable of making simple decisions about his/her own life. **(Benevolent attitude)**		
Someone who has a split personality. **(Social Restrictiveness attitude)**		
Someone who is born with some abnormality affecting the way their brain works. **(Authoritarian attitude)**		
Someone who cannot be held responsible for his/her own actions. **(Benevolent attitude)**		
Someone prone to violence. **(Social Restrictiveness attitude)**		
Someone who is suffering from schizophrenia. **(Authoritarian attitude)**		
Someone who has to be kept in a psychiatric or mental hospital. **(Social Restrictiveness attitude)**		

Most of the remaining ten questions gauged the respondent's knowledge of the categories of mental illness and effective treatments. In addition to asking them about their experience of knowing someone with a mental illness, and their own willingness to seek help or disclose to their family or friends if they had a mental health problem. Although responses to these questions cannot be analysed using Taylor et al (1981) framework, they indicate a leaning towards either authoritarian, social restrictiveness, benevolence attitudes, but instead of the community mental health ideology, since 2008 with the influence of the Time to Change campaign, reflect principles of recovery. Statement such as 'Most people with mental health problems want to have paid employment' and 'People with severe mental health problems can fully recover' are examples of this change.

Critique of the AMIQ

In Chapter Five I will discuss each student's initial responses in the AMIQ with their responses towards the end of their nurse education to gauge whether these differed or remained the same over the duration of the course The questionnaire, however, did not let the students elaborate on their answers or offer insights into the influences that either advanced a change or supported their initial attitude. This was aptly demonstrated when two students completing the AMIQ for the second time, in the third year, wrote reasons for responses in the margins. When one student

responded to ‘services should be community-based’ and ‘people with mental illness are far less a danger than people suppose’ she neither agreed nor disagreed and offered the comment that this was ‘dependent on severity of the illnesses’. Additionally when she neither agreed nor disagreed that medication and psychotherapy are effective treatments for people with mental health problems she offered further comment in the margin that it ‘depends on the individual’s needs and severity of illness’. Another student responded to two statements in question two: ‘Someone who is incapable of making simple decisions about his/her life’ and ‘someone who has to be kept in a psychiatric or mental hospital’ by writing in the margin ‘only in some circumstances’. These amendments appear to identify that the students did not want to make assumptions or generalise about people and found the statements too rigid to express themselves. Additionally for me, their comments justified the use of the mixed methods for data gathering as both students appeared to feel constrained by the strict yes/no categories.

Audio recorded and textual data analysis

Stake (1995) maintains that there are two strategies to analyse data: ‘categorical aggregation’ and ‘direct interpretation’. Categorical aggregation involves clustering complex data into categories or classes to ease the search for meaning. In Chapter Three I categorised the four attitudes of authoritarian, benevolent, social restrictiveness and recovery into dehumanisation and humanisation using Todres et al (2009) values framework so these category clusters were employed to view the words and descriptions the students used during their discussions, interviews and written assignment. I was also looking for the different influences which either supported or undermined their attitudes so I identified these influences using Burnard’s (1987) propositional, practical and experiential nursing knowledges (see Chapter Five). Direct interpretation, as described by Stake (1995), is when the researcher reaches new meanings about cases so for my study I used Mezirow’s (2000) transformative learning phases of alienation, re-framing and consolidation as the direct interpretation and I will discuss this in Chapter Six.

So after each data collection I listened to the audio recordings on several occasions before transcribing them verbatim and rechecking the recording for accuracy ensured I became immersed in the data. But the vast amount of data generated became overwhelming and difficult to manage so I decided to construct a pen portrait for each student. This immersion in the data, first, during the transcription phase and then in construction of the pen portraits offered insight into the students’ frames of reference and confirmed the findings from the first AMIQ.

For instance, Josie's description of patients in her first placement as 'naughty' and 'mischievous' are words sometimes to describe children which confirms her benevolent attitude. But just searching the data for terms or words which either confirm or refute the analysed responses to the AMIQ would not offer the depth of analysis to identify the reasons for any movement or non-movement from one attitude to another.

As this study is interpretive I decided that thematic analysis as described by Attride-Stirling (2001) was useful to ensure the students' voices were heard and to investigate what influenced changes in their frames of reference. In Attride-Stirling's (2001) view thematic analysis consists of six steps:

1. Code the material
2. Identify themes: 'basic', 'organising' and 'global'
3. Construct thematic networks
4. Describe and explore these networks,
5. Summarise thematic networks
6. Interpret patterns

The first step 'coding the material' was assisted by being conversant with the data as I had transcribed all the audio recordings and rechecked this several times for accuracy. Nonetheless, once all the data was collected, including the individual interviews and the discussion of their pictorial representations, I repeatedly listened to the recordings and read the transcripts to make certain I was fully familiarised with the data. This immersion assisted in the initial coding as interesting phenomenon relevant to my research aims was identified. Briefly these codes included the students' thoughts about their own learning, incidents in placement and description of patients they had met. Table 4.3 below illustrates a snapshot of how I coded some of the discussion during the Clinical Supervision session in May 2012.

Once all the data was coded I employed the second step of 'identifying themes' and as this study was interested in the effects of propositional, practical and experiential knowledge on the students' frames of reference, Attride-Stirling (2001) calls these overarching themes 'basic themes' as they cluster patterns of data or obvious concepts that occur in the text together. This clustering is demonstrated in Table 4.3, when the codes 'Questioning reasons for practice decisions' and 'Theory influencing views' appear to indicate that the students were attempting to understand the theoretical rationale underpinning practice so were accorded a 'propositional knowledge' 'basic theme'. In Chapter Five these codes and 'basic themes' are discussed in detail using the data timeline between the two AMIQ collections, when the students commenced the course and thirty months later.

Attempts to code and theme the students' reflective recovery assignment, undertaken at the end of the second year, proved difficult because referring to patients by initials such as Mr. X adhered to confidentiality, using diagnostic labels and descriptions of symptoms to explore the need for interventions and the academic style of writing limited meaningful data and did not necessarily reflect the students' attitudes. This is exemplified in the concluding comments of Josie's assignment: 'Although I had heard about recovery before starting this course, I thought it was really a paper exercise, but now I think it can offer patients life changing options to manage their illness. I think this essay has helped me learn more about it.' Unfortunately this brief reflection on her own practice was limited and does not suggest any inkling that this encounter was the source of her attitude changing disorientating dilemma.

Table 4.4: Codes and basic themes generated during the Clinical Supervision session (May 2012):

Data extract	**Coded for**	**Basic Theme**
They're (placement staff) not, as I am a student, challenged, I will question certain things they have been happy for me to do that as opposed to kind of defensive.	Questioning reasons for practice decisions	Propositional knowledge
I have met a lady with bipolar who was as high as a kite and she wasn't going to let our people (placement staff) in, she wasn't going there, telling me I had to leave, to put it nicely, and she was all over the place, she couldn't settle, she wouldn't sit still. As far as she was concerned there was 'nowt' wrong with her.	Description of service user	Experiential knowledge
The care coordinators had been changed, people being moved to different areas because a lot of the recovery teams have now joined with so there was only one manager but Jane (manager) didn't transfer anybody until their case load had been discharged, which meant there was a couple of people traveling to different areas, but in her opinion that's what was best for the individuals (patients) that they'd been seeing.	Seen as well organised practice management	Practical knowledge
Everyone in the office is going 'he's playing on the system a little bit'	Staff's view of patients	Experiential knowledge
Yeah, I had another lady who wouldn't even have me in the house. As far as she was concerned – I treated her like a child and I was patronizing.	Description of patients	Experiential knowledge
It's only through doing the research into the assignment and looking at other people's views on recovery and specifically with their mental health, I actually think recovery is very personal and it's individualized	Theory influencing views	Propositional knowledge
I went round with CPN who'd knew and when we saw her she was in bed, the police were with her and the housing people came round. When I thought about it later, I should have questioned it and I was bothered about my own practice as well as theirs, because this CPN was very big on being assertive and she said 'these housing officers, they are just using them as a scapegoat, they just want her in hospital.'	Seen as poor practice	Practical knowledge

These 'basic themes' then needed to be rearranged into 'organising themes' of shared impressions (Attride-Stiring 2001). Although the 'basic themes' offered a collective overview of the students' experiences during the first 30 months of their nurse education, and individual attitudes might have been detected, the reasons for either upholding or refuting initial attitudes could not be explored in any great detail. To counter this, each student's codes and 'basic themes' were reworked, guided by their timeline pen-portraits, to compose an individual 'organising theme' for each student (an example is illustrated in Table 4.4). The 'organising theme' of each student in this study detailed their movement towards Todres et al's (2009) humanisation of healthcare, which I argued in Chapter Three embodies recovery principled practice, and will discuss in Chapter Five.

Table 4.5: Carol's pen-portrait

Carol's pen-portrait	**Organising theme: Todres et al (2009) humanisation and dehumanisation**
1st year: Carol liked to be involved in 'interesting cases' and reading the patients' notes to find out their diagnosis and found it fascinating talking to patients about their illness and symptoms. She admitted that she was shocked to find one lady who did not fit in to her image of a person with mental health problems as she was 'dead trendy' and looked 'so good'.	Dehumanisation: objectification Dehumanisation: isolation
2nd year In her opinion, as 'most mental health problems...could not be cured', recovery was not the same as being cured from a physical ailment. She was quick to dissociate herself from the label of depression when discussing a friend's apathy and thoughts of suicide: '..my experience of depression – not me – but someone else, they couldn't be bothered to do anything, didn't want to go out....but as soon as they started feeling better, they got the motivation to carry it through'.	Dehumanisation: reductionist view Dehumanisation: isolation
3rd year She felt this placement changed her view of people with mental health problems: 'we saw a variety of people, I can remember reading someone's notes, and she was doing a psychology degree. How did she get depressed if she can do all this, but then, it obviously can happen to anybody can't it? I think that's what made me change my view'. This revised view of people with mental health problems was upheld during her acute Admission ward placement: '...looking at how poorly someone could be and looking back through their notes....you realise what they have achieved in their life with this illness and it's quite amazing really – so yeah, I have changed my views'.	Humanisation: uniqueness Humanisation: insiderness

Once all the coded data and 'basic themes' had been reworked into 'organising themes', a 'global theme' for each student was deduced. These in Attride-Stirling (2001: 393) opinion,

are the ‘core, principal metaphor that encapsulates the main point in the text’. As the focus of this case study was to investigate what influenced changes in their frames of reference about people with mental health problems, Mezirow et al (2009) transformative learning phases of alienation, re-framing and consolidation, as described in Chapter Two, were used as ‘global themes’, and will be discussed in Chapter Six. Table 4.5 offers an overview of the theoretical perspectives of each type of theme.

Table 4.6: Theoretical perspectives underpinning each theme.

Stake’s (1995) data analysis strategies	**Attride-Stirling (2001) themes**	**Theoretical perspective**
Categorical aggregation	Basic	Propositional, practical and experiential nursing knowledge (Burnard, 1987)
Categorical aggregation	Organising	Humanisation in healthcare (Todres et al 2009)
Direct interpretation	Global	Transformative learning (Mezirow et al 2009)

Attride-Stirling’s (2001) third step of thematic analysis is the ‘construction of thematic network’. These web-like networks clarify how the themes interact and offer transparency of the process undertaken. This method of reducing multiple codes to ‘basic themes’, then ‘organising themes’ and finally a ‘global theme’ undertaken for each student was plotted in a sequential clockwise fashion to reflect the first, second and third years of their nurse education. Although time consuming and initially difficult to construct, these networks were invaluable to illustrate the student’s movement and growth during their education. For example I was alerted to a discrepancy in my earlier assumptions in regards to ‘Will’ who I had considered to have moved seamlessly to an empowering recovery frame of reference following the taught component at the start of the second year, which emphasised recovery principled care. But visually, using Attride-Stirling’s (2001) thematic analysis, it can be noted that his peer, who he had been on the same placements with, was much more aware of different interpretations of situations they were both involved in and this was evidenced when she challenged him on two separate occasions. This appeared, with other experiences, to be the stimulus to change his view of the role of the mental health nurse as he later acknowledged that the discussions in class had ‘broadened’ his viewpoint. To assist clarification and support my analysis his thematic analysis network is included in the Appendix 6.

The fourth step ‘describe and explore the thematic networks’ required returning to the original data and views through ‘organising’ and ‘global’ themes so patterns within these could be

explored (Attride-Stirling, 2001). This step, with the fifth step 'summarising the thematic network', are used to structure Chapter Five to explore common themes expressed by the students and their relationship to Burnard's (1987) nursing knowledges. Attride-Stirling's (2001) last step 'interpreting patterns' is used to shape Chapter Six by combining and contrasting the analysis of each of the students' networks to discuss if they underwent Mezirow's (2000) three phases: alienation, re-framing and consolidation to achieve transformative learning.

Now that I have explained how I collected the data and analysed it I need to discuss my positionality and how it has influenced my choice of thesis topic so for this next section of this chapter I will deliberate on my positionality and the roles of insider/outsider in relation to the students I was studying to offer my ethical considerations when undertaking this research.

Identifying my positionality

In Chapter One I offered a brief overview for my reasons for conducting this research: two chance remarks twenty five years apart (1978 and 2004). The first drew attention to the similarities between myself and patients; and, the second to how mental health nurses can view patients as being different from themselves. So the research problem was my concern that, despite the immense changes in the learning content and environment of mental health nurse education between 1978 and 2004, some mental health students, soon to be nurses, still do not afford patients the same personhood as themselves.

McLean (2006: 316) identifies that 'from the outset, the researcher simply cannot be value-free [and that the researcher's] own systems will influence their fieldwork to a greater or lesser degree'. As this is an interpretive research case study I am mindful that my positionality has been shaped by my personal and professional life experiences and this can have a negative or positive impact on my study (Foote and Bartell, 2011). As Denzin (1986: 12) considers 'interpretive research begins and ends with the biography and self of the researcher'. Morrow (2006) suggests that reflexivity is a strategy encouraging self-examination and understanding of personal assumptions and biases. This critical thinking about self is supported by many qualitative researchers for example Gerrish and Lacey, 2006; Gabrielle, Jackson and Mannix, 2008; Robinson, 2002. Nevertheless, as Freshwater and Rolfe (2001: 529) concede, reflexivity is 'an elusive and contested concept'. Different descriptions of what reflexivity is tend to reflect the author's background and theoretical persuasion. Although difficult to define precisely, it is primarily about challenging the view of objective, neutral and value-free research (Burns and

Chantler, 2011). So there is no right or wrong way to do reflexivity as long as the researcher conceptualises their notion of it and incorporates this into their research practices (Day, 2012).

Helpfully, Freshwater et al (2001) offer three different descriptions of reflexivity which are classed as Type I, II and III. Type I is seen as a 'knee jerk' reaction to an occurrence, they suggest reflexivity as a turning back on itself via mega-analysis to revisit and introspectively consider the process of reflection. Type II is described using Schon (1987) terminology of 'reflection-on-action', but goes further than introspective reflection to consider the social and political context and ways of overcoming these. While, Type III is termed 'reflection-in-action', where critical reflection prompts openness to new ways of thinking and doing and having the skills, expertise and confidence to modifying behaviour in real time. In agreement, Finlay (2002) maintains that reflection sits at one end of a continuum while reflexivity is at the other suggesting reflexivity is more active than mere reflection.

Employing Freshwater et al's (2001) Type I and II of reflexivity has offered an insight into my own frames of reference and resulting behaviour over my thirty-five year career as a mental health nurse and university lecturer. Type I, the 'knee-jerk' introspective reaction, was evident in my responses to the disorientating dilemma comments made by a colleague in the 1970s and a student in 2004. They are occurrences I revisit and I acknowledge that they were turning points in my professional life, but since critically analysing the events I have unearthed my belief that: some nurses, myself included, have not always afforded people with mental health problems the same humanity as we bestow upon ourselves. In Todres et al's (2009) view this perceived lack of humanity advanced patients being seen as a collective group, labelled under a diagnosis, with denial of self-agency and reduction in their expectations of a meaningful life. Type II, the 'reflection-on-action' reflexivity category, has helped me examine how my frames of reference have been shaped by the cultural and social climate as well as the knowledge-base, which was initially biomedical dominated, of mental health practice over the past thirty-five years. So I need to state what my current positionality is: I believe that people with mental health problems are human in the fullest sense, so require person-centred and recovery principled care, which focuses on their strengths and aspirations for the future.

This belief, in turn, has influenced my choice of topic for this research, the selection of students, how the data was gathered and analysed (McLean, 2006). The study endeavoured to explore the frames of reference of a case of a small cohort of student mental health nurses about the patients they met and the role of the mental health role during their three year pre-registration

nursing education. Type III reflection-in-action reflexivity was employed throughout the study to advance my critical deliberation and prompting openness to new ways of thinking. I was mindful that my positionality could have resulted in overlooking or misinterpreting the data thus impacting on my perceptions and actions (Freshwater et al., 2001; McLean, 2006). So, as discussed earlier in this chapter, I ensured that the students were given a pen portrait of the data collected prior to their individual interview to check for misinterpretations from the participants' point of view. Also my academic supervisors would challenge my assumptions and offer differing views thus advancing reflection-in-action. I will now discuss my dual roles of lecturer and researcher in connection to the students within this study and how I attempted to ensure they were not pressured into participating in the study or treated differently to other students.

My researcher role in relation to the students

The role of 'insider' researcher is a key consideration in my study, this refers to researchers who conduct research with populations of which they are also members (Kanuha, 2000). I am a mental health nurse with thirty-five years' experience and have practiced in many of the settings in which the students I studied had undertaken their practice placements. So I share similar experiences, identity, language and experiential knowledge base with the study participants (Asselin, 2003). This 'insiderness' in Krefting's (1991) opinion offered trustworthiness because I recognised recurring nursing patterns, themes and values aiding 'credibility' to the study. Additionally, having similar practice experience and using the same language seemed to encourage the students to volunteer more sensitive information and reduce socially acceptable responses.

Conversely, I am an 'outsider' for I am a lecturer and module leader on the pre-registration nurse education programme so may not be completely accepted by the students or privy to their intimate thoughts (Adler and Adler, 1994). The status of my role and authoritative power might have coerced students' into thinking they had to participate in the case study. This power deferential might have resulted in students feeling that to refuse to participate in this research might jeopardize their education (Ferguson, Myrick and Yonge, 2006). As a nurse educator, I have a responsibility to advance the knowledge of the discipline and this placed me in a position of dual agency of lecturer/researcher with the students/participants, which can lead to conflicting roles, responsibilities and loyalties (Fergusion et al, 2006). For example, I could have desisted from failing my students' assignments to ensure they continued in my study or I

could have refused to intervene when a student was in distress so not to contaminate my research. Both of these issues are relevant to this study as I failed three of the students' assignments in the second year due to lack of critical analysis and when one of the students was emotionally distraught regarding her continuation on the Degree pathway after failing her assignment and undergoing tests for a brain tumour, I offered her time to discuss her feelings and we together sought solutions to her problems. My rationale for both these actions is that mental health nurses need critical analysis skills to provide meaningful care and as a mental health nurse myself I could not ethically see someone suffering without supporting them.

As discussed, my roles of 'insider' and 'outsider' both have an impact on this study however throughout the data gathering period of three years and analyse and writing up, a further four years, I have been guided by my professional code of conduct. I am a nurse, and so (although I am employed as a health care lecturer by a HEI I must maintain my registration) my personal and professional behaviour must adhere to the Nursing and Midwifery Council's (NMC 2008) Code of Professional Practice. The underpinning principle of this code is that nurses should be trustworthy: 'Be open and honest, act with integrity and uphold the reputation of your profession' (NMC 2008: 7). So throughout this study I treated the students as individuals, gained their consent, kept clear and accurate records, and did not abuse my position to persuade them to participate.

Conclusion

This chapter provided a rationale for choosing a multi-method longitudinal case study, underpinned by Skate's (1995) collective approach, to explore my research question: Does the current Pre-Registration Nurse Education produce nurses who 'Promote a culture that values and respects the diversity of individuals and enables their recovery' (DH, 2006b, p5)?

I first identified the context and setting of this study. The data collection methods of the AMIQ, audio-recorded classroom discussions, reflective assignments, semi-structured interviews and pictorial representations of the students' education journey were described and data analysis using thematic analysis were explained. Finally, I explored the ethical considerations of my insider/outsider role as a lecturer and researcher and how this might have affected the students who undertook this study.

Chapter Five will discuss the students' responses to the two AMIQs they completed thirty months apart and the data collected during their classroom discussions between these AMIQs to answer my three sub-questions:

- What were the students' frames of reference about people experiencing mental health problems, at the start of their three-year nurse education course? What appears to have shaped these attitudes?

- Did these students change their frames of reference over their three-year education? If so, how did they change, what was the relative influence of propositional, practical and experiential knowledge?

- If students' had negative unhelpful frames of reference which did not change, what appeared to be the barriers to change?

Chapter 5: The Impact on Attitudes of Propositional, Practice and Experimental Knowledge

Introduction

In this chapter I explore the students' verbal and written descriptions of propositional, practical and experiential knowledges as described by Burnard (1987) during the students' first 30-months of their nurse education. This timescale included the undertaking the two AMIQs and was used to construct a pen-portrait for each student.

First, I offer some background by introducing each student and discussing their reasons for choosing to study mental health nurse education. Each of the students had a 'benevolent' attitude when they commenced their education and, 30-months later, four of the students scored a recovery attitude and the remaining two students had made a marked movement towards the recovery attitude. So I structure the remainder of the chapter, year by year, into exploring the students' classroom discussions and written assignment focusing on their descriptions of propositional, practical and experiential knowledges over this 30-month timescale to examine how and why their attitudes changed.

The students in my case-study.

This research is a longitudinal case-study of a cohort of six mental health nursing students so in this section I provide demographic details about each of the six students, their initial attitude and describe the degree and nature of their engagement with the study. The names of the students have been changed to protect their anonymity.

Gemma (white, working class, 18 years old at the start of the course)

At eighteen, Gemma was the youngest student in this study and when she started her nurse education, she lived with her dad and sister, and had a Saturday job at a bakery. She had no healthcare work experience but had been interested in mental health nursing from an early age. This might have been motivated by working with someone with a learning disability who also suffered with their mental health. Additionally, she had a neighbour and a friend who had mental health problems. She was quite open and frank during the group discussions about herself and her opinions by revealing that she was 'gay', criticising placement teams and challenging other students' views if she did not agree with them.

At the start of her nurse education she had a benevolent attitude and she was unsure if people with 'severe mental illness could recover' (AMIQ, 2010). This stance changed towards the end of her course as there was some movement in the direction toward a recovery attitude. However, it would appear she found the AMIQ questionnaire restrictive as she made comments of 'only in some circumstances' to some of the statements in question two. Nonetheless, her responses such as 'slightly agreeing' that recovery was possible and that medication and counselling were effective treatments, suggested that she still harboured some elements of a benevolent attitude in regard to the ability of people with severe mental illness to recover (see Table 5.1).

Carol (white, middle class, 19 years old at the start of the course).

Similar to Gemma, Carol was a teenager when she commenced the course and had not had any healthcare experience. She lived at home with her parents and decided to be a nurse while at school after talking to two of her Mum's friends who were mental health nurses. Her only experience of mental illness was a family friend who suffered from depression. Like Gemma, she was open and candid about her thoughts and feelings in the group discussions and was not afraid to challenge her peers if she disagreed with what they were saying.

She started with a benevolent attitude and slightly agreed that recover from mental illness was possible. Two years later, her AMIQ responses indicated a marked attitudinal shift towards a recovery attitude. She continued to believe that both medication and counselling were effective treatments and strongly agreed that recovery was achievable.

Will (white, middle class, 23 years old at the start of the course).

Will was in his early 20s and also had no healthcare experience prior to commencing the course, although a family member, a close friend and a work colleague had had mental health problems. He had worked in the leisure industry and decided to study mental health nursing as he 'wanted a rewarding job, something different from 9-5'. He also disclosed personal information about himself during group discussions, offered his own viewpoints and contested peers' opinions in a non-confrontational manner.

He started with a benevolent attitude and was unsure whether counselling was a beneficial treatment or if people with severe mental illness could fully recover. But by the third year he endorsed both medication and counselling as effective treatments and agreed that people with

severe mental illness could recover. Similar to Carol, Will demonstrated a marked shift towards the recovery attitude.

Marion (white, working class, had accessed mental health services, 24 years old at the start of the course).

Marion was in her late 20s when she commenced the course and, like Will, this was a second career. She had no healthcare work experience but had herself accessed mental health services in the past. Although she offered her opinions and discussed her practice experiences, she did not discuss personal information in the early stages of the study, but by the second year she had disclosed to her peers that she had personal experience of mental health care and that she 'dreaded' a placement in a Drug and Alcohol team due to her experience of her father's alcohol problems.

