UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

Nursing

CARRYING HOPE: A GROUNDED THEORY STUDY OF PRE-REGISTRATION NURSING STUDENTS' UNDERSTANDING AND AWARENESS OF THEIR SPIRITUALITY FROM EXPERIENCES IN PRACTICE

By

Mrs Wendy Patricia Wigley

HE Diploma (Child Health), BSc (Hons), PG Diploma (Education)

RN and SCPHN (Health Visitor)

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ABSTRACT

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CARRYING HOPE: A GROUNDED THEORY OF PRE-REGISTRATION NURSING STUDENTS' UNDERSTANDING AND AWARENESS OF THEIR SPIRITUALITY FROM THEIR EXPERIENCES IN PRACTICE

By WENDY PATRICIA WIGLEY

Spirituality is a phenomenon integral to health and wellbeing and a fundamental element of nursing care. Nonetheless, empirical evidence suggests that spirituality is a frequently ignored aspect of care provision. While there is evidence that examines the relevance of providing spiritual care to service users, minimal research has been undertaken that examines the spiritual needs of pre-registration nursing students.

This study used a Glaserian grounded theory design to explore and explain pre-registration nursing students' personal understanding of their own spirituality and the relationship between experiences in clinical practice and spiritual awareness. Participants comprised seven pre-registration nursing students undertaking a three-year educational programme. Data was collected between 2008 and 2013 through two focus groups, twelve one-to-one interviews and theoretical sampling of a variety of literature and media, including artefacts created by the participants.

The findings identified that pre-registration nursing students' awareness of spirituality can be explained in three main Basic Social Processes [BSPs]: *struggling*, *safeguarding* and *seeking*. When their spirit was at risk of becoming broken by negative experiences in clinical practice, then their hope to carry on was at risk and *struggling, safeguarding* and *seeking* were evident. These three concepts are integral to the theory that emerged from the findings: a theory of *carrying hope* that explains participants' resolve between clinical experiences and spiritual awareness.

This study highlights that the challenges associated with spiritual awareness may impact on attrition from pre-registration nursing programmes. If students' spiritual needs and awareness are not adequately nurtured and supported there are implications linked to the aspiration of nursing to recapture the 6Cs (DH 2012). Recommendations from this study include the identification of role models in clinical practice and the implementation of a model of pastoral care for tutors supporting pre-registration nursing students. Further research is required to examine how role modelling and pastoral care can enhance spiritual awareness in pre-registration nursing students. While this study focused on nursing, implications for other vocational professions are identified.

For my mother Beryl whose mind was taken by dementia and whose spirit and hope we are left to carry

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Declaration of Authorship

I, **WENDY PATRICIA WIGLEY,** declare that this thesis and the work presented in it are my own and have been generated by me as a result of my own original research.

Title of thesis: **Carrying hope: a grounded theory study of pre-registration nursing students' understanding and awareness of their spirituality from their experiences in practice.**

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

5. I have acknowledged all main sources of help;

6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

7. None of this work has been published before submission.

Signed:

Date:

Acknowledgements

Many people have supported me on this journey and included in these are colleagues, friends and family.

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I would like to formally acknowledge the support of the Faculty of Health Sciences in facilitating study time and assisting with the fiscal implications of this endeavour. Moreover, the invaluable camaraderie of fellow doctoral peers ensured that when my spirit was almost broken and I could have lost all hope of completion, I carried on. My thanks to the participants, I am privileged to have had this insight into their pre-registration nurse education. Credits go to Tom Hobbs for transferring the findings into art work and Adrienne Spiers for transcribing, to Nick for checking the theory 'made sense' and to Steve for proof reading. My love, appreciation and understanding to my brother Jon, whose role it is to carry the hope of others, even when his own burden is hard to bear. Without him as a role model I would not have completed this work.

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Lastly, I would like to acknowledge Barney Glaser. I have not met him yet and someday I hope I will. I started this process disliking him, I could not understand his writing and I could not see what it was I was supposed to be doing. I read and reread his books and slowly I began to understand the analysis and how to 'do' grounded theory (Glaser 1998). One day deep in analysis and theoretical sampling I came across a poem of R.D. Laing (1972:84) and it is on this I would like to finish:

I am doing it
the it I am doing is
the I that is doing it
the I that is doing it is
the it I am doing
it is doing the I that am doing it
I am being done by the I am doing
it is doing it

I 'hope' Barney that I have 'done it right'.

Abbreviations

BSPs	Basic Social Processes
HEI	Higher Education Institute
ITU	Intensive Therapy Unit
NHS	National Health Service
NMC	Nursing and Midwifery Council (replaced UKCC in 2002)
PC	Personal Computer
QDA	Qualitative Data Analysis
RCN	Royal College of Nursing
SHA	Strategic Health Authority
UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visitors (devolved in 2002)

Chapter 1 : Introduction

This study addresses a previously under researched area of pre-registration nursing students' spirituality. Explored herein is the impact of the clinical environment upon pre-registration nurses' awareness and understanding of their own spirituality. The research question arose from my own experiences as a nurse and nurse educator. Prior to, and during the first four years of the study I was the module lead for a first year pre-registration nursing module entitled 'Context of Care'. One aspect of learning associated with this module was the concept of holism. This topic included a lecture and resources relating to spirituality in nursing. I noted that student evaluations of the module persistently included comments such as "*I do not see the relevance of the lecture on spirituality*" or *"why are we learning about spirituality in nursing".* In consecutive years, as an attempt to improve the student learning experience, I engaged different lecturers on spirituality. These included colleagues with an interest in spirituality and hospital and university chaplains. Yet the lecture on spirituality continued to receive poor student evaluations. It seemed to me that the evaluations appeared to reflect the students' lack of understanding as to why, as nurses, they needed to learn about spirituality, but I could not understand, nor identify a reason for this. I decided that I needed to know more about pre-registration nursing students and their awareness of spirituality, particularly, any awareness that might develop from experience in the clinical environment. As I embarked upon identifying spirituality as the topic for the study, a further revelation to me was the lack of perception in the wider nursing fraternity about the relevance and nature of spirituality to the profession. Several senior researchers in the organisation were perplexed by my choice of topic to study. One prominent professor suggesting, "*Surely you mean emotional intelligence, rather than spirituality?*" I found comments such as this increasingly bewildering; as there is a plethora of seminal theory that identifies spirituality as an essential element of nursing care (Nightingale 1915; Abdellah et al 1960 and Levine 1973 - both cited in Heath 2002; Roy 1980; Rogers 1980; Parse 1981; Watson 1985; Newman 1986; Carson 1989 and Neuman 1989).

Despite theoretical affirmation regarding the relevance of the phenomenon in nursing, spirituality is a difficult concept to express (Speck et al 2004). When does 'spirit' and the

'spiritual' become spirituality? Spirituality is the abstract noun of spirit and spiritual (Soanes and Stevenson 2006). Gillman (2007) suggests that spiritual and spirituality are words used to describe a free flowing of the spirit. All things connected to the spiritual and spirituality have '*fluidity and depth*', whereas religion can often be associated with inflexible pious (Gillman 2007: 30). Nonetheless, the religious affiliated Mothers' Union (2010) defines spirituality as '*the breath of life'; a* definition that has resonance with all that is associated with wellbeing and health. Gillman (2007) advises that the choice of words to describe a cultural expression of spirituality depends upon the individual, organisation, the context of use and the purpose. Consequently, throughout this body of work, spirit, spiritual and spirituality will be referred to interchangeably, depending upon the context of the discussion within the text.

Debate as to the constituents that contribute to a definition of spirituality is evident within nursing literature (King et al 1995; Goldberg 1998; Martsolf and Mickley 1998; Greenstreet 1999; Shih et al 2001; McSherry and Ross 2002; Narayanasamy 2006). My own exploration for a definition in historical dictionaries associated with healthcare identified the following. In Gould's Medical Dictionary (Brownlow 1945; 1295) spirit is described as: *"[spirititus, breath: from spirare, to breathe], 1. The soul"*. Disappointingly, 'The Nurses Dictionary' from the same period (Morten and Taylor 1946), makes no reference to spirit or spirituality. Indeed, latterly, Blackwell's Dictionary of Nursing (1998: 629) simply refers to 'spirit' as "*an alcoholic solution*". Marriner-Tomey (1989:4) suggests a phenomenon is any incident or reality that is perceived or "*exists in the real world*", and is identified by the senses. This may explain why the phenomenon that is spirituality, whether or not it exists, and what the constituents of spirituality are or how this phenomenon presents, has continually concerned the nursing profession. Yet it does seem that regardless of recognition regarding the importance of spirituality by nursing theorists, in contemporary clinical practice spirituality has become a "final taboo in nursing" (McSherry 2010).

Pre-registration nursing programmes require validation and approval by the Nursing and Midwifery Council [NMC]. Higher Education Institutions [HEIs] offering pre-registration nurse education programmes must ensure that the curriculum contains a proportional divide between theoretical teaching and experience in the health care environment (NMC

2004a; NMC 2010). This division in educational experience between the theoretical and 'hands on' practical clinical experiences exposes nursing students to situations and circumstances beyond the 'norm' of the more traditional theoretical and conceptual based experiences employed in higher education. Clark and Olsten (2000) recognise that nurses hold a unique position as observers and assessors of human life. There is also significant evidence that teaching of spirituality is an essential element of nurse education (Greenstreet 1999; McSherry 2000; Shih et al 2001; Narayanasamy 2006). Yet this discussion and debate cannot account for why, in reality, many nurses recall receiving little or no education on spiritual care during their training (Ross 1996; Narayanasamy 1993). Consequently, Narayanasamy (1993) and Ross (1996; 2006) suggest that research into the education of pre-registration nurses could focus upon how nurses are taught spirituality and the extent to which a nurse is competent is assessing spiritual care.

2011 was the final year of an outgoing curriculum and the module 'Context of Care'. As the cohort was small I chose to give the lecture myself, drawing upon the findings presented in this thesis. Following the lecture I received the following email:

> *"I just wanted to say that I really enjoyed your lecture today on Spirituality within nursing. Before starting my nursing course, I did a degree in Theology and Religion and it was great to know that the two can work together effectively and is being taught and envouraged. It is something I am really interested in- not so much from a religious view but a spiritual one, and I definately try to bear this in mind while working and on placement".* [Sic]
> (Communication from student: January 2012)

The relevance of spirituality celebrated through personal faith, religious belief or otherwise, continues to be a central element of nursing care (McSherry 2010, McSherry and Jamieson 2011). The Department of Health's [DH] (2003; 2009) position is that meeting the varied spiritual needs of patients, staff and visitors is fundamental to the care the National Health Service (NHS) provides. Even with this recognition, writers suggest the concept of spirituality is a frequently ignored aspect of nursing care (Bradshaw 1994; Golberg 1998; Costello 2001; Tanyi 2006; van Leeuwen et al 2006, McSherry 2010).

As a nurse educator I wanted to fully appreciate the extent to which pre-registration nurses understand spirituality. How can we teach spirituality if some pre-registration nursing students neither have, nor hold, any personal perception of spirituality? How can we 'teach' spirituality when we have no understanding or insight into the impact that clinical practice has upon students' awareness of their 'own' spirituality? Furthermore,

can pre-registration nursing students internalise any teaching on spirituality if they are unable to recognise their 'spiritual self' and the reasons they entered the profession in the first place? Barnett (1999) suggests that higher education programmes are designed to provide experiences that enhance individual psychosocial *'becoming'*. How can nurse educators who are duty bound to enhance the students '*becoming*' provide guidance and support in recognition of spiritual 'self'?

This discussion and introduction to the thesis indicates that any study into the impact of clinical practice experiences on pre-registration nursing students' own perceptions of the spiritual, should explore the psychosocial processes involved. Especially the relationship between experiences in the clinical environment and personal spirituality, which is recognised as being poorly understood (Ross 2006). Consequently, the overall aim of this study was to explore the interrelation between students' understanding and awareness of their own spirituality and their clinical experience. The findings of this study provide educational insight into the experiences of pre- registration nurses in clinical practice. These findings indicate that educational strategies should focus upon the spiritual care needs of pre-registration nursing students.

1.1Overview of the thesis

Prior to undertaking this study I held some knowledge of spirituality from my nursing practice and my role as a nurse educator. I had already accessed some literature and built up a current knowledge base surrounding spirituality in health care. In addition I have a 'quiet' Christian faith, and my brother is an Anglican Vicar. These latter aspects were of significance for continued objectivity in the study. Urquhart (2011) suggests that the skill for the researcher is to maintain a consciousness regarding imposing other theories and preconceptions on the data. Reflection can enhance reflexivity, helping the reader to understand how an author has 'made sense' of an experience (Bolton 2010). Readers will note that compatible with a feminist stance in grounded theory, my style of writing is reflective and reflexive (Wuest and Merritt-Gray 2001). Consequently, the chapters in this body of work present a reflective and reflexive unfolding picture of the research process, subsequent data analysis, findings and the emergent theory. Revealing to the reader transparency and the extent to which theoretical sensitivity was influenced

and the boundaries between research objectivity and personal subjectivity are explored (Taylor and White 2000; Wuest and Merritt-Gray 2001).

This body of work consists of ten chapters. **Chapter 2** will outline the purpose of conducting a review of the literature prior to undertaking a qualitative grounded theory research study. This chapter will provide the reader with the exploration of literature that formed the background to the study and considers spirituality as a phenomenon. The relevance of spirituality within health care and contemporary nursing care policy and pre-registration education is also considered. Subsequently, nurses' understanding and recognition as to who should provide spiritual care to patients/clients and their carers will be explored. Finally, the relevance of nurse education/preparation with regard to spirituality will also be discussed.

Chapter 3 contains a historical overview of grounded theory and presents a critical debate of research perspectives associated with grounded theory (Glaser and Strauss 1967). This will precede the justification for using a 'Glaserian' variant of grounded theory, based upon the identification of Basic Social Processes [BSPs] (Glaser 1996) from the data and analysis. The language of grounded theory will be explained, as will the central principle of grounded theory, which is the process of simultaneous data generation, collection and analysis.

Chapter 4 conveys the purpose of the study and provides a rationale for undertaking this investigation as a qualitative, two-year, longitudinal, two-phased grounded theory study with pre-registration nursing students. Participant selection, recruitment, initial data collection using focus groups and interviews are explained along with an exploration of other sampling processes. Within the discussion on ethical considerations and trustworthiness relating to the study, my own position as nurse, nurse educator and novice researcher is explored.

Outlined in **chapter 5** is the iterative and phased analysis that was applied to this study. The principles of coding in grounded theory analysis including theoretical sampling, constant comparison and the identification and development of BSPs contained within the data are highlighted. Analysis of data collected using focus groups, interviews and participant generated material is explained, since each of these are all essential elements

in the analysis that produced the final grounded theory. This chapter contains aspects of reflexivity associated with the collection of data, which is demonstrated within field notes, memos and diagrams. BSPs will be demonstrated as integral to the constant development and cultivation of the emergent theory. This theory consists of three essential conceptual components, *Struggling, Safeguarding and Seeking* that are explored and evidenced in the subsequent findings chapters.

Chapter 6 is the first of three findings chapters. This chapter provides details of the participants' perceptions of spirituality in relation to nursing. Investigated within this chapter are the participants' problems associated with *struggling* which includes *defining and explaining* the phenomenon within the context of nursing. This chapter will reveal the concept of spirituality as relating to religious or faith beliefs and a 'call' to nursing. Included in this exposé is *fear and fearing* associated with the disclosure of faith-based practices that are integral to the concept of self within the reality of clinical practice as an 'unimagined' context. Faith based practices that are perceived by participants as inappropriate or not allowed in the 'professionalism' of nursing. As a consequence these practices are undertaken surreptitiously and *hidden* as part of the participants desire to be *prepared* and to *cope* with the unimagined.

The findings explored in **Chapter 7** are concerned with *safeguarding* spirituality against moral dualism and *opposing* values in health care. This chapter provides consideration and exploration of the participants' confusion when faced with contradictions in nursing care. The participants' constant struggle to maintain 'good' practice and to resist being negatively influenced by the health care environment is revealed. *Loss, losing* and spiritual burn out in the profession as concepts perceived by the participants are explored in this chapter, along with the associated responses of *protecting and safeguarding.* A *revealing* process for those students with a religious faith is identified and finally a model of *safeguarding* against spiritual burn out is presented.

Chapter 8 explains the process of *seeking.* The participants seek out ways in which they are able to understand their spiritual self. Associated with this process is *developing resilience.* While this chapter will consider the experiences of all participants, it will centre upon the three participants who continued through both phases of this study. Subsequently this chapter explores the concept *being heard* as the participants transition

toward successfully completing their pre-registration nurse education. In this chapter *storytelling* is conceptualised as a *seeking* behaviour through which and in which, each participant is *carrying hope*.

In **Chapter 9** an emergent theory of *carrying hope* is presented along with diagrammatic representation of the theory as applied to the experiences of pre-registration nursing students and their understanding and awareness of their spirituality as they make transition towards qualification. This chapter will contain personal reflections regarding my personal journey throughout this study. These will include reflections on grounded theory and the extent to which my own insights as nurse and educator have been influenced.

Chapter 10 is the final chapter and contains implications, recommendations and conclusions. This chapter returns the findings of this study to the real world context of spirituality in health and above all the practice of nursing care. The significance of the substantive theory '*carrying hope'* will be positioned against attrition from pre-registration nursing programmes and recent national concerns regarding poor nursing care. The relevance and fit of these findings with other 'vocational' higher education programmes will also be considered. Conclusions from the study will be presented along with recommendations for further inquiry.

Chapter 2 : Background to the study

This chapter sets out the purpose and rationale for exploring literature prior to undertaking a qualitative grounded theory research study. The discussion and debate within this chapter will reflect consideration of literature that informed the background to the study. Considered here is literature that reflects spirituality as a phenomenon, including the relevance of the phenomenon within health care and contemporary nursing care policy. Spirituality within a United Kingdom [UK] health care and nursing context will be explored, as will nurses' understanding and recognition as to who should provide spiritual care to patients/clients and their carers. The relevance of nurse preparation with regard to the spiritual elements of health care will also be considered. The rationale for any evidential review is to improve professional standards and influence the quality of care, which include influencing practitioner behaviour (McFarlane 1970; Donabedian 1989). While it is implicit to the discussion in this chapter that the experiences of the service user[1] are integral to the purpose of this study, the epistemological perspective of the study means that spirituality in relation to the service user perspective is not actively considered. To enable the phenomenon to be put into context and to orientate the reader, the essential elements from the initial literature review surrounding the phenomenon are presented, alongside more recent findings.

2.1 Grounded Theory and literature reviews

Grounded theory is an inductive technique requiring the researcher to enter the analysis free from any preconceived ideas about the phenomenon under investigation and to seek out the core variable rather than commence their study with a research question (Glaser and Strauss 1967; Stern 2009). The premise of grounded theory is that as the theory is derived from the data, it is not a deductive technique based upon logical assumptions (Glaser and Strauss 1967). This premise leads to confusion and debate as to whether or not a review of the literature should be conducted prior to undertaking a grounded theory study (Schreiber 2001). In the use of grounded theory the 'literature' often forms a significant proportion of the data (Strauss and Corbin 1990, Silverman 2010) and is

[1] The contemporary term used in this document to include individuals who receive care or whose relatives/friends receive care within health care provision i.e. Patient, Client or Carer

required to enhance theoretical sensitivity (Gibson 2011). Urquhart (2011:351) recommends that once a theory has been generated, the researcher can then "*sharpen*" their review of the literature and build upon what has gone before. I undertook this study as a doctoral student progressing toward a Clinical Doctorate. Consequently, I was required to provide departmental supervisors and examiners with some consideration of what is known, and what is not known about the area proposed for investigation (Stern and Covan 2001; Schreiber 2001). More recently Wiener (2011) suggests that researchers have an obligation to have currency in the evidence and literature relevant to their professional field, advising that such knowledge can "*enrich interviews*" with participants (Wiener 2011: 299). Prior to undertaking this study I held some knowledge of spirituality from my nursing and my role as a nurse educator. Other than the pragmatic explanations identified above, my reasons for reviewing the literature are outlined below. These reflect the rationale poised by Strauss and Corbin (1990) who justify the purpose of reviewing the literature in grounded theory. Strauss and Corbin (1990) recognise that a researcher brings to any study elements of their personal and professional lives. With reference to the latter this is likely to include relevant disciplinary literature (Charmaz 2006). Schreiber (2001) advises that it is not possible for a researcher to approach the study as if their mind were a blank sheet, devoid of any previous personal or professional experience.

My search for literature prior to the study can be viewed as an "*orienting process*" (Urquhart 2011:351) to establish what research, if any, had been undertaken into pre-registration nursing students' perceptions of spirituality. I wanted to identify what was already known regarding spirituality and health care (in its broadest context) and to establish existing gaps in the nursing and educational literature. At the outset of this study I had little cognisance of research methods or insight into an appropriate method to utilise. In informal discussions with peers and colleagues it was suggested that grounded theory might be appropriate to explore the phenomenon. As a novice to preliminary research I needed to explore and establish my own theoretical perspective and philosophical stance. The early review of the literature enabled me to not only ascertain which research paradigms had been applied to the study of spirituality but was also important in helping me to formulate initial questions and queries regarding the conceptual areas that I would be investigating. Additionally, supporting information from

the literature was required for seeking ethical approval by the relevant ethics committee (consideration of the ethical procedure is available in Chapter 4). Moreover, it was important, prior to undertaking grounded theory, to establish if the area of pre-registration nursing students' spirituality had already been investigated or if a theory already existed (Glaser and Strauss 1967).

An initial search for literature associated with spirituality and nursing was conducted in 2007, prior to undertaking the study. The aim of which was to inform a coherent rationale for undertaking the study. This consideration of the literature also enabled the choice of research design into the substantive area of pre-registration nursing students and spiritual awareness to be explicated. As tools for searching literature, databases and indices contain full bibliographic details of papers and normally an abstract. Some also contain links to the full text (Fisher et al 2001). The following databases and online resources were initially searched: British Nursing Index [BNI] (1994 – July 2007) and the Cumulative Index to Nursing and Allied Health Literature [CINAHL] (1982 – July 2007). The initial search was broad and sought to capture literature related to spirituality and nursing over the last 20 years. Nursing has a strong vocational training tradition in the United Kingdom [UK]. Only since the advent of 'Project 2000' in the mid-1980s, has pre-registration nurse education become the responsibility of Higher Education Institutions [HEIs] (Lord 2002). Therefore, I sought to identify publications that would reflect the UK nursing profession's position on spirituality within nurse education from the mid-1980s to the present day. Latterly, since commencement of the study, where relevant and pertinent to the background discussion, literature pertaining to spirituality from other regions of the world has also been considered. As considered above, the literature in grounded theory is also recognised as 'data' that can be used in theoretical sampling (this will be discussed further in chapters 3 and 4). Literature used as part of theoretical sampling will not be presented in this chapter. The findings chapters will include the literature that enabled the development of the categories and emergent theory. Furthermore, literature that informed the decision to use grounded theory as a methodology will be integrated into the discussion in chapter 3. Subsequently, presented here are the salient points that have informed knowledge of the phenomenon prior to and at the commencement of the study. Since the commencement of the study several high profile systematic reviews and reports have been published (Royal College of Nursing

[RCN] 2010; DH 2011), authored in the main by Wilf McSherry, Professor in Dignity of Care for Older People, University of Staffordshire and advisor to the DH and RCN. In addition, the Nursing and Midwifery Council [NMC] have published new standards for pre-registration nurse education (NMC 2010). Consequently, within this background discussion the reader will find reference to, and exploration of, recent literature and policy post 2007. These have been included to set the *current* context of spirituality within UK health care provision.

I explored databases and indices to identify journal papers and research studies by keywords that were divided into two categories. The first category was *'spirituality'* (keywords: spiritual care, spiritual state alteration, spiritual distress, spiritual support, spiritual comfort, spiritual wellbeing, spiritual healing). The second category was '*nursing*' (keywords: nurse, students, practical, clinical and practice). The search engines 'Google' and 'Google Scholar' were also explored for noteworthy literature using the key words above. While these particular search engines do not lend themselves readily to a systematic review (Greenhalgh 2006), they did reveal several significant and full version seminal texts. Key authors were identified via the search and their literature and position regarding spirituality was further explored. Fellow colleagues and research peers also provided literature, which in turn enabled hand searching to take place using references from these 'gifted' articles, papers and books[2]. The websites of Department of Health [DH] and the Nursing and Midwifery Council [NMC], as the nursing profession's regulatory body, were also explored for guidance and policy documents associated with spiritual care giving and spiritual health.

2.2 Defining spirituality

The phenomenon spirituality is almost impossible to identify since there is a lack of consensus as to what constitutes spirituality (Speck et al 2004). Spirituality is associated with differing meanings for differing individuals in differing contexts (McSherry et al 2004). As an individual I have always been cognisant of my own spirituality. It is integral to who I am and as a result it is integral to who I am as nurse. If I were to try to describe

[2] While of some of these papers and literature were of minimal significance to the study, the nature of the 'gifting' proved to be an interesting action that contributed to theoretical sampling. This will be further explored within the findings of this work.

my concept of spirituality, it is what sings to me from my heart, it is what tells my brain what is should or should not be doing, it is me and I am it. Nonetheless, spirituality holds a variety of definitions and meaning (Carson 1989; Narayanasamy 1993). Carson (1989) suggests that there are vertical and horizontal elements to spirituality; the vertical being associated to a relationship with another higher 'God-like' being that transcends or goes beyond 'self'[3]. While Florence Nightingale has been credited for associating nursing care with the Christian religion (deGraaf et al 1986), contemporary literature concur that spirituality within nursing is considered more widespread than religion (Carson 1989; Speck et al 2004; McSherry 2010). It is here that some confusion and misinterpretation of spirituality may occur. Some individuals may choose to celebrate their spirituality through a religious faith (DH 2009) and this faith becomes a framework of values and life style that link and mirror the vertical transcendent relationship with a God-like other (Carson 1989). Carson (1989) is clear that the vertical element - the relationship with a 'God-like' other - is not *necessarily* associated with religious belief. Citing Maslow's (1968) hierarchy of needs, Carson (1989) suggests that the horizontal element reflects a pursuit of need and self-actualisation as human 'being', validating who we are, our interactions with others, our environment and our purpose in life. The horizontal is associated with a framework of values that an individual chooses, consciously or unconsciously, around and through which life is organised; a continuum that reflects a variety of perspectives. These perspectives are wide ranging and potentially hold different meaning for different individuals, perspectives that for each individual summarise a personal (Runcorn 2006) and often private (Gillman 2007) unique interpretation of holistic well-being. In humanistic terms, Rogers (1983) associates well-being and self actualisation with personal openness, acceptance and empathy and intrinsic beliefs. However, Goodwin (2006) might place emotional intelligence along this continuum, given that this concept reflects a personal ability to understand and to empathise with others. Whatever our unique and personal beliefs, the horizontal element of spirituality reflects deep personal understanding and meaning regarding the

[3] A person's essential being that distinguishes them from others, especially considered as the object of introspection or reflexive action (Soanes and Stevenson 2006)

way human life and society is organised and sustained (Gillman 2007; Brown and Garver 2009).

This broader concept of spirituality is reflected in the definition of Meyer (2003) who characterises spirituality as:

> "*The core essence of the self, capable of experiencing inner peace and interconnectedness with a higher power that provides meaning and purpose in life displayed by interconnectedness with others and concern for the natural environment*" (Meyer 2003:185)

Carson (1989), Ross (1994; 2002; 2006) and Narayanasamy et al (2004) suggest that in times of detrimental health need caused by suffering, illness, loss and emotional stress, a consciousness of spirituality is often brought into focus. While Meyer's (2003) definition would seem appropriate for day-to-day living, it does not adequately reflect the complexities of clinical practice as observed in any health care situation. Narayanasamy et al (2004:7) view this additional dimension of spirituality as that which "*demonstrates the existence of love, faith, hope, trust, awe and inspiration…*" all of which are essential in promoting well-being and coping strategies relating to negative connotations associated with illness (Speck et al 2004).

As the study commenced a working definition of spirituality was thought to be necessary to minimise latent misconceptions surrounding the purpose of the study and to enable applicability and pertinence for all involved. The following definition is my adaption that combines definitions of spirituality by Meyer (2003) and Narayanasamy et al (2004):

> *Wider than religion, the inner 'self' that arouses feelings of love, faith, hope and trust that provides meaning, inner peace and purpose in life.*

Subsequently, the ethics committee were assured by the definition that the study would not intrude solely on sensitive religious issues or adopt an evangelical/extremist position. The definition provided a starting point for the purposes of the initial research proposal. This definition was also intended to inform potential participants on recruitment, that the views being sought by the study were broader than religious affiliation. As the study progressed it became evident that the observations of McSherry (1998:36) regarding the "*subjective and deeply personal*" nature of the phenomenon meant that any definition for the purposes of this study in the longer term was inconsequential.

2.3 Spiritual health and nursing care

The word 'health' has its origins in the Old English, meaning 'whole' (Soanes and Stevenson 2006). The well-established definition of the World Health Organisation [WHO] (1948:100) considers health to be "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". Nonetheless, for some cultures this original WHO definition is not sufficiently holistic in nature (Chuengsatiansup 2003). Like spirituality, health is a "*largely a subjective and private experience*" only partially observed by health professions (Olson 2000:36). In 1998 the WHO declared that spiritual health needs should be considered alongside the domains of physical, mental and social well-being. Latterly, this declaration has been explicated due to the subjective nature of the phenomenon. The WHO now recognise that spirituality is "*an emergent property of a complex living system and exists only when such a system is examined in a holistic manner"* (Chuengsatiansup 2003:2). The Integrated Household Survey April 2010 to March 2011: Experimental Statistics (Office of National Statistics [ONS] 2011) identified that 79.8 per cent of UK household report a religious affiliation. These same statistics identify that there is an increase in religious affiliation from the ages of 34 until later life (age 65 years and plus) (ONS 2011). This statistic supports Carson's (1989) premise that spirituality is associated with personal growth towards actualisation. Spirituality within health care provision has been widely studied across the world and considers a variety of perspectives. These perspectives range from providers and recipients of nursing care to other professionals involved in providing health care (Ross 2006). In nursing, the greatest focus has been on spiritual health needs assessment, traditionally commonplace in end of life care (Carroll 2001; Speck et al 2004; DH 2011). Attention has likewise been given to the assessment of older people's spiritual health care needs (Ross 1994; Narayanasamy et al 2002; Narayanasamy 1993; Narayanasamy et al 2004). The two aspects of end of life and old age are often brought together in literature that considers the palliative care needs of older people with multiple pathologies (Hockley and Clark 2002). More recently, spirituality as an essential element requiring recognition and assessment in mental health has been highlighted (DH 2009; Elliot 2011). While the concept of spirituality is traditionally viewed as integral to the 'holism' of nursing care practices within the United Kingdom [UK] (Ross 1994, 2006; McSherry 1998; Narayanasamy et al 2004; Narayanasamy 2006), there has been concern expressed that spirituality within

contemporary nursing models and theories is not easily identified (Martsolf and Mickey 1998). Martsolf and Mickey (1998) suggest that as an easily identified concept, spirituality is either absent or forms a sub-element of another concept within some theories and models of nursing care. The inconspicuous nature of the phenomenon makes recognising the spiritual needs of those in their care, confusing for nurses. There remains uncertainty regarding the role and responsibility of nurses in the provision and delivery of spiritual nursing care (Greenstreet 1999, Ross 2006; van Leeuwen et al 2006; McSherry 2010).

Concern has been expressed within the nursing literature about the absence of 'caring' within modern nursing practice (Greasley et al 2001). It has been suggested that this may be due to circumstances of limited resources and organisational problem orientated 'tasks' through which nurses attempt to practise (Greasley et al 2001). McSherry (1998 and 2010), Martsolf and Mickey (1998) and Narayanasamy et al (2004 and 2006) point out that while nurses perceive meeting the spiritual need of those in their care as integral to their role and practice; it would seem that in reality the provision of spiritual care by nurses is often sporadic or neglected (Baldacchino and Buhagiar 2003; Ross 2006; McSherry 2010). This may account for why the concept of spirituality is identified as a frequently ignored aspect of nursing care (Bradshaw 1994; Golberg 1998; Costello 2001; Tanyi 2006; van Leeuwen et al 2006; McSherry 2010).

2.4 The political and professional drivers relating to spirituality

Within the UK context of health care provision and service, meeting the varied spiritual needs of patients, staff and visitors is fundamental to the care the National Health Service (NHS) provides (DH 2003; DH 2011). The 'Best Practice Guidance' (DH 2009) was published to enable those responsible for care provision to operate and comply with diversity legislation, which includes religion or belief. Diversity particularly in relation to spiritual issues associated with mental health and subsequent therapeutic interventions (DH 2009) and end of life care (DH 2011). Historically, statutory guidance for meeting spiritual care needs has been explicitly addressed within the Codes of Professional Conduct (United Kingdom Central Council for Nurses, Midwives and Health Visitors [UKCC] 1986; 2000). Since the change of name of UKCC to the Nursing and Midwifery

Council [NMC] in 2002, more recent codes (NMC 2002; 2004b) have been more implicit regarding the provision of spiritual care. Referring to nurses' duty to:

> *"Promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs"* (NMC 2004b: 5).

The current regulatory guidance known as "*The Code: Standards of conduct, performance and ethics for nurses and midwives*" (NMC 2008) contains no specific reference to either spirituality, religious or cultural beliefs. Instead this guidance reminds nurses of their duty to: "*demonstrate a personal and professional commitment to equality and diversity*" (NMC 2008: 5). From a regulatory body perspective, it is encouraging that since the publication of "The Code" (NMC 2008) the NMC has released "*Guidance for the care of older people*" (NMC 2009). This guidance document provides specific reference to assessment and treatment that respects spiritual needs of this section of the population (NMC 2009). McSherry and Ross (2002) and the Department of Health (2011) suggest that *'respect of'* and the *'assessment of'* spiritual needs differ from the premise of actually '*meeting* spiritual needs. Given the variety of meaning associated with spirituality, an understanding of precisely what aspect of the phenomenon care providers should be assessing frequently eludes the nursing profession (McSherry et al 2004; McSherry 2010; DH 2011). The NMC (2004) guidance on pre-registration nursing education suggested that to meet standards of proficiency students must be able to:

> "*Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities*" (NMC 2004a: 28)

And in addition:

> *"Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences*" (NMC 2004a: 30)

Six years on from the standards that informed pre-registration nurse educational programmes at the commencement of this study (NMC 2004), new standards have been published (NMC 2010). These new standards for the education of pre-registration nursing

students (NMC 2010) recognise spirituality as a tenet of person-centred care. Containing an underlying professional expectation that pre-registration nurses will attend to and support the holistic needs of those in their care (NMC 2010). Whilst the '*Consultation on a framework for the standard for post-registration nursing*' (NMC 2010) clearly identifies six "*spiritual competencies*" (NMC 2010:14), the contemporary pre-registration education standards (NMC 2010) do not require such a competency to be assessed within an individual contextual domain. In addition, the ten standards for educational programme approval and delivery (NMC 2010) are intended to specify what is expected of HEIs regarding the teaching, learning and assessment of nursing students. These standards do not refer to spirituality.

Without any clear regulatory or statutory guidance surrounding the inclusion of spirituality as an identified element of a pre-registration curriculum, the relevance of the phenomenon in pre-registration nursing education, while seen as integral to care giving, is often overlooked (McSherry and Ross 2002; McSherry 2010). A conjectural void continues between the expectations of policy regarding the meeting of spiritual needs and those who receive provide and teach spiritual nursing care (McSherry et al 2004; DH 2011).

2.5 Nurses' perceptions of spiritual care giving

A decision was made prior to commencement of the study to pragmatically consider literature pertaining to nurses' perceptions of spiritual care giving by a logical means, to ascertain relevance of issues pertaining to the background of the study (Thompson and Dowding 2007). Crombie's (1996) framework was adapted for this process, which is summarised in Appendix 1. Ten research studies were initially identified through searching in 2007. While these ten informed the rationale and paradigm for the study, their findings have been substantiated by more recent studies. Eight of the studies identified in 2007 explored nurses' spirituality (Ross 1994; McSherry 1998; Narayanasamy & Owens 2001; Carroll 2001; Narayanasamy et al 2002; 2004; McSherry & Watson 2002; Milligan 2004) and two predominantly considered nurse education and spirituality (Narayanasamy 1993; Ross 1996). As previously outlined, consideration of research literature on spiritual perception in nursing was limited to the UK. Spirituality in relation to the patient/client and/or carer perspective was not actively considered. Nevertheless,

some studies do draw upon the experiences of this group (McSherry & Watson 2002). Samples within nine studies identified consisted of qualified 'registered' nurses, and one study considered a sample of pre-registration nursing students as a comparative against a convenience sample of diabetic outpatients (McSherry & Watson 2002).

Identified research studies that considered nurses' spirituality focused upon nurses' professional and personal awareness and perception of the spiritual needs of patients, clients and carers. Included in these studies was an exploration of professional and personal attitude and response to meeting spiritual needs. Three of the studies adopted a quantitative approach to investigating the phenomena of spirituality. McSherry (1998) used specially designed questionnaires to measure nurses' perceptions of spiritual care needs with the intention of developing similar scales for practice. McSherry & Watson (2002) also used a questionnaire to compare and contrast nursing students' and patients' awareness of the importance of spiritual need. Milligan (2004) used an evaluative questionnaire that consisted of a five point Likert scale, open free text questions and multiple-choice questions. Methods that aimed to establish the extent to which nurses perceive spiritual care giving as part of their role, recognise spiritual care needs and evaluate their ability to act upon these needs (Milligan 2004). Qualitative approaches were adopted by a further five studies. Carroll (2001) used interview techniques to explore nurses' perceptions of spiritual care needs. Narayanasamy, who has published widely on spirituality, used critical incident analysis to explore nurses' perceptions of spirituality (Narayanasamy & Owens 2001) and nurses' responses to spiritual needs (Narayanasamy et al 2002; 2004). Only Ross (1994) used a mixed method design of postal questionnaires and in-depth, semi structured interviews in her investigation into nurses' perceptions of spiritual care needs.

The findings from both quantitative and qualitative studies indicate that while nurses feel they are able to identify and assess spiritual needs (Ross 1994; McSherry 1998; Narayanasamy et al 2002; 2004; Milligan 2004), in the main they feel unprepared to provide spiritual care. Resulting in spiritual care giving that is sporadic (Ross 1994; McSherry 1998; Narayanasamy & Owens 2001). This finding continues to be established in primary investigations into the subject (McSherry 2010; McSherry and Jamieson 2011; DH 2011). Where spiritual care is promoted such as in the care of the dying (Carroll 2001)

and in elderly care (Ross 1994; Narayanasamy et al 2002; Narayanasamy et al 2004) nurses are experienced and educated in spiritual care giving (McSherry & Watson 2002). Nurses in these clinical areas often have resources available to meet the spiritual needs of patients and carers (Carroll 2001; Narayanasamy et al 2002; Milligan 2004). The initial literature and more recent findings suggest that when nurses are able to recognise and understand their spirituality, spiritual care giving can be enhanced (Ross 1994; Narayanasamy and Owens 2001; Narayanasamy et al 2002: 2004). Greenstreet (1999) and (DH 2011) advocate the need for nurses to be able to recognise their own spirituality before they are able to recognise their patients' spiritual needs. This understanding has been subsequently supported by McSherry's (2010). In his survey undertaken for the RCN one respondent is quoted verbatim as stating the following:

> *'"I think that many nurses need support to understand their own spirituality and spiritual needs before they can truly help others. It is something that develops over time and with life's experiences and does not always have to relate to a specific religion. I would like to see educational institutions and professional bodies support this."*
> *Respondent 1523'* (McSherry 2010:24)

While Narayanasamy and Owens (2001) and Narayanasamy et al (2004) express ethical concerns regarding inappropriate strategies used by some nurses to impose their 'own' spiritual beliefs, the RCN survey identified that:

"The responses from atheists and humanists; while not necessarily accepting spirituality as a fundamental aspect of nursing these respondents were acutely aware of the need to support other people with their personal beliefs and practices" (McSherry 2010:17).

Consequently, dichotomy exists between identifying spirituality and recognising the value of the phenomenon in nursing care.