Marion begin with a benevolent attitude and considered counselling, more than medication, to be an effective treatment and was unsure whether people could recover from severe mental illness. In the third year there was a marked movement, similar to Carol and Will, toward a recovery attitude. There is some similarity with Will, who had initially believed only in medication, while she was only sure of counselling, by year three Marion believed that both medication and counselling were effective treatments. Additionally, from a stance of being unsure whether people could recover from severe mental illness, now thought they could recover.

Mia (white, middle class, had worked in a mental health residential home, 23 years old at the start of the course).

Mia was in her early 20s when she commenced her nurse education and differed from the first four students because she had experience of caring for older people in a mental health residential home and had chosen mental health nursing as a career after completing a National Vocational Qualification in Healthcare. She had also worked with someone who had mental health problems. Mia was reserved and tended to sit quietly listening to other students' views and experiences without offering her own. However, when asked directly she would make some insightful comments and, as she became more confident, question her peers' standpoints.

Mia originally held a benevolent attitude, but strongly agreed that recovery was possible. However, her responses to other questions did not support a recovery attitude and often contradicted each other and she 'slightly agreed' that counselling was an effective treatment,

but was ‘unsure’ whether medication was effective. Retaking the questionnaire two years later, she had a similar attitudinal stance to Carol, Will and Marion because she now had a more recovery-focussed attitude. She continued to believe that recovery from mental illness was possible, while she now agreed that both counselling and medication were effective treatments.

Josie (white, middle class, had worked in mental health settings for many years, 45 years old at the start of the course).

Josie was the oldest student, at 45 years old, and the only one who was married or had children. She had seven children, the oldest of whom had just qualified as a mental health nurse. She had also worked in healthcare, first with people who had severe autism, and for several years in a male, low to medium secure forensic unit. In addition, her husband had become depressed when he had been made redundant. Initially, she tended to be forthright and lead discussions by stating her views first, but as the course progressed she sat back and listened to her peers more often. Additionally, she was inclined to ‘mother’ the other students by instructing and organising their time at university, and again this declined throughout the course.

Josie began the course with a benevolent attitude. She ‘strongly agreed’ that both medication and counselling were effective treatments, but was ‘unsure’ whether people with severe mental illness could recover. In the third year she appeared to find the questionnaire limiting because she did not answer all the questions but added her own comments in the margins. For example, she wrote ‘All of these could be answered yes or no, it depends on the individual and their needs’. Additionally, from a stance that both medication and counselling were effective treatments she now wrote ‘Not in all cases, it depends on the individual and the severity of the illness’. However, in the first AMIQ questionnaire, she was ‘unsure’ whether recovery was possible, in the second she slightly agreed that it was. Consequently, Josie achieved an equal split between a recovery and benevolent attitude, but by not answering the questionnaire as formatted it was difficult to ascertain how far her attitude moved towards recovery. This change in attitude is similar to Gemma, who also made additional comments, and who was also dubious about recovery for people experiencing severe mental illness. Josie and Gemma’s uncertainty about recovery from mental illness was also detected in their comments during classroom discussions as will be discussed later in this chapter.

Table 5.1: Summary of the students' attitudes at the start and towards the end of their nurse education

	Authoritarian	Social Restrictiveness	Benevolent	Recovery
Year 1			Gemma Carol Will Marion Mia Josie	
Year 3			Gem Jos	ma Carol Will Marion Mia Ie

As illustrated in Table 5.1, all the students started the course with a benevolent attitude and by the time they retook the AMIQ again (30-months later) four of the students (Carol, Will, Marion and Mia) had shifted their attitude to a recovery one and Gemma and Josie were moving towards this attitude.

The benevolent attitude could be expected from students commencing their nurse education as they may represent a public perception that mental health patients are incompetent or have a character weakness, and therefore need controlling care (Rusch et al, 2005). Additionally, some of the students had not experienced working within mental health services, so have not been exposed to recovery principles of care. Interestingly, the two students (Mia and Josie) who had previous experience as Healthcare Support Workers (HCSW) also had a benevolent attitude, which in Stacey and Stickley's (2012) opinion may be due to witnessing practices in their previous roles, which socialized them into this stance contradicting the values of recovery focused practice.

In Shuval's (1980) opinion, professional socialisation involves acquiring, in addition to the requisite knowledge and skills, the sense of occupational identity and internalization of group values and norms which will be reflected in behaviour and self-concept. This process takes time and consists of three phases. The knowledge, skills and acquiring a nursing identity group norms resonates with Burnard's (1987) typology of three nursing knowledges. Shuval (ibid) maintains that the first 'pre-socialisation' phase is when the 'stage' is set and influenced by the nature of secondary school population values, the values of significant socialisers and the image of the profession. Several of the students identified either family members or friends as

being mental health nurses or had personal contact with services so these significant socialisers may have been influenced the students by experiential knowledge to choose mental health nursing as a career. Additionally, all the students stated they chose this career as the wanted to 'care' for people with mental health problems which could be said to be commendable image in society.

The second 'formal socialisation' phase, consists of cognitive and interactional spheres which promote learnt behaviour in the appropriate professional manner. Mia and Josie who had previously worked in healthcare as HCSWs, had already been exposed to this 'formal socialisation' phase but this practical knowledge might have been within a culture that fostered benevolent attitudes rather than recovery focused. Additionally, they might not have had any propositional knowledge for example, recovery-focused training in their previous careers so might not have been able to consider the practical and experiential knowledges they encountered such as group norms, values and behaviours.

The third, 'post socialization' phase happens during the period of practice after formal socialization until retirement when the outcome of socialization is considered, which in Shuval's (1980) opinion, would be entered into following registration. It is important to note that the context of my study is within 'formal socialisation' phase when the nurse education the students received included propositional, practical and experiential knowledges. Nevertheless, I took into consideration the 'pre-socialisation' phase by ascertaining the students' attitudes at the beginning of the course and asking students what motivated them to take up mental health nursing.

However, while it could be said that the AMIQ identified (despite its or my analysis shortcomings as discussed in Chapter Four) there was no indication *why* the students changed their attitudes. So data collected from the other methods used in this study will now be employed to explore the variety of influential factors for these attitudinal changes. Table 4.1, in Chapter Four, illustrates a timeline of the dates and description of data was gathered. The descriptions and specific language employed by the students will be cited directly to ensure their 'voices' are heard (hooks, 1990: 151-2). In the sections that complete this chapter I make a chronological account explaining year by year how exposure to different types of knowledge influenced the students' view of patients and the role of the mental health nurse/patient relationships.

First year experiences

In this first year two classroom discussions were recorded. The first was during the students' first placement, when they returned to the university to meet with their personal tutor to discuss their placement. Unfortunately, the majority of the time was taken up with the students asking for clarification from their personal tutor what they could use to demonstrate they had achieved the Nursing and Midwifery Council's (NMC 2004) proficiencies. Only two students Josie and Gemma spoke about their placements in detail and the patients they had encountered. The following section explores what these students discussed in terms of their relationships with patients in the recorded session.

Patient contact

Josie was on an Older Adult ward and stated 'the patients are naughty, really naughty' and when challenged by her personal tutor about her terminology she reframed 'They are mischievous – they have characters, brilliant' (Josie, 27:05:11). It was apparent she had got to know some of the patients as well as she mentioned a man who tried to hit a member of staff with this walking stick. She offered the following reason for this:

> [H]e had been watching the news about the Afghanistan conflict and as he had been in the Second World War and had received a commendation for his involvement, he may have been reliving this experience due to his dementia. (Josie, 27:05:11)

Josie's usage of the terms 'naughty', and when challenged 'mischievous', in her description of patients appeared to confirm a benevolent attitude. This depicts patients on the Older Adults ward in childlike terms and places them in a dehumanising position of passivity (Todres et al, 2009). It could be suggested that her use of phrases such as 'patients' and 'they' to include all the patients collectively reflecting homogenisation, but she did describe one man as a distinct person.

When Gemma spoke about the best thing about her placement she seemed to promote a benevolent attitude in her description of patients because of her use of diagnostic labels indicating that five months into her nurse education she identified with the biomedical model, which I argued in Chapter Three, re-enforced benevolence. Nonetheless, she also offered a reason why the general public were scared of people with mental health problems:

> The best thing - the patients, they are so interesting. Everyone has this big idea that they are scary, but you find they are really nice. People think like schizophrenia and bi-polar and stuff like that, the media make people wary. But if you saw them on the street you won't know, they are really nice, pleasant. (Gemma, 27:05:11)

Although only two of the students, albeit the ones who both had not completely moved to a recovery attitude after 30 month, spoke about their experiences in practice during this session, the influence of propositional knowledge in the form of diagnostic labelling was evident. Both appeared to view patients as fixed in their diagnosis reflecting Todres et al's (2009) 'loss of personal journey', which I, in Chapter Three, allied to a benevolent attitude. In the next classroom discussion during Transition to Specialised Field session, which was at the end of year one, some of the students appeared to see patients as dangerous.

Perceived danger

Both Gemma and Carol expressed a social restrictiveness attitude and an example of this was when their personal tutor asked why students should not give lifts to patients who needed to attend a group as part of their therapy or for hospital appointments. While Will and Marion thought it was for financial reasons as 'you'll not be paid mileage' (Will) and Josie thought it was 'acting outside your remit', by contrast, both Carol and Gemma cited issues of personal safety:

> Patient unpredictability, say if you and the patient are in the car, then obviously it is one on one, you'll have no-one there to advise you what to do or say. They could get really personal. Your own safety. (Gemma, 13:12:11)

> [D]anger side of it, if they feel uncomfortable with you. (Carol, 13:12:11)

Gemma and Carol's concerns about patients in the community being 'unpredictable' and dangerous mirrors the social restrictiveness attitude and Gemma, especially, seemed to have radically changed her opinion from the 'media make people wary' to 'they're really nice' recovery attitude. None of the students considered that this might create dependencies and inadvertently disempower patients. Again this theme of personal safety was re-visited after Will wanted guidance on how much self-disclosure was appropriate:

> I had this situation where I had someone who was quite a few years older than me, mid to late 40s, and she has disclosed a lot of personal information about her life and it must have

> been hard for her but obviously the environment was right and she felt comfortable talking to me. She did ask me questions and I spoke a little bit about things that I was comfortable in saying. Is that acceptable if they show an interest in you, you know, general questions like 'what are you doing this weekend?' Is it allowed to say what you are doing so that you can give something back without going into that over-familiar area? (Will 13:12:11)

A similar concern about nurse patient boundaries was also raised by Marion:

> I think saying certain things are ok, people have asked my mentor what she is doing for Christmas and she said 'my husband and I don't do Christmas, we just walk the dogs' it's just basic sharing at the end of a session and little things like that just make you more human (Marion, 13:12:11).

While agreeing with Marion in regards of the humanness of the nurse involved, Carol again brought up the issue of personal safety:

> I think people are more honest with their nurses if they get a little bit back. They think they are more human. But can I say where I live? It's a quite small place where I live so if they wanted to follow me for any reason like 'mental health services wrecked my life' sort of thing, they could probably come and say where is Carol, she is a student nurse. I just don't know. (Carol, 13:12:11).

In response, Mia appeared to want to reassure Carol but also offered the view that giving too much personal information was a 'social restrictiveness' threat:

> I think it's ok to answer general questions; it's being polite, if you don't you can come across as quite selfish, you've got to find the middle ground. What you do one weekend is different to another weekend, so you can't be traced (Mia, 31:12:11).

Several issues are evident in these interactions: Will was wanting reassurance from the lecturer that he was keeping within the Code of Professional Conduct (NMC 2008), while Mia joined Gemma and Carol in voicing concerns over their personal security. The students appeared to be confused by the boundaries of the nurse/patient relationship and the nurse's behaviour within this role. Although it could be suggested that Gemma was advancing recovery when she stated 'they are really nice, pleasant', she with Carol, Marion and Mia appeared to think people with mental illness were dangerous reflecting a social restrictive attitude which in Chapter Three I reasoned was an attitude underpinned by the biomedical model of a dysfunctional brain.

The lecturer explained that transporting patients in cars could disempower patients and it would be better to use their usual forms of transportation e.g. buses, taxis etc. to reduce the possibility of dependency and promote long-term recovery. And after acknowledging that appropriate self-disclosure was acceptable to promote therapeutic nurse/patient relationships, Will sounded relieved:

> [Y]es it could be detrimental to the relationship you are having with the patient 'cause they may be thinking I'm disclosing all the time and I'm not getting anything back. All the hard work you put into it could be jeopardized because the patient can be self-disclosing all the time and getting nothing back (Will, 13:12:11).

Despite appearing to support a recover attitude, Will's next response to a peer's comment indicated he underpinned his practice using the biomedical propositional knowledge taught in university as he was categorised patients into diagnostic cases. The next section will explore the students' discussion regarding the different patients they met in practice but instead of seeing people they classed the patients as cases.

Patients as diagnostic cases

First, Carol spoke about cases instead of patients as people when she stated:

> It sounds silly, but I like interesting cases – like in the Recovery Team you will read their file before you go out with your mentor just to get a brief summary of what their diagnosis is and the more things that have happened to them, the more interesting. (Carol, 13:12:11).

Will expressed a similar attitude:

> When I was on a day ward, we didn't have that many complex cases. They were quite tame, but when I was on the ward for an insight visit, I got to see people who were a lot more ill. Seeing actual people who were like you have read about with schizophrenia or something like that, but actually seeing it in a person is far better because it is something visual and it seems so real for them there. That was interesting. (Will, 13:12:11).

Likewise, Mia stated:

> I do like more interesting cases, but every case has a background, you come across something that you have never done before, so add to your experience and knowledge (Mia, 13:12:11).

These comments imply that most of the students, by the end of their first year, were viewing patients as collective, diagnostic and biochemical 'cases' replicating homogenisation, objectification and reductionist dehumanisation with an authoritarian attitude (Todres et al, 2009; Taylor et al, 1981). This was apparent in Carol's comment about her interactions with patients, which showed that despite a placement in a community Recovery team, she still focused on the signs and symptoms of mental illness:

> Many of them would sit there and talk to me for ages about bipolar or how they are feeling and tell me about the voices they hear, some voices were like old friends and things like that and I find it fascinating. If you start chatting to them you get so much more information than asking your mentor, well they obviously know, but someone first hand hearing their experience is so interesting, I love that side of it. (Carol, 13:12:11).

Although Gemma challenged her peers' opinions by emphasising the embodiment and uniqueness of patients, she still identified medication as the mainstay of treatment mirroring an authoritarian attitude:

> Everyone's different obviously, although the people we meet will have mental illnesses but they are still their own individual person so I don't think there is any point in saying I want to meet 'this sort of person' you can meet two people with schizophrenia but they can be two different people in the way that they deal with it, obviously with medication etc. so yeah, the same illness but with different people living with it, how they act differently with it. (Gemma, 13:12:11).

To which Carol conceded that some patients did not fit this stereotype but this tended to be on their appearance not due to their uniqueness, self-agency or personal journey (Todres et al 2009):

> Yeah, I know, one lady in particular, she is dead trendy and when I went to see her my mentor had said a bit about her but geeze for someone that looks so good has got all these problems (Carol, 13:12:11).

So it appeared, denoted by their terminology of cases, symptoms and risk, that some of the students (Carol, Gemma, Mia and Will) had their initial benevolent attitude either re-enforced or shifted to an authoritarian or a social restrictiveness attitude in the first year of their mental health nurse education. It was not however apparent what influenced this shift. The following section explores possible influences and is framed using Burnard's (1987) three-fold typology of nursing knowledge.

Propositional, practice and experiential knowledges gained during the first year

The themes running through the students' discussions during their first year of nurse education were 'diagnostic label', 'unpredictable behaviour' and 'patient contact'. My findings about the first two themes supports Stickley and Timmons' (2007) opinion that students of all branches enter their nurse education with lay beliefs about people with mental health problems, portrayed in the media as mentally deficient so incapable or dangerous, the former embodied within the benevolent attitude and the latter within the social restrictiveness attitude, which both support the medical model of mental illness. As explained in Chapter One, the first year is called the Common Foundation Programme and students from all branches of nursing attend the same lectures and are introduced to biological sciences, social sciences, evidence-based practice and nursing theory. This might explain why Carol, Mia, Gemma and Will use terminology which indicates a move from a benevolent to a biomedical authoritarian attitude. Anecdotally, I have found that many mental health students complain that their first year of theory is too adult nurse orientated and dominated by the biomedical model of illness and disease. This was reflected in comments Will made in his last year:

> The first year was very adult based, I know you need to know that side of things, biology etc. but everything was about general nursing. I know it's important but I didn't find it interesting (Will, individual interview, 11:10:13).

So the propositional knowledge the students were taught in their first year could be said to promote mental health problems as an illness similar to a physical illness (Stickley et al, 2007). As Burnard (1987) maintains, propositional knowledge informs their practical knowledge of

psychomotor or interpersonal skills undertaken in their placement settings, so the students in my study take with them the view that mental illness is a dysfunction of the brain. This was evident when some of the students spoke about interesting, complex cases and used diagnostic language such as ‘dementia’, ‘schizophrenia’ and ‘bi-polar’ to describe patients. When recalling their experiences in practice, the students spoke about being encouraged to engage with patients, which offered instances when mentors and other healthcare staff promoting person-centred care. However, with a biomedical mind-set they used these interactions to learn about the signs and symptoms of mental illness, rather than learning about the person. Nonetheless, there were instances when Josie, Gemma, Carol and Will spoke about their ‘patient contact’ and this experiential knowledge allowed them to see patients as individuals, countering objectification, homogenisation and reductionist dehumanisation (Todres et al, 2009). But, when patients were spoken about as a collective, issues of risk and personal safety were expressed again offering view of the students grappling to understand that people with mental health problems were human. The students were unaware that their description of practice, underpinned by the propositional knowledge of mental health problems as a medical illness, could result in the dehumanisation of patients into cases, symptoms and unpredictable others.

Year two experiences

In the second year all of the propositional, practice and experiential knowledge taught focused on recovery from mental illness which emphasised the skills, strengths and aspirations of the patients they would working with. In the course different theories about causes of mental health problems were explored; the students practiced their communication skills, and, people who had experienced mental health problems discussed their recovery. The next section will consider how the students dealt with this different focus on recovery, how they attempted integrating these principles into their practice, and, the role models who influenced their view of patients.

Understanding the stigma of having mental health problems

The seminal lecture of the year-long mental health module in the second year was the Recovery session, which introduced the principles of recovery-orientated care. After a PowerPoint presentation on the different perspectives of recovery and current government policies, discussion was central to this session because students were asked their opinions about and

experience of recovery focused care gained during the first year. The session began by asking the students how people with mental problems are perceived by society and they all conceded that having a mental health problem lead to other people distancing themselves from those with this label. Josie's comment illustrates:

> People with mental illness are not what is expected so should be avoided. Unfortunately often with schizophrenics, where you have got this deep bizarre behaviour or holding a conversation with yourself on the bus, it's still viewed as strange (Josie, 20:01:12)

The students' statements acknowledged that people with mental illness experience stigma in society. In the same way as her peers, while recognising social stigma, Josie appeared oblivious to the fact that she was labelling people with mental health problems in a collective diagnostic fashion by stating 'often with schizophrenics' reflecting an authoritarian attitude. After challenging Josie on her use of the term 'schizophrenics' and suggesting using 'person first language'[7], the lecturer instigated a discussion by asking the other students what the difference is between a schizophrenic or a person with schizophrenia. Mia, Will and Carol accepted that this reduced the person to a diagnostic label and, while Marion considered this she also confirmed her view of mental illness:

> You're putting them in a group. So you need to see the person first not the diagnosis. I suppose the other thing is saying a person is schizophrenic or bi-polar is a bit in your face isn't it, oh and you see that sort of reaction from people, whereas if you word it differently they might view it differently. But habits are hard to break when you have got used to saying that they are bi-polar or whatever, you have really got to think about it. I have found it difficult (Marion, 20:01:12).

Marion's comment 'But habits are hard to break' indicated that she had adopted the medical model of labelling patients by their diagnosis and defining people by their diagnosis. In discussions students were able to offer different points of view from each other. This was aptly illustrated when Carol discussed a friend's apathy:

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[7] Person first language emphasizes the person, not the disability or condition to avoid perceived and unconscious dehumanisation e.g. a person with schizophrenia rather than schizophrenic person see Dunn and Andrews (2015).

> I think from my experience with depression, not me, but someone I know with depression, he can't be bothered to do anything, didn't want to go out this, that or the other (Carol, 20:01:12).

Although earlier she had spoken about how people with mental health problems were stigmatized, Carol was quick to dissociate herself from someone who used the label of mental illness, and appeared to see the person as being stuck in their diagnosis indicating 'loss of personal journey' (Todres et al, 2009). But this negative judgement was not supported by her peers who offered reasons for people finding it difficult to change, such as Josie who said 'It is like a comfort, their norm' (Josie, 20:01:12), while Marion explained:

> A lot of people are frightened of change. A step forward, it is a massive leap into the unknown, you step out of your comfort zone it can be scary for a lot of people. If you are depressed you probably have lived in their own little bubble, you might drift back so it can sometimes be two steps forward, one step back. (Marion, 20:01:12).

> Yeah, waiting for the bubble to burst. (Mia, 20:01:12).

These remarks indicate that the students had started to see empathetically how patients face stigma through diagnostic labelling and the retort to Carol from Josie, Marion and Mia exemplify this: rather than 'not being bothered', they propose that her friend was just experiencing a common human reaction to change. When the conversation turned to what the students thought the meaning of 'recovery' meant in terms of having a mental health problem, the discussion centred on the students' experience of recovery planning; among the definitions offered were:

> It's a person's own interpretation of their own recovery isn't it? Each person has a different recovery, it's their own personal recovery. (Carol, 20:01:12).

> Recovery is about the patient's interpretation, it is individual. So everything in a recovery plan is going to be specific to that individual and their needs to attain recovery. (Josie, 20:01:12).

> It is a case of prioritizing which one has the worst implications to them, you deal with that first, then moves on to the next one in stages so like having a timeline. If the timeline

> comes to an end and it is not quite reached it doesn't have a negative impact, it is more a positive one because you have got so far. (Mia, 20:01:12).

The incongruence of differing perspectives expressed by the same student appeared to indicate that they were struggling with the different concepts being discussed. For example, when Carol spoke about her friend who she stated had depression 'couldn't be bothered' to do anything which appeared to dismiss her friend's autonomy, she now acknowledged 'it's their own personal recovery'. While, Josie initially spoke about 'schizophrenics' as a collective, where now she spoke about recovery being 'individual'. Both Josie and Mia had previously worked in healthcare but only Mia appeared consistent in her person-centred responses, although she did not often contribute to discussions unless asked for her views, she tended to observe and reflect on what she heard and observed. This was demonstrated when the conversation turned to patients and staff the students had worked with in their first year placements and it became apparent the impact other healthcare staff have on the students' attitudes.

Benevolent influences from role models

Marion and Carol were in community placements and appeared to be influenced by the negative comments about some patients of their mentors, who were registered nurses who had undertaken additional training to allow them to support students. In Will's case this negativity was expressed by several members of the day ward staff, he encountered who seemed frustrated when patients did not adhere to their treatment plans was. This frustration was also experienced by Marion who offers an account:

> There was a gentleman diagnosed with schizophrenia and he felt that his neighbours were talking about him, and he wouldn't leave the house. Everything that you suggested, everything that you came up with he had an answer for, he contradicted himself, it was like pulling teeth, and my mentor was getting to the point where she was going to have to discharge him because what he was saying and how he was presenting seemed totally different. He was always grateful that she came round, but as she pointed out later in the office, she is not there to be his friend, she is there to help him, because that's not how mental health practice works these days. I was surprised but then I understood what she was saying. (Marion, 20:01:12).

Carol also spoke about her mentor's frustration:

> We had a bloke he took overdose after overdose. He had the capacity[8], he knew what he was doing, his goal in life was to kill himself, he refused all treatment except for medication but he didn't take it that regularly, he just took it to overdose. I think that was a cry for help as he always had the excuse as to why he couldn't do it properly and after a certain amount of time the CPN just thought 'what can I do', you exhaust your list of help. The CPN was quite frustrated because he wasn't doing anything so basically we just had to say we can't stop someone if they want to kill themselves. (Carol, 20:01:12).

Will also gave an example of how patients' behaviours and perceived inability to change impacted on how the patient was seen:

> On the day ward, as soon as anyone mentions the word discharge some of them seem to deteriorate quite rapidly. But it seems to scare people because they have become reliant and it has become like a little community like a day centre. Everyone was socially accepted, there are people sat there showing massive self-harm marks which they might not do that in another environment. (Will, 20:01:12).

Mia who was on the same placement at the same time as Will countered his stance as instead of just observing patient behaviours, she demonstrated she had reflected on the lack of nursing focus within the service.