2.6 Nurse Education and spirituality

The previous discussion has laid out for the reader the opinion that teaching spirituality is an essential element of nurse education. The research literature reviewed prior to this study supports this principle (Ross 1994; McSherry 1998; Carroll 2001; Narayanasamy 2006). While much of the previous discussion and debate considers spiritual teaching, only two research studies were identified that specifically considered the education of nurses within a UK context (Narayanasamy 1993 and Ross 1996). Narayanasamy (1993)

adopted a quantitative investigation into nurses' awareness and educational preparation for meeting the spiritual care needs of patients. Questionnaires were used to survey a group of qualified nurses who attended a care of the elderly course. Ross (1996) used a mixed method approach of postal questionnaires sent to a sample of 685 qualified nurses working in elderly care settings and semi-structured interviews to a sub sample of 12 participants, to explore the methods and efficacy of teaching in spiritual care. The findings of Narayanasamy (1993) and Ross (1996) suggest that qualified nurses would welcome further education in spirituality. This is because they recall receiving little or no teaching on spirituality and spiritual care giving during their initial training. McSherry & Watson (2002), while not exploring nurse education per se, also express concern about widening of the theory-practice gap between patients' perceptions of their spiritual needs and the pre-registration nursing students' perception of that need. All of which raise questions regarding the effectiveness of spiritual education in pre-registration nurse education. Eight years on, findings identified by McSherry (2010), McSherry and Jamieson (2011) and DH (2011) concur that the problem of how to teach spirituality to nurses still exists.

The literature considered in 2007, prior to undertaking this study, identified that nurses need to be adequately educated in spiritual care and that further investigation was necessary into how best to educate nurses regarding spirituality. At the time this was sufficient background information to demonstrate that a knowledge base was required to explain how pre-registration nursing students might develop awareness and understanding of their own spirituality, particularly from their experiences in clinical practice. Moreover, there was no knowledge to explain how pre-registration nursing students' perceptions of spirituality might develop over time as they progress through an educational programme. Furthermore, the exploration of the literature revealed that a grounded theory study to explore this unknown area had not been undertaken. This confirmed that grounded theory would be an appropriate research design for undertaking a study into the substantive area of pre-registration nurse education and spirituality.

2.7 Summary

The discussion regarding nursing and spirituality within this chapter suggests that while there are research studies that have considered the spiritual perception and spiritual care

giving experiences of qualified nurses, few studies have considered this phenomenon in relation to the education of pre-registration nursing students and their experiences in practice and none has utilised a grounded theory design. This chapter has identified a paucity of knowledge to explain how recognition of spiritual 'self' in pre-registration nursing students might develop throughout a three-year educational programme. Notwithstanding this review of the literature, the extent to which clinical experiences (undertaken during pre-registration educational programmes) impact upon their awareness of spirituality is unknown. In retrospect, a consideration remains that those who educate pre-registration nursing students could better equip and support an understanding of spirituality. The following chapter explains the methodological decisions used in this study that then, informed the inductive technique. The discussion will then present grounded theory as the appropriate research design to discover how pre-registration nursing students become aware of their spirituality from experience in practice.

Chapter 3 : Grounded Theory

Chapter two provided a critical review of the phenomenon that is spirituality within the context of nursing and the provision of nursing care. Identifying that how pre-registration nursing students become aware of their spirituality from experience in the clinical environment practice is unknown. This consideration of the literature similarly revealed that no study has explored this substantive area using qualitative grounded theory. Consequently, this chapter will present a historical exploration of the perceived divergent paths of grounded theory and the originals authors, Barney Glaser and Anslem Strauss. This consideration informed the rationale for the grounded theory design for this study (chapter 4). The purpose of using gerunds to identify Basic Social Processes [BSPs] in grounded theory will be discussed to provide an explanation for the analysis in chapter 5. The two primary tenets of data accumulation in grounded theory, theoretical sampling and constant comparison, are explained in this chapter along with clarification of the language of grounded theory. Principally, this chapter will present a rationalised overview for utilising a qualitative paradigm, evidencing why grounded theory was chosen as an appropriate design for the purpose of the study.

3.1 The qualitative research paradigm

Qualitative research paradigms[4] set out to describe lived experiences and attach meaning to these experiences using interactive methods, which are subjective by nature (Burns and Grove 2001) and thus, naturalistic (Silverman 2010; Guba and Lincoln 1985). Qualitative research recognises that the world is made up of multiple realities that are intrinsically related to each other (Guba and Lincoln 1981). This approach differs from the quantitative paradigm. While both paradigms are arguably systematic, qualitative research in general does not set out to objectively test cause and effect nor the relationship between variables (Burns and Grove 2001). This is often because the purpose of qualitative studies is to provide thick and descriptive findings (Silverman 2010; Burns and Grove 2001). The quantitative approach is often viewed as a more positivist or

[4] An accumulation of beliefs and values that make basic assumptions about what is real, the relationship between inquirer and subject and the nature of truth. Often separated between the scientific and naturalistic (adapted from Guba and Lincoln 1981)

scientific epistemology. Quantitative research is precise in its enquiry as to the nature of knowledge, viewing world phenomenon as 'external' and subject to prediction, manipulation in scientific testing (Guba and Lincoln 1981; Cluett and Bluff 2000; Charmaz 2006). Bowling (2004) and Flemming and Fenton (2007) argue that research methods should not be viewed in a formally ranked order, because often the query or evidence required will dictate the research method of choice. Speziale and Carpenter (2007) suggest qualitative nursing studies fundamentally identify values, characteristics and behaviour that are believed to be best in the individual. Ross (2006) and Martsolf and Mickey (1998) conclude that the personal emotions and experiences associated with spirituality are most appropriately explored using the qualitative paradigm. While previous research into spirituality and nursing has adopted both qualitative and quantitative approaches, during a review of the literature none were identified that had utilised a grounded theory design. From a philosophical stance Mills et al (2006) suggest that a chosen paradigm, such as grounded theory, should have fit with the researcher's own truths and beliefs about 'being' (ontology) and where and how knowledge is created (epistemology), suggesting that the researcher's ontological perspective will guide the "*epistemological and methodological possibilities that are available*" (Mills et al 2006:2). As this study sought to identify a meaningful way to describe and understand the complexities of the substantive area of pre-registration nursing students' spirituality in relation to their experiences in clinical practice, it became necessary for me to inform my knowledge by continually referring to grounded theory literature during the duration of the study. This review of grounded theory literature informed an understanding of the historical roots of grounded theory and facilitated an appreciation of the full relevance of this methodology in the study design.

3.2 Grounded theory methodology

Methodology is the study of research methods (Soanes and Stevenson 2006). For a novice unfamiliar with grounded theory, the twists and turns in the methodological history can be hard to follow as one attempts to apply grounded theory to research practice (Stern 2009; Star 2011). This section will explore grounded theory as a research method and document my knowledge and understanding of grounded theory, an understanding that has developed throughout this academic endeavour. This knowledge

will be reflected in my application of grounded theory to the research design in chapter 4. Made known by Barney Glaser and Anslem Strauss (1967), grounded theory is a qualitative, inductive approach to research design. The original approach, viewed as 'traditional' by some authors (Mills et al 2006; Charmaz 2006), emerged from the field of social sciences (Strauss and Corbin 1998; Bowling 2004; Charmaz 2006) and sought to discover the 'true' reality that emerges from data (Mills et al 2006:3). Guba and Lincoln (1985:104) view the term objectivity as "scientific". The systematic 'objective' approach of grounded theory by Glaser and Strauss (1967) gave credence to qualitative research that in the 1960s was considered lacking in the positivist rigour and credibility of quantitative research methods. Grounded theory generates theory as opposed to verifying an existing theory; the design concerns itself with explanation of a real world context, not description (Glaser and Strauss 1967). Consequently, the aim of grounded theory is to explicate a theory from data that has been systematically collected, coded and analysed.

A grounded theory is either substantive or formal (Glaser and Strauss 1967). A substantive theory is developed as part of an empirical enquiry into a specific substantive area, in the case of this study, pre-registration nurse education and spirituality. A formal theory is broader than a substantive area of study from which the theory is developed. Kearney (2001) advises that a formal theory describes a human experience that can be demonstrated across different situations and contexts, for example, spirituality of individuals in varying contexts. Both substantive and formal theories must be grounded in the data presented. In doing so they present the '*cumulative nature of knowledge and theory'* (Glaser and Strauss 1967:35). Over the years grounded theory has become one of the most commonly applied research methods in nursing (Schreiber and Stern 2001; Morse et al 2009). Since '*The Discovery of Grounded Theory*' (Glaser and Strauss 1967) grounded theory design has been subject to metamorphic changes dependent upon the philosophical stance of the researcher. The extent of these changes has precipitated a 'new' movement in grounded theory. It is now common in grounded theory literature to see reference to 'second' and sometimes 'third generation' grounded theorists (Schreiber and Stern 2001; Morse et al 2009; Charmaz and Bryant 2011). Most notably the chronology of these changes stems from the divergent career paths of the original authors Glaser and Strauss (Charmaz 2006; Morse 2009; Stern 2009). Strauss continued

in academia (Morse 2009), focusing on the experiences of those with chronic illness. Glaser, while contributing to teaching, concentrated on the explication of grounded theory, from his experienced perspective. To ensure the premise of grounded theory was highlighted effectively and successfully Glaser started his own publishing company (Stern 2009). Glaser has since developed an associated not for profit web site resource – the Grounded Theory Institute (http://www.groundedtheory.com/). In my search for a better understanding of grounded theory, I considered a variety of texts to help me identify how the divergence in the method occurred. This web resource has proved useful in my purchase of Glaserian grounded theory text and has exposed to me further consideration and discussion associated with the comparison of grounded theory to qualitative data analysis methods [QDA].

Throughout the 1990s both Glaser and Strauss continued to publish, although their now differing approaches to grounded theory became evident to the world of research inquiry (Charmaz 2006). Glaser continued to sanctify the methods used in the original grounded theory text (Glaser and Strauss 1967). Glaser published an update of the original method used in 1967 (Glaser 1978), methods that centred on constant comparison to develop theoretical sensitivity in the identification of social processes (Glaser 1978 and 1996). Strauss, teaming with Juliet Corbin, moved towards focusing on the processes and verification of grounded theory, producing in 1990 the seminal text 'Basics of Qualitative Research' (Charmaz 2006). In response to Strauss and Corbin's (1990) publication heated and heart felt correspondence between these two original grounded theorists ensued (Glaser 1992). Much of this communication surrounded Glaser's perception that Strauss and Corbin (1990) had misunderstood the original ideology of the method. Glaser argued that Strauss had substituting emergence with forcing and in doing so besmeared Glaser's intellectual property (Glaser 1992). I had always assumed that an unresolved rift existed between Glaser and Strauss. Yet, regardless of their methodological differences Glaser and Strauss remained friends until the death of Strauss in 1996 (Stern 2009). As I came to know grounded theory I wanted to maintain a methodological allegiance to both the original authors. Consequently, I was touched to see that Glaser's (2001) publication contains the following heart felt dedication:

"As always in remembrance of Anslem Strauss and our incessant discussion on the nature of Grounded Theory" (Glaser 2001: vii)

The new generation of grounded theorists have utilised the work of the original authors and their writings on the use of grounded theory sometimes take a differing epistemological stance. These developments are referred to as a "*genealogy*" (Morse 1990:16). I have become captivated by the debate and discussion grounded theory continues to attract. As grounded theory has advanced, separate views pivot upon what grounded theory is and what it is not. Like a metaphorical 'House of Glaser' and 'House of Strauss' the lineage has developed due to the worldview and philosophical stance of more recent researchers' use of grounded theory (Stern 2009). Speziale and Carpenter (2007) consider the outsider, or '*etic view',* to be the epistemological perspective through which the researcher observes the situation but is not part of that situation. The objective approach to grounded theory proposed by Glaser (1978) requires the researcher to be detached from the subject literature and the participants. Indeed, Strauss and Corbin (1998) would agree. This detachment enables the ensuing data analysis and subsequent findings to be presented 'truthfully'. The aim of impartiality is to ensure that the meanings of the participant are accurately represented (Glaser 1978; Strauss and Corbin 1998). Strauss and Corbin (1998) consider the participants as viewed and the researcher the viewer, objective in their stance without seeking to verify predetermined ideas or motives. All that is shared by researcher and participant is the interest in the phenomenon being investigated (Mills et al 2006). Whereas, the main tenet of Glaserian grounded theory is the dictum *"all is data"* (Glaser 1988 cited in Glaser 2004:3).

Bryant (2002; 2003) and Charmaz (2006) assume a constructivist approach to grounded theory which, while moving away from the positivist roots of 'traditional' grounded theory, retains robust principles and processes in data sampling and analysis. The constructivist approach reflects assumptions about research enquiry that investigators conducting qualitative research are not impartial and neither is the research process (Schreiber 2001; Charmaz 2006; Star 2011). In constructivist grounded theory the theory is 'constructed' from the data. Glaser (2002) emphatically disputes this approach, insisting and advising that findings 'emerge' from the data. Glaser (2002) argues that constructivism is a move away from the conventional grounded theory process,

maintaining that the constructivist approach is a remodelling of QDA that favours descriptive findings and lacks conceptual rigour. Yet, other authors including Mills et al (2006:2) argue that methods such as a constructivist approach to grounded theory are but a thread of a "*methodological spiral*", a helix that has developed and diverged over the years and still retains the original ethos and intention to develop theory from data. A view supported by Stern (2009) who, as an early protégé of Glaser, maintains that should the original authors of 'Discovery' (Glaser and Strauss 1967) ever have had an opportunity to revisit their seminal text, they would recognise the method as 'constructed'. Whether House of Glaser or House of Strauss, the final theory generated by grounded theory is not based upon hunches, but 'valid' data that emerges from the participants and is 'grounded' in their 'real world' (Guba and Lincoln 1985:102). Consequently, the theory can be situated within the logic of a traditional post-positivism that recognises only an objective and verifiable reality (Porta and Keating 2008; Charmaz 2006; Mills et al 2006).

This understanding of the historical roots and divergent paths of grounded theory was fundamental in helping me grapple with what initially had seemed an unwieldy research design. At the start of the research, I found it difficult to be creative and tried to seek out guidance on grounded theory that would 'tell me what to do'. Stern (2009) advises that this search for clarity in grounded theory is quite normal, particularly for those in the nursing profession who are naturally drawn to systematic frameworks that impose structure and organisation (Stern 2009). I initially followed Charmaz's (2006) constructivist approach until a change of supervisor encouraged me to broaden my understanding of grounded theory. I began to recognise that much of my desire to 'get it right' was personal uncertainty as a novice researcher. The more I read regarding grounded theory, the more I understood that there are three main principles of analysis of the data that run through all approaches, regardless of the world view of the grounded theorist. These principles are theoretical *sampling, constant comparison* and *memo writing*. Grounded theory is an assemblage of methods used to undertake qualitative research, as opposed to an exact and prescribed method (Bryant 2003, Charmaz 2006; 2009). This observation is borne out by Charmaz (2006) who maintains that when researchers "*treat grounded theory guidelines like recipes*", opportunities for innovation are missed and data not fully explored (Charmaz 2006:114).

How sampling, constant comparison and memo writing are embedded in the research design is dependent upon the view of the researcher and consequently, how these principles are applied (Glaser 1996). In grounded theory what is required of the researcher is to immerse 'self' in the analysis of the data. Subsequently the researcher is enabled to reflect upon and understand the participants' experience (Mills et al 2006). As a consequence the researcher can identify a pattern of behaviour associated with that experience (Glaser 1978). While reading around grounded theory, I came across Glaser's (1996) text '*Gerund grounded theory: The Basic Social Process Dissertation'.* The manner in which the exemplar dissertations in this text explored basic social processes [BSPs] caused me to contemplate how BSPs might apply to my own work and I became fascinated by gerunds. Consequently, I adopted a research design for this study that sought out the BSPs by which pre-registration nursing students become aware of their spirituality from experience in clinical practice.

3.3 Basic Social Processes [BSPs] and their place in Grounded Theory

The original and seminal text by Glaser and Strauss (1967) advises that grounded theory is a qualitative research design that explores the basic social processes [BSPs] inherent in human interactions. For Barney Glaser the continuing premise of 'good' grounded theory is that it is based upon a reality that is governed by BSPs (Glaser 1996). Issues concerning society and the impact of the industrialisation of the 20th century caused social psychologists to look for theoretical perspectives that might account for human behaviour (Benzies and Allen 2001). In the original grounded theory method (Glaser and Strauss 1967) both authors brought with them the products of their early academic influences. For Strauss this influence was the work of Herbert Blumer, a social psychologist (Stern and Covan 2001). Herbert Blumer's work on symbolic interactionism is based on three principles: human beings attach 'meaning' to things and act towards them in relation to this meaning; these meanings are driven by social interaction; and, thirdly, meanings are dealt with and adjusted through interpretation by individual (Blumer 1969). In holistic terms this requires an understanding of individual behaviour, individuals lived experience and the level of relevance they attach in certain situations (Jeon 2004). Within the context of this study the situation was the environment in which pre-registration student nurses learn their clinical practice.

Glaser's early academic influences were from the work of Paul Lazarsfeld, whose area of research interest was qualitative statistics (Stern and Covan 2001), factor analysis (Glaser 1978) and the processes of interpersonal communication between groups (Katz and Lazarsfeld 1955). Glaser drew on these areas in his advancement of grounded theory and theoretical sensitivity to develop the concept of basic social processes [BSPs] (Glaser 1978). In his 1978 text Glaser identified '*two types of BSPs: basic social psychological process [BSSP] and basic social structural process [BSPP]*' (sic Glaser 1978:102). However, in his 1996 text Glaser appears less pedantic about two types, preferring instead to refer to a singular concept of BSPs (Glaser 1996).

Core categories are identified in the analysis of data and remain related to basic social processes [BSPs] (Glaser 1978; 1996). BSPs are actions that appear to be happening in the data and that change over time (Glaser 1978; 1996). One way to identify and explore BSPs is to use gerunds (Glaser 1978; 1996). A gerund is an English verb which ends with an *'ing'* but that primarily functions as a noun (Soanes and Stevenson 2006). Gerunds can be used in grounded theory as part of the coding process (Glaser 1978) and are useful for enhancing memo writing (Charmaz 2006). Gerunds can be used to identify and explain actions of the participants that are associated with a given code (Schreiber 2001). Therefore, gerunds can assist conceptualisation, abstraction and form a basis for theory development. Glaser's (1978) and his 1996 assertion is that any emergent theory should account for patterns and processes of behaviour that are grounded in the data. These processes occur over time as stages and as they change, they become sequenced together (Glaser 1978; 1996). Occurring 'over time' is of great relevance to this inquiry, as I was intrigued as to what might be happening to pre-registration students' thoughts about their spirituality over the three years of their educational programme.

3.4 The language of grounded theory

The language of grounded theory differs from other qualitative research designs. Each grounded theorist uses slightly different terminology, which can be confusing for those unfamiliar with the method (Stern 2009). It took me almost the duration of the study to fully appreciate the semantics of grounded theory. Nathaniel and Andrews (2007) provide one of the clearest discussions, which I have found particularly beneficial. In grounded theory the main findings of the study are described as 'concepts' or

'categories'. Concepts and categories are in turn, made up of lesser concepts or 'properties'. The 'core category' is the central concept that holds other concepts and properties. Properties and concepts are connected to each other and the core category by theoretical codes that provide a hypothesis about the BSPs. In other words, asks, *"how do these properties connect to these categories and how are the categories held by the core*?" Figure 3:1 (overleaf) presents these relationships as a Venn diagram. This diagram will be found again in chapter 5 demonstrating findings identified during analysis of the data.

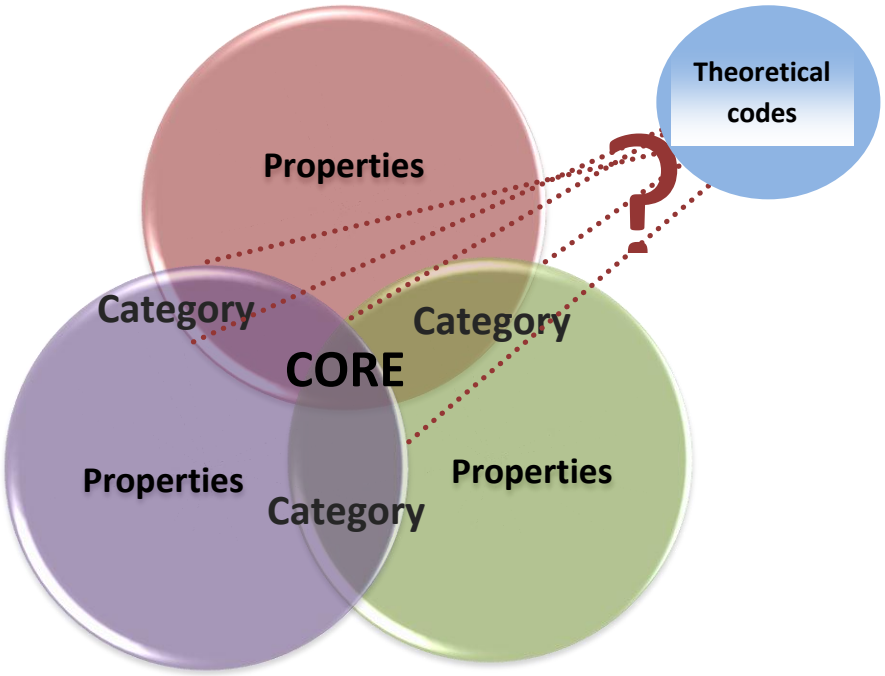


Figure 3:1 Venn diagram illustrating connection between properties, categories and the core

3.5 Data and grounded theory

Central in grounded theory is the process of simultaneous data generation, collection and analysis. Theoretical sampling is a fundamental process for acquiring data in grounded theory (Glaser 1992; 2002). In a grounded theory design one cannot independently separate the participant sample and data sample with any ease. In grounded theory 'sample' not only reflects the participants involved, but also the data the sample group create (Glaser 1978; Speziale and Carpenter 2007; Birks and Mills 2011). Theoretical sampling requires the researcher to concurrently move between collection of data, coding and then analysing the data (Glaser 2004; Schreiber 2001; Glaser 1978), meaning

that this sampling process is guided by the emerging theory and visa versa (Schreiber 2001; Glaser and Strauss 1967). Theoretical sampling successively illuminates categories that emerge from the data that can then be built upon further. In this way the emerging theory matches the data (Morse 2009; Charmaz and Bryant 2011). Charmaz and Bryant (2011) explain that as the data collection continues the researcher may also seek out people, events and literature associated with the emerging theory. This reflects Barney Glaser's edict '*all is data'* (Glaser 1988 cited in Glaser 2004:3) indicating that any data generated is worthy of comparison with other data. This comparison ensures that data are simultaneously developed into category and then concept but, as this process is occurring, constant comparison continues. Subsequently, theoretical sampling associated with grounded theory seeks to develop and clarify categories by building on concepts and questions as the analysis progresses, until theoretical saturation in the data has been achieved (Charmaz 2006; Corbin 2009). To enable categories or variables to 'emerge' the researcher undertakes constant comparison of the data, not sequentially, but in synchrony (Stern and Covan 2001). Constant comparison enables the researcher to look for fundamental patterns relevant to the phenomenon under investigation (Glaser 1992; Glaser 2004). The consequences of comparing data with data are that further theoretical concepts are generated (Charmaz 2006). When the researcher finds a category that appears to have relevance the next step is to seek other existing knowledge pertaining to the subject. This process enables concepts to begin to fit together, described by Schreiber (2001:70) as *'emergent fit'*. It is important to continually revisit and redefine data to ensure that the analysis is not superficial and that no further theoretical insights and substance can be gleaned from the data (Dey 1999; Charmaz 2006). Accordingly, theoretical sampling and constant comparison provide a simultaneous, continuous, interactive and iterative analytical process. Inherent in these processes are the use of memos and field notes to guide data collection.

In grounded theory, the researcher writes field notes and memos to record their observations of participant actions and idiosyncrasies during data collection (Schreiber 2001; Speziale and Carpenter 2007; Charmaz 2006). Field notes and memos then become flexible data that can assist the researcher to put into context different observations acquired during the other data collection methods (Schreiber 2001; Charmaz 2006). Within this study the reader will observe how I blended field notes with reflexive memo

writing to fully explore how participants felt about the phenomenon. This was achieved through a writing style that is not necessarily scientific, but literary exploration and '*whimsical wondering'* (Charmaz 2006:135) of feelings, situation, and real time recognition of the data and its acquisition. Writing facilitates the researcher's attempts to understand the assumptions that impact upon the participants' world, to learn what occurs in various situations and what the research participants' lives might be like as a part of that situation. By doing this the researcher can ensure that the participants' view point and meaning can be made evident thus enabling the reader to identify the connection between the analysis the participants' experiences of their world (Charmaz 2006; Mills et al 2006). Backman and Kyngäs (1999: 149) use the analogy of 'discussion' to describe the relationship between the data, the emerging theory, the researcher and the memos. This metaphorical discussion causes the data to be broken down, made sense of and then fitted back together in a structured manner. The process, while messy and uncertain for the novice researcher (Glaser 2004), does enable a systematic structure to be developed, which describes, explains and 'grounds' the phenomenon in the data. Therefore, the theory is inductively derived from the study of the phenomenon (Backman and Kyngäs 1999).

3.6 Grounded theory and analysis

The purpose of data analysis is to give meaning to the data collected as part of any study (Burns and Grove 2001). Glaser (2004) suggests that traditional QDA methods used in some studies seeks to verify and describe information gathered in the process of that study. Thus, Glaser's concern is that QDA methods impose conceptual problems and theoretical frameworks whereas grounded theory analysis methods encourage the 'emergence' of theory (Glaser 2004). The principle of analysis in grounded theory is to demonstrate a systematic process by which data moves beyond the verified description to an explanation of what is happening in the data, finally accumulating in generation of theory (Glaser and Strauss 1967). The key to the development of this theory is to identify a core concept or category. As identified in figure 3:1 (p 29), through constant comparison, this category binds all the other categories together to transparently explain how the problems associated with the phenomenon are being resolved (Glaser 1996).

As explained in section 3.5 constant comparison is essential in the analytical method used in the establishment of a theory that is 'grounded' in the data. Constant comparison requires the researcher to move back and forth through the data as each new concept is identified. The concept is explored in preceding data and investigated for in new data. This way the researcher can identify the relevance of new theoretical properties to the concept and vice versa. This constant comparison generates more questions that reveal more concepts, which again require exploration (Glaser 1978). Constant comparison bores deeply into the phenomenon and rather like a detective asks questions of what is found. Theoretical sampling then explains these findings in the light of comparison with other findings (Glaser and Strauss 1967, Corbin and Strauss 1998; Charmaz 2006). The overall principle of grounded theory analysis is to ensure the theory is grounded in the social world of the participant. This process requires clarity, structure and sequence in the analysis of data to *"generate an inductive theory about a substantive area"* (Glaser 1992:16).

3.7 Summary

This chapter has provided the reader with an interpretation of grounded theory that reflects my knowledge and understanding of the broader methodology. This chapter has presented an overview of grounded theory from the historical context to the modern day. Included within this chapter was my personal understanding of the principles and processes of grounded theory that developed over the period of the study. I have come to know grounded theory as a versatile tool, rather like a Swiss army knife that offers many practical and innovative functions for examining data. Consequently, a qualitative grounded theory was felt to be an appropriate research design to explore the substantive area of pre-registration nursing students' awareness and understanding of their spirituality from their experiences in the clinical environment. The following chapter will demonstrate how the scope of my knowledge in the initial stages of this study was used to facilitate a grounded theory design for the study.

Chapter 4 : A grounded theory design

Chapter 3 provided an overview of grounded theory methodology presenting a considered rationale as to the application of grounded theory to the substantive area of pre-registration nursing students' awareness and understanding of their spirituality from their experiences in the clinical environment. This chapter will determine the purpose of the study and the grounded theory design used, including participant recruitment. This design relied upon the specific grounded theory techniques of theoretical sampling. In this chapter ethical considerations in relation to 'self' (the researcher) and the participants is explored and discussed. Subsequently, reflexivity in the form of field notes and memos will be evidenced as having guided the study design for the collection and accumulation of data.

4.1 The purpose of the study

According to Glaser (1996) most researchers start with a topic that they wish to explore. The purpose of this study was exposed in an initial title, required for the Faculty research office. The title became '*to explore the way in which pre-registration nursing students might develop awareness and understanding of their own spirituality from their experiences in practice.*' Star (2011:79) recognises that "*grounded theory is an excellent tool for understanding invisible things*". As previously demonstrated in chapter 2, spirituality, exactly what it is and the manifestation of the phenomenon is unclear (Speck et al 2004, McSherry et al 2004). The broader purpose of the study was to contribute to the body of knowledge on spirituality, thus enabling potential learning and teaching strategies on the subject of spirituality to pre-registration nursing students to be informed and enhanced. Due to the reasoning in chapter 2, it was an educational requirement of the doctoral programme I was studying to produce a substantiated written discussion. This discussion was obligated to highlight why grounded theory was an appropriate research design for the exploration of the phenomenon. As a consequence, a set of broad aims was devised to advise relevant persons, including supervisors, peer reviewers and the ethic committees regarding the intention of the research. Glaser's preposition of any study is that the researcher should have no preconceived ideas about what they intend to find. The finding should 'emerge' as the

study progresses and the design develops (Glaser 1998). Nevertheless, Charmaz (2009) refers to the 'journey' of grounded theory. For me as a novice to qualitative grounded theory, an identified purpose of the study provided direction, a 'start' to my research journey. An identified purpose to the study also enabled me to explore how I might recruit to the study and begin the sampling process.

4.2 Recruitment

As highlighted in chapter 3, the term 'sample' within grounded theory is all encompassing and includes theoretical sampling. Speziale and Carpenter (2007) suggest that the selection of research participants for the purpose of data collection should be directed by and reflect immediate personal experience associated with the phenomenon under investigation. Pre-registration nursing students from the cohort of September 2007 intake were invited to participate in both Phases 1 and 2 of the study. As identified in chapter 3, central to grounded theory is the process of simultaneous data generation, collection and analysis. As a starting position, the researcher gathers some data with an initially purposive sample (Birks and Mills 2011). Participants were purposively sampled from the 2007 intake of 215 Diploma, Advanced Diploma and Bachelor of Nursing students undertaking a three year pre-registration nurse education programme within one site of a University School of Nursing and Midwifery. An email was sent out prior to the recruitment process to staff with academic responsibility (academic tutor) for a 2007 intake student nurse learning/teaching group. This email informed the academic tutor about the purpose and aims of study and invited them to contact the researcher for further clarification. At this stage in the process it was anticipated that there could be a risk of over recruitment to the study. To reduce this risk, recruitment was undertaken by selecting the learning groups[5] from the 2007 intake, sequentially and incrementally from a list of seventeen groups. Each 2007 intake pre-registration student received via the academic tutor a pack that included an invitation to participate (Appendix 2) and an information sheet that explained the overall purpose and aims of the study and advised students that they were invited to participate in Phase 1 or Phase 2 or *both* Phases of the study (Appendix 3). Reply slips were included that reflected the student's decision as to

[5] Learning groups contain a minimum of 10 and a maximum of 16 students. They are used at the designated study site to facilitate enquiry based learning.

the Phase(s) in which they were expressing interest. Volunteers were asked to return the reply slips to the researcher via an addressed envelope provided. Originally I had anticipated that one group would be selected from the top of the list each week over a six-week period in the sequential numerical order that they occurred, until the desired number of volunteers for each of the phases of the study was obtained. After the first week when no expressions of interest were received I increased this number to four groups at one time, which reduced the recruitment phase to four weeks.

Initially I found it hard to understand why few volunteers had come forward. Lee (1995) suggests that in sensitive research there may be difficulties accessing populations and then encouraging members of the population to participate. The literature pertaining to spirituality suggests that this phenomenon has the potential to induce sensitivity in some individuals (Ross 2006). This potential sensitivity was not considered problematic at the outset of the study and came as an initial surprise. In my recruitment design I had made a naïve assumption that students would be interested in participating and contributing to a broader body of knowledge on the subject of spirituality. Retrospectively, I am surprised that I did not fully appreciate nor consider implications highlighted in the literature that spirituality might be limited amongst the student nurse population (McSherry & Watson 2002). Mitchell et al (2006) identifies that not all nursing students are 'comfortable' with the notion of spirituality. While Meyer's (2003) study established that students in the United States, who perceive spirituality to be an important component of nursing care, usually attended educational institutions with a religious affiliation. It is well documented in literature on learning and teaching in higher education that students are intrinsically driven by an interest in the topic/activity (Biggs 2005). It is probable that the majority of the students that did volunteer and consistently participated in this study were either comfortable discussing and/or held strong feelings regarding spirituality and a vested interest in the phenomenon. As the study progressed, I came to appreciate that sample and data in grounded theory holds different meaning and my anxiety surrounding obtaining 'sufficient data' was conquered. Due to the low response to recruitment the study was based upon the following participant sample size: *Phase 1:* two focus groups, each consisting of two pre-registration nursing students; Phase *2:* nine one-to-one interviews conducted with seven pre-registration nursing students, three of whom were involved in Phase 1.

4.3 Collecting the data

Initial data collection was longitudinal, undertaken over a two-year period from 2008 to 2010. Data from participating pre-registration nursing students was obtained in two phases using focus groups, interviews and additional participant generated material (artefacts)[6]. Phase 1 required the formation of two focus groups. Charmaz (2006) suggests that obtaining deeper insights into research participants' meanings can be achieved by involving them in the creation of data. Bringing groups of people together to focus upon a particular topic was originally conceptualised for market research purposes (Bloor et al 2002; Speziale and Carpenter 2007). This method of investigation utilises group dynamics to stimulate participant discussion and create ideas (Bowling 2004). Consequently, focus groups can be advantageous in gathering data regarding group meanings and norms in a way that is accommodating for the participants (Burns and Grove 2001; Bloor et al 2002). A selection of dates and times, to establish the most convenient occasion, were sent to each of six participants who agreed to partake in a focus group. When these details were established each participant was sent an information letter by email and invited to select a date and time from a range provided. Also included was a detailed guide that explained the process of the focus group (Appendix 4). In response to dates and times identified as convenient to the participants, two focus groups were convened. Each focus group consisted of two students. Attempts to contact the other two were unsuccessful possibly due to recruitment issues explored above. Consequently, of the six students that agreed to participate in Phase 1 focus groups, only four attended this phase[7].

Bloor et al (2002) suggest that often the topic being explored and the participants' characteristics will impact upon group size; this should not be viewed as problematic. Smaller sized groups may be an advantage for studies of a sensitive or complex nature and which may require the participants to have sufficient time to express their views (Speziale and Carpenter 2007; Bloor et al 2002). The focus groups were conducted using

[6] An article, object, material, symbol or process chosen by the participant that enables them to consider and explore their own spirituality from experiences in practice. Examples of an artefact are: a narrative, reflective accounts/stories, meaningful imagery (paintings, pictures, drawings, and sculpture) or images participants have created.

[7] A table identifying the demographic of the participants can be found in Appendix 12

a structured schedule to ensure a focused discussion (Appendix 5). Silverman (2010) advises any initial data collection that involves the researcher asking questions of the respondents will result in data that is not naturally occurring or impartial. Bloor (2002) suggests that some structuring should be introduced to the process to ensure that the research topic is addressed while not inhibiting the flow of the interaction between members of the group and the facilitator. The findings and outcomes of the two focus groups were intended to generate broad data to begin the process of exploring participants' belief systems and understanding of what might constitute their own spirituality. The focus groups took place at a location and a time convenient for the participants (Bloor et al 2002). I personally facilitated the focus groups and the sessions were audio recorded. Due to the small size of the group the decision was made not to include an observer as this may have been disconcerting for the participants (Bloor et al 2002). Consistent with theoretical sampling, the themes and issues identified from the two focus groups in Phase 1 were used to inform and guide Phase 2 of the study, one-to-one interviews.

Phase 2 of the study involved individual participants in twelve semi-structured one-to-one interviews undertaken at four to six monthly intervals over two years of a three-year pre-registration nursing programme. The participants recruited for Phase 2 interviews were volunteers who had *either* participated in one of the focus groups in Phase 1 *or* been informed about the research via the learning group. Some participants of Phase 2 had elected not to have been part of Phase 1. Prior to attending for interview participants who had agreed to take part in Phase 2 were sent a further information sheet by email that detailed what to expect from the interview process (Appendix 6). All participants were contacted by their preferred communication method to arrange a convenient time and venue for each of the interviews and this arrangement was then confirmed in writing. Interviews were conducted at a venue convenient and comfortable to the participants. Although participants were invited to choose the location, in all cases the participant chose to conduct the interview on University premises and within a building associated with nursing and midwifery education. Participants were invited to select a time that suited them and were informed that the interview should last for a maximum of sixty minutes. To foster reciprocal trust between the researcher and the participant (Lee 1995;

Speziale and Carpenter 2007) each interview opened with an informal personalised conversation to help the participant feel at ease with the researcher and the audio recording equipment. During the initial interviews open-ended questions were used that focused upon the topics and issues elicited from the two focus groups. The categories and issues identified from the focus groups in Phase 1 were then used as part of theoretical sampling to inform and guide the interview process in Phase 2 of the study to further explore topics and issues uncovered by the focus groups. The interviews followed the process described by Speziale and Carpenter (2007): *reminiscing* on experiences to date; *contextualizing* and probing of emerging concepts and categories revealed by the participant; *closing* or concluding; and, *reciprocation* - feedback on issues discussed. One-to-one interviewing is a useful method in grounded theory for collecting qualitative data, particularly if the interviews are guided by previous theoretical sampling (Stern 2009). Constant comparison along with theoretical sampling required me to dig down into the data from the interviews and to probe for further information (Charmaz 2006). Consequently, over the two years of the study, new and altered themes appeared that warranted in-depth exploration with the participants. The interviews became a tool to explore with the participants the impact their experiences in clinical practice might have on the awareness and understanding of their own spirituality. This data collection method was intended to facilitate obtaining detailed and in-depth accounts of participants' experiences, beliefs, and perceptions of spirituality from their encounters in the clinical environment. Flexibility of the interviewing process enables the researcher to learn what is happening to '*correct tendencies to follow preconceived ideas*' (Charmaz 2006: 29). Charmaz (2006) suggests that participants' stories may not always be forthcoming and that considerable work may be needed to discover the subtlety and complexity of individual's intentions and actions. Using previous data to semi-structure or guide the interview process drew out the participants' hidden meanings and assumptions about their experiences (Strauss and Corbin 1998; Charmaz 2006) in relation to spirituality and the clinical environment. The benefit of which was to continually develop and enhance clarification of the participants' perceptions (Bowling 2004; Charmaz 2006), thus creating and clarifying subsequent data (Glaser 1978). Guiding the interview process using the previous themes from Phase 1 assumed more direct control over the collection and construction of data (Charmaz 2006; 2009) by probing further into

a participant's response to encourage them to explore issues relevant to them about the phenomena under investigation. Successive interviews with specific participants focused on artefacts they had sent prior to interview or that they brought to share with me. Within this study this data is termed as "*artefacts*". Bowling (2004) and Charmaz (2006; 2009) encourage the collection of additional data such as written text, creative materials or objects (drawings and other imagery or symbolisms) to provide the researcher with ideas and insights into the personal structures and cultural influences of participants. Researcher and participant can then explore this additional data in greater depth. Throughout the data collection process participants were encouraged to send to me beforehand or bring with them 'artefacts' that expressed their thoughts, feelings and concerns surrounding spirituality. These images were then used to further guide, inform and help construct the next interview (Charmaz 2006). One participant provided a drawing (see figure 6:2) along with an email and I received another email from one other participant. In these 'artefacts' they attempt to articulate their individual perspective of spirituality (Appendix 7). While not all participants shared personal artefacts with me, those sent by others provided cues and insight for theoretical sampling. After a final interview one participant sent me a presentation on spirituality that she had undertaken for the local hospital chaplaincy (Appendix 9). During interviews with this particular participant I came to understand the importance of ethical considerations in any research design.

4.4 Ethical considerations

Spirituality is a potentially sensitive and emotive phenomenon (Carson 1989; Ross 2006). A responsible researcher recognises respects and acknowledges the rights of participants (Burns and Grove 2001) particularly in relation to the ethical principles of autonomy, beneficence and justice. Permission to recruit students was obtained from the Head of School and the School Ethics Committee granted approval for the study. I made certain that my relationship with the participants was maintained appropriately in keeping with the NMC (2008) *Code - Standards of conduct, performance and ethics for nurses and midwives*. I found that Vallis and Boyd's (2002) relevant ethical principles of *protective responsibility*, *responsibility for narrative integrity* and *candour*, identified in end of life decision making, useful to explore the ethical considerations required for this study.