> [The day hospital] did become a bit like a meeting place where people went to discuss general topics and it lost its use of getting well again and became more like a socialized place. But they might not have the social skills to go out in the community to socialize so that should have been the focus of the day ward. (Mia, 20:01:12).

During placements students were exposed to the potential of practical and experiential knowledge and hearing staff make disapproving comments about patients' behaviour may have had an influence on the students' attitudes. These negative comments reveal dehumanising objectification because the patients' subjective interpretations of their experiences are being

[8] The Mental Capacity Act (DH 2005) provide a legal framework for acting and making decisions on behalf of adults who lacked capacity to make particular decisions for themselves.

ignored and they are expected to passively accept choices made by staff (Todres et al, 2009). The nurse/patient relationships within these scenarios did not appear to be a partnership as recommended by contemporary mental health policies and they also offered 'formal socialisation' of learnt professional views (Shuval, 1980) that patients are contradictory, manipulative, dependant on services and fixed in their diagnoses. But the practical and experiential knowledges students were gaining supported the biomedical propositional knowledge taught in the Common Foundation Programme in the university, but did not reflect the recovery curriculum they were currently studying.

So, while the six students had agreed that recovery was an individual process and needed the patient's own interpretation, it was not reflected in these later remarks. However, it must be acknowledged this was the first formally taught session on recovery, therefore the students might not have had sufficient time to consider placement experiences through the person-centred, recovery lens. Both Will and Mia's comments about the day ward further suggested that the patients' need for social connectedness with their community (togetherness) and a comfortable, familiar place (sense of place) were discounted. But Mia's view that the focus for the day ward should be refocused indicated she had considered the patients' need for recovery-principles interventions. What these discussions also demonstrates is that the students engaged in healthy discussions and gained experiential knowledge by sharing their experiences and challenging each other's opinions as they grappled with the paradoxes within mental health nursing.

Questioning of assumptions about experiential knowledge was again apparent when the students undertook clinical supervision during their first placement in their second year. Again it was about annoyance with patients' behaviour and involved Will and Mia who were both on the same placement on a recovery ward.

> One patient in particular who'd been told he's going to move to another setting, he's accepted it but then all of a sudden, it seemed quite deliberate, 'I'm hearing voices their telling me to kill myself'. Everyone in the office (nursing staff) says he's playing on the system. I don't like to look at it as negative, so it can be looked at it from two points of view: is this patient saying I'm not ready to go or are they playing the system? I'm going to be honest, it's frustrating for myself and it's probably frustrating for the team as well. (Will, 22:05:12).

The discussion continued with Mia challenging Will's view of the ward they were both on placement by saying:

> Yeah, but how frustrating for them [patients] when different members of staff have different rules for different patients. One day they are allowed to do that and the next day they are not. How unfair is that to them? (Mia, 22:05:12).

Will appeared to reconsider his viewpoint about the reasons for patients' behaviours as he responded:

> I know what you are saying like in terms of the consistency, there isn't any throughout the team which is confusing for a lot of patients and I can see that side of it. (Will, 22:05:12).

Will seems to be purporting an authoritarian attitude of staff-know-what-is-best by expecting passivity from the patient to readily accept a transfer to another healthcare setting (Taylor et al, 1981; Todres et al, 2009), and although frustrated at the patient's behaviour, he attempted to analyse why the patient may not want to leave as either the 'patient saying I'm not ready to go or are they playing the system' (Will 22:05:12). Mia, on the other hand, appeared to critically analyse, first, the lack of social skill education on the day ward and then the lack of consistency between staff on the recovery ward. On both of these placements she had been accompanied by Will who tended to reflect on his own interpersonal practice with patients without the perspective of contextual influences in his placements. Although Mia was not inclined to speak much in these discussions, which may have been due to shyness, she felt comfortable enough to challenge what Will said. Where Will spoke about specific patients and how he has been involved in their care which identifies how he is learning from experiential knowledge, Mia never offered examples of patients she worked with to illustrate her arguments, despite being encouraged to by the lecturer, which might to have been due to her concerns regarding confidentiality or a result of her shyness. Marion, on the other hand, when discussing her own feelings of frustration at a patient's behaviour, and disappointment with herself for not questioning practice, appeared to see the bigger picture, but ends by sharing her mentor's viewpoint about the patient, this was illustrated within the clinical supervision session:

> I went out with my mentor to see somebody at home. She was just lying in bed, motionless, did not speak to us, I felt sorry for her. The housing officer who was dealing with her wanted us to go round because of arguments with neighbours, her house is a complete tip,

> can't see the carpet, it's disgusting. I think she's got a personality disorder. (Marion, 22:05:12).
>
> Why do you think she's got a personality disorder? (Clinical Supervisor, 22:05:12).
>
> Very challenging behaviour. Basically they wanted her out because they are getting complaints from the neighbourhood. The nurse I went with, she was really good but very big on being assertive, and she said the housing officer just wanted her in hospital, he was just using us as a scapegoat. Afterwards I thought was that without being horrible about her was it more about her wanting to put him in his place than protecting the client? I could see it from both points of view, but when I thought about it afterwards, I should have questioned it and I was a bit bothered about my own practice as well as theirs I was a bit bothered that I hadn't sort of questioned it more. I met her (the patient) again recently, the police had taken her to the crisis house and the crisis team did not want her there 'she doesn't belong in there and we're just reinforcing the behaviour'. So we went to take her home, she were quite pleasant in the car, when we got her back we dropped her off and she started effing and blinding, she was shouting, she was really verbally aggressive and claimed she had lost her keys. She was very, very challenging, she wasn't physically violent but she was very aggressive, swearing constantly like it was our fault. I felt that she was manipulating us to try and get her own way. I can completely see what they were talking about. (Marion, 22:05:12).

This quotation demonstrates some of the complexities and issues within mental health nursing. The housing officer was responding to the patient's neighbours who had complained about her argumentative behaviour and he wanted the nurse to admit her to hospital to resolve this situation. This behaviour could be seen as evidence of a social restrictiveness attitude in both neighbours and the housing officer (Taylor et al, 1981) due to concerns for their personal safety or signs of the stigma of people with mental illness face. The nurse felt she was being pressurised by the housing officer to remove the patient from her home and resisted this either from a stance of 'putting him in his place' or employing the principles of recovery as guided by current government policy (DH 2006: DH 2011).

Marion, as an observer, felt it was a battle of wills between the housing officer and her mentor, which did not consider the patient. None of these dehumanisation attitudes (whether on the part of neighbours, housing office, mentor or Marion) took into account the patient's perspective of being a person in need of help (Todres et al 2009). Additionally, it exemplifies how practical

and experiential knowledge influences propositional knowledge (Burnard 1987), because it had only been four months prior to Marion recounting this experience that she had been introduced to the concept of personal recovery and she had tried to explain to Carol that ‘a lot of people are frightened of change, A step forward is a massive leap into the unknown’ (Marion, 20:01:12). Despite reflection and ‘being bothered’ about her own practice, her initial ‘sorry for’ benevolent attitude returned to diagnostic labelling the patient as a ‘personality disorder’. This authoritarian attitude was after encountering abuse from the patient first-hand and resulted in her ‘completely seeing’ what her mentor and some members of the crisis team had ‘seen’. So it appeared that, even with a student who has experienced mental health problems herself, propositional knowledge is hard to hold on to in the face of the realities of practice.

However, Marion experience does not reflect all of the students so now I will explore the students’ accounts of nurses who promoted working in partnership nurse/patient relationships. Josie had found her placement within another crisis team inspiring. She felt she could ask questions and the team were ‘crystal clear and there is no qualms or questions that they will try to avoid’ (22:05:12). The team were experiencing ongoing service reconfiguration, which could have been unsettling for patients and staff, because staff had been moved from different areas, so that different nurses may have been involved in their care.

> The manager was brilliant, she didn’t transfer anybody until their case load had been discharged, which meant there was a couple of staff travelling long distances to different areas, but in her opinion, that’s what was best for the individuals that they’d been seeing, which reduced the amount of distress that could be caused. (Josie, 22:05:12).

She thought the team consistently took the patients’ wishes into consideration and gave the example of visiting a patient at her home with a male nurse, after the patient’s mood had become elated.

> When we got there, unfortunately she presented with psychotic features and she doesn’t like men so I went into the house and he stayed outside, which actually made me feel brilliant as if I was part of that team. But home treatment wasn’t really an option. She reached the point where it was unmanageable within the community setting. When the doctors and social worker arrived, she refused to go. So I said ‘You are going in, I will see that you walk in of your own freewill, then you don’t have the stress and trauma of being

> sectioned' and it worked, she went in informally. So it just goes to show that sometimes it is about the connection you make with people. (Josie, 22:05:12).

Within this account Josie continues to display an 'I know best' benevolent, underpinned by the biomedical model attitude which she appeared to hone during her former healthcare experience. She was moved by the inspirational 'what was best for the individuals' manager who seemed to be working with a recovery attitude. However, in Josie's account of the woman who exhibited psychotic features she (Josie) was still taking charge of the situation, although this could be said to be in the patient's best interest and was rewarded by the staff's appreciation. So it appeared that she continued to practice with a benevolent attitude. Although Josie acknowledged that the manager had ensured that nurse/patient relationships were not severed by the reconfiguration, in her own practice she was still the most powerful person in her relationships with patients. However, she felt her interpersonal skills had improved and attributed this improvement to her nurse education:

> I had another lady who wouldn't even have me in the house. As far as she was concerned I treated her like a child and I was patronizing. I think I got a lot of that is from the School of Nursing, especially with communication, you look at what you do, you think about what you're doing, and you change the manner in which you normally act, you adapted to the situation. So there's times to be quite open and honest and there's other times to be a listener, and that's what I'm mindful of. (Josie, 22:05:12).

So the propositional knowledge on recovery, experiential knowledge of an inspiring manager who appeared to advocate for recovery focused nurse/patient relationship, did not seem to have shifted Josie's practical knowledge. She no longer used diagnostic labelling within her language but referred to symptoms 'psychotic features' (22:05:12), and she appeared to have reflected on her previous experiential knowledge encounters illustrated by the woman who found her 'patronizing' so used the propositional knowledge gained at the university to improve the way she communicated with patients. It can be suggested that Josie became aware of how condescending she came across from her previous interactions with patients, so changed the way she interacted to the differing situations. There appeared to be realisation on Josie's part of her previous disempowering benevolent attitude and the need to improve her interpersonal skills, but she still gave the impression, through her accounts, that she was in charge of patients' future lives.

Will, on the other hand, seemed to embrace the recovery attitude after meeting an inspiring nurse in his 'recovery' ward placement who reflected the propositional knowledge taught in the University. The nurse embodied practical knowledge by emphasising personal recovery to include the patients in all decision-making and, despite setbacks, remained positive about their achieving a meaningful life.

> It's nice to see there are some nurses who have still got the passion, drive and empathy even being in the job for 30 odd years. It's really positive to see that there are people still passionate about the job. (Will, 22:05:12).

He also commented that the content of the Recovery module had had an effect on his practice.

> Before this module, my opinion of recovery, for example, if you've got a broken leg within 6 weeks you're going to recover from it so that was my interpretation of it, probably a bit naïve in that respect. Yeah, but it's only through doing the research into the assignment and looking at other people's views on recovery that I think recovery is very personal and individualized. But some patients think 'there's nothing wrong with me', they've not got insight, so it's harder for them to understand what you're trying to say. (Will, 22:05:12).

Will's comments acknowledged his previous authoritarian attitude and appeared to demonstrate movement towards a recovery one, but this was still dependant on the patient's 'insight'. What is also evident in both Josie and Will accounts was the encounter with the inspirational role-model, who fostered recovery orientation 'formal socialisation' values, enabling them to link the propositional knowledge gained during their time in university to their practice (Shuval, 1980; Burnard, 1987).

This second-year module was underpinned by the principles of recovery and the students were assessed by a written care study of using recovery in their work with a patient during a placement. All of the students explored the opposing definitions of recovery from the medical (symptom elimination and cure) and personal model (focusing on the patients' strengths and capabilities). Although they used the DSMIV (1994) diagnostic categories to explain the patients' mental health issues, which could be seen as dehumanising language, this was an assessed academic assignment, which required appropriate referencing. So while this might seem like a dilemma for the students because the module was focused on recovery and they were expected to describe the patient's problems, they also had to be aware of different theories

of mental illness. All of the assignments (except Mia's) offered a sense of the person they were working, many through the patient's direct quotes. Not sensing the person Mia was working with may have been due to her academic style of writing, because when she reflected back on this experience she felt she had developed her interpersonal skills to form a nurse/patient relationship, underpinned by the theories of Egan (1998) and Rogers (2003). She spoke of encouraging her patient to discuss her thoughts and feelings to enable her care to become more personalised. The use of the same theorises were employed by Will and Marion who also felt they had advanced their communication skills. Gemma felt she had learnt effective communication skills, although she did not offer communication theories to support this, to apply recovery-focused care 'which I intend to use in my future nursing career' (Gemma, 23:11:12). Carol, on the other hand, stated that the recovery principles researched during the module had illustrated that 'no two patients are the same' (Carol, 23:11:12). Similarly, Josie felt the module and assignment had 'increased my knowledge about this concept, I feel it can result in offering patients life changing options to manage their illness' (Josie, 23:11:12). However, as discussed in Chapter Four, the assignments did not allow in-depth data for analysis, although the assignments demonstrated that the students had researched the different meanings of recovery. Josie's assignment for example, did not imply the devastating effect meeting this patient had on her view of the role of a mental health nurse and her attitude towards patients. This reaction and the consequences of this meeting will be discussed in Chapter Six but in brief it shattered her belief in who she was, her behaviours towards patients and her own mortality.

Knowledge, skills and experiences gained during the second year

During the second year of their nurse education the students' discussions centred on the 'stigma' of having a mental health problem, and how 'role models' in practice had a positive or negative influential on their views about patients. These themes within the students' verbalisations will now be explored through Burnard's (1987) three-fold typology of nursing knowledge.

Josie's initial comment of the collective 'schizophrenics' (Recovery session, 20:01:12) and Marion's attributing a patient's 'challenging behaviour' to the diagnosis of 'personality disorder' (Clinical Supervision, 22:05:12) indicates that at the beginning of the second year both viewed mental illness as a medical dysfunction of the brain. Anecdotally, this mirrors the views of the former mental health students at the end of the first year, because they complain

about the adult nursing focus of the Common Foundation Programme so it could be suggested that the content of the propositional knowledge promoted a biomedical orientation to care. This authoritarian attitude, besides viewing patients in collective diagnostic groups (homogenisation), emphases that patients must follow instruction and adhere to their care plans (passivity) (Todres et al, 2009). The propositional perspective taught during the second year illustrated the contemporary ideology of person-centred, recovery-focused care for people experiencing mental health problems. Both Josie and Will identified the propositional knowledge gained during the recovery module as underpinning their practice: Will found researching recovery from different perspectives encouraged person-centred care, while Josie found communication skills sessions had helped her adapt her interactions to meet the needs of the patient. Additionally, both Will and Josie had witnessed nurses who practised in this recovery way which appeared to support the propositional knowledge taught in their second-year of study. Although the other students did not verbalise the knowledge and skills gained in the university in their classroom discussions, all of them acknowledged propositional knowledge as having an impact on the practice within their assignments and this will now be discussed.

The practical knowledge of developing effective interpersonal skills underpinned by the propositional theories of Egan (1998) and Rogers (2003) was noted by four of the students (Mia, Will, Marion and Gemma) in their written assignment. They identified that their practical knowledge was underpinned by propositional knowledge which offered them an understanding of the reason for their interventions and strengthened their relationships with patients (Burnard, 1987). Additionally, Josie gave an example of her developing communications skills, during clinical supervision (22:05:12), when she spoke of her successful interaction with a patient who required hospitalisation. She compared this to an earlier incident when a patient refused her access to her home citing she spoke to her in a patronising manner and ‘treated her like a child’. The former example respects the patient’s ability to make choices and the freedom to act (agency) while the latter placed the patient in a disempowered, submissive position (passivity) (Todres et al, 2009). Although this was to protect the dignity of the patient Josie was still taking charge of the situation.

This view of patients as passive recipients of care was also implied by Will and Marion complained that patients obstructed their planned care (Clinical Supervision, 22:05:12). This appeared to reflect the attitudes of some of the staff they were in practice with, who were

frustrated by the non-compliance of some patients to the plans of care. Traditionally students tend to value highly the views of established clinicians, so they might have adopted a superficial understanding of recovery and mimicked the practice they observe. However, both Will and Marion did not accept these views uncritically and had started to consider alternatives: in Will's case he considered possible reasons why the patient had stated he was hearing voices telling him to kill himself when discharge had been mentioned; while Marion reflected on the differing motives of her mentor and the housing officer when assessing the patient following neighbours' complaints. Conversely, not all nurses were dehumanising role models, as both Josie and Will testify; each one enthused about a nurse they had worked with who practiced in a humanising, recovery orientated manner. In Josie's case it was the crisis team's manager who ensured patient's care was consistent by assigning one nurse to support them up to the point of their discharge while the service was undergoing reconfiguration. Will spoke in glowing terms about a Recovery in-patient nurse whose 'passion, drive and empathy' (Will, 22:05:12) to promote recovery-focused care had not diminished despite a 30 year career in mental health nursing. By the end of the second year both of these students spoke about the propositional knowledge gained in the University as altering their practice so it can be surmised that witnessing the inspiring role models advancing practical knowledge of recovery orientated care upheld the ethos of recovery taught during this year long module.

Another element noted in the data gathered during this module was that the frustration described by some students appeared to reflect their level of involvement with the patients. When students were observing the nurses, and therefore in the role of spectators of care, some tended to uncritically accept the views expressed by the nurses. This was evident in Carol's account of the patient who refused all treatment, except medication, which he took as overdoses. She agreed with the nurse's expression of irritation by saying 'we just had to say we can't stop someone if they want to kill themselves' (Carol, Recovery session, 12:01:12). The experiential knowledge gained through personal encounters with patients was apparent in the students' written assignments. Each student wrote about their experience of coordinating the care of a patient in their care study, including how they amended care according to the patients' needs, strengths and capabilities. These essays reflected the 'insiderness', 'uniqueness' and 'agency' of the recovery approach (Todres et al, 2009). It could be suggested that as this was an academic assignment in which the students had to demonstrate that they used the principles of recovery to underpin their practice so they were able to instrumentally articulate a list of principles without changing their beliefs and attitudes about people with

mental health problems. All of the students offered comments during classroom discussions indicating benevolent, authoritarian, social restrictiveness and recovery attitudes which appeared to be due to the mixed messages they were receiving from the propositional, practical and experiential knowledge within their experience on the course (Burnard, 1987). This phenomenon will now be explored further as students discussed their views during their last year on the course.

Year three experiences

The 'Group Work Facilitation' session was the last classroom discussion capturing set prior to the students retaking the AMIQ. The aim of this session was for the students to gain the theoretical knowledge of group development, different leadership styles and the skills needed to facilitate effective group therapy in practice and consider the managerial roles that registered nurses are expected to carry out. Following the theoretical component of this session, each student facilitated a group discussion with their peers, with pre-planned questions for debate. The questions elicited that they were still struggling to make their minds up about the causes of mental illness and their view of what recovery meant and they described how their attitudes had been influenced during the course. First I will explore their discussion to the question asking them what caused mental illness.

Mental illness – nature or nurture?

When asked what caused mental illness, four of the students stated that people can be born with a trait for developing mental illness but this may be triggered by life events, this view was illustrated by a number of comments in the following exert from one of the discussions:

> I think people can be born with the trait of schizophrenia, but then they go through a life change or something horrific in their life that would bring it forward or they might never experience or take drugs or anything like that so same trait, different reactions. (Gemma, 15:01:13).
>
> You can't get away from something you might be born with (Marion, 15:01:13).
> What like in your genes? (Mia as discussion facilitator 15:01:13).
> Yes, and there is childhood and growing up problems that might link to depression. That's what the stress vulnerability model is based on, people can cope with maybe losing their

> job or something but you get two to three things happening at once and that's when things start to get unpleasant. (Marion, 15:01:13).

> Its multi-factorial, triggered off during your life, up-bringing, childhood experiences, genetics could play a part of it. But I think everyone maybe prone to having a mental health issue, anxiety, stress, depression. Speaking for myself, I've had anxiety and felt stressed out, just need that little trigger. It's a 50/50 thing really, if you have people in your family, you may be more prone to sort of depression. (Will, 15:01:13).

Carol was more forthright and appeared to differentiate between categorises of diagnosis by stating 'Some mental illnesses are biological, others were stress-related' (15:01:13). Josie, on the other hand, seemed to be struggling to understand the causes of mental illness:

> Well there are some elements of mental health problems and I can never work out, I can never get it right whether it's biological or induced. I think it's fair to say that it's more than one contributing factor. It's very rare that there is just one thing, it's usually a multitude of circumstances that pull together which usually brings on an episode, due to outside stresses that become too much to cope with. (Josie, 15:01:13).

Although more tentatively Josie was in agreement with the other students, except Carol, believing had that mental illness was caused by a combination of biological and stressful life events inferring either a benevolent or recovery attitude. Their comments identify that they have shifted from a purely medical reason for mental health problems, which was apparent at the end of their first year of nurse education, to considering alternative explanations. This change appeared to be advanced by propositional knowledge as noted by Marion comment about the 'stress vulnerability model' and also by the student's own experience of mental distress as can be seem in Will's admission that 'I've had anxiety and felt stressed out' (15:01:13). Only Carol was explicit in that she thought different causes for mental illness were dependant on diagnosis, but her peers appeared to express similar beliefs when asked whether people with mental health problems can recover. However, most emphasised that recovery was personal and unique to the person involved.

> A lot of people with anxiety or depression the person can recover using coping strategies, meds, exercise etc. but something like schizophrenia or bi-polar it's something not working quite right in the brain, it's manageable but do people fully recover? A patient

> who still hears voices all the time, he does things that he didn't think he could do, so if that's what he thinks is recovery, it's their meaning of recovery. It's individual. (Marion, 15:01:13).

> There are different paths of recovery, different stages. You can recover from depression or bereavement more than schizophrenia because it's always going to be there. (Gemma, 15:01:13).

> It's like diabetes, not everyone recovers from a physical illness, do they? It's manageable, but you are not cured. (Mia, 15:01:13).

> I think, if you had an acute psychosis and it disappeared then maybe yeah, but if you are hearing voices for the rest of your life, I didn't think you would be fully recovered. But recovery is individual, it's how the person defines what recovery means to them, very individual. In the Recovery team, they didn't say we are going to get you back on the road, they asked the patient what recovery meant to them. (Will, 15:01:13).

The inconsistency of first, grouping different mental diagnosis into either recovery-achievable or recovery-not achievable categories, and then, stating recovery is what the person with mental illness decides it is, indicates the students were still unsure whether recovery is possible for all people. Their responses also reflected in the diverse viewpoints of Gourney (1995) and Barker (1997) on the causes of mental illness and the supremacy of either the biomedical model or recovery orientated approaches to treatment and care, resulting in differing opinions on the role of the nurse in nurse/patient relationships as discussed in Chapter One. What was apparent was that the pre-planned questions in the Group Work Facilitation session got the students to think aloud and question their own and others beliefs and attitudes. From my own past experience of delivering this session, former students stated that they were unaware, until the final year in their education, of the diverse views held by themselves and their peers and how these can effect approaches to care. Many have reported this triggered self-reflection, self-awareness and changes to their opinions. Challenges to different opinions was evident when Carol responded to Will's assertion that the patient was the expert in their own definition of recovery:

> Yeah, in placements, we've seen the worst case scenarios and they are not at their final stage of their recovery, they are at the start, middle or relapsing. So yes, I think with any

> mental health situation: depression, schizophrenia, anything like that, even if you're not back to how you were ten years ago, you can be recovered. (Carol, 15:01:13).

So some of the students continued to use diagnostic labelling when discussing different mental health problems and remained dubious about the extent that people with serious mental health problems could recover. But all of the students, except Gemma, endorsed the principles of recovery and saw patients as unique individuals when discussing establishing the therapeutic relationship. They all believed that having time to develop these relationships was paramount, that the nurse needed to adapt their approach with each patient (Mia and Will) and needed to find some common ground (Josie, Carol and Marion). Patients were seen as distinct individuals (uniqueness), with their own interpretation of recovery (insiderness) and their abilities to make choices and their freedom to act were respected (agency) (Todres et al, 2009). However, Gemma identified patients' behaviours as detrimental to forming effective relationships and promoting recovery:

> Yeah it depends who you are working with, some patients are very head strong and want to take control of their care and some who don't want to do anything, they need you to push them. (Gemma, 15:01:13).