Protective responsibility (Vallis and Boyd 2002) is the practitioner's responsibility to protect the vulnerable from harm. Research participants may be potentially vulnerable, especially if the phenomenon is of a sensitive nature and more so if they do not realise the full implications of participation (Speziale and Carpenter 2007; Lee 1995). Speziale and Carpenter (2007) suggest that informed consent must be based upon the ethical principle of autonomy. To ensure participants were able to make an informed decision regarding their contribution to the research they required access to adequate information about the study (Speziale and Carpenter 2007). The relevant information sheet (Appendices 4, 5 & 7) and a copy of the appropriate consent form were sent to participants prior to the focus group and/or interview. Participants were first asked to read and confirm their understanding of the relevant information sheet. Participants then gave informed consent by voluntarily signing a consent form at the time of either the focus group or the initial interview. As the study progressed, participants of Phase 2 were verbally asked to reconsider their consent at each interview. Speziale and Carpenter (2007:64) advise that emergent qualitative designs require a different approach to informed consent. They describe this approach as '*consensual decision making',* meaning that the researcher should re-evaluate the participants' willingness to participate in the study. This approach to consent can also accommodate the evolving process and progress of the study (Speziale and Carpenter 2007). Throughout the data collection process consideration was made for consent to be re-negotiated should unexpected events or consequences occur. For example in one interview the participant began to cry:

> *"W: Ahh. Are you alright to carry on going?*
> *D: Yes.*
> *W: Are you sure?*
> *D: Yes. (Pause 0.06). Sorry.*
> *W: I think it's – when you are talking about these very – they're very poignant moments in life and as nurses we're very privileged to be part of such poignant… Shall I pause the tape?*
> *D: No, it's alright.*
> *W: You sure?*
> *D: Yes, it's OK.*
> *(Pause 0.05)"*

By asking the participant if she wanted the audio recording stopped and then confirming her choice to continue, I ensured she was involved in the decision to resume with the

interview. Over the period of the study I came to recognise the sensitive nature of personal spirituality for this particular participant. The data and findings that emerged because of this sensitivity will be explored in later chapters.

Vallis and Boyd's (2002) *responsibility for narrative integrity* involves knowing people well and defending their best interests including maintaining confidentiality and anonymity. Conversely, Speziale and Carpenter (2007) suggest that the very nature of qualitative data collection make true anonymity impossible. Small sample sizes and thick descriptions mean that confidentiality cannot always be fully maintained (Speziale and Carpenter 2007). In keeping with the eight principles of the Data Protection Act (1998) an attempt was made to maintain optimum protection of the participants' identity and personal views throughout the study by undertaking the following processes. Following receipt of the verbatim transcripts for analysis the participants' first names were replaced with a letter(s) to ensure anonymity. To protect the identity of the clinical environment any placement name when referred to by the participants has been removed and replaced with the 'speciality' title i.e. *Children's oncology*. Audio recordings have been stored separately to consent forms, each in a locked desk only accessible by the researcher. Audio recordings and transcripts will be kept for 10 years after collection or subsequent publication, whichever is later and then destroyed in keeping with the University research integrity and academic conduct policy (2010). Participants have the right to access any data pertaining to them should they so wish.

The final ethical principle highlighted by Vallis and Boyd (2002) is *candour:* being completely open and truthful. The nature of the study meant that participants were offered the opportunity in Phases 1 and 2 to express personal feelings. This may have caused potential ethical issues to arise. The sharing of knowledge, the longitudinal nature of this study, the psychosocial changes and emotional experiences to which the participants were exposed could have caused inappropriate interaction between participants and researcher. There was a potential that I would be viewed as counsellor and/or therapist (Lee 1995). Speziale and Carpenter (2007) and Lee (1995) advise that while the researcher should be open and truthful with the participant, the challenge for the novice researcher is to not drift from the focus of the interview. I might also have

been vulnerable due to the potential intensity of interaction (Speziale and Carpenter 2007). In section 4.5 the reader will recognise the extent to which the experiences shared by the participants impacted upon me. Nonetheless, the resulting reaction was to further guide theoretical sampling through exploration of literature, and then comparison of what was found, to other literature. In many ways this making sense of the students' experiences, traumatic as they were to hear, enabled me to explain and set these experiences in a greater context. All the while bearing in mind that Parahoo (1997) cautions the aims of the researcher and/or that of the study should not be put before the needs of the participants. In keeping with the NMC code of Conduct (2008), in the unlikely event of disclosure that the participant, vulnerable adults or child was at risk of significant harm, relevant information would have to be shared with an appropriate third party. The participant information sheet details this (Appendices 5 and 6). If such a situation had occurred, participants would have been reminded verbally of my professional and ethical obligation with regard to third party disclosure. While during the study nothing untoward was revealed, I have used reflexivity to reflect and maintain truthfulness and transparency of the research process.

4.5 Reflexivity

Reflexivity demonstrated throughout this document is intended to enable the reader to assess how and to what extent my emotions; interests and position within the educational institution and personal assumptions regarding spirituality may have influenced the inquiry (Charmaz 2006; 2009). Urquhart (2011) suggests that the skill for the grounded theory researcher is to maintain a consciousness regarding imposing other theories and preconceptions on the data. Reflexivity throughout the study was essential in exploring and exposing my responsiveness as the principal researcher. Particularly as I would be required to recognise the extent to which the boundaries between objectivity and subjectivity relating to the phenomenon became blurred (Taylor and White 2000). This process has involved the scrutiny of the research experience for 'self' as researcher, 'self' as nurse and the perception of 'other' as participant (Charmaz 2006: 2009; Taylor and White 2000). Lee (1995) advises that reflexivity can enhance emotional distancing from those being studied. While coding one particular interview all the raw emotion I felt at the time of the interview came flooding back to me:

> *"MEMO: again here I couldn't help but want to try to 'make it alright' for D….is that the nurse/teacher in me…I felt this participant was desperately seeking affirmation/ confirmation and some direction…I could almost 'smell and taste' her struggle and feel her anguish, her pain…spiritual pain."*

> *"MEMO: this was the most difficult of interviews and the second on that day. I had no idea it would be so hard and so poignant…and I had no idea that as researcher I would feel so helpless and found myself drawing on my 'nursing skills' to reassure and to 'teach'. I wanted to say "it's OK"….and deep inside to scream to my profession…"how can we have done this…what have we done to this person…how can we have 'wounded' her so!!!!!"*

Reflexivity and memo writing helped me make sense of my main conundrum: should I be true to the participants and myself or was I trying to follow an 'academic' recipe as researcher? Pizzorno (2008) articulates this moral tension well by suggesting that as human beings we are constantly torn between the need to be true to 'self' and the extent to which we seek recognition from others suggesting that:

> "*People ought to behave without concern for the judgement of others, and that doing the right thing should be sufficient compensation*" (Pizzorno 2008:166)

The epistemological research perspectives of emic (insider) and etic (outsider) have been explored by Speziale and Carpenter (2007). Insider research is considered the extent to which the '*emic view'* or personal insider perspective of the participant might be discovered (Speziale and Carpenter 2007). Speziale and Carpenter (2007) consider the outsider, or '*etic view',* as the extent to which the researcher observes the situation but is not part of that situation. My main concern at the early stages of the study was that like a steady pendulum, I seemed to swing between the two opposing views. As teacher and qualified nurse within the same educational establishment as the participants it might be argued that the participants' view me as 'outsider' while having been a student nurse I viewed myself as an 'insider'. Charmaz (2006) suggests the nature of the grounded theory encourages the researcher to adopt the 'emic'/insider view in attempting to enter the participants' world and ground the analysis in the social process that may be occurring (Glaser 1992). A view recognised by Harry et al (2005) who suggest that often in social sciences the researcher is studying a topic within a field they know quite well. Glaser (2006) advised that this prior knowledge may inadvertently cause the novice researcher to 'force' data. The phrase 'forcing data' is used almost as frequently by Glaser in his literature as the term 'all is data' (Glaser 1992, 2006), meaning that an inexperienced researcher may make assumptions about the findings that are weak,

descriptive and unsubstantiated in the data (Glaser 2001). Memo writing and reflecting back on field notes not only helped me to make sense of preconceived ideas but also, as the analysis progressed, instilled a confidence that I could interpret the data and identify when I was being influenced by preconceptions or forcing the data.

Consequently, reflexivity in this study will be seen to be contained within some memos revealed in the findings. As referred to earlier, reflexivity within field notes and memos was essential in informing the research process and guided where new data might be sampled. The reflexive process has been pivotal in identifying data, maintaining exploration and interpretation of the data through theoretical sampling. The reflexivity used in this study will enable the reader to identify how I moved between theoretical sampling and constant comparison to reach conclusions highlighted in the findings chapters. In keeping with grounded theory, this process became iterative and instinctive in nature (Covan 2001; 2009 and Stern 2011). The reflexive process began as I coded the transcripts. Memo writing and reflexivity were particularly useful in the case of one participant, D. D was a pre-registration nursing student who participated in both phases of the study. While D had volunteered, she always seemed hesitant to talk and share her thoughts and experiences with me. I tried to understand so that I could explain, yet I followed my instincts: instincts that were driven by care and concern for this potentially vulnerable individual. Speziale and Carpenter (2007) advise that while ethical guidelines give some preparation and framework for the ethical dilemmas the researcher may face, the realism of the moral picture presented in the study may be far more complicated. Ethical knowing in nursing is associated with moral knowledge and the ability to value the individual (Carper 1978). After over 30 years of practising as a nurse I have developed what Benner (2001; p vii) would describe as *'clinical knowledge and moral agency*'. Decision-making and ethical actions associated with who I am as 'nurse' have assumed a balance between the transactional approach of 'doing things right' and the transformational approach of 'doing the right thing' (Handy 1999; Hardacre 2001). In the case of D, theoretical sampling enhanced confirmability. I found that sharing prompts with D that came from the analysis of other transcripts, illustrated to her that she was not alone in her experiences of clinical practice. As a nurse, this was more important to me than exploring potential concepts further. I wanted D to be reassured, even if it is seen as unconventional within the context of unbiased research. The constant reflexivity detailed

in this thesis will enable readers of the research to be able to identify how theoretical explanations were reached. Subsequently, the originality, significance and contribution of these explanations towards the emergent theory should be evident.

4.6 Summary

The purpose of the study has been explored along with the rationale for the chosen research design. The processes and principles associated with grounded theory have been critically discussed and explored and related to recruitment and ethics in conjunction with the sensitive nature of the phenomenon. The extent to which reflexivity and memo writing informed transparency of the research process has also been considered. The next chapter will present the procedure followed in the analysis of the data, demonstrating the extent to which I utilised theoretical sampling and constant comparison as a grounded theory design to meet my '*emergent needs'* (Glaser 1998: xii).

Chapter 5 : Data Analysis

This chapter will examine the methods of analysis in this study, using a grounded theory design. Consistent with grounded theory the data collection and analysis was on-going from the beginning of the study in the search for patterns within the data (Glaser 1998). The purpose of the analysis in this study was to identify a core variable that informed a substantive theory that would explain how the participants gained an awareness of their spirituality from experiences in clinical practice. Within this chapter, an overview of the iterative analytical process adapted from Maxwell's (1977 cited in Glaser 1996) stages of constant comparative analysis will be provided. Each of these sequential stages are then expanded and explored throughout the analysis, each step building on the previous. While there are sequential stages to grounded theory Glaser (1992; 2004), Strauss and Corbin (1998) and Charmaz (2006; 2009) encourage openness, advising against an analytic method that is too constraining. Stern (2009) suggests that while the data should be respected, the analytical process will involve a certain amount of originality and should be creative. Nonetheless, there is a perception of a lack of structure to grounded theory analysis that can prove very disconcerting (Glaser 2004). Therefore, for ease of explaining the analytical process in this study the iterative stages are named as:

- *Creating analytical units* for coding (selective and theoretical), tentative *concept formation* through 'in vivo' coding and theoretical sampling;
- The *development* of *concepts* that occurred as part of the application of memo writing, diagramming and adopting gerunds;
- *Concept integration* that involved the analytical process of returning to, and re-examining earlier data and the expansion and classification of gerunds.

Each stage is enhanced by literature identified through theoretical sampling to accumulate data and develop categories. The diagrammatic representation or the analytical process in each phase can be seen in table 5:1 on the following page.

Table 5:1 Stages of data analysis and integrating Maxwell (1977)

Iteration process	Stages in each phase	Intention	
Creating analytical units	Gaining an overview of the data: Field notes, focus groups, interviews and artefacts	To enable a sense of the data and the participants' meanings to develop	*Phase 1*
	Initial 'line-by-line' coding	To set in motion the conceptualisation of ideas; certain codes will bring together meanings and actions from the data	
Concept formation into tentative categories	'In vivo' codes identified	To identify "*participants' special terms*" (Charmaz 2006:55)	
	Theoretical sampling	To develop properties of the emerging categories	
	Identification of prompts for semi-structuring of interviews	To ensure that initial codes were further explored in subsequent interviews with the participants	*Phase 2*
	Second level coding, developing categories	To identify how the various codes may or may not fit together	
Concept development	Memo writing and diagrams	To enhance the process and an understanding of the social processes associated with the phenomena of spirituality and concepts that developed from the coded data.	
	Adopting gerunds	To illuminate categories, explore basic social processes and foster theoretical sensitivity	
Concept integration to identify the core variable	Revisiting and re-examination of earlier data	To develop categories further and integrate data with data	
	Expansion of gerunds	To ensure saturation of all concepts and further explore abstraction	
	Developing categories through memo writing and theoretical notes	To increase the level of abstraction of ideas	
	Theoretical sorting	To help integrate and bring together data	
	Classification of gerunds using Roget's classification	To identify how a core category might be developed	
	Using literature to develop categories	An aspect of theoretical sampling that enables categories development	

Generating theory through writing

5.1 Creating analytical units

In grounded theory the purpose of creating analytical units is to ensure that all relevant data are considered available for analysis. Maxwell (1977 cited in Glaser 1996) suggests that the identified data units can then be constantly compared to each other to provide theoretical categories and to place emphasis on the relationship between properties. In doing so, potential patterns in the data are identified reasonably early on. This enables the researcher to begin to follow up, act upon instinct (Schreiber 2001) and identify other analytical units. Thus, comparison is an on-going process that requires interpretation at differing progressive stages, as each stage becomes iteration for the next and continues until an explanation of what is happening in the data develops or emerges (Maxwell 1977). The analysis commenced by gaining an overview of the data. After each focus group the audio recordings were listened to via iPod and Personal Computer [PC] and rough pencil notations made to enable a sense of the data and the participants' meanings to develop. A colleague with research and secretarial expertise then transcribed the audio recordings verbatim into a word document to ensure accurate documentation of the data. As each transcript was completed it was emailed back to me. I then replayed the audio recordings while simultaneously reading the transcripts on the PC screen. This ensured that the transcripts were accurate. Several authors advise against the researcher becoming too familiar with their data early on, as this could lead to premature preconceptions about the data (Dey 1999) or distract the researcher into descriptive accuracy (Glaser 1998). Glaser (1998) and Stern (2007) suggest the researcher can become over focussed on the accuracy of participants' 'verbatim' language than the meanings that may be hidden in the language. I found that the field notes I had made during the data collection enabled me to recall subtleties I had noted at the time. These subtleties were not always evident when listening to the audio recordings of a focus group or an interview. For this reason field notes have as much relevance and currency in the analytical process of grounded theory as does accurate audio recordings (Schreiber 2001).

Field notes are the researcher's written observational data about their experiences during data collection including observation of participants' actions (Speziale and Carpenter 2007; Charmaz 2006). Field notes are flexible data and can be useful for helping the

researcher to put into context different observations acquired during the other data collection methods (Charmaz 2006). In this study the analytical journey began as soon as data was collected from the first focus group and much of this data was in the form of field notes. During the initial analysis of the data, field notes were blended with memo writing to fully explore and ask questions of the data. This process is demonstrated below in a field note I made during the first focus group. This field note documents my interest in the participant's hand movements during the focus group. This observation was then integrated during the listening process into the original transcript:

> *A: But everybody's experienced different things and you will find that you have got your – part of your spirituality is the same as, like one of your patients and so everybody contributes to this whole ….. This whole* ***thing*** [Laughter]
>
> **Field notes**… throughout the discussion 'A' had remained mostly still and at one point sat on her hands. At this point she began to use her hands to try to describe this '**thing**' [spirituality]. She raised both her arms and reached up and made a sort of a mushroom shape with her hands…what is interesting is that what she couldn't articulate with words she could almost 'sign' by using her hands. Extract from Focus group 1 (P14: lines 22-31)

As the analysis progressed I continually revisited field notes to extract data that was then further blended with memo writing. This facilitated further notions and ideas that could be coded and followed up or explored in subsequent data (Glaser 1978).

The first step in grounded theory data analysis is to label or 'code' initial data either 'line-by-line' (Charmaz 2006) or 'open' (Glaser 1991). Schreiber (2001) advises that coding systems associated with grounded theory can be confusing; the process of coding can be described with a different name depending upon the researcher's preference. The name assigned for each coding process and the associated grounded theorist depicted in table 5:2 on the following page. Glaser (1978) refers three 'phases' of coding during grounded theory analysis. Accordingly, the first coding phase is the primary interpretive iteration of a developmental process that gradually moves from allocating a name to a code through to theorising (Schreiber 2001, Maxwell 1977). In the analysis of this study the first iterative process involved coding each line of data while simultaneously reading the transcripts and listening to the audio recording. The 'insert comment' tool in Microsoft Word (2007) was used to document the initial codes that arose during this process at the same time I referred back to field notes. This helped me recall and weave in recollections of participants' actions and behaviour (see table 5:3 overleaf).

Table 5:2 Table of coding names and theorist

Phase (Glaser 1978)	Level (Schreiber 2001)	Code 'Name'	Grounded Theorist
Input – data moves as part of the researcher's thinking	First level (concepts)	In situ, in vivo, open codes,	Glaser, Strauss and Corbin, Charmaz
		Line-by-line	Charmaz
"*In-phenomenon*" many different ideas but no clarity	Second level codes (categories)	Focus Codes	Charmaz
		Selective Coding	Glaser
		Axial coding	Strauss and Corbin, Charmaz
Saturation – writing results of analysis	Third level coding (relationships between 1 & 2)	Theoretical coding	Charmaz
		Substantive coding	Glaser
		Selective coding	Strauss and Corbin

During this first iteration of the analysis the aim was not to describe what was happening but to attempt to explain by continually asking questions of the data (Glaser: 1978; 1991; Stern and Covan 2001). Whichever coding term is used to describe this initial overview of the data units, the process of looking intently through the data can instigate conceptualisation of ideas (Charmaz 2006), leading to concept formation.

Focus group 1: 5: 1 – 10	**Code**
A: You're just completely thrown into it from when you start your first placement that's it, it's completely different, you've got to learn to interact with people and to understand feelings and these are feelings that I've never experienced myself that I'm trying to understand them from that person's point of view but it's really hard if you've never experienced that, if you've never lost anybody or you've never lost like a limb or something coz I had a patient who just had an amputation and I was thinking I've no idea how to relate to that feeling so… **Memo:** sounds almost exasperated at the situation, by herself ineptitude at not knowing…	Thrown into it…rapid process New experiences/interactions Cannot imagine but trying to understand/grappling Uncertainty Questioning self/hopeless/out of depth
Focus group 1: 9: 23 – 24	**Code**
B: *You just don't know what it is, that's the **thing**, it's a funny word, and it's not a word you can actually… it's not black and white is it?*	Spirituality as indefinable

Table 5:3 Coding and associated field notes/memos

5.2 Concept formation

This is the stage at which the constant comparative process begins (Maxwell 1977 cited in Glaser 1996). This early analysis requires the researcher to be "*acting upon the data*" Charmaz (2006:59), attempting to view the phenomenon from the standpoint of the participant (Charmaz 2009). This process enabled me to stand back from the data and look for significant new strands/ideas for further analysis. These concepts then formed the foundation for further theoretical sampling. Again, field notes were important in illuminating subtleties within the data.

> *But I do find it's quite lacking, um, on the wards, like it's not really the sort of thing people discuss and um, there's a Liverpool Care Pathway and there's this whole spiritual section which normally is left blank and I* ***struggle*** *with that because I don't feel like I have been trained to kind of go through that section with patients but, um, to me that was the most important thing on the pathway but it's not usually addressed. Um, yes. So I just kind of want to learn a bit more about that.*
> **Field Note:** This is interesting...has R come to me to try to learn more…does she think being part of this research will help her understand?? (R Interview 1, P3: 9-17)

I then began to identify *in vivo* codes. *In vivo* codes are the particular words participants adopt to explain or name something (Schreiber 2001, Charmaz 2006). Each transcript was further formatted by use of using the 'track changes' tool (Microsoft Word 2007) to highlight an in vivo code.

Table 5:4 'in vivo' codes

Focus group 1: 12; 29 –32 & 13; 1 - 8	**Participants' '*special terms*'**
Researcher: *So do you think they… you said an interesting thing, A, you felt they'd lost their spirituality.* A: *Um, yes… It's kind of…* B:... *maybe you don't see it; you don't know you have it.* A: *No you don't* B: *When you walk into a strange ward with ill people it hits you like...' phwoa'. And I don't think those nurses there realise, you know, newies have this thing when they walk in which takes time to…* **Memo: there is something about the newness, naivety and vulnerability of being students that these participants see as making them able to recognise spirituality…but as you become 'stagnated' by the clinical work and business of the work…this ability to see/recognise spirituality is lost.**	*'it'* spirituality *'newies'* '*new nurse*' '*This* ***thing***' spirituality

As illustrated in table 5:4 (above), memo writing was used at during this stage to highlight a concept to which the in vivo codes might be eluding. For example, the *in vivo* codes (above) and the subsequent memo prompted theoretical sampling of literature

surrounding the experiences of pre-registration nursing students on entering the profession.

The purpose of theoretical sampling in grounded theory was discussed in chapter 3. The application of theoretical sampling will be referred to frequently along with constant comparison, as both were fundamental in the data analysis of this study. Theoretical sampling involves the researcher simultaneously moving between collection of data, coding and then analysis of the data (Glaser 2004; Schreiber 2001; Glaser 1978). In keeping with the sampling methods used in grounded theory, codes identified in the first iterative process and the participants' special names/*in vivo* codes were subsequently selected as prompts. As part of theoretical sampling these prompts were then used in Phase 2 to direct the interviews (table 5:5 below). In turn, these prompts further guided the data selection and sampling process (Glaser 1978). At this point sampling of data became more abstract. On hearing I was undertaking a study on spirituality, colleagues, peers, friends and relatives began to share with me their opinions, experiences and literature they had come across. I used this data in a manner that Schreiber (2001:65) describes as going '*into the pot with the rest*' adding to the accumulation of data for analysis. Different weighting was given to this additional data, depending upon the quality, gathering in an overall picture of personal perspectives of spirituality within health care.

Table 5:5 Example of verbal prompts used in first interviews

D: Interview 1: 1: 15-25
W: … *discussion groups really. And these are the sort of kind of ideas that came out – this idea of um – the two main ones were recognition of self in others, that came out of both groups; um, and the idea of protection of self, um, and resilience - um are the sort of two main things that came out from discussions. We also, also came out with things about trained staff* ***losing it****, um, having deep thoughts, spirituality being linked to being a* ***good nurse****. Um, some debate around the art and science – some people found it hard to explain spirituality; they called it this* ***"thing"*** *– it was a thing. Um, and they saw it as being a very individual thing but also a* "need". *Um, one of the participants talking –talked about, it's something that walks beside them. Um, and this idea about* "**being self**" *– if you didn't have* ***"it"*** *then you couldn't be who you are*.

The interview data from Phase 2 was subjected to the same analytical sequence as for Phase 1: line-by-line and in vivo coding. Initial codes from each interviewee transcript were further explored with the relevant participant. These codes became relevant

'prompts' to semi-structure and explore in the subsequent interview: see Table 5:6 (overleaf).

Table 5:6: Example of interview prompts

Page number in transcript	Prompts for 'B' in interview 2
3	Christianity as conduit for spirituality
4	Age
5	Time
6	Calling Efficiency
7	'Wonderful care'
10	Spiritualism
13	Spirituality as professionalism
14	Hierarchy in nursing
16	Being needed
17	'squishing'

During Phase 2 of the study participants began to send me their artefacts (section 4.3). This alternative data included a drawing, emails and a presentation. I explored the meaning behind the 'artefact' with the related participant in greater depth at a subsequent interview (Charmaz 2006). All of which provided additional ideas and insights into the personal structures and cultural influences of participants and helped to add depth to emergent concepts and second level coding.

Second level coding enables the researcher to identify how the various codes may or may not fit together (Backman and Kyngäs 1999). As second level coding compares existing data to new data the process is more directive and selective than initial coding. Often described as focused coding (Charmaz 2006), second level coding is used to organise (Glaser 1978) and explain (Charmaz 2006) larger sections of data. The data derived from second level coding becomes less concerned with describing incidents and more 'focused' on abstraction. In the early stages of analysis I described some categories 'tentative'. Schreiber (2001:70) suggests that a novice researcher may sometimes 'fret' about what to call a category and that it is fairly 'normal' in this instance for a category name to be derived from the data. Glaser (1978) warns that for the apprentice grounded theorist the

tentative nature of categories can be representative of anxieties that the data should describe the phenomenon. In this study there were codes I identified at initial coding that then became a significant property of a conceptual category (table 5:7 below).

Table 5:7 Examples of codes becoming conceptual category within the transcripts

Excerpts from transcripts	Conceptual category
D: *And for a lot of people – I found it hard actually, I didn't know what to say, I didn't know what I could say, what I was allowed to say really, and whether that would have been professional for me to do it, to say anything, so I didn't really say very much at all in words*. (Interview 1: P 2: 26-29) R: *Um. I, uum, it's hard. Um. It's not something that people ever really talk about. You hear about nurses getting into trouble for offering prayer and stuff and I don't actually agree with offering prayer as I do feel that it's forcing yourself on people*. (Interview 1: P 4: 35-36) B: *But then I – that's what I find – because it's not the norm, very occasional, and I would never be nasty and say… But then you see what happens if the Sister tells a student to do that? Which I find offensive, you know I won't do that. There's one – my last ward somebody had flowers and she told me to take the flowers away and I said, no, you want the flowers away you can take them away, I'm not taking the flowers away. You know what I'm saying?* (Interview 1: P17 20-25)	**Being Allowed**

Initially in the analysis, tentative categories can be the researcher's attempt to bring unconscious processing of the data into some meaningful format (Locke 2011) but such categories may have a limited generalizability (Maxwell 1977 cited in Glaser 1996). The middle column of table 5:8 below gives an indication of two tentative categories and demonstrates how these progressed into properties of conceptual categories.

Table 5:8 Progression of code to category

Initial code	Tentative category	Properties	Conceptual category
Struggling/grappling to explain No time Uncertainty Doing a good job as nurse Rules and hierarchy	Spirituality hidden Own and other's mortality	**Being 'allowed'** **Protection of 'self'** **Protection of 'other'**	**Fearing** **Safeguarding**

5.3 Concept development

At this point other theoretical data was explored and examined, to identify and explain the relationship between the participants' responses and literature surrounding nursing and spirituality. This stage was determined by memo writing and diagramming. Further theoretical sampling exposed and illuminated other data that I then examined as part of concepts connected to the spiritual. As part of theoretical sampling I included analysis of fantasy literature (Tolkien 1954, 1955; Anderson 2003), folklore (Opie and Tatem 1992; Anthony et al 2006), poetry (Thomas n.d; Davies 2003) and lyrics from songs and hymns (Bono 2000; Carey and Afanasieff 1993; Struther 1986). The identification of this data was predominantly shaped by and then held within written memos.

Glaser (1992:109) describes memos as '*the fund of grounded theory*'. Memos are essential for making order out of the chaotic thoughts and ramifications that have happened as part of the analytical process (Charmaz 2006) (see figure 5:1 below). In the analysis memos and diagrams were essential in concept development. The importance of memo writing is that it '*slows down'* (Glaser 1978:88) the researcher's drive to identify a core variable prematurely and affords the researcher time to reason with other '*baggage'* and preconceptions she may be unwittingly holding on to (Glaser 1978:88). Memos are not required to be long texts nor grammatically correct. A memo can be a single line, a collection of words or a monologue. Memos are simply the product of thoughts and ideas that as soon as they occur are captured in a visual format (written or diagrammatic) that reflect the researcher's thought processes. Memos in the form of diagrams can be complex or simply a set of interrelated boxes (Charmaz 2006). As the analysis progressed, initial memos I wrote spawned new memos that became increasingly complex, abstract and honest; a conversation between my thoughts and the paper on which I was writing. See table 5:9 overleaf

Being allowed *'Self' as nurse somehow spirituality 'dirty' subject – to be kept hidden/kept secret and not revealed to others...(see newspaper article 2008) This leads to internal conflict and stress, loyalty struggles between 'self' as Christian and 'self' as nurse. Not same though for K Pagan perspective seems to have allowed for exploration of 'self' as spiritual – but this exploration comes as part of something else – personal experience- childhood upbringing; own struggles with MH issues. K very analytical able to use the interview to explore – research process helping her…somehow cathartic? Helping her to 'make sense' [conversely for me as researcher I am finding it more confusing!?!]*

Table 5:9 Brief memo on 'being allowed'

During the coding of Phase 2 the real significance of memo writing and diagrams was realised. This proved important given the poignancy of some of the interviews, bizarre though they may seem, I made the decision to add these 'tussles and tensions' of dialogue to the data (Morse et al 2009), see table 5:10 below. I felt it important that that the significance of these ideas would not be lost as they were part of making sense of the data.

Table 5:10 Example of a more conceptual memo

Health and the mountain *It is an irony of health and health care is that nursing 'traditionally' has dealt with the sick, disease and conditions that in some way have been viewed as being misaligned from the 'normal' of health as perceived by cultural norms and practices.* *If spirituality is viewed as being an essential element of health perhaps somehow pre –registration students struggle to see how the concept links to sickness???* *(Where am I going with this...I have no idea I had a brilliant thought in the bathroom and now it's gone ...)* *Nurses don't 'tend' the healthy...they don't 'administer' to the healthy...they don't 'heal' the healthy. So if Spirituality is seen as integral to health then does its absence in an individual suggest that they are unhealthy...?* *Also in the bathroom I had a vision of the students climbing a mountain...a really steep mountain that at times seems impassable and beleaguered with monsters and Ogres and Orkes and Orikae (rather like in the Tolkien trilogy) and then floating here and there are angels waiting to help them up and negotiate their way around...should we as teachers who have been through these experiences be the ones to help them.*

Diagramming in grounded theory is also essential in making sense of and analysing data to examine how it fits together (Glaser 1978). My use of diagrams was integral to the whole analytical process. Diagrams enabled incidents significant to me at the time of an

interview, such as the participants' emotional responses to be compared with contrasting "*dissimilar events*" (Charmaz 2006: 53). Schreiber (2001) describes such incidents as differences in the data that should be 'sampled' for and addressed in case they are lost as higher order categories develop. I noted that differences existed in the emotional responses participants revealed during interviews. These responses were particularly noticeable while participants were talking about their personal spirituality in relation to their clinical experiences. The participant's emotional response was either positive or negative. In grounded theory analysis negative cases and illustrations are used to improve theoretical sensitivity, thus guarding against potential bias (Schreiber 2001). Negative cases can appear to be saying the opposite of the emerging theory. The identification of negative cases can also enable the researcher to 'step back' and think about how and why something that stands is different and how it fit with the other data (Schreiber 2001). Moreover, negative cases encourage the researcher to think abstractly about the data (Glaser1978; 2004) and the phenomenon under investigation (Schreiber 2001). The diagram below (figure 5:1) enabled me to realise that one particular participant's perception of spirituality in relation to experience in clinical practice differed considerable from that of the other participants.

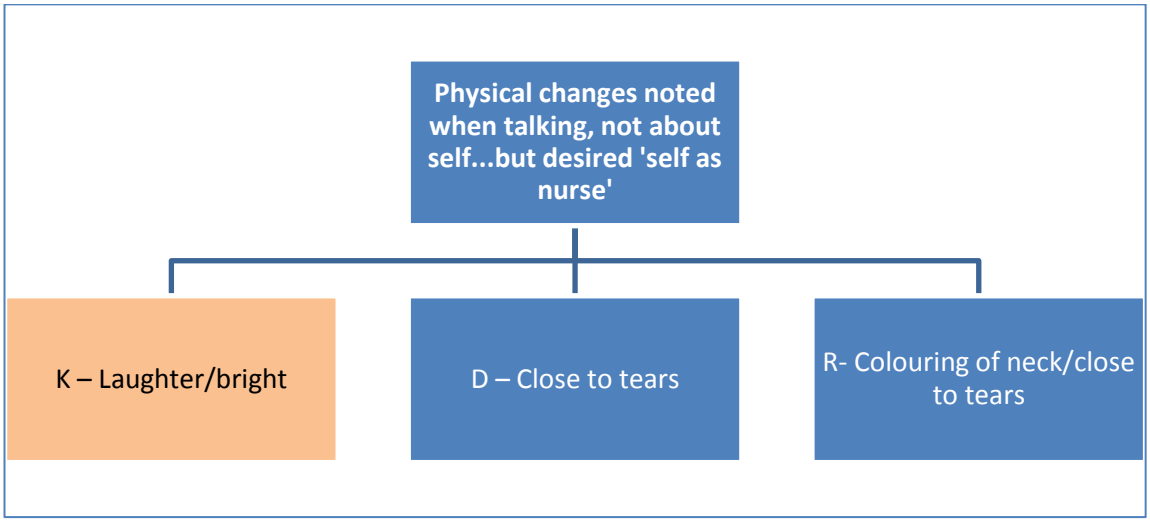


Figure 5:1 Emotions observed when speaking about spirituality

The comparison of incidents, positive and negative, enabled further insight into reasons for the participants' responses and enhanced exploration of the data. While several participants found speaking about their personal spirituality stressful, one participant (K) was relaxed and comfortable. Diagramming was significant in enabling me to gain a sense

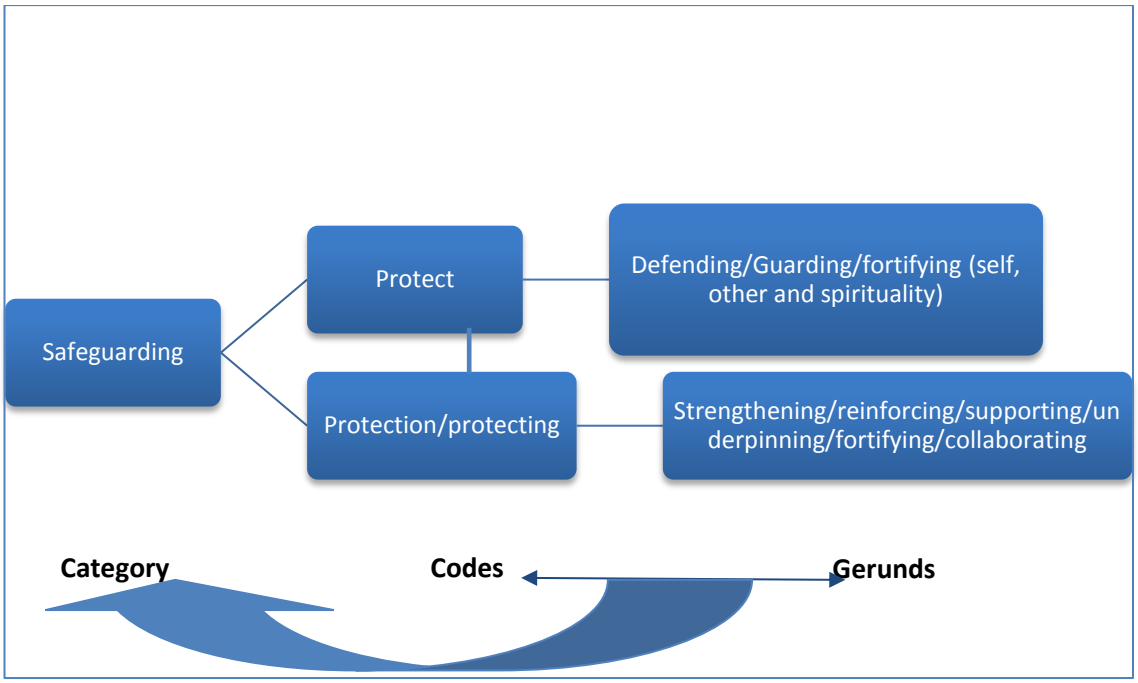
of the emotional facets associated with participants' perceptions of spirituality, particularly the extent to which their emotions impacted on their responses. At the outset of the study I had no idea that speaking about personal spirituality would elicit such opposing emotions. Schreiber (2001:59) describes beliefs and ideas held by the researcher as '*sensitizing concepts*'. Citing Dey (1993), Schreiber (2001) goes on to suggest that the focus for the researcher should not be on ignoring own existing knowledge but how this knowledge is used regarding assumptions and beliefs about the phenomenon under investigation. My initial and naive belief was that personal spirituality would be easy for students to speak about. A belief not only connected with spirituality but also about the research process and my personal identity as 'nurse'. The following text is taken from a memo I wrote following the first batch of interviews:

> *"What came to me was that as fellow nurse/ colleague I was concerned for their emotional pain (R and welling up with tears –D) and was glad I had written into the guidance about seeking support/counselling regarding anything that may affect them from the interview process (K email). For myself as 'insider' I felt torn by my attempt to remain an 'objective outsider', however (and I hope this isn't too mercenary) I gained an appreciation of the wealth of data these interviews, emotional as they were enabling me to collect."*

During concept development, the greatest gift of memo writing was that my memos forced me to question my suppositions (Glaser 1978). This enhanced my understanding of the social processes associated with spirituality and concepts that developed from the coded data. At this point in the analysis I began to explore gerunds to identify basic social processes [BSPs] within the data based on Glaser's (1996) conceptual explanation of BSPs. The use of gerunds in grounded theory analysis is explained in chapter 3, section 3. BSPs are actions that appear to be happening in the data and that change over time and can be used as part of the coding process (Glaser 1978; 1996). As this study was longitudinal there was an accumulation over an 18-month period of original datum obtained through focus groups and interviews. I began searching and coding for BSPs as they occurred in this accumulation of datum, be they psychological or social. I became increasingly inquisitive about the extent to which the contextual features of the environment (clinical practice) impacted upon the participants' BSPs (Backman and Kyngäs 1999; Schreiber 2001).

During this iteration of the analysis each of the codes from the first interviews was, where possible, converted into a gerund: for example fear became *fearing*, protect *protecting* and so forth. Where a code could not be converted the synonyms and thesaurus (Microsoft Word 2007) was used to expand the code's meaning in an attempt to identify a linking gerund: for example *precious* became '*valued*' leading to the associated gerund *'valuing'*. The result was that over time a series of properties were produced that related to each category (see figure 5:2 below) and enhanced concept integration.

Figure 5:2 Relationships between code, gerund and category



5.4 Concept integration

Concept integration enhances and enables identification of the core emergent variable that will relate to all the other variables (Maxwell 1977 cited in Glaser 1996). At this point in the iterative process I needed to identify a way in which the concepts I had identified related to one another. As part of constant comparison this iteration of the analysis began with revisiting and re-examination of earlier data. Moving through the laborious and meticulous task of line-by-line coding, constant comparison, theoretical sampling for emergence to finally theoretical saturation, can be confusing and mentally exhausting for the researcher (Stern 2009). Glaser and Holton (2004) and Holton (2011) recognise the

'chaos and uncertainty' that the grounded theory researcher grapples with when undertaking analysis. The researcher needs to keep an open consciousness and instinctive awareness about their data (Holton 2007). This consciousness can evolve into the manifestation of conceptual ideas which Holton (2007:273) describes as "*a creativity characterized by the exhilaration of eureka sparks of discovery*". These sparks of discovery and conception of ideas in the iterative process are described as a "*drugless trip"* or an *'in -phenomenon*" (Glaser 1978:127). Glaser (1978) advises that such force in the analytical process can determine integration of concepts and the "*bigger or whole picture"* (Glaser 1978: 127). Glaser (1978) recommends that analytical exhilaration in should be respected by the analyst and those around him [*sic*] since such an energetic stimulation of thought will enhance theory generation.