This criticism of 'head strong/needy' patient behaviour contradicts each other: the former appears to want patients to passively accept care decisions while the latter wants patients to be active partners in care choices. The disparity within her comment where both 'agency' and/or 'passivity' are seen as troublesome/destructive for effective relationships with patients demonstrated Gemma was unaware of this contradiction (Todres et al, 2009). As the patient's attitude and/or behaviour is to blame, Gemma can relinquish any responsibility or reproach for failing to develop therapeutic relationships. It is difficult to ascertain why she did not view the onus for developing and maintaining therapeutic relationships with patients as the remit of mental health nurses. As she was absent, due to ill health, on two of the occasions during the second year when data was collected the only reference to her attitude was via her assignment. In this she wrote about how she had applied recovery-focused principles to underpin a patient's care and that she intended to use these principles 'in my future nursing career', but her 'head strong/needy' comment does not support this. It could be suggested that during her 'formal socialisation' she has encountered negative blaming professional values which did not confirm the propositional knowledge underpinning her mental health nurse education (Shuval, 1980; Burnard, 1987). However, along with all her peers, she was critical of some staff's disparaging

comments about patients. Such views are not uncommon with practice staff and are explored in the following section.

Encountering judgemental staff

All of the students stated that they were surprised and, at times, shocked that staff within mental health care described patients in a derogatory fashion. This mainly occurred during handovers, at the start and finish of shifts when all the patients and their care is discussed. The students described these comments as: 'detrimental and rude' (Gemma, 15:01:13), 'slagging patients off' (Carol, 15:01:13), 'judgemental' (Mia, 15:01:13) and examples of the terminology used included 'a revolving door patient' (Marion, 15:01:13) and 'totally lost the plot' (Josie, 15:01:13). In addition to this, Marion, identified that she had 'accessed services myself and seeing it from both sides' (Marion, 15:01:13). Gemma and Carol felt that they had lost respect for the staff who engaged in this behaviour. All the students thought this judgemental language was used as a release of emotions from a stressful job, and Marion acknowledged that 'it made me see that mental health nurses are human, they get frustrated and need to get things off their chests (Marion, 15:01:13) '. Will who had been facilitating this group discussion, summarised his peers' views, stressing the humanness of nurses, but also identified how this can be put to positive effect.

> From what we are saying there seems to be a common theme, so nurses are professionals on one hand, but behind closed doors it seems to be a different story. I have seen that first hand, the role of the nurse should be seen as professional, uphold the integrity of nursing and NMC (Nursing and Midwifery Council), but I do think that behind closed doors you need to vent, get things off your chest. I witnessed people saying stuff like that, its frustration. But it's a very serious job, you are dealing with people's lives, they are telling you really heart-breaking things. We are human, it's hard to go home and switch off. It's a release, it can be a positive thing, you are getting it off your chest in a supportive way; you have other staff to bounce it off. In my last placement the team was really good and it was done in a really positive way, if you are sharing as a team, you might be sharing things that may be missed (Will, 15:01:13).

Both Marion and Carol were shocked by the judgement comments they had heard and attempted to make their own minds up about patients:

> I actually found out on my last placement, after I got to know this person that they'd

> stabbed somebody in the neck and when they told me I said 'No, she can't have done, that person would not dream of doing that'. I could never understand when people said 'the voices are telling me to do it', I wouldn't say I was judging it but I never understood it. But now that I've sort of heard that and seen that person, I don't think there is any way she would do that while she was well. So yeah think, it's given me a bit more of an understanding of things. (Marion, 15:01:13).

> I'd heard this term called personality disorder when in the community and thought it was what a doctor gave when he didn't know what else to diagnose. But since being on an acute ward I found them [patients with the diagnosis of personality disorder] so hard to work with. They are manipulative. I was on the ward and after speaking to a patient, she repeated our conversation to the staff, but not in the way I said it. The staff weren't happy with me. It has changed my views on patients 'cause I didn't think this problem existed, but it clearly does. So I wasn't very happy about my next placement which is in-patient setting for people with personality disorder but after talking to the lecturers and watching a video on the Trust website I'm quite looking forward to it. I will come cross it, so I need to man up and understand it (Carol, 15:01:13).

These accounts demonstrate the power of experiential knowledge through interactions with patients, but rather than simple agreeing with the placement staff views both students reflected on the patient's behaviour during the group discussion. In Marion's case she found it difficult to comprehend that the patient she knew could be seen as dangerous and it offered her insight into hallucinations and how these can effect a person's behaviour. While Carol, who initially did not believe in the diagnosis of personality disorder, now believed that people with this diagnosis were manipulative and difficult to work with. Although she acknowledges that her view of patients with this diagnosis has changed and she could have adopted a stigmatizing attitude, she researched the condition to ensure she understood how this can manifest in patients' behaviour.

Similar to Carol, Marion also had concerns regarding her next placement and she openly admitted she initially had a judgemental attitude towards this patient group. Whereas Carol was proactive in researching for her next placement, Marion had already had a change in attitude but this was through her previous experiential knowledge:

> I must admit my biggest concern before I even started the course was getting a placement

> in drugs and alcohol. I was bothered because my Dad's an alcoholic so I'd kind of lived with it. Even on nights out, drunk people get on my nerves and I don't want to have to deal with it. My next placement is drug and alcohol, I'm kinda of looking forward to it now because when I was on a general placement, I did meet somebody who has an alcohol problem. At first she was detoxing she thought she was at home. She was trying to leave the ward, so I tried to distract her and keep her where she was and all I focused on was, I just need to keep her there. I wasn't thinking any sort judgmental horrible thoughts about her. I just thought I need to do this, just focus. She was in for a few days, there was some problem at home, and when she was herself she was really pleasant, I got on really well with her and I think it's allowed me to see past that and to be more understanding towards people (Marion, 15:01:13).

Despite acknowledging judgemental attitudes towards patients by using their collective diagnostic label, such as 'alcoholic' which can indicate a dehumanising authoritarian attitude, Marion revised her view through her experiential knowledge of interacting with a patient. Carol, on the other hand, had been proactive by researching her next placement and using propositional knowledge to gain an understanding of the patients she would meet there. Each of these approaches and experiences are explored further in the following section.

Knowledge, skills and experience gained during the third year

Although none of the students explicitly mentioned propositional knowledge (Burnard, 1987) during the last group session they identified changes in their attitudes about people with mental health problems, and recognised bio-psychosocial reasons for the cause of mental illness, they all emphasised the principles of recovery in their discussions which were underpinned by the theoretical component of their second-year of nurse education. References to practical knowledge tended to centre on the skills of developing and maintaining therapeutic relationships with patients reflecting the humanising values of uniqueness, insiderness and agency. However, Gemma later contradicted herself by stating that some patients are 'head strong and want to take control of their care' (15:01:13) as if this were a bad thing, which may reflect the judgemental comments expressed by some of the nurses she had worked with. The other five students had also encountered judgemental staff and though shocked by this, most felt this was used as a 'release' from the stresses of mental health nursing. Carol's experiential knowledge of talking to a patient, who later misconstrued this conversation when relaying it back to other staff, appeared to confirm the judgemental comments she had heard about people

with a diagnosis of personality disorder as 'manipulative'. However, instead of adopting a judgemental stance, she decided to undertake research prior to a placement of a ward for people with this diagnosis to aid her understanding. While Marion described an encounter with a patient who was detoxing from alcohol helped her to confront and move away her own judgemental attitude which again highlighted the effects of experiential knowledge.

Although many of the students contradicted themselves during this last classroom discussion, the pre-planned questions as a pedagogical strategy encouraged them to consider the different viewpoints and experiences of their peers. Additionally, it might have triggered self-reflection, self-awareness and a change in their opinions. By being given the opportunity to reflect and discuss as a group what they had gained through propositional, practical and experiential knowledges over their three year course may explain why all of the students changed their initial benevolent attitude when they retook the AMIQ for the second time in May 2013. Carol, Marion, Will and Mia changed their attitude to a recovery one while there was movement by Gemma and Josie towards this attitude (Taylor et al, 1981).

Conclusion

In this chapter I give a chronological account of the two AMIQs, audio-recorded classroom discussions, a written assignment of a cohort of six students during their first thirty-months of studying mental health nursing. My aim was to investigate the students' attitudes to patients with mental health problems with reference to Burnard's (1987) typology of nursing knowledge. Using the AMIQ (2010) I identified a change in each students' attitude: on the first occasion, all the students had a benevolent patronising attitude, which is kindly and sympathetic but sees the patient as stuck in their diagnostic label, incapable of making decisions or comprehend relationships between concepts (Taylor et al, 1981; Todres et al, 2009). When the students retook the AMIQ in their third year Carol, Marion, Will and Mia had a more recovery focussed attitude, while both, Gemma and Josie had an equal split between this attitude and a benevolent one.

I explained these changes by drawing on an analysis of student' discussions through the course. Propositional, practical and experiential knowledge (Burnard, 1987) all appeared to influence these attitudes in different ways and at different times in the course. By the end of the first year, the students had received propositional knowledge about the biomedical model of mental illness. They also gained practical and experiential knowledge within mental health care

settings. At this point they all used diagnostic terminology and spoke of patients collectively as ‘cases’ reflecting an authoritarian attitude or had their initial benevolent attitude reinforced by viewing mental health problems similar to physical illnesses (Taylor et al, 1981). However, when propositional knowledge was field specific and underpinned by recovery principles during the second and third year, most of the students appeared to struggle with changing attitudes, which was evident in their contradictory statements; about the meaning of recovery, their construction of patients, and, the role of the mental health nurse/patient relationship. Slowly, viewing their practical knowledge through the recovery focus lens, the students were able to identify what they saw as inspirational or judgmental practice. However, all the students, except Mia, acknowledged the humanising experiential knowledge they had gained from working with patients. But unfortunately, while the data in this chapter offered insights into the students’ thinking and views during the first thirty-months of their education, it does not identify specifically why their attitude changed. As noted in the last classroom discussion they still struggled with the concept of recovery but four months later, when analysed by their AMIQ responses, four students (Carol, Will, Marion, Mia) all recorded a recovery attitude and Josie and Gemma has moved significantly to this attitude.

So in Chapter Six data from each student’s individual interview and the pictorial representation of their journey during their nurse education will be explored through the theoretical lens of Mezirow’s (2009) transformative learning to identify whether a disorientating dilemma caused this shift in attitude. Additionally, it focuses on some of the unanswered questions within this chapter such as why Josie and Gemma did not change their attitudes as dramatically as their peers’ and why Mia did not offer personal descriptions of her experiential knowledge of working with patients.

Chapter Six: How Transformative Learning Changed Attitudes towards Patients

Introduction

The purpose of the chapter is to advance this argument of the thesis that the pre-registration mental health programme studied in the university had the ability to produce nurses who value and respect the diversity of individuals with mental health problems to enable their recovery. It does this by building on the last Chapter which identified that different propositional knowledge either confirmed or refuted the students' attitudes and interpretations of practical and experiential knowledge. While the last chapter focused on acquisition of knowledges and the evidence of attitude change, I have not yet considered whether the students have experienced transformative learning.

In the data from observations discussed in the last chapter none of the students identified a disorientating dilemma which is the first phase of Mezirow's (2000) transformative learning so this chapter will examine whether they said they experienced one and, if they did, whether it led to change to their frame of reference and a shift towards the recovery attitude. So this chapter focuses on the students' experiences of transforming attitudes from their own perspective. It explores whether the students' acknowledged changes and, if so, what they themselves attribute this to. The data gathered in the students' individual interviews during the third year (October 2013) and their pictorial representations (December 2013) are used to investigate their perceptions of and reasons for any frames of reference changes. To examine whether the perceived reasons can be said to be transformative, I have analysed the data in terms of Mezirow's (2009) three phases: alienation, reframing and consolidation, which will structure the Chapter.

First I discuss three interlinking circumstances (linking theory to practice, stressful experiences and identifying similarities with a patient) which led to alienation by producing disorienting dilemmas for five of the students. Secondly, I examine the elements (feeling safe and being challenged) which helped the students to re-frame the frames of reference. Thirdly, I identify consolidation of this new frame of reference by using students' comments about how their practice had changed. Finally, I conclude that five students realised that given the right circumstances or life events they too could experience mental health problems, so they were able to empathise with patients and this empathy lead to them wanting to practice in a recovery principled way. However, transferring this re-framing into practice took a considerable time:

in the last six months of their education students began to incorporate the recovery values into their practice.

The students' experiences of 'alienation'

Mezirow (2000) states that transformative learning tends to be triggered by one disorientating dilemma when a situation, experience or opinion does not resonate with the person's own habits of mind and points of view. In my study only one student described a moment when she experienced such a dramatic dilemma. However, Mezirow (2000) did concede that for some people small, strengthening augmentation triggers can occur and, in the case of four students, this incremental effect of small triggers appeared to change their frames of reference. One student of the six did not report such a trigger.

As noted in Chapter Five, the students entered their nurse education with benevolent frames of reference and this was upheld by the theoretical component of the shared Common Foundation Programme (CFP), which was underpinned by the medical model of illness and disease. But by the thirty-months, and in Josie's case thirty-four-months, into their three-year nurse education five students had changed their frames of reference to the recovery one of working in partnership with patients and the sixth student was moving towards the recovery frame of reference. Again in Chapter Five, their change in frame of reference was attributed to a combination of Burnard's (1987) typology of nursing knowledges.

Each student received the same recovery-principled propositional knowledge in the University at the same time and their placements within in-patients and community settings offered similar practical and experiential knowledges, so I need now to explore why there is an inconsistency between the students' movement towards a recovery frame of reference. Additionally, as Mezirow (2000) states, transformative learning depends on the person acknowledging that previous habits of mind (assumptions) and points of view (expectations) have been altered, so I also need to explore whether the students recognised that they had changed their frames of reference towards people with mental illness and how this influenced their view of the role of the mental health nurse. Drawing on the students' comments in their interviews and discussion of their education journey pictorial representation three interlinking themes emerged that triggered a disorientating dilemma and resulting change or shift of frame of reference: linking the theory they were taught in university to their practice experiences; suffering a stressful experience; and, meeting a patient in whom they found some similarity to themselves, these themes will now be discussed.

Linking theory to practice

During the first year of the students' education, the students' description of patients reflected their benevolent frame of reference. For example, Josie described the patients on the older adult ward as 'naughty' and 'mischievous', while Carol, Will and Mia referred to patients as 'cases'. When, in their second year, propositional knowledge was underpinned by the concept of personal recovery, the students appeared to struggle to incorporate into their habits of mind (assumptions) and points of view (expectations) the notion that people with mental illness have strengths and aspirations when they were discussing events in placement and interpreting patients and nursing roles. Recounting their experiential knowledge acquisition from practice all the students expressed inconsistent viewpoints. For example, stating recovery was individual and the patient's own interpretation and then appearing to criticise patients who either took the initiative in creating their own plans of care or refused to adhere to those made by staff. An example of these habits of mind was Gemma's contradictory description of some patients as 'very head strong and want to take control of their care and some who don't want to do anything, they need you to push them' (15:01:13). Also, despite expressing their disapproval of the attitudes of staff they met and praising staff who reflect the ethos of recovery, only Mia (who was quiet in group discussions) did not continue to diagnostically label patients and criticise them for not adhering to their treatment plans.

At the point when these comments were made the students had studied recovery-focused mental health nurse education for between four months and a year but their benevolent frames of reference persisted. These in-grained frames of references were supported by the Common Foundation Programme theoretical component of the medical model cause-effect relationships for illness and disease, whereby mental illness was conveyed as a dysfunction of the brain with patients expected to follow passively medical advice and treatment. So it could be suggested that it would be unrealistic to presume the students would change their frames of reference simply by providing recovery principled propositional knowledge and working alongside some nurses who practiced in this way. The effect of theory on practice is evident in Will's comment:

> Seeing people with an actual illness like bi-polar, there was one woman that I'll always remember, I've got this image of her and how her symptoms were and that's how I learn, visual. Obviously doing the theory side of things it just enhances it. If I've been on placement something comes up, I relate back to the theory (Will, 22:10:13)

So it appeared that the propositional knowledge supported their benevolent frames of reference, which in turn, was the lens they viewed practical and experimental knowledges. However, the propositional knowledge expanded in the second year to include the principles of recovery but this did not have an instant impact until some of the students experienced their own mental health problems, which appeared to align recovery with their experiential knowledge. So in the next section I will explore how five of the students experienced stressful situations, which appeared to make them realise that given the right circumstances or life events, they too could undergo mental health problems and this appeared to be a catalyst for shift in their habits of mind.

A stressful experience promotes understanding of mental illness

As identified in their individual interviews and depicted in their pictorial representations, in the last six months of the second year and early in their third year. The five students experienced negative life events which could be described as stress-related incidents. While, Mezirow (1978) acknowledged that transformative learning can occur when something different happens, which is often a personal crisis, can cause a disorientating dilemma, the stressors on the learner of undertaking an academic programme does not appear to be accounted for in Mezirow's explanation. However, in my own experience, as a lecturer and personal tutor, many, if not all, students experience stress, anxiety and, some, depression, during their education, with students complaining about the intense workload of studying while having to attend 3200 hours over three years of assessed practice. Several students have complained that university teaching is not always reflected in the clinical practice they observe. Additionally, most students have to support themselves, and their families, so often work part-time to facilitate this. Evans and Kelly's (2004) study of student nurses found that students nurses experienced stress and this involved two mains stressors during their education were academic and clinical. Academic stressors involved the amount of self-directed learning, intensity of the workload, lack of academic support with assignments and consequences of failing assignments, while clinical stressors referred to disparity between educational emphasis and the reality of clinical practice. The students, except Mia, appeared to experience academic stressors and with Carol, Gemma and Josie this involved failing an assignment on the first submission, thus jeopardising their goal of becoming a mental health nurse. While they could have re-submitted a revised assignment, all three decided to drop from the degree pathway to the diploma one.

In Carol's case, it was deeply regretted:

> I've dropped down from degree which I'm disappointed that I did and I did it on a bit of a spur of the moment thing after failing an assignment. I should have spoken to [Personal Tutor's name] about it but I didn't and that's my mistake. With the support, because I didn't realise, in the second year with all the changes going, I thought I won't get the support anyway but then seeing how [names of two lecturers] are with the support, like helping us, I probably could have done it but, it has taught me to calm down a little bit and not think I can't do it. Sod it. But I wish I hadn't. (Carol, 21:10:13).

While Gemma was 'absolutely distraught' at failing her assignment:

> 'I didn't really put a lot into it and that made me realise that when it comes down to your academic stuff you really do need to work at it so that's been a challenge. And I realised it is that easy to fail because I didn't think that it was before and I was absolutely distraught when I did. (Gemma, 19:10:13).

Nonetheless, in her next placement her mentor informed her that she was not achieving the level required of a third year student:

> I was feeling very confident but my mentor told me I was not going to pass my placement as I wasn't achieving the levels! So I thought stop catastrophizing, you can do it and we made an action plan and I passed. (Gemma, 19:10:13)

Josie felt anxious at failing an assignment and this was compounded by a health scare:

> During my first year I questioned whether I'd made the right decision to start the course as academically I struggled. Having to do assignments with placements and obviously I've got children at home so juggling lots of different things. I felt more confident after the first year, passing all my assignments, but after failing an assignment. Then they thought I had a brain tumour and had to take some time off. So had to make the decision to drop off the degree, it was that or give up. (Josie, 23:10:13)

A year after dropping the degrees both Carol and Gemma appeared upset when recounting their experiences of failure. Josie was also emotional when she spoke about the events of the previous year: failing an assignment and concerns for her own mortality, these were increased when the option of reverting to the diploma pathway was offered and the investigations for a

brain tumour was an additional stressor. In each of the three students these stressors were evident in their pictorial representations.

For Gemma, who called her picture ‘peaks and troughs’ similar to a mountain range, with happy and sad faces incorporated to identify her emotions. From a standpoint of apprehension when she commenced the course, she was effortlessly ascending up a mountain until the end of her second year, but fell rapidly into a ‘trough’ when she failed her assignment (Appendix 7). Being confident in her own practice skills enabled her to swiftly reach the top again, only to promptly descend towards the bottom again when her mentor told her she was not meeting the required level of practice required of a third year student. With her mentor’s help she climbed up the mountain, but what is evident is the half-way ledge she had drawn, indicating this was a much more considered and structured climb.

Similarly, Carol added happy and sad faces to depict her feelings, and also included some words to explain her picture, which was a long rambling pathway. Commencing the course she ‘felt proud’ as she was ‘making a difference’ but her first placement (on an Older Adult ward) was a ‘disappointment’, nonetheless she continued along the straight path until falling into a deep pothole when she ‘failed an essay’ and ‘dropped down from degree’. Her emotions at this point were evident as she drew a sad face with tears, which was replaced by a happy face and veering back onto the path when she went on holiday. She continued on the path snaking twice when she was ‘looking forward to final placement’ (happy face), then ‘worried about ‘finding a job’ and attending an ‘interview’ (sad face) before returning to the path as she was ‘looking forward to qualifying’.

Josie’s pictorial representation also contained sad and happy faces and words to explain her road map. However, it differed from both Gemma and Carol who had decorated their pictures with flowers, animals and love hearts and her road was a mostly straight line without obvious ‘peaks and troughs’ or potholes. It contained small diversions which looked like bends in the road. When she started she was ‘excited’ as she had ‘waited a long time to do it’ (happy face), but she felt ‘unsure’ during the first year because she found the academic work difficult (sad face), and this was compounded when she ‘became unwell and struggled’. So she had lost some of her momentum, but by the middle of her second year she was ‘feeling more confident’ speeding along (happy face), only to have to brake sharply ‘because of having to give up the degree’ due to failing her assignment. Slowly throughout her third year she built up speed again

but although ‘looking forward to qualifying’ she was ‘a little sad and apprehensive’ about losing the ‘support’ of her peers.

While each of the students’ nurse education pictorial representations offered a snapshot only of their three year journey, they did identify that failing an assignment, with or without other stressors, had a considerable impact on the understanding of mental illness. Their aspirations for a meaningful life, including being a nurse, was in danger of not being a reality, the feelings of distress and loss offered some recognition of how it might feel to experience mental illness.

For the other two students, Marion and Will, the workload of undertaking a degree programme with placements, part-time work and attempting to juggle a home life proved distressful. Marion found the quantity of assignments and placements difficult:

> The worst time was at the 18 month mark, very intense. I felt like I was walking through trees, it’s usually school, placement, school etc. At first I thought, well I've done loads and then, but I've still got the same amount to do again! Even when you’ve passed an assignment, you still had two deadlines straight after. I've really felt sort of alone and thought 'I've had enough', but remembering why I wanted to do nursing made me re-focus. (Marion, 28:10:13).

Her pictorial representation echoed as well as added context to her brief interview account. She drew a long straight road starting in the first year to the end point of ‘Degree’, with slip roads to the left and right offering insights into her stressful experiences. The right hand slip roads identified her achievements such as ‘good grades’ in the first year, swiftly followed by ‘achievements on placement’, ‘good feedback’ in the third year to just before finishing the course ‘tutor and peer support’. All these comments were accompanied by a happy face, but all the slip roads on the left had negative comments with exclamation marks. Starting just after the end of the first year with ‘Aaargh!!’, then at the eighteen-month point ‘ENOUGH!!!, with the last one just before the end of the course ‘Tired!’. So despite outwardly appearances of a competent and capable student, Marion found the course stressful.

Similarly Will found balancing study and placements intense:

> This year we were going on placement, the dissertation to think about, passing placement outcomes and two assignments. I worried about how I going to fit this all in as well as doing placement stuff and trying to hold down a part-time job. It's intense. And it's like

> trying to manage your time as best you can. I've been using like the half days in uni, going to the library because I'm already in here, so I'm going to stay. Once I'm here, I'm here. But it's hard, you need money, you need to live (Will, 22:10:13).

Will's pictorial representation, however, did not offer as much information as the other students, about his feelings until his third year. His picture appeared to be a hill climb with a slight undulated pathway, 'work assessments' [in placements] added downward steps while 'good mark' and 'passed year 1' straightened the path again, there were no comments until year three when he drew steps across a deep crater filled with 'workload' and 'research'. The steps across which could be described as a rope bridge appeared to be his solution to using his spare time at university to good effect (Appendix 6). What his drawing lacked in clarifying his stressors was often discussed in the group discussion, for instance by the end of the first year he admitted he was finding the course difficult due to travelling for 3 hours a day, working part-time and researching and writing assignments. This had affected his relationship with his girlfriend, he did not have time to socialize with his friends, he was tired and, at times, 'lonely'. By the start of the third year his relationship with his girlfriend had ended, he had lost contact with his former friends, he was back living with his mother and he admitted 'Speaking for myself, I've had anxiety and felt stressed out, it just needs that little trigger' (Will, 15:01:13).