It was during this iteration, undertaking theoretical sampling and applying gerunds to codes, that I revisited 'K's second interview. During the revisiting of this transcript something happened in my analysis. I could suddenly see around and through the data and I felt as though I was instinctively undertaking theoretical sampling. While concurrently reading the transcript and listening to the interview, Tolkien's trilogy *The Lord of the Rings* (Tolkien 1954; 1955 and 2001) suddenly surfaced in my mind. Within the interview and transcript I began to visualise the characters and monsters, dilemmas and story line depicted in this fantasy. All bound together in dichotomy, bravery, overcoming personal fear, and good triumphing over evil and in spite of everything, fulfilling a quest to protect from evil that which is most precious. As I read and listened again, via my PC, to each section in the transcript it was as if a story of quest was emerging in the data. This integration of concepts highlighted the impact of the participants' real world experiences, as they journeyed through a pre-registration nursing programme towards their ultimate goal of qualification and registration. Furthermore, the participants' experiences were illuminated as highly personal and at times disturbing. Theoretical sampling and constant comparison then led me to discover elements of fantasy, stories of quest and folklore in the other data as I sampled including the Tolkien trilogy (Tolkien 1954 and 1955) and Aesop's Fables (Anthony et al 2006) and biographical accounts of Tolkien's life (Anderson 2003; Garth 2011). Theoretical sampling and constant comparison prompted further memo writing, theoretical exploration and

comparison of the data. Consequently, the abstract conceptualisation I experienced as part of the 'in-phenomenon' was pivotal in the study for bridging the gap between concept development and concept integration (Glaser 1978).

Glaser and Strauss (1967) encourage the creativity and intellectual imagination in the development of theories. The 'in phenomenon' experience finally freed me to be adventurous with the analysis and prompted me to use other methods for exploring the data. I purchased a good quality thesaurus to help me explore gerunds in further depth. I moved away from the electronic document and began to explore gerunds further making notes in long hand and adding other meanings in pencil to a hard paper copy. Now I was not only looking for gerunds but other meanings for words and I became curious as to what the opposite meaning or antonym of the gerund might be. For example antonyms of the gerund 'protecting' are 'exposing, neglecting and harming'. Searching for gerunds was the longest process of the analysis. I would take a code, the code's associated gerund and then explore this gerund using the thesaurus until I could find no other relevant descriptors. I would then return to the next code on the list and undertake the process again. I continued with this process until all the codes had been examined. In total the process took about four months. I found this iteration absorbing, exciting and creative. I undertook the same process with the second interviews, revisiting interview transcripts and the associated codes. Using the process with the second interviews it became apparent that I seemed to have identified fewer new codes and, as a consequence, fewer new gerunds were created. Now I had to make my analysis look beyond the gerund and identify how these gerunds formed a pattern to explain what was happening in the data. I was beginning to focus down and get to the core problems the participants were experiencing and I could begin to see the names of the relevant categories. I was beginning to feel and sense theoretical categories by looking through and beyond the data as I returned to it. Gerunds are useful for enhancing memo writing (Charmaz 2006). Gerunds can be used to identify and explain actions of the participants that are associated with a given code (Schreiber 2001). As data generated by gerunds continually expanded and retracted (see table 5:11 overleaf), memo writing and theoretical notes began to be interwoven with BSPs as my mind explored where these were taking me.

Table 5:11 Expansion and contraction of data

ACQUIESCENCE and IDENTITY
Coming home **– homecoming** return
Connecting relating spiritually to 'other'
Recognition, being recognised, recognising, accepting, acknowledging....
Being acknowledged for who you are...who 'self' is (important to D)
Permission (**being allowing**) acquiescence (D now felt she could pray) as opposed to antonym of Interview 1 r*esistance* to the urge to pray... praying acquiescently.
Challenging now but contemplatively, contemplating, **reflecting**.
Asserting (Assert) **claiming** (right to be heard to have an opinion to be who she is)
Honesty sincerity self-effacing
FEAR and REVERENCE (Hospital as Sacred)
Hierarchy, chain of command
Protecting – but now patient/other not 'self' protection as caring shielding
SPIRITUALITY AS SUSTENANCE – TOUCHWOOD (dry decayed wood that can be used as tinder English dictionary) ahhhh to light to ignite something...to keep something **burning**...the lamp
Supporting – Sustaining, nourishing
SEEKING ANSWERS BY YEAR 2 – Self-Validation
DOING THINGS RIGHT vs. DOING THE RIGHT THING
PROTECTION (of what??)
Students of patients
Staff of students
Look up death and the Victorian... need to protect dichotomy of a world in which the media do not protect us and yet we feel we must protect each other

At this point the fundamental properties were 'fear' and 'protect' and their associated gerund 'fearing' and 'protecting'. I was aware that there was something else about a chain of BSPs that was occurring, a process that the students seemed to be going through over time as they moved chronologically through each area of practice. To explore this further at the time, I wrote a significant memo of which figure 5:3 (overleaf) is an extract. This memo (figure 5.3) demonstrates the analytical process now involved, digging deeper into each concept and exploring philosophical roots. Memos at this point raised concepts into theoretical categories and, as a result, provoked further concept integration. At this stage I realised the need to begin to 'sort' the data I had accumulated.

Figure 5:3 Memo on 'seeking' caused by the application of gerunds 28/04/2011

It feels to me that they are seeking answers by year 2...
In year 2: **searching, struggling** was very evident they desperately needed to **protect** themselves from the horrors they observed and the stresses of the profession they had entered, they did not want to become tainted, marked and poisoned by bitterness and complacency... they did not want to **lose** their identity, who they were their sense of 'self'...and yet they are **hurting**...badly....and they feel '**lost**'. They are **frightening** and **overwhelming** and **fearing** that by all that they are exposed to, they will be crushed...by this '**thing**' they wanted so badly that could well be the **undoing** of everything they hoped they would be. In year 1 **story telling** was very evident...powerful images of their experiences in practice...they were using me to seek **affirmation** to help them make sense. I remember how frustrated I felt...this was not what I had expected and was certainly not the way of the researcher.
By year 2-3: they seem to have **found** some inner strength for somewhere they have **grown** in confidence but are still **seeking** answers to **protect** not so much for themselves now, but their **patient**s. For the participant with a faith that is a **recognition** that it's 'OK' to pray ...still tentative but supported by others who are also Christian...like moths they seem to be **drawn to** the same light... by year 2/3 they have a sense of '**homecoming**'...a new identity of 'self as nurse' is **forming**...it may not be exactly as they thought...but it is **forming** slowly. They are braver, they are **challenging** and they are **actively seeking answers** but not so much to protect now...but to understand. The stories are less evident in the later interviews and when they occurred were less powerful in their imagery...as if the participants are **beginning to make their own sense**, often by **reading** literature and **looking to the evidence** in the profession.
They are still struggling with the dichotomy of doing things right and doing the right thing but are beginning **to explore a way round** this.
They are more contemplative. They **recognise** that as a student you don't really belong...but instead of this 'being frightening' as it was in year 1 it is now more accepted...and in fact if you find yourself in a placement you really don't like you can either leave or you can think to yourself "that's OK the next placement might be better"
By year 2/3 for those without a definitive faith nursing seems to have become their faith...through which they identify spiritual self (see K)
"K: I think… it can also be a little bit like a religion because you put on special clothes for it and you're going to a special place and you're obeying a certain set of rules (K: interview 2. 22: 2-4)"
It is through nursing that the battle between good and evil is played out for them (Lord of the Rings style) they see themselves as integral to this battle on the side of good...but are acutely aware that there are those who are not and still have a **slight fear** that they may go over to the other side.
They are **learning** to begin **to protect** themselves by whatever means possible...so long as it does not require a detachment from what they see as the most important element their own **'hope'** what they had **hoped** to become. It is as if they are ready to give themselves up ...a sort of '*contemplative self-validation*' is **appearing**

Theoretical sorting is an essential element of grounded theory and is necessary to integrate and bring back together data that has been broken into many constituents (Glaser 1992; 2004). Sorting is particularly helpful in preventing the researcher from reaching a conceptualisation 'peak' too soon, and likewise prevents the researcher rushing off on flights of fancy with over conceptualisation (Glaser 2004). Sorting is a

concrete way of bringing memos together to make order out of the chaotic thoughts and ramifications that have happened as part of the analytical process (Charmaz 2006). Sorting is a creative process between the researcher and the data they have accumulated via the analytical process. According to Glaser (1992; 2004) sorting is an essential stage of grounded theory analysis and to miss this stage is at the peril of rendering any analysis linear and lacking in depth and substantiation. Initially, I had considered using Glaser's (1978) coding families to support my sorting of the data. Glaser (1978) has identified 18 coding families that aid the researcher in identifying relationships, action and interactions between categories that form the centre of the phenomenon (MacDonald 2001). Macdonald (2001; 132) suggests that these coding families can be conceived as a 'shopping list'. I considered the list of categories but could not identify how my codes had any sound 'fit' with any of Glaser's 18 categories. Where there was fit with the data I sensed I was making it fit, hence forcing the data (Glaser 2002). Returning to the text on grounded theory analysis I discovered I was not alone. Urquhart (2001) recounted that she had had similar issues in using Strauss and Corbin's (1998) axial coding, which is intended to assist the researcher in examining the data for *conditions*, *interaction among the actors, strategies and tactics*, and *consequences*. Urquhart's (2001) frustrations caused her to seek out another framework to look for the connections between data, as at this time she was not aware of Glaser's (1978) coding families.

I found I was reaching a period of stagnation in the analytical process. Grounded theory analysis can be tedious; the researcher can tire and lose momentum (Glaser 1996; Urquhart 2001). I then recalled Roget's classifications. During my journeys back to the data to re code, code check, create a gerund, and to formulate a category, a Roget's thesaurus of English words and phrases (Kirkpatrick 2000) had been my trusted companion. Roget's thesaurus is divided into six classes. The first three cover the 'external world': *Abstract Relations, Space*, and *Matter* - this study sought to identify a relationship between the participants and their external world. The final three categories envelop the internal world of human being: *Intellect* concerns itself with the human mind, *Volition* with human will and *Emotion, Religion and Mortality* with the human heart and soul. Roget himself borrowed the scheme of classification from natural history and saw the six classes as part of innate human sequences that accumulate in self-actualisation

and achievement (Kirkpatrick 2000). Roget also recognised that the world does not fit comfortably into differing compartments, some words fit into two or more classes. Hence, Roget's thesaurus uses copious cross-referencing to link words, causing a web of meaning to be created (Kirkpatrick 2000). Roget's six classes enabled the process of theoretically sorting and conceptualisation of the data, and like Glaser's (1978) coding families elicited connections between codes, concepts and categories. I constructed a table and labelled each column left to right as follows; '*Class, Section* (of class), *Gerund, Original Code, Antonym* and finally a *Notes* column in which I cross-referenced to other classes or wrote specific observations (Appendix 8). This process of sorting, allocating and mapping original codes took approximately four weeks. During the process I discovered some new gerunds that I noted in the table with an asterisk. As I mapped I wrote further memos and notes to myself (table 5.12 below). Charmaz (2006) would liken this process of mapping and writing to 'clustering' and 'freewriting'. Clustering is a visual and flexible technique that involves grouping and then linking codes to understand and organise research data, while freewriting liberates the researcher's thoughts and feelings about their research and enables the transference of ideas into text (Charmaz 2006).

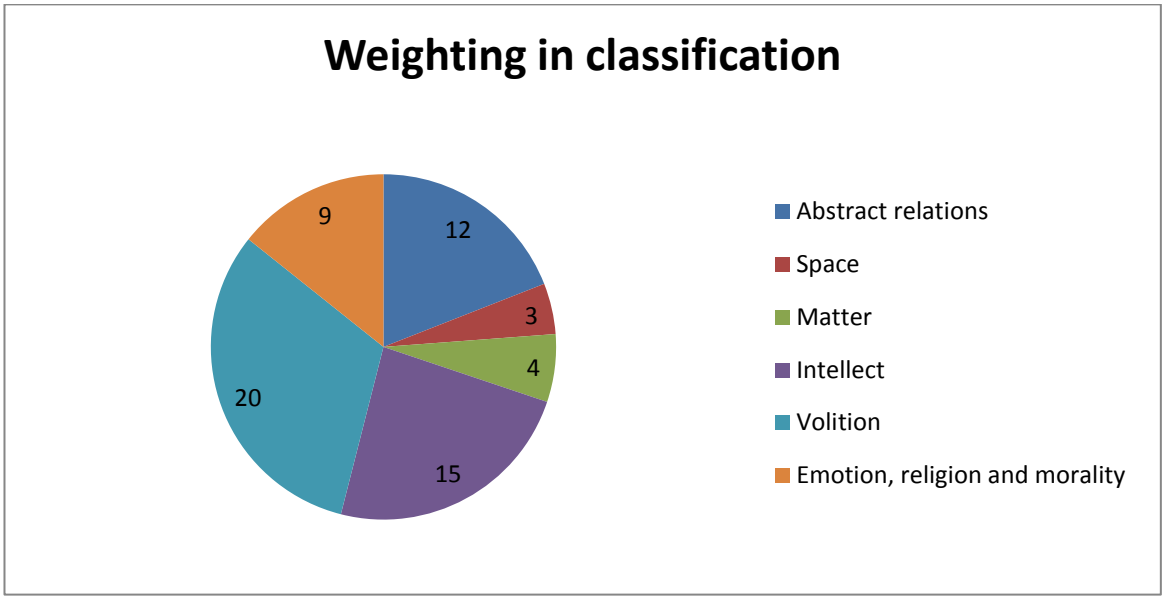
Table 5:12 Example of freewriting note to self

So most of what they feel in the early days ... What happens to them... they can't help ... **involuntary volition**... But as they progress and their **intellect** develops, stories help them to **make sense**...so that as they progress they understand and can have more control over their destiny. But the point for us as educators is...if we know this is what happens... If this is the simple theory ... What happens when it doesn't ... When the sense isn't made...when it goes wrong...? Do we end up with a poor practitioner? For those who will say ' we already know this because of reflection'... Well the students aren't cognitively ready to reflect in the beginning... Their **intellect** is not developed...They need to tell stories and have them listened to... To be reassured... And guided (note to self September 9th 2011)

I became aware that various codes, gerunds and antonyms begin to 'fit' into some classes more than others. As the process continued I developed a cognisance of a pattern emerging; yet, I was having difficulty visualizing this pattern in the data. Campbell and Machin (2003: 52) suggest "*a picture is worth a thousand words and there is no better way of getting a 'feel' for the data than to display them in a figure or graph*". The

representation of data in numerical form or as a graphical illustration is normally associated with quantitative data analysis (Bowling 2002). Nonetheless, Glaser (1978) and Pursley-Crotteau et al (2001) suggest that, as 'all is data'; quantitative data can be relevant in the search for the core category around which all the others sit. To aid visualization, data generated through the use of gerunds was transferred into a graph to identify any pattern in the data as a collective whole. The number of 'hits' that occurred in each of Roget's classifications were counted. Figure 5:4 (below) is a pie chart that depicts the 'weighting' of hits for each of the codes in the six classifications.

Figure 5:4 Pie chart to illuminate classification weighting



Intellect, volition and abstract relations had the greatest relevance in the data, with emotion, religion and mortality close behind. This process in the analysis was not intended to be scientific nor provide definitive evidence. It was simply another method of classifying data and identifying other patterns that might illuminate the core category.

5.5 The core category and developing theory

The overall goal is to identify a theory that is 'grounded' in the data. This theory should explain clearly what is going on and have 'fit' with daily realities that can be recognised by anyone (Glaser and Strauss 1967). Using BSPs to develop a grounded theory is one attempt to *"generate a theory that accounts for a pattern of behaviour which is relevant and problematic for those involved"* (Glaser 1978: 93). The core category must have 'fit

and grab' and be proven over and over again along with its integrating relationship to all the other categories. While the pie chart (figure 5.4 overleaf) reflected a pattern that was developing, a process the student participants seemed to be undergoing, I could not identify the emergent core category. At this juncture Glaser (1978, 1992, 1996 and 2004) proved invaluable text in reconciling an understanding of how the core category is recognised. Glaser (1978 and 1996) ascertains that the researcher should identify the *main* problem afflicting the participants. I returned once more to theoretical sampling and constant comparison of memos, transcripts and the thesaurus.

Considering the phenomenon under investigation one might assume that '*hope*' as revealed in the long memo (figure 5.3), was an integral and central tenet to a study on spirituality. I was certain that I had not made any assumption during the analysis of the data and my reflexivity throughout the study is evidence of this. If anything I had tried to avoid 'belief' and 'hope' as they seemed to be obvious concepts relating to spirituality. The more I considered the data it appeared that for the participants their notion of spirituality and belief are the same. Data collection with participants had focussed upon their meaning of spirituality. Their response was to tell me about their spiritual beliefs, their fears and *hopes*. I needed to make sure that I was not prematurely forcing the data towards hope. I returned again to earlier memos and found that I had included the word 'hope' in almost all. *Hope* is found in Roget's Thesaurus under the classification of *emotion, religion and morality* (Kirkpatrick 2000:328). Amongst other concepts hope is associated with, '*faith, belief*' and '*keeping ones spirits up'*. As I returned to the data I began to realize that *hope* was a potential core to the theory.

Another conceptual element that had come to the fore early on in the analysis was the notion of movement. Moving through, journeying, pilgrimage and travelling are all properties that would account for a BSP that happened over time - three years as the participants moved from one clinical area through to another. Theoretical sampling led me to the gerund 'carrying'. The word '*carry*' falls into several classifications in Roget's thesaurus, including motion and volition; associated with personal choice and decision (Kirkpatrick 2000). Sampled data and memo writing then revealed that the process involving movement and the behaviours demonstrated within the data was *'carrying'*. I returned to the data and undertook theoretical sampling of *carrying* and *hope* and the

relationship between these two concepts. Consequently, *carrying hope* became the core problem for the participants that explained their attempts to resolve awareness of spiritual self and their clinical experiences. The relationship between the primary properties, the concepts and the final core as identified during the analysis is outlined in the Venn diagram (figure 5:5) below and will be further explained in the findings chapters 6, 7 and 8.

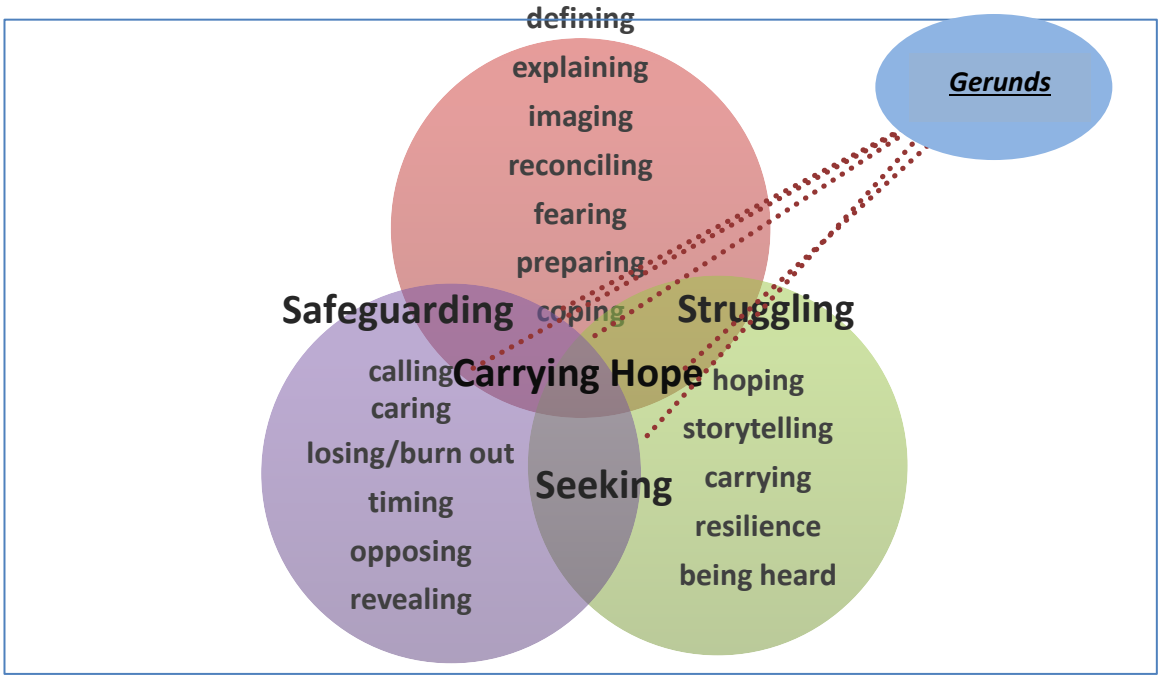


Figure 5:5 Venn diagram illustrating the connection between properties, categories and the core

5.6 Saturation

In grounded theory sampling and data collection continues until the point when the researcher cannot find any new insights, perceptions and meaningful properties from the data (Milliken and Schreiber 2001). The preferred term to describe saturation in grounded theory in the seminal text (Glaser and Strauss 1967) is theoretical saturation. It is at this point that the researcher should stop sampling (Glaser and Strauss 1967). Dey (1999:117) expresses concerns that the term 'theoretical saturation' may suggest that all sources of data "*have been systematically exhausted*". It was difficult for me to ascertain when there was sufficient data to halt the generation of categories and the relationship to their properties (Dey 1999). Indeed, Morse (2011) suggests that there is no finite end

to theoretical sampling in grounded theory. Nonetheless, Dey (1999) recognises that at some point the process of searching for new data has to stop. This point in the research process is described as theoretical sufficiency by Dey (1999) or theoretical redundancy by Schreiber (2001). I reached a point in the analysis where I felt that I had sufficient data to fit into the emergent categories and could begin to formally write down the findings from the study. Schreiber (2001) and Charmaz (2006) identify that while the researcher is writing the findings, the literature continues to be explored to enhance rather than constrain the developing theory (Charmaz 2006). Subsequently, in this study theoretical saturation did not fully occur until the theory was formally explained in chapter 9. While it should be recognised that any data is open to new interpretation (Glaser and Strauss 1967), the theory that emerged from analysis of the data in this study is an acceptable recess for the completion of a doctoral award.