So five of the students had experienced stress that was related to their nurse education of either failing an assignment or the sheer workload, although this was compounded in Josie's case by undergoing tests for a brain tumour. Each of the students stressful experiences were retold appropriately a year to eighteen months after they happened and in the interviews the distressing emotions triggered in the retelling was evident. Additionally, these incidents were included in the pictorial representations of each of the students' timeline, which tended to be drawn as a major dip in their journey towards becoming a mental health nurse. As noted previously, the pictorial representations of Will and Gemma, along with their responses to the AMIQ, pen portraits, have been included in Appendices 6 and 7. Interestingly, all five students, although Gemma required help from her mentor, revealed self-awareness and self-agency, actively engaged in strategies to reduce their distress by becoming more proactive in their own learning and planning their workloads into manageable schedules.

By the time the students had started their third year of study, they had studied recovery-focused propositional knowledge, which advocated working in partnership with patients, and had also

undergone stressful experiences themselves, which offered them insight into experiencing mental illness. However, one more experience, following their own distress, was needed to change the students' frames of reference. As noted previously in this chapter, five of the six students demonstrated a recovery frame of reference when their either re-took the AMIQ or at interview (Josie) and this appeared to be influenced by meeting patients who they found an affiliation with, this will now be discussed.

Noticing similarities with patients

Four of the students spoke about meeting patients with whom they could identify with. Carol was surprised at meeting someone with depression who looked 'trendy', and was 'so young, married, had a child and had a house to keep', but she admitted that this encounter 'didn't change my view' of patients. This meeting took place during her first year of study while studying the CFP, so her surprise might have resulted from her benevolent frame of reference about patients being passive and incapable or as Mezirow et al (2000) acknowledged, this disorienting dilemma might be regarded as a 'one off' and unlikely to be transformative and this appeared to be true for Carol:

> I didn't change my view then, it changed when I was in the crisis team and met a student. She was studying psychology, doing this degree and I thought, 'Crickey, how did she get depression if she can do all this', but then, it obviously it can happen to anybody and that's what made me change my view and also on [acute admission] ward, looking at how poorly someone could be and looking back through their notes, you realise what they have achieved in their life with this illness, so yeah, I have changed my views (Carol, 21:10:13).

Her admiration for the patients combined with own stressful experience of undertaking a degree, did not fit with her previous benevolent 'nurse on top' frame of reference. She now believed that given the right circumstances anyone can experience mental illness.

Similarly, Marion's stated 'a couple of people' helped her change her view about patients who misused drugs and alcohol. On two occasions during group discussions she spoke about growing up with a father who misused alcohol and that she 'absolutely dreaded' a placement in the Drug and Alcohol services. Although she did not have a placement within these services she met several patients who had problems with either alcohol or drugs. In her second year she helped with the care of a patient of similar age to herself who was:

> Hallucinating as she was coming off alcohol and I just sort of focused on explaining where she was. When she had detoxed a bit, we got chatting about her life, horrific, and it helped me understand (Marion, 28:10:13).

The similarities between Marion and the patient's upbringing made Marion realised that if she had not got help for her own mental health in childhood, she might 'be walking in her shoes'. Again rather than be a 'one off' trigger for a disorientating dilemma the accumulation of meeting someone else with misuse problems:

> There was a gentleman on my last placement on the acute ward who took amphetamines and he could be difficult to communicate with but at other times I got on absolutely fine with him. So, yeah I do think it's helped me to sort of step outside the box a little bit (Marion, 28:10:13).

These encounters made her realise that when she had started her nurse education she had thought she 'was completely non-judgemental but then I've sort of realise that actually I wasn't'. Through these incremental disorientating dilemmas Marion gained self-awareness and this influenced how she saw patients: 'They are not abnormal. We are all human at the end of the day but you need to see the person in front of you as a person' (Marion, 28:10:13).

In Will case encounters with patients who he could relate to had a positive effect on his frames of reference and again concerned people who misused substances. He admitted he had preconceived assumptions about people who took drugs:

> I'd try and be more open minded. For example druggies, I didn't understand them, but these are just normal people like me and you, something might have happened in their lives, something's triggered them off. My misconception was that drug users were down and outs but actually when you meet people they've got quite high up jobs and they are working professionals, it's just you know it opens your mind about it and, yeah, not be as judgemental and to be more open to people and get to know the person before jumping to a conclusion (Will, 22:10:13).

As previously discussed, Will held down a part-time job while studying for his degree, used his time at university effectively and he stated he was proud of never missing a day during placement or failing an assignment, but his strong work ethic caused him anxiety and he had felt 'stressed out'. So to find that people who took drugs were 'hardworking professionals'

appeared to be a revelation to him and seemed to be the catalyst for his change in frame of reference.

Where Carol, Marion and Will's disorientating dilemma resulted from incremental shifts in their frames of reference, Josie disorienting dilemma was dramatic and thought provoking. In her community placement she visited a man who 'to the outside world had everything, he was happy-go-lucky, everybody's rock' (23:10:13) who had attempted suicide, and this encounter made her comprehend:

> He couldn't tell anybody because he was always had to be the strong one. That made me realise, he was the least likely person you would expect to and that was quite scary, no-one's exempt. Even knowing what you know, even being able to see it in others doesn't always mean that you can look in the mirror and see what's going on because you can always choose to look at everybody else's problems because it's easier. So everyone has the potential to become mentally unwell. I didn't always think that (Josie, 23:10:13).

Josie recognised the similarities between herself and the patient as she was the mother of seven children, the 'glue that holds the family together, the organiser' (23:10:13) and this meeting happened soon after she had been the 'all clear' from the test for a brain tumour. However, as indicated in the AMIQ, which she undertook six months after this 'one-off' incident, she had shifted towards a recovery frame of reference but still held on to some of her in-grained benevolent habits of mind. Mezirow et al (2000: xii) acknowledge some people can 'get stalled' due to the 'threat to long-established sense of order' and this appeared to happen to Josie. Her previous experience of being a mother, working in healthcare for many years and priding herself as an advocate for patients appeared to stall or take time to shift her frame of reference. But her frame of reference appeared to have shifted to a recovery one: 'There's a big element of me that's now changed from wanting to heal the world, to being there to support as opposed to doing for' (Josie, 23:10:13). Later in this chapter I will explore how Josie incorporated these recovery principles in her practice.

For Gemma it was not patients she met following her stressful experience of failing an assignment but reflection on a previous patient which appeared to shift her frame of reference. In her interview she spoke about her first placement and caring for a lady who was 'so depressed she couldn't get out of bed', and admits her initial thoughts were 'Oh, you've got depression, just cheer up' but she now knew 'It's a thing that can take over you' (Gemma,

19:10:13). Although she did not explicitly state when her point of view changed, it must have happen following her comments in twenty-four-months into the course when she spoke about some patients 'who don't want to do anything, they need you to push them' (15:01:13), and undertaking the questionnaire again at thirty-months when there was a marked shift towards a recovery frame of reference. While failing her assignment could be construed as a 'one-off', the incremental effect of not achieving effective practice appeared to make Gemma re-evaluate her taken-for-granted habits of mind. Although this re-evaluation lead to her 'being more passionate about nursing' and 'more on the side of the patient, giving them choice and upholding their rights' (28:10:13), in her interview she did not offer any instances to substantiate that she had incorporated into her practice.

The five students identified similarities between themselves and patients who they could relate to. What seems to link all the students' stories is that the recovery propositional knowledge offered a lens to view practice, but until they had experienced their own mental distress they were unable to relate the same humanness to the patients they met. Their own idealised self-image appeared to have changed from a person who could not have mental health problems, as they did not have a dysfunctional brain, to understanding that given the right circumstances or life events they too could experience mental health problems. As Mezirow (1978: 105) maintained transformative learning, while triggered by a disorientating dilemma, requires critical reflection to recognise 'the difference between the old viewpoint and the new one and make a decision to appropriate the newer perspective as being of more value'. The students' change in habits of mind and resulting points of view was evident during their interviews when each stated that: 'They [patients] are just normal people like me and you' (Will, 22:10:13), 'They are not abnormal. We are all human at the end of the day' (Marion, 28:10:13), 'It (mental illness) can happen to anyone' (Carol, 21:10:13), 'it's (depression) a thing that can take over you' (Gemma, 19:10:13) and 'everyone has the potential to become mentally unwell. I'm not invincible' (Josie, 23:10:13). This realisation, which caused them to reconsider how they had viewed patients, had the potential to revise their thinking about the role of the mental health nurse in nurse/patient relationships, but only Josie spoke about the effect this had on her personally.

As Mezirow (2000: 6) argues disorientating dilemmas promote awareness that the 'assumptions undergirding our ideas' are mistaken or inappropriate and are 'often intensely threatening' experiences, which can provoke feelings of shame, fear, guilt or anger. Yet only Josie voiced her feelings of shame and guilt. She attempted to justify her previous frame of

reference and also identified the role of the recovery propositional knowledge and the timescale when her frame of reference changed:

> Even though I understood the concept of the fine line between nurturing and disempowering, putting it into practice, not doing it intentionally, so no malice meant, but little things that I didn't even consider as being disempowering. It's only in the last six months I've thought like this (Josie, 20:11:13).

It could be suggested that as Josie's disorientating dilemma was dramatic it produced this response, the other students' (Carol, Will, Marion and Gemma) experienced a more incremental confrontation to their habits of mind (assumptions), so feelings of shame, fear, guilt or anger was felt at a slower pace thus emotionally they were more protected by a gradual build-up of differing dilemma than Josie. While Josie's disorientating dilemma had a more intense effect on her and Gemma reflected on past experience, their frames of reference did not change as quickly as the other students, which was evident when both their responses to the second questionnaire resulted in a shift towards, rather than moving directly to, the recovery frame of reference. Nonetheless, these five students appeared to have adapted their subjective habits of mind about their own sense of self, which in turn, changed their belief system and interpretation about patients and the nurse's role within nurse/patient relationships (Mezirow, 2000).

Mia moved from benevolence to a recovery one, but she was adamant that her attitudes about patients had not changed: 'My opinion on the services have changed, but not about the effects of disorders or the people'. Mezirow et al (1978: 105) would not class her as having undergone transformative learning because she did not undergo 'a conscious recognition of the difference between the old viewpoint and the new one'. Although different speculations can be advanced for the changes in responses in the questionnaires and her denial of a change in frame of reference, it appeared to be an accumulation of propositional knowledge and her growing self-confidence/awareness. In her interview she did not identify having a disorienting dilemma but spoke about her preferred style of learning:

> Like the recovery module, linking that back to the people I meet. Mind you, you need to treat people as individuals, like if you meet two people you need to build up a therapeutically relationship in a different way. (Mia, 30:10:13).

Additionally, it was evident she was self-aware and actively protective of her own mental health. Even though she was eligible to study at degree level she chose to continue on the

diploma pathway: ‘I was happy to plod on as I am, if I look too hard at the future I panic’ so ‘I just take one day at a time’. She was also conscious of her lack of confidence and by the end of the first year she spoke about her aspirations to build up this up. But she often tended not to contribute to the discussions in class, rather sitting quietly listening to the other students’ comments, opinions and experiences. But her introvert trait of quietly and inwardly processing information appeared to have been perceived as a lack of self-confidence by her mentors:

> People [mentors] become obsessed with your confidence and that knocks your confidence even more, you sort of suffer from paranoia thinking, all they ever do is watch me. It’s disheartening. (Mia, 30:10:13).

While having two placements with Will might have cemented their friendship, but when compared to the outgoing, self-assured Will, she appeared to be lacking in confidence. It is evident how she felt at being watched as illustrated in her pictorial representation which offers the view that it had a devastating effect (Appendix 8). Resembling a game of snakes and ladders, she showed that every time she climbed the ladder to achieve her explicit goal of being a mental health nurse, she slide down a snake by her perceived lack of outer self-confidence. But as her picture illustrated she persisted with the ladder climbing and she offered this response to my question about challenges in her interview: ‘Everything's a challenge because it's all new isn't?’ In her last placement she was able to gain her confidence when her mentor was absence due to a bereavement:

> I had her caseload, so I sort of run it for her, that was unexpected but, actually, it did me good, because when I’m being assessed I get very nervous. Without sounding horrible, it sort of worked in my favour as it gave me time to get over my lack of confidence, I built it back up. But I did it I proved to her I could do it (Mia 30:10:13).

So differing from the other students Mia did not identify a disorientating dilemma or undergo the alienation phase but as her comment about treating people as individuals and building therapeutic relationships in different ways to reflect she appeared to incorporate the recovery principles into her practice. Differing from the other students who changed their frame of reference by realising they were not immune to mental health problems so adapted their own sense of self (subjective habit of mind) (Mezirow, 2000), Mia was well aware of her own mental health so had decided not to attempt the degree pathway. Also she was aware of the negative effects of other people perceptions about mental health patients and how this can impede recovery. This was evident during the group discussions when on several occasions she

challenged her peers and appeared to assist them in moving towards Mezirow's second phase re-framing, which will now be discussed.

The students experience of re-framing their frames of reference

Critical dialogue underpins Mezirow's (2000) second phase when learners test the validity of their new habits of mind by communicative learning through informed and thought-provoking dialogue. This testing can have the effect of re-framing frames of reference, but as Mezirow (1991) stressed, discussion needs to be accurate and complete, free from coercion and distorted self-perception. The learner must to be able to reflect critically on their assumptions and their consequences; weigh evidence and arguments objectively; be open to alternative perspectives; have equal opportunity to participate; and, be able to accept the reasoned and rational consensus.

As noted in Chapter Two, when Mezirow's transformative learning theory was discussed, the University's curriculum offered many and varied opportunities for the students to discuss their viewpoints and experiences. And as will be explored below Mezirow's (1991) ideal conditions were integrated into two themes: 'feeling safe' enough with their peers and the lecturers facilitating the session to verbalise their thoughts and feelings openly and to accept these views 'being challenged'. The first of these themes, feeling safe, will now be discussed.

Feeling safe to discuss viewpoints.

In the last section on alienation it was established that five students had undergone stressful experiences from either failing an assignment or the workload of studying to be a mental health nurse. Additionally, I suggested that the sixth student, Mia, suffered from stress throughout her education. But within all the students' accounts, during their individual interview, the classroom discussions appeared to be an environment in which the students felt safe enough to talk openly and frankly about their views and experiences. The safe atmosphere was exemplified when Gemma was able to discuss the shocked reaction of her family to telling them she was gay at sixteen and Marion discussing her childhood growing up with a father who misused alcohol and that she had accessed mental health services in her childhood. The students also identified that these group discussions enabled them to learn about and from different perspectives. Marion's commented:

> I've enjoyed the lectures with group discussions, it brings things out, different people's placements, experiences and how they have dealt with or seen situations. I think that helps

> the overall understanding and seeing things from different points of view. (Marion, 28:10:13)

In Gemma's case she also found the discussions altered her opinions:

> During the course, I've opened up more. I've learnt more during discussions with the other students, they have very different opinions, you hear different viewpoints, and this has changed my views. (Gemma, 19:10:13).

These discussions offered Josie a sense of belonging with her peers and self-awareness as she realised that, initially, she tended to dominate conversations:

> I'm the oldest in the group and it's just nice knowing that there is some common ground and I now listen to the others and think things through a bit more, whereas I used to be jump in. (Josie, 23:10:13).

Will found that the discussions enhanced his understanding of recovery principled care:

> The recovery assignment was when I learnt about empowering people, it's not actually about what we can do for them but what they can do for themselves. The discussions we had about our different views and situations helped to broaden my viewpoint. I think, that's sort of shifted my opinion really, so getting people to do things for themselves, you're there to help and guide, be proactive. (Will, 22:10:13).

So the classroom discussions assisted the students to consider their own assumptions and the consequences in light of their peers' opinions and experiences. In turn, this lead to them weighing up differing perspectives which, by their own admissions, either changed or broadened their points of view reflecting some of Mezirow's (1991) ideal conditions for re-framing. Three students (Carol, Gemma and Marion) also cited the discussions with their mentors in placement as helpful in altering their perspectives. Both Carol and Gemma highlighted discussions with their Recovery mentors.

> I loved the Recovery team, loved my mentor, she was really supportive, explained in great depth and I really learnt a lot from that placement. I learnt how to do depots (intramuscular injections), got to know the patients and gained confident. (Carol, 21:10:13)

Gemma also ‘loved’ her mentor who ‘was absolutely fantastic’ and she ‘learnt so much from the discussions we had’. She also said that when she ‘gained something from a lecture’ she would ‘go to placement and discuss it with the nurses’. While Marion stated:

> They've [mentors] all been really great, answering questions but once I start I can't seem to stop myself and they said they'd rather have someone ask questions “it shows you want to learn”. So mine have all been positive in different ways, good mentor and team support and discussions, they kind of push me out of my comfort zone (Marion, 28:10:13).

Where practice discussions differed from classroom discussions was that none of the students admitted that they were as open about their personal life or viewpoints as they were with their peers. This was highlighted in Marion’s remark after reading her pen portrait ‘I know in our group discussions, we know each other so well, we say things in a certain way, but [describing a patient as] ‘high as a kite’ sounds so disrespectful’ (28:10:13). The classroom discussions in which the students were exposed to their peers’ opinions and viewpoints appeared to offer them the opportunity to weigh up the different perspectives and arguments to critically reflect on their own assumptions. Additionally, all the students had the opportunity to participate in these discussions without coercion so some of Mezirow’s (1991) ideal conditions for communicative learning was evident in this ‘feeling safe’ environment. However, as will be explored in the next section of this chapter, ‘being challenged’, feeling safe to discuss their thoughts and feelings also lead the students being able to contest and dispute each other’s points of view.

Viewpoints being challenged

In part Mezirow’s (1991) ideal conditions to foster communicative learning had been met by the students feeling safe enough to air their views, opinions and experiences with their peers in the classroom discussions. But without these viewpoints being challenged all of Mezirow’s conditions would not be fulfilled as the information discussed might not be accurate, students might continue with distorted self-perceptions and not be open to alternative opinions.

As already discussed, the students’ conversations in the classrooms were often open and frank, and this was evident in their recorded discussions over their three-year nurse education. Upholding Mezirow’s (1991) ideal conditions for communicative learning appeared to start early in their education when in their second meeting with their personal tutor she challenged Josie’s ‘naughty, really naughty’ description of the patients she was working with on the older adult ward. This probing appeared to be used to help Josie consider her habitual way of thinking

about (habit of mind) and judging (points of view) patients, and although she changed her description slightly to 'They are mischievous, they are characters, brilliant' it took experiencing a disorientating dilemma to shift her imbedded frame of reference (Mezirow 2000).

Other students also challenged each other during the classroom discussions, which in Mezirow's (2000) opinion can act as a trigger for critical reflection. By the end of their first year, when Carol and Will stated they wanted to see more 'interesting cases', Gemma challenged her peers: 'I don't think there is any point in saying I want to meet 'this sort of person', you can meet two people with schizophrenia but they can be two different people in the way they deal with it'. Additionally Mia, who tended to sit quietly listening to her peers views and opinions, twice challenged Will's view of patients' behaviour. The first time was when he complained that patients used the day ward, where Mia and he had been of placement together, as a social meeting place. Whereas Will simply observed the patients' behaviour, Mia offered an alternative view of the situation by stating there was a lack of nursing focus on assisting the patients to learn social skills. The second time she challenged him was when he complained that the staff (on the ward they were both on at the same time) felt frustration with some patients' behaviours, to which she counter that there was inconsistency within the nursing team's approach to patient care causing the patients to feel frustrated. In the examples above, when peers offered different views and opinions this appeared to have made the students reflect on their previous assumptions as in each case they conceded that they had not considered alternatives.

Although Josie re-framing of her habits of mind did not involve communicative learning with her peers, the two elements of feeling safe and being challenged are evident within her account. Following her encounter with the patient with whom she could relate to because he reminded her of herself, rather than discuss it with her mentor she waited until she returned home to discuss her thoughts and feelings with her husband:

> Who said "About bloody time, don't get me wrong, me and the kids aren't affected, but sometimes I wish you wouldn't make it your problem". It made me consider: I work with people and I sit there time after time explaining how they have to do a process of elimination, they have to learn let go, the body and mind only has a certain amount of capabilities and then I take on everybody else's problems. Yeah, now I think before I get too involved. (Josie, 23:10:13).

What was different between the students' peer and Josie's husband discussions and those with mentors is that the mentors are in a powerful position in relation to the students. Mentors both supported students' learning and assessed the students' practice skills, so had the power to either pass or fail the students' practice component of the nursing programme. Being free from coercion is one of the core elements of Mezirow's (1991) ideal conditions of communicative learning, but the students appeared to feel intimidated by the power their mentors had as Mia's (30:10:13) account of feeling continually watched demonstrated. The students did not challenge the mentors' viewpoints directly but as illustrated in Chapter Five their agreement or disagreement with their mentor's frame of reference was aired during classroom discussions.

The students, however, were all at the same stage of their education so, although diverse opinions were aired, they were able to discuss, question and challenge each other's viewpoints. Additionally, Josie who had been married for twenty-five years, and as she readily admitted her husband and herself often disagreed and argued, also respected each other's opinion. The trusting relationships between the students, and Josie and her husband, resembled the recovery nurse/patient relationship, and this appeared to be key to them feeling safe to discuss, challenge, question and contest differing points of view upholding Mezirow's (1991) ideal conditions for communicative learning. Nonetheless, there is no evidence of student' disorientating dilemmas in the recorded classroom discussions but these were identified in their individual interviews. This lack of evidence in their group discussions might be due to the data only being a snapshot of their interactions over their three-year education or as four of the students' frames of reference changed in an incremental way, they were unaware of the significance of the events.

Five of the students had undergone 'a conscious recognition of the difference between the old viewpoint and the new one', while Mia did not acknowledge that she had (Mezirow 1978: 107). During their interviews five students felt that they had changed their habit of mind about people with mental health problems and the role of the nurse in nurse/patient relationships during their education. The questionnaire responses of three of the students (Carol, Marion and Will) implied they had a recovery frame of reference when they retook it thirty months after commencing the programme. Gemma and Josie had shifted towards the recovery frame of reference but Josie's responses in her interview six months later suggested she had also moved to a recovery frame of reference. Only Mia disputed that she had changed her frame of reference at all. Although the other five students acknowledged their change in frame of reference, I will now explore whether they continued to Mezirow's (2000) final phase of transformative learning by consolidating this change into their nursing practices.

Consolidation

Mezirow (2000) maintains that contractual solidarity or consolidation is the crucial decision to adopt new perspectives and incorporate it into one's worldview. This phase includes trying out new roles, building competence and confidence in the new roles and relationships, until finally these new perspectives are reintegrated into one's worldview and behaviour. I will now discuss whether the five students who either experienced a disorientating dilemma or incremental triggers stated how they had changed their practice. For four of the students, this was to expand their repertoire of skills to work in partnership with patients.

Working in partnership with patients

Will claimed that when he entered their nurse education that he presumed that medication was most effective treatment for mental illness: 'I had this impression that people would probably get cured with medication, I wasn't aware how effective talking therapies could be. Now I try to people to open up more to find what their goals are'. (Will, 22:10:13). Gemma had a similar view:

> I never used to really believe in talking therapies to be honest but now I think they are fantastic. I mean acute psychotic behaviour, obviously medication is the best way, but being on this course has shown me that a few sessions to get stuff out is better than medication which can block it all off and it's still all inside you really. (Gemma, 19:10:13).

Marion, on the other hand, had considered talking therapies to be the best form of treatment, but now conceded that they was a place for medication:

> I wouldn't say I was an advocate of medication. I still don't think it's the be all and end all, but I do think the medication can help to ease symptoms, then you can start talking (Marion, 22:10:13).

For Josie, the change in her practice was dramatic because she changed from behaving in a benevolent manner when one patient refused to let Josie enter her home as she 'spoke to her like a child' to a recovery one:

> I was working with this young lady [in the Drug and Alcohol team], who had a diagnosis of ME since 12 and I did say to her "I'm not going to patronise you by pretending I understand how devastating that must have felt at that age, instead what can we do to help you move forwards?" (Josie, 23:11:13).

The time lapse between Josie's disorientating dilemma and her moving through transformative learning phases was longer than the other four students who also moved to a recovery frame of reference, and might be explained by her previous care giving experience as a mother and healthcare support worker. Although Josie did not state her goals for the future several of her peers did.

Gemma reflected on her growth throughout the course and stated that she:

> Had more passion now about my nursing and this is because of working with patients, growing up and finding myself. When I qualify I'd love to go into schools, go into assemblies and lessen the stigma of mental illness. I think what is missing is targeting young people at a young age. (Gemma, 19:10:13).

Similarly, Will's 'area of interest' was health promotion for children:

> They've got a lot of emotions going on, they don't know how to deal with them. If you can get in early, giving them the tools and skills to deal with them, then later on in life we wouldn't have as many people doing self-harm or using negative coping strategies like alcohol or substances. (Will, 22:10:13).

Carol, reframed her initial point of view about her first placement on the older adult ward:

> I was really disappointed and obviously nervous, looking back it wasn't boring it was just that I was a first year, I didn't have any knowledge. But towards the end I did enjoy that placement and I got good feedback and that's where I'm going for a job interview next week. (Carol, 21:10:13).

So the five students who had changed from a benevolent frame of reference to a recovery one appeared to have started to integrate these different beliefs and assumptions into their nursing practice (Mezirow, 2000). This exploration led me to the conclusion that transformative learning is not an instantaneous reaction to a disorientating dilemma and that a combination of events, often linking to Burnard's (1987) nurse knowledges and the students' self-image, was needed to advance the reframing and consolidation characteristics of transformative learning.

Conclusion

Of the six cast-study students only did not go through the transformative phases towards the recovery frame of reference, although not all went through all the phases. Nonetheless, they all were working towards incorporating partnership working with patients.

This chapter, supports Evans and Kelly‘s (2004) findings about the stressors some student nurses endure during the education. It also offers insights into the contributing factors needed to either cause a disorientating dilemma or trigger incremental shifts towards changes in frames of reference. The underpinning propositional knowledge taught in the university appeared to influence the way patients and mental illness was viewed. However, experiencing a stressful situation led the students to realise that given the right circumstances or life events they too could experience mental health problems. Meeting patients who they resonated with, following this stressful event, appeared to strengthen the triggers for adapting the students’ subjective habits of mind about their own sense of self (Mezirow, 2000). The communicative learning, supported by feeling safe and being able to challenge and be challenged, in classroom discussions enabled the students to test out these new habits of mind, and slowly incorporate recovery into their practice. With one exception, all the students went through the transformative phases towards the recovery frame of reference, although not all went through all the phases. Nonetheless, they all were working towards integrating partnership working with patients.

Chapter Seven: Conclusion

Introduction.

In this final chapter, I first summarise the answer to my over-arching research question by exploring each of the sub-questions using the findings from my study. I go on to consider the implications of my research for policy, mental health nurse practice, mental health nurse education and future research. Finally, I discuss the contributions to knowledge made by my study.

Revisiting the Research Questions

In this section I summarise how my research has addressed the research questions I set out in Chapter One. The main research question was: Does mental health nurse education promote transformative learning which values and respects the diversity of individuals and enables their recovery, if so how and if not why not? which has been answered with reference to three sub-questions.

> 'What were the students' frames of reference about people experiencing mental health problems, at the start of their three-year nurse education?',

In Chapter Five I discuss the Attitudes to Mental Illness Questionnaire (AMIQ) which established a frame of reference at the start of the curse All the students commenced their education with a benevolent patronising attitude, which views patients as defined for always by their diagnostic label, who are viewed as incapable of making decisions or comprehend relationships between concepts (Taylor et al, 1981; Todres et al, 2009). As discussed in Chapter Six, it became apparent that their attitudes were shaped by the exposure to the UK society's views and media representations during their upbringing, which viewed people with mental illness as 'other'.

> **'**Did these students change their frames of reference over their three-year education and, if so, how did they change?'

This sub-question was answered in part by the students retaking the AMIQ towards the end of their nurse education. Four of the six students (Carol, Jennie, James and Amy) had a more recovery-focussed attitude, while two (Hannah and Sarah) had moved towards it but continued to hold benevolent points of views. Additionally, the students' classroom discussions illustrated slow, gradual movement from viewing patients as diagnostic labels, signs and

symptoms of mental illness and from struggling with the concepts of recovery (evidenced in their contradictory statements) to using their practical and experiential knowledges to develop a recovery lens.

> ‘If students have negative unhelpful frames of reference which do not change, what appeared to be the barriers to change?’

Not all the students completed Mezirow’s (2009) transformative phases of alienation, re-framing and consolidation. So, it can be suggested that timing of trigger elements promotes alienation and reframing: recovery-principle propositional knowledge, a period of stress when the students gained an understanding of how it felt to experience mental health problems and meeting patients who the student resonates with. However, not all of the students fully consolidated the recovery frame of reference into their nursing practice by the end of their three year nurse education.

So in relation to the main research question, this thesis shows that nurse education can be transformative but requires: time to embed humanisation into practice; reflective discussions to gain insight into other people’s points of view; and, student/lecturer relationships which mirror the recovery principles of hope, empowerment and opportunity.

Implications for nurse education: the dominance of the biomedical model in the Common Foundation Programme.

My findings identified three issues that had an influence on transformative learning in the nurses’ course of education: (1) the dominance of the biomedical model of care and treatment in the students’ first year of study (2) the practice-theory gap where the propositional knowledge taught in the university did not reflect the practical and experiential knowledges the students encountered in placement and, lastly (3) the stress students experienced during the course.

The first issue is that the first-year course content of shared propositional knowledge is dominated by the biomedical model which re-enforced the benevolent and for some students a social restrictiveness attitude. It should be kept in mind that both benevolent and social restrictiveness attitudes, which tend to be underpinned by authoritarian attitude, are viewed as dehumanising in Todres et al’s (2009) values framework. This dehumanisation is not aligned to contemporary thinking and policy about caring for people with mental health problems, which emphasises mental health nurses working in partnership with patients to focus on their

strengths and coping strategies to promote resilience (DH 2006a). Partnership working, in turn, changes the role of the nurse in nurse/patient relationships from the expert directing care options, to the patient being the 'expert-by-experience' uncovering and discovering what 'works' for them to achieve a meaningful life (Slade, 2009).

To counter this biomedical dominance, the recovery propositional knowledge should be introduced earlier in mental health nurse education and should, I suggest, be included in the shared taught sessions as adult student nurses also encounter people experiencing mental illness. This suggestion upholds Stickley and Timmins (2007) opinion that all nursing students should be taught different theories of the contributing factors to mental illness such biomedical, psychological, psychoanalytical, behavioural, humanistic and socio-cultural theories as contributors to mental illness, offering these different theories and approaches early on the course has the potential to reduce 'othering' people with mental health problems.

Additionally, Todres et al's (2009) values framework should be incorporated into lectures, seminars and discussions throughout the whole of the nurse education with all students because it conveys the importance of seeing all patients as people (regardless of their diagnosis). The categories of humanisation and dehumanisation encourages students to consider the subjects taught in the university being applied to a loved one and a lens through which to view their own and other healthcare staff's practice. As demonstrated in my findings it was only after the students had received recovery propositional knowledge in the second year that they started to identify recovery-principled inspirational or judgmental practice. This suggestion of equipping students with a values framework from the commencement of their nurse education was similarly recommended by Willis (2012: 6) who comments that 'patient-centred care should be the golden thread that runs through all pre-registration nursing education and continuing professional development'. However, a more worrying concern for the future of mental health nursing education has been debated for many years of the introduction of a generic education for all field of nursing. So, I will now discuss the detrimental effect this could have on the care of people with mental illness.

The Pre-Registration Nurse programme that the students in this case-study undertook was specific in offering the knowledge and skills in the university and mental health placements to equip the students to become registered mental health nurses. This model has not been adopted in all countries and tends to be exclusive to the UK, Republic of Ireland and Belgium resulting in different nursing qualifications upon completion of the course. Criticism has been levelled

that this specialist nurse education is not economical due to duplication or overlap of content in the different speciality curriculums and conversely, the restriction in specialist focus is not seen as offering holistic care (Grant, 2006). So, I now explore the differing opinions on introducing generic nurse education into the UK.

Many nurse educationalists in Australia and New Zealand, who have adopted a generic programme for undergraduate nurse education since the 1980s, advance that their comprehensive education provides students with sufficient grounding in all aspects of care equipping them to work in any nursing setting (Happell, 2001). Generic education was advanced in Australia as producing nurses with a wide range of skills which could be used in different clinical settings, and, would reduce the stigmatization of people with mental illness and improve their physical health (Wand and Murray 2008). But when Prebble (2001) reviewed the rationale surrounding New Zealand's uptake of the generic programme, with its premise that patients' holistic needs can be catered for by an adult nurse with extra training in mental health, she found that it was underpinned by the misunderstanding of the role of mental health nursing.

This doubt about generic training is support by Cowman et al (2001) who suggest that the problem is role ambiguity and difficulty defining mental health nurse core skill-base. The diversity of mental health problems a patient can experience requires different patterns of care at different times to promote physical, psychological, spiritual and social well-being so one theoretical approach does not fit all nursing care. Additionally, concerns have been raised that generic nurse education does not prepare nurses adequately to work with people with severe mental health problems (Warelow and Edwards 2007). As demonstrated in my findings when in the shared first year modules which were underpinned by the biomedical model, mental illness is viewed as a disease or mal-function of brain chemistry requiring a cure. Terms such as mental 'symptoms', 'case', 'pathology' and 'prognosis' lend themselves to the biological mode of thinking about mental health problems and as discussed in Chapter Two this focus of education returns to Gournay's (1995) view of the role of mental health nurses to ensure compliance with prescribed treatment.

In the UK there has been an on-going debate about implementing generic undergraduate nurse curricula. Genericists in the UK bemoaned the lack of courage to make Project 2000 (UKCC 1986) a generic preparation for nursing, with its eighteen-month Common Foundation programme (CFP) of shared learning component seen as just a halfway house (White et al,

1998). The CFP was further reduced to one year when the Making a Difference (1999) curriculum was introduced, in part, due to the concerns expressed by managers and traditionally trained nurses that mental health nurses upon registration had limited knowledge and skills for caring for people with mental health problems. Despite the review of mental health nursing education in 2006 by the Chief Nursing Officer (DH 2006b), which underpinned the curriculum that the students in my study undertook, less than a year afterwards the Nurse and Midwifery Council commenced a consultation of pre-registration nurse education in 2007, besides focusing on the level of award (diploma or degree), views on the amount of shared learning and if this should lead to a generic/specialist qualification was asked for. Although 91% of mental health nurses who responded to this consultation wanted the separate fields to remain (NMC 2008), Hurley and Ramsey's (2008: 15) warned, mental health nursing remained 'a profession under imminent threat of non-existence'.

Once again nurse education has been discussed in the Shape of Caring Review (Willis 2012) which recommended a generic two-year foundation followed by field-specific one year, reminiscent of the Project 2000 structure. Additionally, it proposes a further specialist year of preceptorship once qualified. But this has been criticised by Coffey et al (2015) who state the two-year generic foundation will be dominated by adult field and one-year field specific will not offer the sufficient time to develop the knowledge and skills required for mental health practice. Even though to date there has been no decision on this recommendation, I feel this would be detrimental to mental health patient care, because as my findings reveal, the timescale from a benevolent, kindly but paternalistic, frame of reference supported by the biomedical model to a recovery, empowering to promotion self-resilience, frame of reference took over a year and some of the students had not consolidated their practice to reflect this by the end of their three-year course.

As currently mental health nurse education remains a separate speciality and involves clinical placements in mental health settings such as in-patient and community teams, I will now discuss the second issue found in my study that of the gap between what is taught in university and experienced in practice.

Implications for nurse education: Theory-practice gap

As shown in my findings, the students in the first year and beyond, viewed patients as 'cases' and 'signs and symptoms' of mental illness, despite placements in recovery teams and the

efforts of mentors to get students to actively engage with patients. While not stating all the practice they experienced was recovery focused as noted by the students' comments about judgemental staff, the students' initial benevolent frame of reference, supported by their first year shared propositional knowledge, clouded their view of the patients as people. If, as suggested earlier, different theories of health and illness and Todres et al (2009) values framework were taught prior to students commencing their first placement, students would be perhaps be able to view the care practices through different lens.

Additionally, mentors and other staff in practice need to know what is being taught in university so discussions regarding the content of contemporary nurse pedagogy needs to be available to practice. One way of doing this would be to include this information into the annual updates mentors need to attend to continue to support and assess students, facilitated by lecturers. In the university in which this study was conducted and my current university, the generic Mentor Update content is revised annually by the universities who have students in the county's healthcare placements and staff from practice settings. Although often presented as a PowerPoint presentation, these updates are flexible enough to encourage discussion and debate of relevant information so mentors would be aware of propositional knowledge taught by the universities. This can act as a prompt to mentors to link the theory to practice but also alert them to new theories and current research and policies.

Another way to close the gap between theory and practice is through the Befriender Scheme, which was not a new initiative as the adult field had piloted it (in the university this study was conducted), and I advanced this in the mental health field. The Befriender Scheme supported Healthcare Support Workers (HCSW), who in turn predominately support first year students to settle in to the routine of the ward or team and understand the role of caring. Comprehending the student assessment criteria for practice, how this can be met and supporting student nurse learning in practice are the goals of this scheme, but additionally supporting the HCSW own learning and practice is a major aim of the Scheme as they support students. So again, Todres et al (2009) values framework could be included in their induction to the Scheme and reiterated during the bi-monthly meetings with university lecturers. Included in these discussions could be how mental health patients are perceived by the general public, different theories on the causation of mental illness and how the HCSW would like to be treated if in the same situation as a patient in an attempt to reduce 'them and us' frames of reference.

Both of the suggestions above require lecturers to work in partnership with practice staff which offers learning about the propositional, practical and experiential knowledges taught in the university but also how this is reflected in clinical settings ensuring that the recovery principles and humanisation healthcare are viewed as practiced in the 'real world' of mental health care.

I now discuss the last main finding of my study which identified the stress the students experienced during the course, starting first with a brief overview of the context the study was undertaken, which will explain why a model of coaching, similar to the principles of recovery, can be employed to support and empower students.

Implications for nurse education: Experience of stress

The study started just before a reconfiguration of the university's nurse education provision in the county, which resulted in ending their involvement in nurse education, forecasted closure of the three education centres and transfer of staff, in three yearly phases, to another provider. Due to transfer, retirement and gaining a post another university, one year into this study only two mental health lecturers, including myself were left to teach three cohorts of students (approximately 86 students) all their field specific propositional knowledge in university and support them and their mentors in practice. Also, both I and the other lecturer were acutely aware that we would be leaving the university three months before the last cohort of students finished their education. We were mindful that student nurses were face unique stressors which differ from other students due, in part, to the nursing curriculum involving study in equal parts in the university and clinical placement, which do not occur in other undergraduate education (Crary 2013). So, after discussions regarding allocating different roles, we decided to use a coaching approach to personal tutoring, which resembling the recovery nurse/patient relationship, advocated in the curriculum we taught.

We adopted Hallett's (1997) seven stages of student nurse coaching as a structure as we felt this captured the stages many students went through in their nurse education. The stages are: 'encountering reality', 'having a go', 'being assessed', 'thinking through and understanding', 'developing ideas', 'gaining confidence' and 'being independent'. This coaching approach offered an environment that fostered 'hope' of learning the knowledge and skills of mental health nursing, 'empowerment' in a collaborative partnership to learn and flourish from stressful situations and 'opportunity', which developed resilience, to practice effective, but also

in a humanisation manner. All students in group and individual clinical supervision, tutorials and classroom discussions were encouraged to engage in this coaching approach.

As noted the students in my study experienced stressful events during their nurse education so it can be suggested they 'encountered reality' of the assessment criteria and workload of studying nurse education. In their individual interviews, all but Mia, identified being supported to think through and understand what they had experienced which assisted developing ideas and gaining confidence and independence. In Will and Gemma's pictorial representation (Appendices 6 and 7) this stressful reality check and the subsequent forward movement was evident. However, as Mia's pictorial representation illustrates (Appendix 8), not all students availed themselves of this supportive coaching and subsequently endured continuous stress throughout their education.

So, my suggestion is to incorporate relevant coaching approaches to the lecturer/student relationships and to ensure consistency in practice including information regarding coaching in Mentor Updates. While Hallett's (1997) framework was used in this study, more research has been undertaken and Reyes et al's (2015) research into nursing students' stressors offers a contemporary framework for including a coaching approach into supporting students in the university and in practice. Having explored the findings of my research and the implications for education, I now discuss my intensions for further study and offer guidance to other researchers.

Further research

My study was undertake was 2011-2014 and since this time the students have been registered mental health nurses for four years. In these proceeding years I have met five of them when I have visited different practice settings and witnessed their careers flourishing. Marion, Gemma and Carol are Community Mental health nurses each with a caseload of patients, Josie is a Sister of an Older Adult ward and Will is a Manager on an acute mental health ward. I have not seen Mia since she completed the Pre-Registration Programme but I heard that she returned to the Community Home she previously worked in as a registered nurse. So it would be revealing to interview my participants again to find out what their frames of reference are now and if they had changed what had prompted the change. When undertaking this current study I found that the most informative data was collected during the Group Work session, individual interviews and pictorial representations, which offered insights into their opinions about the

causes of mental health problems, the concept of recovery and the role of the nurse in nurse/patients relationships, as well as their personal experiences. Therefore I would consider adapting the questions from the Group Work session and individual interviews and asking them to draw a picture to explain their career journey.

I will now offer advice to researchers wanting to use case-study methodology. As noted previously my study was a longitude case-study underpinned by Stake's (2000) collective category, where each student was an individual case within a cohort group case. I combined Stake's (2000) intrinsic case-study principles to tease out stories of those living the case, and instrumental case-study principles to identify issues and generalisations, to identify categories within the collective category which allowed me to explore similarities and differences between the students' learning experiences during their nurse education. Additionally, as the study was longitudinal over three years it offered an in-depth analysis of who each student was, what shaped their opinions and identified meaningful moments throughout the programme. I found employing Stake's (2000) case-study which did not stipulate a rigid study plan at the commencement of the project allowed me to explore issues as they emerged and offered diverse data collection methods to explore these issues. So to conclude, I would recommend using Stake's (2000) case-study methodology due to its flexibility and guidance, employing varied data collection methods to offer different ways of capturing and validating findings and pen-portraits to organising data and ensure trustworthiness.

I realised soon after starting this project that some data collection strategies provided more detailed information about the students' views, opinions and experiences than others. The Attitude to Mental Illness questionnaire offered a baseline of the students' attitudes and knowledge about mental illness at the start of their programme but did not enable them to elaborate on their responses. The classroom discussions yielded large amounts of data, some of which was informative however much did not concern the focus of my study, but when there was a pre-plan structure to the discussion, as in the Group Work session which resembled focus group methodology, more in-depth data relevant to the research question was captured. In some respects, as each student was asked for their opinions the Group Work session, this method of data collection provided more clarity of their views which were either agreed with or challenged, than the individual interviews. The focal point of these interviews tended to centre on the student's own education journey and for some quieter students, such as Mia, it was difficult to get her to expand on her responses to the questions. The pictorial representation was

a novel idea suggested by one of my supervisors. Each student was asked to draw a picture of their education journey on an A4 piece of paper and then they explained the meaning of their drawing. Initially I did not realise the important role it would play in supporting my findings, but the potholes, troughs, diversions, deep craters on their journey from A to B, depicted graphically the distressing moments each of the students encountered. The method which did not yield any significant data was the reflective assignments, which might be due to the students' academic style of writing. So in future I would plan individual meetings with each student to discuss their reflective assignment to tease out what they had learnt from the encounter.

In terms of analysis, as this was a mixed methodology study but mainly qualitative, there was large amounts of data to organise and I found, after several attempts of trying to arrange into individual tables, that constructing a pen-portrait for each student offered an overview of the students' personal views, opinion and experiences throughout their education. Additionally, as the students were given their pen-portrait prior to their individual interviews they could either clarify or dispute any aspect of the pen portrait, thus advancing trustworthiness of my findings.

This thesis was exploring if the curriculum advanced transformative learning and I found two problems with Mezirow's (1978-2009) theory. The first was that Mezirow (1978) stated that to achieve transformative learning the learner must acknowledge that their frame of reference has changed. Mia, despite her responses differing in the two Attitude to Mental Illness Questionnaires (AMIQ), worrying about her personal safety in the second year, never discussing her nursing care contact with individual patients and identifying that stressful nature of the programme, nevertheless appeared to adopt a recovery frame of reference by the end of the programme. While it could be conceded that she grew in confidence only, in my opinion she had changed her frame of reference and was unaware or was unwilling to admit her previous habits of mind. Following Mezirow, in my study she was considered to be a learner who did not realise transformative learning, nonetheless, rather than showing disempowering behaviour, Mia's change in frame of reference behaviour as a self-assured patient-centred student was equal to Josie's partnership working.

Mezirow (1991a: xi) conceded that his 'theory [is] in progress' and explained or amended some aspects due to ongoing criticism, for instance the terminology used to describe his theory (see Appendix one). Nevertheless, the ten stages which are arranged into three phases: alienation, re-framing and consolidation remained. Yet, the second problem is that my study does not

support a logical progression through these stages as only one student experienced a dramatic 'disorganising dilemma' and seemed to feel some guilt about her previous actions of disempowering patients. The other four students appeared to have small accumulating triggers and did not express how these made them feel, so my study illustrates a more incremental approach which does not generate overwhelming emotions in the alienation phase of transformative learning. Nevertheless, all the students spoke about the vicarious learning they were exposed to during their classroom discussions, which is included in Mezirow's re-framing phase. This communicative learning allowed the students to hear their peers' views and opinion, and at times, challenge or be challenged, adding to their pool of knowledge. Additionally, the five students who acknowledged that they had changed their frames of reference to a recovery one and all spoke about how they were planned to incorporate these principles into their practice. By the end of their nurse education only two students consolidated recovery principles into their nursing by integrated partnership working with patients. I found problems with attempting to fit each students learning experiences into Mezirow's (1978-2009) stages and phases so I suggest it is possible to change frames of reference without experiencing all the stages.

Contributions to knowledge

Viewed through Mezirow's (2009) transformative learning phases and Burnard's (1987) nursing knowledges, my findings identified different aspects of propositional, practical and experiential knowledge which either advance or hinder recovery frames of reference. As noted in Chapter Three, studies into attitudes of mental health student nurses are rare so this study offers fresh theoretical insights into the lived experiences of these students. The study also contributed to understand what promotes and what constrains transformative learning by identifying that: a benevolent attitude in mental health promotes a 'them and us' view of patient care; that the stressful nature of nurse education requires time; and, and that the usefulness of coaching relationships between students and lecturers lies in promoting values. While it can be suggested that other studies have found similar themes individually, my investigation demonstrated how these three findings when taken together reveal how students change to take on the principles of recovery.

A further contribution to knowledge relates to the debate about the UK commencing a generic nurse education curriculum. My findings identified that when the students shared the generic propositional knowledge, which was dominated by the biomedical model, in their first year,

supported their benevolent attitude and they tended to view patients as ‘cases’ or ‘symptoms’ rather than people. These new insights into mental health nurse education have already been incorporated into my own and my colleagues teaching practice in my current university. For example, I present a session to all the first-year nurse students based on Todres et al’s (2009) values framework and link it to their experiences in practice. Additionally, all first-year students attend skills sessions facilitated by mental health lecturers and mentors where discussion focuses on common mental health problems such as stress, anxiety and depression and how the recovery model underpins person-centred care. Furthermore, my colleague and I have introduced clinical supervision for all mental health students using a coaching approach and this has now been taken up by adult lecturers who have found it useful in identifying students who are experiencing stressful situations. They offer ways of learning from and working within contemporary healthcare environments.

While my study was focused on mental health nurse education, I suggest that within this thesis there is transferable knowledge for other disciplines. The nurse/patient relationship is view as an important component of all fields of nursing and the Nursing and Midwifery Council (NMC) (2015) stress the significance of this. The first NMC (2015) standard is termed Prioritising People and states that patients should be treated with respect, their dignity respected, their rights upheld and discriminatory attitudes and behaviours challenged. Todres et al’s (2009) humanisation and dehumanisation framework explicitly identifies the values which should underpin all healthcare so is applicable to other disciples not just nursing.

Furthermore, to develop understand of transformation theory, exploration of the crucial elements in transformative learning itself would be helpful, particularly the place of emotions as trigger for disorienting dilemmas and during self-reflection.

Conclusion

This thesis offers an insight into contemporary mental health nurse education, the students’ experiences of nursing in the 21st century and how transformative learning requires a considerable amount of time to be integrated into practice.

As discussed in Chapter One, mental health nurse education has change significantly in the past thirty-five years, from the apprenticeship-model of training-on-the-job in large isolated hospitals to learning within Higher Education Institutions with placements in in-patient units

and the community. This shift changed the emphasis of pre-registration from training students to capability undertake nursing tasks to education which produced students who could think critically, problem-solve and reflect on their practice. As my research illustrates over their three-year nurse education the students slowly acquired these skills which was evident in their classroom discussions and individual interviews. So from accepting handed-down 'knowledge' they considered the evidence from differing viewpoints to underpin their practice.

The changes in nurse education happened during a time when care for the mentally ill patient was also transforming from benevolence to recovery. From patients being pitied due to their incurable disorder, their strengths, coping strategies and aspirations for a meaningful life are now the forefront of care. The change in emphasis from dehumanisation to humanisation values views patients as individual and unique people, who have different hopes and desires so their self-agency should be respected and championed. In my study the concept of recovery was at the very heart of the students' propositional education but, at times, their own frames of reference, and practice and experiential experiences did not reflect these principles. However, over time and by experiencing their own distress due to failing an assignment or the sheer amount of study, the students began to incorporate the values of humanisation into their nurse/patient relationships.

Finally, my thesis demonstrates that mental health nurse education can be transformative. By underpinning the curriculum with recovery principles, which reflect humanisation values, patients are seen as unique people rather than diagnoses. However, my study identified that these values took time and personal distress change frames of reference and be integrated into nursing care. They also required 'communicative learning' in the form of discussions free from coercion and self-perception to gain insight into other people's points of view to aid self-reflection. Additionally, as this transformation thought-provoking it can be distressing so student/lecturer relationships necessitate supportive role modelling and coaching mirroring the recovery principles of hope, empowerment and opportunity.

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Appendix 1: Refinement of Merizow's Transformative Learning (1978-2009)

1978

Initial research of re-entry mature USA women students concluded that some students underwent *personal transformation*, leading to the formulation of the ten stage theory of Transformative Learning.

1981

Adapted Habermas' (1971) three types of learning: technical (rote), practical (social norms) & emancipatory (introspective) to devise a critical theory of adult learning and education renaming them: *instrumental* (transmissional), *dialogic* (transactional) and *self-reflection* (transformational). He exhorted that only learning by self-reflection of assumptions can be lead to *perspective transformation*.

1985

Defined *meaning schemes* as the collection of values, beliefs & judgments that generate *meaning perspectives*, the assumptions, world-view & mindset, which acts as perceptual filters shaping interpretations of experiences. Identified the process of learning as operating in present *meaning schemes*, by obtaining new *meaning schemes* or through *meaning perspective.* Although the latter being the main route to *perspective transformation* via sudden, painful & challenging *disorientating dilemmas*, he now conceded that an accumulation of small modifications to beliefs & values can initiate this process.

1991

Stressed the importance of altering present relationships & forging new relationships to assist critical reflection of distorted *meaning perspectives*. He contended that there were three types of *meaning perspectives*: epistemic (knowledge & how the person uses it), sociolinguistic (language & how it is used in social settings) & psychological (the way people view themselves).

1995

Forwarded that there were three types of reflection: content (thinking back on experiences resulting in learning with present *meaning schemes*), process (considering reasons for actions which may alter *meaning schemes*) & premise (deliberate on the larger picture of own value system which may transform *meaning perspectives*).

1998

Articulated two new facets of critical reflection of assumptions: objective reframing (contemplation of own belief system) and subjective reframing (contemplation on causes for own belief system).

2000

Revised original terminology & elaborated on meaning: *meaning perspectives* became *frames of reference*, which comprises of *habits of mind* (sense of self, belief system, interpretation of social systems) that are unpinned by *points of view* (opinions formed through experience = *meaning schemes*). Learning can be achieved by: elaborating on existing *frames of reference*, learning new *frames of reference*, *objectively reframing points of view* or subjectively reframing *habits of mind*.

2009

Reworked former types of learning & narrowed them down: *instrumental* (empirically testing beliefs & assumptions) and *communicative* (validating or justifying contested beliefs & assumptions through discourse). Examined other people's view of *Transformative Learning* & demonstrated how they were included in his version.

Appendix 2: Ethical Approval

2011/5/JH

School of Education – Research Ethics Approval Form

The University of Nottingham

Name	Fran Mablethorpe
Main Supervisor	Melanie Walker and Monica McLean
Course of Study	PhD
Title of Research Project:	Student nurses' belief about people experiencing mental health problems
Is this a resubmission?	No

Date statement of research ethics received by PGR Office: 10.01.11

Research Ethics Coordinator Comments:

My apologies for the delay in processing this application.

On the whole, you seem to have taken account of the ethical concerns which might arise. I would raise a few matters (see below); most can be addressed quite easily, but point 4(b) is a little more complex.

1. In the consent form, you use the phrase "I have heard about and fully understand the research project detailed in the Information Sheet". I think you should use a phrase more like: I have been informed about the research project, and read the research project detailed in the Information Sheet, which I fully understand.
2. You should explain briefly what (in the consent form) the phrase "any information I give is confidential" means, i.e., what steps will you as the researcher take in order to ensure that the information remains confidential?
3. The consent form includes the statement: "I am fully aware that taking part in this research project is voluntary and that I can withdraw at any time without giving a reason." This needs to be strengthened by pointing out that choosing not to participate, or to withdraw, will cause no detriment to the student in their progress on the course.
4. You say in the Information Sheet for first year students: "the Transition to Branch day, you attend at the end of the first year, will be audio-recorded. In the second year you will again be asked to ... participate in an audio-recorded focus group"; the second years are asked to "participate in a [*sic*] audio recorded focus group". In relation to focus groups and the Transition to Branch day, you need to reflect on and explain:

Outcome:

Approved [✓] (subject to condition stated)

Revise and Resubmit [ ]

Signed: [signature]

Name: Professor John Holford (Research Ethics Coordinator)

Date: 2nd March 2011

(a) how you will ensure confidentiality of what a participant says when other members of the group, as well as yourself, will presumably hear (or, to put it another way, what "confidentiality" means when other research subjects will also hear what is said? – I would recommend at least an amendment to the consent form in which each participant formally agrees to maintain confidentiality in relation to any matter which they hear from another participant in the course of this research);
(b) how you will proceed in the event that one or more participants in the T to B day decline to participate (in which case it is presumably not possible to record the day)?

This consent is given subject to the condition that, in respect of points 1-3 and 4(a), suitable amendments are made along the lines I have suggested (and endorsed by your supervisor), and in respect of 4(b) that no detriment is caused (e.g., by being asked not to participate in the Transition to Branch day) to any student who chooses not to take part in the research.

Outcome:
Approved [✓]
(subject to condition stated)

Revise and Resubmit [ ]

Signed: [signature]

Name: Professor John Holford
(Research Ethics Coordinator)

Date: 2nd March 2011

Appendix 3: Information Sheet

Information Sheet

I would like to invite you take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Please ask me if there is anything that is not clear, my contact details are at the end of this sheet.

What is the purpose of this study?

This research project is part of my PhD in Higher Education. The aim of the study is to chart whether student nurses' beliefs about people with mental health problems change over their three year Pre-Registration Mental Health Nurse education.

Why have I been invited to take part?

You have been asked to take part because you and other students in your cohort are at the start of your Pre-Registration Mental Health Nurse Education. As the aim of the study is to chart whether student nurses' beliefs change during their education, the research needs to start when participants commenced their education.

Do I have to take part?

Taking part in this study is entirely voluntary so you do not have to take part. If you would prefer not to, you do not have to give any reason. If you choose to take part you can still leave the project at any time, without giving a reason. Whether you decide not to take part or leave during your education, will cause no detriment to their progress on the course.

What will happen to me if I take part?

If you agree to take part in this research study the data will be collected in several ways:

1) In your first year: you will be asked to complete the Attitude of Mental Illness Questionnaire (AMIQ), I will also take notes some selected sessions within the university.
2) In your second year: I will take notes selected Theory or Clinical Supervision sessions.
3) In your third year: you will be again asked to complete the AMIQ and will be invited to partake in an individual interview.

If all students in your cohort agree to participate in this study, sessions maybe audio-recorded instead of notes being taken.

What are the disadvantages to taking part?

Although I cannot foresee any physical risks, you may find discussing your own beliefs or hearing other students' views about people experiencing mental health problems distressing. You can leave at any point during data collection and I will offer time to discuss your feelings at a mutually convenient time. As I am a Mental Health Nurse I have the training, experience and skills to support you in this way; additionally, if I judge it to be necessary, we will discuss a referral to the university's Counselling Services.

What are the benefits of taking part?

Although there may not be any direct benefits to you besides assisting with reflection on your experiences of Pre-Registration education, the findings of the research can direct learning strategies for future students.

Will my taking part in the study be kept confidential?

The usual practice of maintaining confidentiality during your education will be upheld by all students and lecturers. I will discuss issues arising from this study with my supervisor but your identity will be protected by a pseudonym. During the research process and any following publications confidentiality and anonymity will be maintained. That is, your real name and the name of the university will never be used.

What happens if I don't want to carry on with this study?

As your participation is voluntary, you are free to withdraw at any time without giving a reason. The information collected up to that point cannot be erased and this may still be used in the research findings. As stated earlier, deciding to withdraw will not cause any detriment to their progress on the course.

What will happen to the results of the study?

The findings of this study will be included in my dissertation and any articles for publication. All information collected during the research will be kept strictly confidential and stored securely.

What if I have any queries or concerns after reading this information sheet?

If you have any concerns about any aspects of this study, please do not hesitate to contact me Fran.Maplethorpe@nottingham.ac.uk or my Academic Supervisor Melanie.Walker@nottingham.ac.uk

Appendix 4: Consent Sheet

Consent form to be used with prospective participants

- I have need been informed about the research project, and read the research project detailed in the Information Sheet, which I fully understand.
- I agree to participate in this research having fully considered all the information provided.
- Any questions, which I have asked, have been answered to my satisfaction.
- I am fully aware that taking part in this research project is voluntary and that I can withdraw at any time without giving a reason and this will cause no detriment to my progress on the course.
- I know I will remain anonymous and any information I give is confidential and will not be discussed with other people except the researcher's academic supervisor.
- I have received a copy of the Information Sheet and Consent Form.
- I understand that if I require any additional information that I can contact the researcher Fran Maplethorpe who will answer any additional questions.

Participant's Name

Participant's Signature

Date

Fran Maplethorpe

Mental Health lecturer

Division of Nursing, University of Nottingham

Education Centre, County Hospital

Greetwell Road, Lincoln, LN2 5QY

01522 848148

Fran.Maplethorpe@nottingham.ac.uk

Appendix 5: Attitudes to Mental Illness Questionnaire (AMIQ)

Department of Health Questionnaire (2010)

Are you male or female?

Your age: 16-34 35-54 55+

Why did you choose to study Mental Health Nursing?

What experience of people with mental health problems did you have before starting your Mental Health Nursing?

Do you agree or disagree with the statements below?	**Strongly agree**	**Slightly agree**	**Neither agree nor disagree**	**Slightly disagree**	**Strongly disagree**
One of the main causes of mental illness is a lack of self-disciple & will-power.					
I would not want to live next door to someone who has been mentally ill.					
As soon as a person shows signs of mental disturbance, he should be hospitalised.					
Mental illness is an illness like any other.					
Less emphasis should be placed on protecting the public from people with mental illness.					
Mental hospitals are an outdated means of treating people with mental illness.					
People with mental health problems should have the same rights to a job as anyone else.					
It is frightening to think of people with mental problems living in residential neighbourhoods.					
We need to adopt a far more tolerant attitude toward people with mental illness in our society.					
We have a responsibility to provide the best possible care for people with mental illness.					
People with mental illness don't deserve our sympathy.					
A person is foolish to marry someone who has suffered from mental illness, even though he seems fully recovered.					
As far as possible, mental health services should be provided through community based facilities.					

Do you agree or disagree with the statements below?	**Strongly agree**	**Slightly agree**	**Neither agree nor disagree**	**Slightly disagree**	**Strongly disagree**
People with mental illness should not be given responsibility.					
There are sufficient existing services for people with mental illness.					
No-one has the right to exclude people with mental illness from their neighbour.					
Most people who were once patients in a mental hospital can be trusted as babysitters.					
People with mental illness are far less a danger than most people suppose.					
Increased spending on mental health services is a waste of money.					
Residents have nothing to fear from people coming into their neighbourhoods.					
Virtually anyone can become mentally ill.					
The best therapy for many people with mental illness is to be part of a normal community.					
There is something about people with mental illness that makes it easy to tell them from normal people.					
Anyone with a history of mental problems should be excluded from taking public office.					
People with mental illness are a burden on society.					
Locating mental health facilities in a residential area downgrades the neighbourhood.					
People with mental illness have for too long been the subject of ridicule.					

Question 2

Which of these statements do you feel usually describes a person who is mentally ill.	**Yes**	**No**
Someone who has serious bouts of depression.		
Someone who is incapable of making simple decisions about his/her own life.		
Someone who has a split personality.		
Someone who is born with some abnormality affecting the way their brain works.		
Someone who cannot be held responsible for his/her own actions.		
Someone prone to violence.		
Someone who is suffering from schizophrenia.		
Someone who has to be kept in a psychiatric or mental hospital.		

Question 3, 4, 5 & 6

What is your experiences & views in relation to people who have mental health problems	**Yes**	**No**
Are you currently living with, or have you ever lived with, someone with a mental health problem?		
Are you currently working, or have you ever worked, with someone with a mental health problem?		
Do you currently, or have you ever, had a neighbour with a mental health problem?		
Do you currently, or have you ever had, a close friend with a mental health problem?		

Question 7

Statements about your future relationships you may experience with people with mental health problems	Strongly agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Strongly disagree
In the future, I would be willing to live with someone with a mental health problem.					
In the future, I would be willing to work with someone with a mental health problem.					
In the future, I would be willing live nearby to someone with a mental health problem.					
In the future, I would be willing to continue a relationship with a friend who developed a mental health problem.					

Question 8

Statements about mental health problems.	Strongly agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Strongly disagree
Most people with mental health problems want to have paid employment.					
If a friend had a mental health problem, I know what advice to give them to get professional help.					
Medication can be an effective treatment for people with mental health problems.					
Psychotherapy (e.g. talking therapy or counselling) can be an effective treatment for people with mental health problems.					
People with severe mental health problems can fully recover.					
Most people with mental health problems go to a healthcare professional to get help.					

Question 9

Do you agree or disagree that each of the following conditions is a type of mental illness?	**Strongly agree**	**Slightly agree**	**Neither agree nor disagree**	**Slightly disagree**	**Strongly disagree**
Depression					
Stress					
Schizophrenia					
Bipolar disorder (manic-depression)					
Drug addiction					
Grief					

Question 10

Who is the person closest to you who has or has had some kind of mental illness?	**Tick**
Immediate family (spouse/child/sister/brother/parent etc)	
Partner (living with you)	
Partner (not living with you)	
Other family (uncle/aunt/cousin/grandparent etc)	
Friend	
Acquaintance	
Work colleague	
Other please specify)	
No-one known	

Question 11

What proportion of people in the UK do you think might have a mental health problem at some point in their lives?	tick
1 in 1,00	
1 in 100	
1 in 50	
1 in 10	
1 in 4	
1 in 3	

Question 11

If you felt that you had a mental health problem, how likely would you be to go to your GP for help?

Very likely	Quite likely	Neither likely nor unlikely	Quite unlikely	Very unlikely

Question 12

In general, how comfortable would you feel talking to a friend or family member about your mental health, for example telling them you have a mental health diagnosis & how it affects you?

Very uncomfortable	Moderately uncomfortable	Slightly uncomfortable	Slightly uncomfortable neither comfortable or uncomfortable	Fairly comfortable	Moderately comfortable	Very comfortable

Appendix 6: Will's Pen Portrait

After agreeing to participate in this study Will completed the Attitudes to Mental Illness questionnaire (DH 2010) which also asked for his age, familiarity with people experiencing mental health problems and the reasons he chose to study mental health nursing. He is male, aged between 16-34, who had no experience of people working with mental health problems and decided to study mental health nursing as he 'wanted a rewarding job, something different from 9-5' to 'get out as much as I put in'. Although answering 'neither agree nor disagree' to five of the statements in question one, his remaining responses indicated a 'benevolent' attitude'. His replies to question two tended to support the 'benevolence' attitude: he felt someone with a mental illness cannot be held responsible for their actions and have to be kept in a mental hospital. Although he did not feel they were incapable of making simple decisions, born with a brain abnormality or prone to violence. He correctly identified depression and schizophrenia as mental illnesses, and also felt that split personality was one. This was partial reflected in the question regarding types of mental illness, where he strongly agreed that schizophrenia and bipolar disorder were, but only slightly agreed that depression was, in addition to stress and grief. He disagreed with drug addiction being in this category. He knew one in four of the UK population would experience mental health problems at some point in their lives. He stated he had experience of a family member, a close friend and a work colleague who had mental health problems and was willing to continue these relationships. He felt that medication was an effective treatment, but was unsure about the benefits of talking therapies and of the advice he would offer to obtain professional help. He disagreed that all people can recover from mental illness. He slightly disagreed that most people would go for professional help and this was mirrored in his response to the question about visiting his GP if he had a mental health problem, although he would be fairly comfortable telling his family.

In the Forum he talked about his current first practice placement which was with a community Older Adults team. His placement was arranged last minute due to the unavailability of his initial practice setting and he did not know what to expect as it was his first experience of working with older people and in a healthcare environment. He did not always feel supported as he had two part-time mentors, and if neither were there he was left to his own devices so did not feel he was getting many learning opportunities in this placement.

In the Transition to Branch session Will stated he worked part-time as a care officer for in a residential care home for children to supplement his bursary. He lived with his girlfriend, who he had been with for two years and they had just got another little kitten, so he felt he was growing and maturing. His aspirations for the forthcoming two years was to expand his knowledge in mental health nursing, see different therapies in action and to pass all his assignments. He felt that as his cohort was small, job prospects would be good locally although he would like to emigrate to Australia in the future. To achieve this he was willing to give his time and effort as university was his number one priority but already he was finding the course difficult due to the travelling for 3 hours a day, working part-time and the assignments. This had affected his relationship with his girlfriend, he did not have time to socialize with his friends, he was tired and, at times, lonely.

Although he found starting a new placement ‘quite hard’ as he did not want to come over as too confident but also he had concerns of missing learning opportunities by slipping ‘into the background’. He felt first impressions were important so his strategy was to introduce himself and be as helpful as possible to let people know he was there. His current placement was on a Day Ward which did not have many ‘complex cases…..quite tame’ so he went to one of the wards for an insight visit and saw people who were ‘more ill’. He found seeing, rather than reading about, people who were experiencing schizophrenia or having auditory hallucinations ‘interesting’ as ‘it seems so real for them’.

When the conversation turned to why it was not advisable to offer lifts to patients who needed to attend groups or hospital appointments, he felt that this was due to financial reasons as they were not paid mileage for this type of work and it could be seen as doing NHS duties. However following prompting from the lecturer he realized that this could ‘disempower’ patients and it would be better to promote their usual forms of transportation e.g. buses, taxis etc to ensure long-term recovery and reduce the possibility of dependency.

He had concerns about how much he was allowed to divulge about himself to patients and spoke about a patient who had felt comfortable enough with him to disclose a lot in-depth personal information and asked him questions about himself. He felt she was just ‘showing a general interest’ in him and he felt comfortable answering these general questions but wondered if it was right to talk about himself at all. When the lecturer acknowledged that appropriate self-disclosure was acceptable, he was relieved as he thought that the relationship would be jeopardized if the patient was ‘getting nothing back’.

When another of the students voiced her own ‘young age’ as a disadvantage in creating the nurse/patient relationship, Wil returned to his discussion about disclosing personal information and re-iterated that this patient was over twenty years his senior but felt she was able to discuss her problems. He did feel worried about asking some of the intimate questions on the admission documentation but stated if the student acted in a professional manner, age would not be an issue. If the patient had a problem with answering them it was their right and had no bearing on the person asking them.

In the Recovery session Will stated his reasons for choosing mental health nursing to study were two-fold: he wanted to be a professional with a career ‘in something that I could be respected for doing’ and as he had ‘enjoyed psychology’, nursing ‘seemed the best way to get some hands on experience’. He intended to study ‘different therapies’ once he had completed his nurse education. Although he felt he practiced in a recovery focused way he considered that despite being offered ‘fancy therapies and medications….some people will never be helped’ as they do not ‘work for everybody’.

He admitted being surprised at the behaviour of some of the service users he encountered in his last placement: ‘people sat there showing massive self-harm marks’ and ‘as soon as anyone mentions…...discharge they automatically….deteriorate quite rapidly’. As the day centre catered for people experiencing mental health problems he thought the service users felt ‘socially acceptable’ so exhibited behaviour that ‘they might not do in another environment’ and were ‘scared’ of leaving this service ‘they had become reliant’ on. He advocated reassuring service users that although they were ready for discharge, the ‘services are always going to be here’ for them.

He thought the media tended to portray people with mental health problems as ‘being different’ and dangerous by using headlines like ‘mentally ill attacker’ and he felt this was to ‘sell more papers’. Nonetheless, recently he had seen a few ‘positive and supportive’ features about living with mental illness on TV and this, coupled with more celebrities ‘coming out about having mental health issues’, he felt there was less stigma but ‘still a long way to go changing how people see mental health but it is going in the right direction’.

During the group Clinical Supervision JWill spoke about how his view of recovery had altered since commencing the Mental Health Branch component of the course. Previously he thought recovering from a mental health problem was similar to getting better from a broken leg in that the patient follows the instructions given by the clinician and the leg will be fixed in six weeks.

The combination of the module lectures and reading around the subject, which offered other people's points of view and values, he now sees recovery as 'very personal and individual' and it can be seen as living beyond the illness and making the 'best situation' of it.

His current placement was on a Rehabilitation ward but he had found that the principles of recovery were not always being followed. Although nurses were there to guide and support, some patients got 'a shock' when they were admitted as the onus was on the individual to take ownership and control of their recovery, while others did not accept that they are ill. He also thought that as the unit was new, had excellent amenities and patients were able to keep their state benefits, this could hinder recovery as some patients did not have an incentive to move back into the community. Will could see how some staff became frustrated at this 'bed-blocking' but although this frustration was voiced on many occasions very little action was taken to resolve this situation and he thought this was due to staff being scared of the ramifications if an ex-patient 'did something' . Will spoke about an incident when a patient was informed he was ready to move to a less structured environment, although he did not appear reluctant to do this but suddenly stated he was hearing voices telling him to kill himself. This to Will appeared to be a deliberate action to remain in the unit and this was echoed in the comments of fellow staff who felt he was playing the system and everyone felt frustrated by the patient's behaviour. When a peer in the group Clinical Supervision, who was on the same placement, suggested that inconsistency between staff who had different rules was more frustrating for patients, he agreed with this and admitted it was confusing. When another student suggested that this was due to recovery being a relatively new concept, he countered this by talking about a nurse who had been trained many years before but who practiced within the principles of recovery: she had 'the passion and the drive and empathy' and was inspirational to him.

In his Recovery assignment Will explored the difference between the medical (focusing on a cure) and the social model (focusing on the patients' strengths and opportunities, definitions of recovery) and how mental health nursing had veered from the medical to the social over the past decades.

In his care study, he described how he had initiated and developed the therapeutic relationship with a patient recently transferred to the rehabilitation ward. He calls the patient Mr X, for confidential reasons, and uses the DSMIV (1994) diagnostic categories to explain his mental health issues. However, later in the assignment there is a sense of who Mr X is when Will used

his direct quotes about his feelings of guilt and despair are mentioned. Will discussed how he related knowledge from Egan (1998) and Rogers (1957) to his practice during one-to-one sessions with Mr X, resulting in his awareness of his body language and the affects this may have on the therapeutic relationship.

During the Group Work Facilitation session Will stated that his knowledge about the effects of mental health problems had changed ‘dramatically’ during the course: prior to commencing nurse education he tended to support the media view that the mentally ill were violent or aggressive. He was now more critical of this negative portrayal feeling it was a ‘spin’ to sell newspapers and cited meeting patients, lectures and reading about mental health for this turn round. He offered the example of when he was given a panic alarm on the first day on an admission ward which appeared to confirm his initial belief, but once he got ‘to know the patients, know who they are’ he found ‘they were more vulnerable’ than the media implied. Additionally, he felt that researching for his Recovery assignment changed his views about therapeutic relationships between nurses and patients. The type of relationship depended on the patient and their needs so nurses needed to adapt their interactions to facilitate this. During the course he had worked with different age groups of patients and never found that his young age had a detrimental effect on developing relationships with them.

He had heard nurses discussing patients in a judgemental way but he considered this to be their way of venting frustration. He regarded mental health nursing as a ‘very serious job’ which was stressful due to the personal nature of the things nurses heard from day to day and as nurses are ‘human’ this could be seen as a positive ‘release’, but he stressed that this should be in the confines of confidential team discussions.

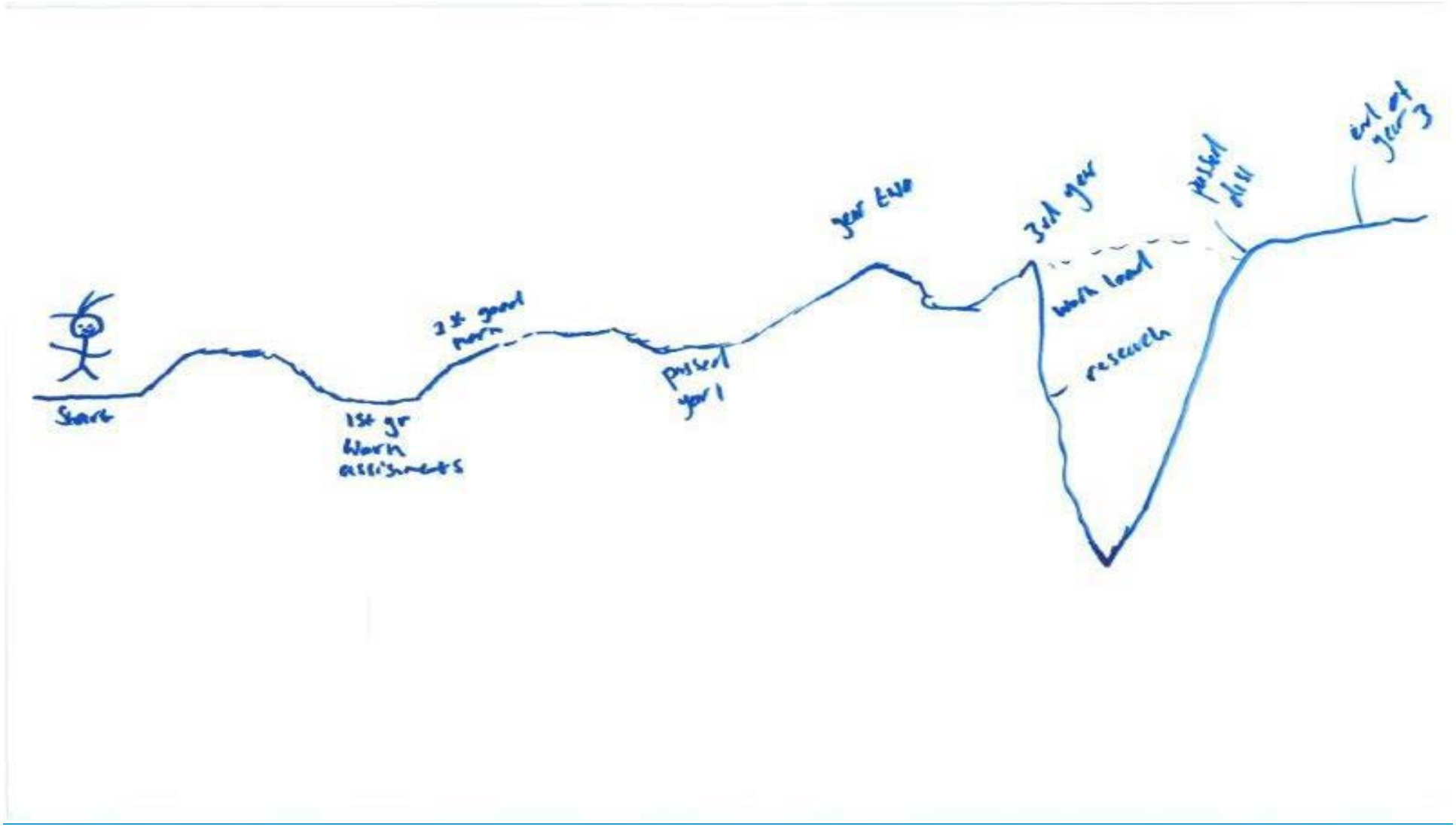
He now thought that there were ‘multi-factorial’ causes for mental illness and cited stressors, childhood experiences, up-bringing and heredity factors. He thought that everyone was prone to mental health problems to some degree and admitted he had suffered anxiety and stress at times. He felt that recovery should be defined by the person with the mental health problem but conversely stated that if the person heard voices for the rest of their life they could not ‘be classed as fully recovered’ and he had never met someone with schizophrenia who had held down a job.

At the beginning of his third year of study Will was again asked to complete the Attitudes to Mental Illness questionnaire (DH 2010). Many of his responses had changed since the first questionnaire: he now slightly agreed that ‘mental illness was like any other illness’ and

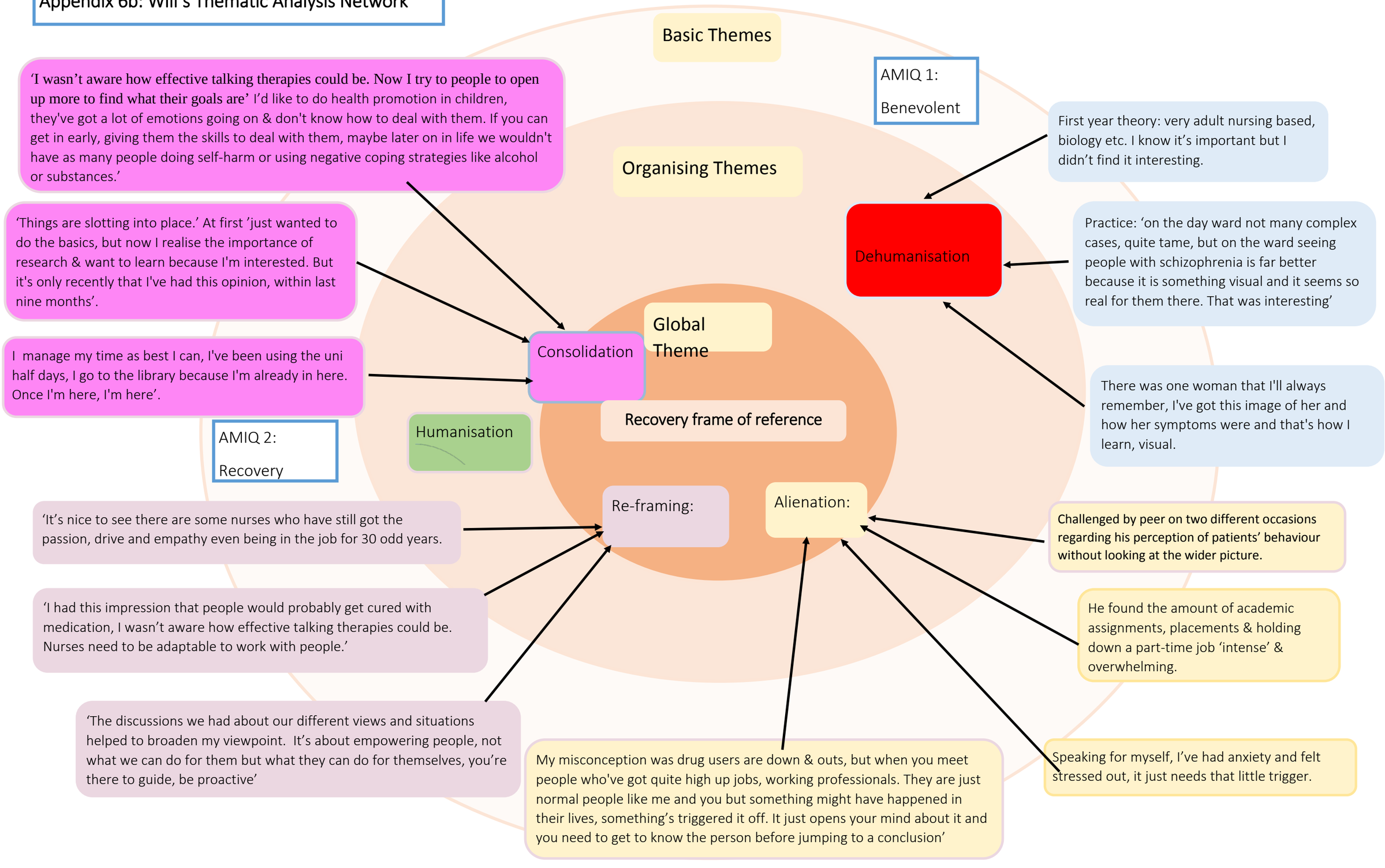
strongly disagreed that it would be ‘frightening to think that people with mental health problems living in the neighbourhood’. Additionally, he strongly agreed that ‘virtually anyone can become mentally ill’, agreed that ‘less emphasis should be placed on protecting the public’ and that ‘residents had nothing to fear from people with mental health problems coming into their neighbourhoods’. This time his answers to question one when analysed indicated a move towards the ‘recovery’ attitude, with the ‘benevolent’ lagging significantly behind.

In question two, many of his answers were the same as when he undertook the questionnaire the first time, although he did not give an answer to the statement ‘someone who had a split personality’ and now dis not believed that a person who was mentally ill was ‘born with some abnormality affecting their brains’ and could still ‘be held responsible for their own actions’. Also, his view about people with ‘severe mental health problems ability to fully recover’ had changed from strongly disagreeing to strongly agreeing to disagree and he would be ‘willing to live with someone with mental health problems’ in the future. His knowledge about different mental illnesses and the proportion of people in the UK with mental health problems remained consistent with the first questionnaire. His responses indicated a recovery attitude.

Appendix 6a: Will's pictorial representation



Appendix 6b: Will's Thematic Analysis Network



Appendix 7: Gemma's pen portrait

After agreeing to participate in this study Gemma completed the Attitudes to Mental Illness questionnaire (DH 2010) which also asked for her age, familiarity with people who have experienced mental health problems and the reasons she chose to study mental health nursing. She is female, age 18 when started her nursing course, and has worked with someone with a learning disability who also 'suffered with mental health'. She chose to study mental health nursing to pursue her 'interest in mental health... to learn how care differs when mental health is involved'. Her responses to question one tended to be 'neither agree nor disagree' with very few strong opinions and indicated a *benevolent* attitude, closely followed by *recovery attitude*. However, her answers to question two did not support either attitude as she did not feel 'a person who was mentally ill was incapable of making simple decisions' or 'could not be held responsible for their own actions' but they 'had to be kept in a mental hospital'. She felt that they could be described as having 'a split personality', 'depression' or 'schizophrenia'. In question nine she 'strongly agreed' that schizophrenia, in addition to bipolar disorder and drug addiction were types of mental illness, but only 'slightly agreed' that depression was. Although she had never lived with someone with a mental health problem she had worked, had a neighbour and a friend who had mental health problems and would be willing to continue these relationships. She correctly identified that one in four of the UK population might experience mental health problems in their life time, but was unsure of what advice she would give a friend to get professional help; she only 'slightly agreed' that either medication or counselling were effective treatments. She was unsure if people fully recover or if they would seek professional help, which was reflected in her response of 'neither likely nor unlikely' to go to her own GP for help if she was experiencing mental health problems, although she would feel 'fairly comfortable' discussing this with her family. Her responses reflected a 'benevolent' attitude.

In the Forum she spoke about her first practice placement on an acute admission ward. Initially she did not like being there as she was bored, felt she was just sitting around and kept asking for jobs to do. But once she got to know the patients and they got to know her better, she became more involved in their care. This was the result of her mentor explaining to her that she needed to spend time with the patients to get to know them before she would 'really get into the placement'. She then started to enjoy her placement and found it interesting talking to the patients and gained an understanding of some of their problems. She stated that everyone has this big idea that people with schizophrenia or bi-polar were 'scary' and that it is the media who promotes this, making people 'wary' of them. But she thought that if you saw any of the individuals she was working with in the street, you would not know and that they are really interesting and 'pleasant' people.

In the Transition to Branch session Gemma disclosed she worked in a bakery on Saturdays to supplement her bursary and still lived at home with her Dad and sister, so tended to live the student life of seeing her friends and spending her money as she chose. She did not like getting up early and the travelling to university each day and was worried about the course exams. Nonetheless, she was enthusiastic about mental health nursing and was interested in specializing in drug and alcohol services and wanted to do a degree to achieve this.

She did not know where her next clinical placement was and would like to be more confident in her knowledge base and communication skills but stated that she would 'do what people told' her to do. Nonetheless she would go with a positive attitude and, as she felt that first impressions were important, so goes in with a smile but not too 'in your face'. She wanted to build up relationships with people when she was there and, although she acknowledged the patients she would meet would have a mental health diagnosis each person was different. She found her placement in the Recovery team 'really, really interesting' as two people with schizophrenia would deal or manage their illness differently, 'obviously with medication' but for some it was a 'big thing' whilst for others it was 'a day to day thing'.

When the lecturer asked why students should not transport patients to groups or hospital visits etc., she cited it was for the student's own safety as the patient may be unpredictable, they may get 'really personal' and that there would be no-one else to advise on what to say or do. She differentiated between being friendly as offering someone the opportunity to talk and be listened to and being a friend as someone who shares your personal life. She acknowledged that asking direct personal questions was appropriate because previous abuse can 'lead to mental health problems'. She did, however, complain that her young age had a detrimental effect on nurse/patient relationships in some situations as a number of patients did not want to disclose information to her saying she was young enough to be their 'granddaughter'.

Gemma was absent from the Recovery session so the next data collected was her Recovery assignment, in which she discussed the different meanings of recovery between the medical, total absence of symptoms, and social, living an independent life even if symptoms persist. She maintained that the current concept of recovery moves away from professional definitions towards patients' self-definition irrespective of presence of symptoms or on-going use of mental health services. Additionally, she explored how experiencing mental health problems can lead to stigmatization from society, work colleagues, family and friends.

Her care study examined her involvement in the care of Sandra* who was a 84 year old woman on a Dementia Assessment ward, who prior to admission had thought her neighbour was stealing from her and as such she had threatened this neighbour with a weapon. Gemma stated that Sandra had a dual-diagnosis of dementia and schizophrenia, was compliant with medication but had no insight into her mental health condition as she believed she was on the ward to help others.

To assist in Sandra's recovery and promote social inclusion Gemma encouraged her to undertake escorted walks away from the ward environment and attend the hairdressers. Utilising her non-verbal skills, each evening they would summarize the day's events to help illustrate Sandra's progression towards recovery. Reflecting on this experience Gemma felt she had learnt about effective communication and the principles of recovery which she intended to use in her future nursing career.

At the beginning of her third year of study Gemma was again asked to complete the Attitudes to Mental Illness questionnaire (DH 2010). Her responses to the first question this time differed from the first questionnaire: initially she did not offer an opinion by ticking 'neither agree or disagree' to many of the statements whereas now she 'strongly agreed' that 'Virtually anyone can become mentally ill'; 'Less emphasis should be placed on protecting the public from people with mental illness' and 'No-one has the right to exclude people with mental illness from their neighbourhood'. Additionally, she now 'strongly disagreed' that 'One of the main causes of mental illness is a lack of self-disciple & will-power' and from 'slightly agreeing' that 'Mental illness is an illness like any other' she now 'slightly agreed'. Nevertheless, her answers to question one, when analysed, still indicated a *benevolent* attitude, closely followed by *recovery* one.

Her answers for the remaining questions tended to reflect those given in the first questionnaire except that she would more likely know what advice to give a friend with a mental health problem to get professional advice and 'slightly agreed', where she was initially unsure, that 'People with severe mental health problems can fully recover'. Also in the first questionnaire she stated she would feel 'fairly comfortable' talking to a friend or family member about her own mental health problem, she now felt 'slightly uncomfortable'.

During the Group Work Facilitation session Gemma stated she had been interested in mental health nursing since she was young. However, she did not feel the course had lived up to her expectations although she found placements 'enjoyable', she did not like writing assignments. She had learnt a lot about the different mental illnesses and this had made her want to know more and she would like to support the rights of people with mental health problems. She finds people's reaction of 'Oh God – be careful', when they

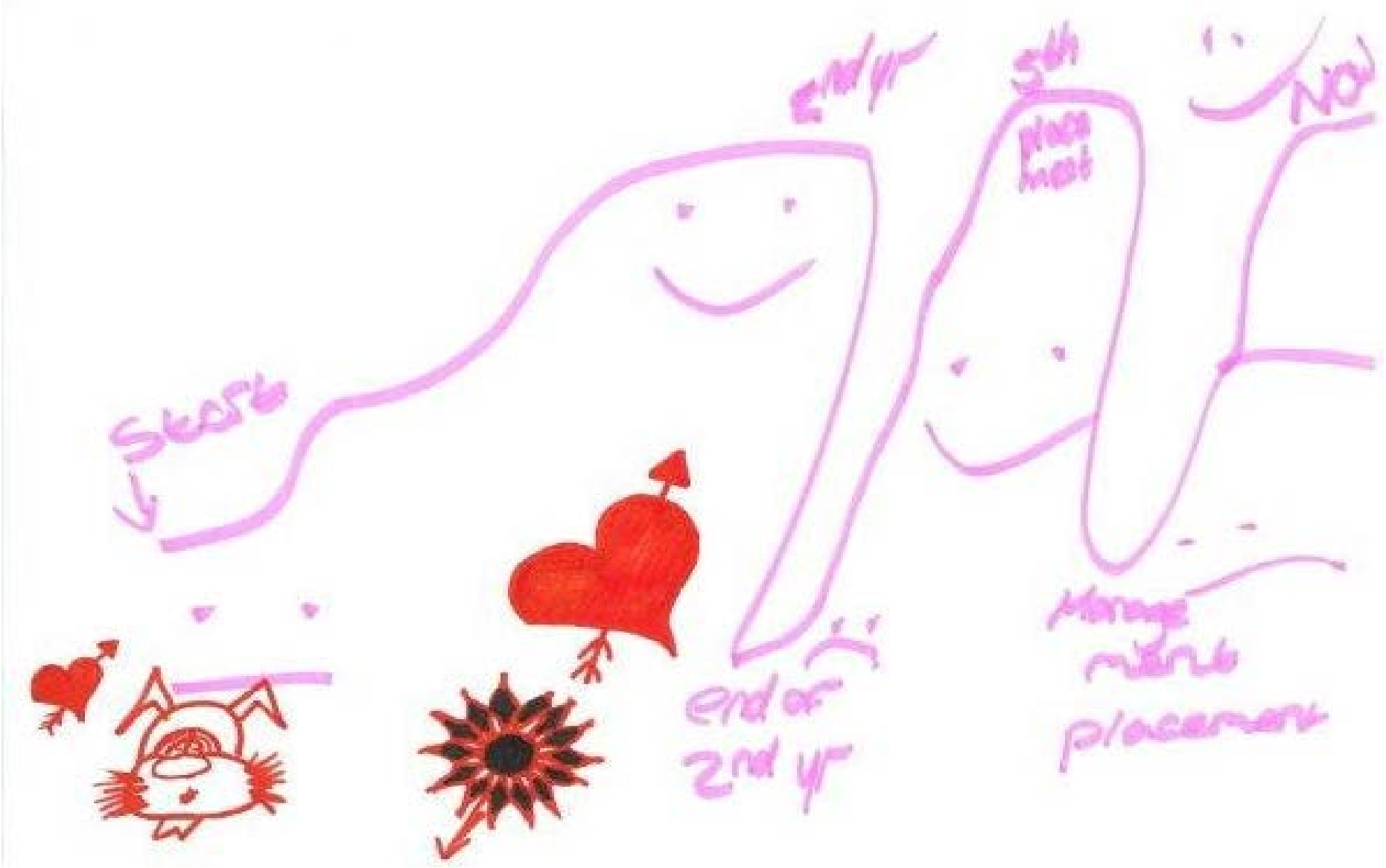
find out she is a mental health student nurse, quite amusing but she likes to start a ‘debate’ to discuss mental health issues.

She was unsure about the causes of mental illness but suggested that some people ‘were born with the trait of schizophrenia’, but this may never result in a mental health problem as they may never have a traumatic life event or it depended on their reaction to the life event. She felt that recovery was more possible with depression or bereavement rather than with a schizophrenic but there were ‘different stages’ on the ‘path to recovery’ and it is the individual’s own interpretation of recovery which counted.

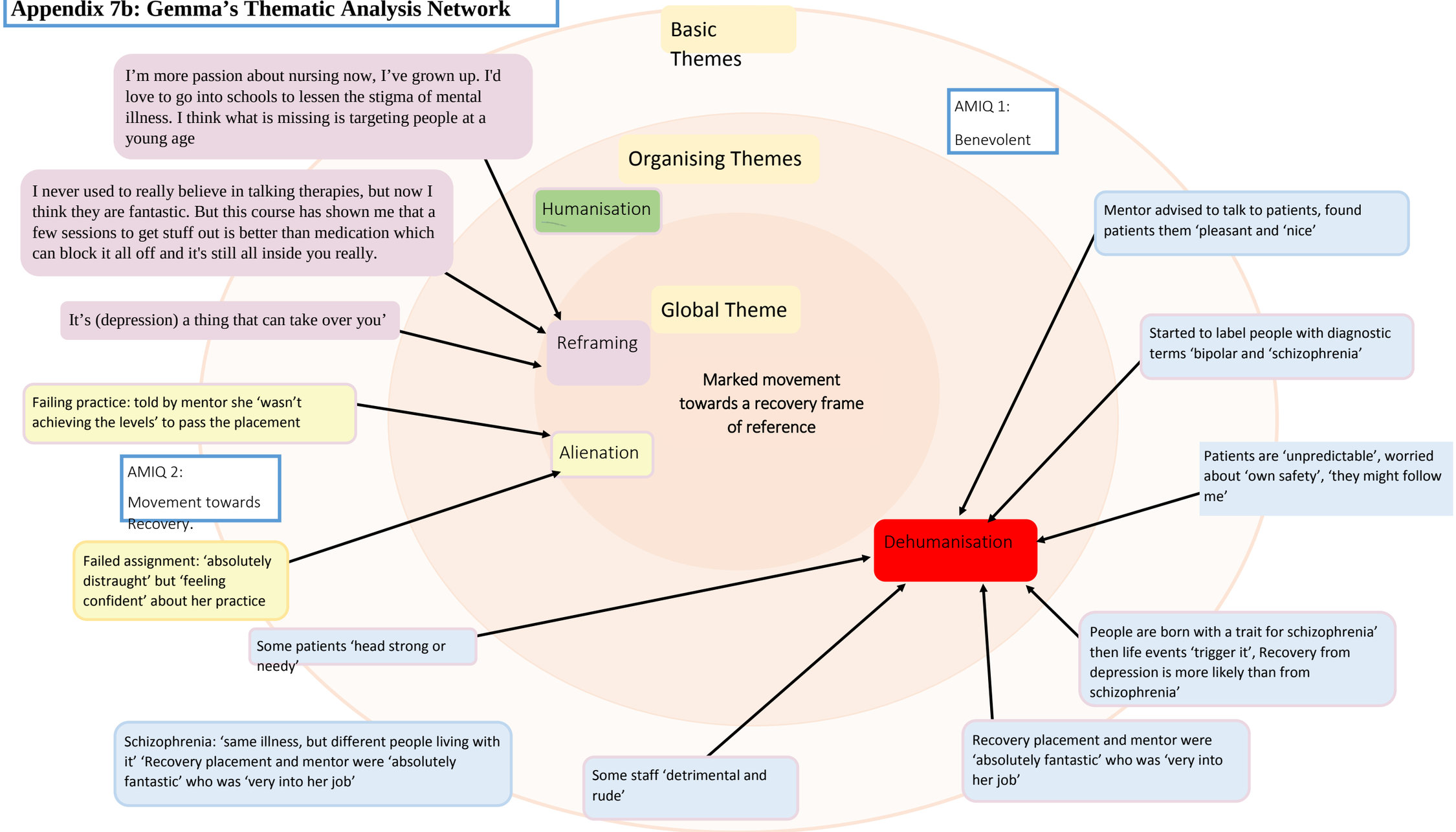
There were also different types of nurse/patient relationships and she found that some patients were harder to work with than others. Some were ‘head strong’ and want to control their own care, whilst others do not want to do anything and they ‘needed to be pushed’. So she felt that it had to be the right relationship for the patient, but she would not become too involved as it was ‘banned’. She had found some nurses ‘fantastic’ with patients but had been disappointed hearing them making detrimental comments about patients during handovers. This, she conceded, maybe because they were having a ‘bad day’ but she still felt it was ‘gossiping’ and not professional.

During her third year of study Gemma was again asked to complete the AMIQ (DH 2010). Her answers to the questionnaire this time differed slightly from the first one: where she initial answered that ‘strongly disagreed’ with the statements ‘I would not want to live next door to someone who has been mentally ill’ and ‘As soon as a person shows signs of mental disturbance, he should be hospitalised’, she now ‘slightly disagreed’. From a stance of ‘neither agreeing nor disagreeing’ she now ‘slightly agreed’ that ‘Residents have nothing to fear from people coming into their neighbourhoods’ and that ‘The best therapy for many people with mental illness is to be part of a normal community’. Her answers this time, when analysed, remained as a benevolent attitude, but there was a marked movement towards a recovery attitude.

Appendix 7a: Gemma's Pictorial Representation



Appendix 7b: Gemma's Thematic Analysis Network



Appendix 8: Mia's Pictorial Representation