5.7 Summary

This chapter has explained the iterative analytical process and methods used in this study. These methods are consistent with grounded theory, particularly the search for basic social processes. In keeping with grounded theory, the analysis was on-going from the beginning of the study. Even while writing up my findings I was constantly looking for the pattern of BSPs within the data. While this written articulation of the analysis may appear sequential, the methods described above were undertaken concurrently. These methods enabled sensitivity to the data and subsequently identification of gaps in the data. This analytical progression driven by theoretical sampling and constant comparison facilitated the exploration of a range of data. This data came from focus groups, interviews, 'artefacts' and data surrounding spirituality, including literature relating to fantasy, quest stories and folklore, poetry and lyrics. Exploration and theoretical sampling using a thesaurus enabled BSPs within the data to be revealed. Hence, an emergent theory was discovered to explain how pre-registration nursing students seek to resolve the problems they encounter in the clinical environment. These problems impact upon their perception of their spirituality that was bound in the hope that they carried through the programme. The findings of this theory will be evidenced in chapters 6, 7 and 8. These findings are integral components of the theory '*carrying hope'*, a substantive grounded theory that fits with the data and is explained in chapter 9. Chapter

10 will conclude this body of work by demonstrating to the reader the implications for pre-registration nurse education and a theoretical fit to other social contexts.

Chapter 6 : Struggling

General introduction to the findings chapters

The previous five chapters introduced the context of the study, outlined the background, explored the methodology of grounded theory and presented the data analysis. The next three chapters present findings interpreted from the focus groups, interviews and artefacts. As part of theoretical sampling additional data that has contributed to the findings is drawn upon, including relevant literature associated with nursing and healthcare. Consistent with grounded theory, theoretical sampling and constant comparison instigated the exploration and investigation of more unusual, pertinent data. The purpose of grounded theory findings is to *explain* the experiences of the participants, not to *describe* these experiences (Glaser 2002). The findings in this study are derived from problems relating to the participants' 'spiritual self' encountered while in the clinical environment and my interpretation of how these problems are resolved (Glaser 1998). The analysis of the data (chapter 5) involved identifying Basic Social Processes [BSPs] that explain how the students try to resolve problems they encounter in the clinical environment, problems that impact upon their awareness of their spirituality. In the remainder of this body of work I may simply refer to BSPs in the discussion as 'processes', my reasoning for this is to ease the flow of the text for the reader. The following findings chapters will explore the BSPs participants experienced in the clinical environment and explain the relationship of these processes to the students' personal spirituality. In addition to the participant data, other data has been explicated from superstitious and cultural beliefs, often practised within a health care setting (Cleary 2004). Stories of quest, myth and folklore, poetry and lyrics that have resonance with all things spiritual (Campbell 1988; Campbell 1996) have also been sampled. In keeping with the principles of grounded theory this literature will be interwoven in the discussion of the findings. This is normal practice in grounded theory where literature and subsequent discussion give depth to the data and findings (Charmaz 2006). The integration of this literature as part of theoretical sampling will highlight to the reader the impact of the participants' real world experiences, as they progressed through a pre-registration nursing programme

towards their ultimate goal of qualification and registration. Furthermore, the participants' experiences will be illuminated as highly personal and at times disturbing. Accordingly, the findings presented in this chapter and chapters 7 and 8, have resonance with personal quest and the BSPs entailed therein. These are *struggling, safeguarding* and *seeking*.

This chapter and the next two findings chapters will adopt a narrative style to enable the reader to follow a logical sequence that will facilitate a realisation of how the theory emerged. Throughout the findings chapters I will use the formal research term 'participant' interchangeably with the more personal term 'student' depending upon the nature of the discussion. The rationale for interchanging these terms is that I came to understand the participants' problems in two professional contexts, that of principal researcher and as a nurse educator. Evidence of this understanding can be seen in the reflexivity that is woven through the discussion in these findings. This reflexivity also highlights for the reader the challenges I have experienced in attempting to separate these two professional contexts over the five years of the study. In the presentation of a grounded theory study the particulars and minutiae relating to the participants, the time or the venue is not considered relevant or necessary (Glaser 2001). Where I have felt it important in the findings and in setting the context, relevant points of interest regarding each of the students will be revealed. This information will augment an understanding of the world from the perspective of the participant (Charmaz 2006). The final findings chapter (chapter 8) includes the personal contexts of three students (K, B and D) who participated in both Phases of the study through to their third and final year. Chapter 9 will then bring the preceding three chapters together to explain the emergent theory of *carrying hope.*

This first findings chapter will introduce the reader to *struggling*, a concept based upon codes and properties identified through exploration of the early experiences and perceptions of the participants. The participants were novices to nursing and held a naivety surrounding the nursing profession. This naivety was associated with entering into an unfamiliar environment and was further evidenced by preconceived and unsubstantiated images and understandings regarding the nursing profession, resulting in uncertainty and incongruity for the participants. That which was imagined in nursing and

personal beliefs regarding spirituality and faith, contrasted with the reality of the students' experiences. This mismatch is revealed in certain Basic Social Processes [BSPs]. These BSPs involve *struggling* to explain and define the indefinable concept of spirituality and identifying that spirituality is a precious, valuable aspect to 'self as nurse'. Processes of *fearing* and *hiding* are also explored and explained: fear that the disclosure of spirituality will result as being judged and considered unworthy of professional recognition. Consequently any personal belief or faith is kept hidden. *Preparing* and *coping* are presented as dilemmas surrounding exactly how to seek security and to protect personal spirituality. The first properties associated with the BSP of struggling include *defining, explaining* and *reconciling*.

6.1 Defining, explaining and reconciling spirituality

As a research venture, the initial purpose of this study was to establish how pre-registration nursing students gain a perception of their spirituality. Two focus groups were held towards the end of the first year of the students' training. During these focus groups participants were prompted to consider what spirituality meant to them as pre-registration nursing students. Both groups were quite different in their articulation of spirituality from a personal perspective. Group one consisted of two female students, A and B. Both A and B professed no particular or strong religious faith, but described themselves as able to relate to traditional Christian beliefs. As a group these students struggled to describe spirituality and when probed by me to further define spirituality, they could not do so.

> *B: You can't because, you can't pin it to anything, actually. I can't pin it to anything. I wouldn't use the word, that's why it's interesting, but I feel I am in my understanding of the word and I can see other people are and I don't think other people read those things of each other* (Group 1: Student B: 3: 16-19)

Instead of articulating a definition, the participants chose to focus on the art and science of nursing, in an attempt to place spirituality within a familiar context. The participants in this group reached the conclusion that while most aspects of their nurse education could be identified as scientific and able to be taught, the concept of spirituality could not be taught in lectures because in clinical practice it could not "*be boxed*".

> *Because it's not scientific, maybe, not being black and white. It's not a box and we can't say that or that because we haven't gone there yet, us humans…people.* (Group 1: Student B: 27: 22-24)

It seemed at this early stage in their educative journey that participants in the group one felt greater affiliation with the 'art' of their chosen profession as opposed to the 'science'. Group one became quite focussed upon the difference between the concept of nursing art and the concept of science. Associating science with medicine and mathematical ability and nursing with the art of care:

> *A: Personally, I feel that if that* [maths] *comes naturally to you you'd do medicine; it's more the academic side and if that side came naturally to you you'd do medicine whereas we are more caring and arty and…*
>
> *B: It's that caring side*
>
> *A: …we think outside the box*
>
> *B: It's the caring side; it's that caring side and thinking outside the box so there it ties up with the creativity and - cos you've got to think outside the box I think.* (Group 1; 29: 25-32).

Having articulated their understanding of a difference between the art and science of a profession, group one struggled to express their perception of a distinct difference between spirituality and science. Debate proceeded between the students as to where exactly in their clinical practice the concept of spirituality sat. At this stage it became evident that the group were grappling to make the intangible tangible. The participants were struggling to articulate their perception of spiritual beliefs, including how and where spirituality sat within the nursing care they provided. I decided to ask them if they could draw their explanation in relation to '*the box'*, which they kept mentioning. Student A took the pencil and began to draw "*the box*" outside of which she drew spirituality (Figure 6:1 overleaf).

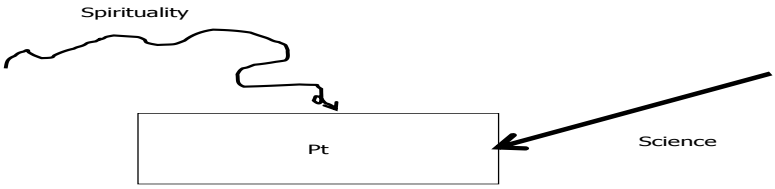


Figure 6:1 "The Box"

Whilst Student A was drawing the following discussion between her and the other group member, Student B ensued:

> *That's the patient… Right there! And like, coming… obviously that's like the patient but coming into that you have his spirituality (how do you spell spirituality?), then you have, you do have the science there as well, but that's kind of more direct; that would be like a big arrow… that's more direct, that's what everybody sees but the spirituality is like a little airy fairy arrow that goes round the outside but it's, it's really important to….* (Group 1: Student A: 32: 23-30)
>
> *We're taught that, we're taught the black thing; we're not taught that…* [Taps finger on squiggly line] (Group 1: Student B: 32:31)
>
> *Oh yea. But you can't teach that. You can't teach spirituality (*Group 1: Student A: 32:32)

In her drawing, A identified the science of nursing as a clear bold arrow that impacted upon the patient and 'spirituality' as a vague and squiggly line. Spirituality was nebulousness floating above and around the patient, an insubstantial and ethereal part of the patient's life that as nurses the participants could not name or identify. Yet this phenomenon was important to the care these students saw nursing as providing. I recall that whilst A was drawing "the box", B had become very animated, stimulated by the debate, the discussion and watching the drawing. Suddenly B appeared to have a moment of personal discovery as with great passion she said:

> *That's why you've got you…, um, because people who have got this thing* [spirituality]*, this lovely little light thing... have it!* (Group 1: Student B: 33: 3-4)

Synonyms of *lovely* include *divine, exquisite*, *delicate* and *elusive* all words associated with the spiritual (Waite 2009). In my first interview with her after focus group 1, B disclosed that she saw herself as 'spiritual' and she used this to help the patients:

> *How do I use it? I use it because I see people who are frightened and I, er, a lot – I use it when I see them – I feel their spirituality -not their pain here – of fear, of loneliness, stuck in some place without their family, of, er, just wanting to feel a little bit of kindness from some source.* (B, Interview 1:8:32-35)

It seemed that for B any lack of empathy towards a patient meant a lack of spirituality and care. It was important to B to value life and to care:

> *I'm not religious in terms of being religious; it's a strange thing – religious in terms of valuing, um, other people, in valuing other human - or even a fly, not just human beings - any living thing. Anything. Not even a living thing. Do you know what I'm saying? It's valuing – the wonder of some…(*B, Interview 1: 10:17-20)

I coded this section of the transcript with '*life as precious'*. This was the first indication that this lovely 'thing' 'spirituality' as described by B, could be explained as *precious* and treasured by the participants. A tangible object, like jewellery, might be contained in a box. The participants struggled to describe and define spirituality; spirituality while essential, integral and precious, remained elusive and could not be boxed.

Regardless of students in the focus groups struggling to articulate the fit of spirituality into art or science, students in groups one and two revealed similarities in their consideration of spirituality. Both groups viewed spirituality as relevant in the clinical environment and an important aspect of nursing, essential to patient care. This finding reflects entirely the conclusion of studies that examine the subject of spirituality in nursing. Studies that have persistently identified that nurses are able to recognise spiritual needs. These studies also acknowledge that meeting the spiritual needs of service users is integral to the caring role and practice of nursing (McSherry 1998 and 2010; Martsolf and Mickey 1998; Narayanasamy and Owens 2001 and Narayanasamy et al 2004 and 2006).

Although the participants saw spirituality as important to their role as a nurse, they seemed unable to 'name' the phenomenon and to coherently identify an understanding of spirituality. I observed that students in both groups often used their hands to gesture to each other and to me that which they were trying to explain. As the excerpts from the transcripts and my field notes below reveal.

> *But everybody's experienced different things and you will find that you have got your – part of your spirituality is the same as, like one of your patients and so everybody contributes to this whole ….. this whole thing*. (Group 1, A.14: 22-24)

> Field note: throughout the discussion A had remained mostly still and at one point sat on her hands. At this point she began to use her hands to try to describe this 'thing' [spirituality]. She raised both her arms and reached up and made a sort of a mushroom shape with her hands…what is interesting is that what she couldn't articulate with words she could almost 'sign' by using her hands
>
> *…without deities being this sort of paternal kind of thing; so, um, I'd say it's a different direction, perhaps; it's more sort of workaday kind of; obviously working in cahoots with them and the father and child aspect.* (Group 2, K. 3: 31-32 & 4: 1-2)
>
> Field note: here came the hands again to explain the 'thing' that can't be verbalised.

Even with drawing and gesticulation, students in both groups could not capture the essence of the phenomenon they were trying to describe. An explanation of the phenomenon eluded the students, to the extent that they seemed reluctant to utter the word 'spirituality', almost as if it was unmentionable and forbidden. The unmentionable word is a familiar association in theatrical myth, associated with William Shakespeare's tragic play 'Macbeth'. Historically actors have believed that the witches' song within the play holds supremacy to cast evil spells and bring misfortune. Consequently, actors avoid quoting 'Macbeth', either outside the performance or to each other, preferring to say instead 'the Scottish play' (Opie and Tatem 1992). During the discussions in the focus groups students frequently referred to spirituality as the '*thing*', or *'something'*, intangible and unmentionable. Whether connected to a personal belief or part of nursing "*this thing*" which had been identified as spiritual was precious. Yet, disclosure of its existence was associated with hesitancy, suspicion and fear. In the early stages of the analysis I had not anticipated that I would discover in the data parallels with superstition and folklore. During the analysis the concept of fear and a process of fearing began to emerge. Fear that disclosure of spirituality would be seen as unacceptable to the nursing profession.

6.2 Fearing and hiding spirituality

I began to notice in the data wariness and vacillation associated with spirituality that I had not expected. In the drawing produced by group one (Figure 6:1 page 74) the wispy line that indicated 'spirituality' was so fine, that in its construction the pencil barely touched the paper. It was as if by touching the paper spirituality would become embodied in the pencil mark. The phenomenon would be forced into existence. As I have considered the

students' endeavour in creating this drawing, the wispy line denoting spirituality seemed to resemble an apparition. Rather like a will-o' the wisp, this 'thing' that the students were attempting to define either verbally or pictorially, as part of nursing practice, was evading them. *Will o' the wisp* comes from the Medieval Latin: *ingnis fatuus* meaning "foolish fire". It is the name often given to a ghostly light, usually caused by methane gas and seen by travellers over bogs and marshes. The phenomenon resembles a flickering light that recedes when approached. This unusual light has become associated with trickery and deception, drawing those who see it away from a safe passage (Briggs 1978). Moving from darkness into light and the lighting of candles is a practice symbolic of death and remembrance and hope of an everlasting life. The practice is documented throughout religious history (Speck 1978) and in the nursing literature (Vale-Taylor 2009). In the Christian faith the burning candle on a church altar is associated with the 'light of Christ' (Ayliffe-Poole 2010). Opie and Tatem (1992) suggest that throughout history the customary burning of a candle following death is associated with not only the Holy, but with superstition surrounding curing and protection. As Campbell (1988) advises, spirituality has a natural connectedness with all things uncertain and unknown. The concept of fearing for spirituality was connected to uncertainty: helplessness and hopelessness as articulated by A during focus group one, and reflected in my field note/memo at the time:

> *You're just completely thrown into it from when you start your first placement that's it, it's completely different, you've got to learn to interact with people and to understand feelings and these are feelings that I've never experienced myself that I'm trying to understand them from that person's point of view but it's really hard if you've never experienced that, if you've never lost anybody or you've never lost like a limb or something coz I had a patient who just had an amputation and I was thinking I've no idea how to relate to that feeling so…* (A: Group 1, 5: 1-8)
>
> Memo: A sounds almost exasperated at the situation, by her self-ineptitude at not knowing

During interviews with participants in Phase 2, I began to notice a range of powerful emotional responses in the participants. These responses became evident when incidents connected with personal belief about spirituality were explored. Speaking of these incidents initiated a physical and distressed demeanour in the participants including stress rash and tears. During the interview with R, she talked about her confusion, reticence and fear regarding the reactions and lack of respect of qualified staff. These

reactions were in response to the decisions made by a woman who was dying of liver cancer and who refused conventional treatment, relying instead upon her faith. My field note at the time reveals the intense reaction that I witnessed in R as she spoke about the event:

> *"Um, but I found that a lot of – I don't know if I should say this… but a lot of the nurses didn't respect her because of that decision that she'd made. Um, like, in private they were kind of like –um, I guess like laugh about it and think it's just ridiculous. I just kind of realised that I should think carefully about what I say, about my views because, um, it just doesn't seem the sort of thing that nurses really discuss – spirituality"* (R, Interview 1: 5:1-11)
>
> Field note: R appears to becoming anxious and I notice a stress rash developing on her chest. She was leaning over the table resting her head on her left hand and as she talked she began to lean forward…lowering her body towards the table top…rather like a position of submission seen in a young animal.

AM was a participating student who came only for one interview part way through year two of her education. A short memo constructed as I analysed my interview with AM, indicated that the same physical response occurred in AM when she recounted to me her feelings. On first examination, the transcript indicates that AM laughed, conversely the field notes at this time indicate an opposite emotional response.

> *Um. Just the fact that these horrible things were happening to people and… obviously I knew how people could be ill and die and things at such young ages, but I just didn't… I don't know. Something just made it really sink in. And er, I did find myself asking why a lot of the time. But then asking who am I asking why too? Do I have some sort of…. Am I blaming someone? Like do I have a God that I'm blaming? So, when I explored it I didn't really feel that I did believe in a God as such but I felt like… um, how can I explain this? Yea, I wasn't blaming anybody; I was just blaming life, like in itself* [laughs]. *So I felt like I needed to explore that to wonder why I got so angry* (AM, Interview 1: 11: 6-14)
>
> Memo: in my field notes I have written 'stress rash' so at some point AM must have displayed to me the extent to which she was feeling the emotion associated with these experiences/revisiting these experiences

It appeared that these students were frightened and being emotionally wounded. Fear of 'getting it wrong' or being 'found out' or 'judged' was not only identified in students who identified themselves with Christian beliefs. Apprehension was also noted in participants who were seeking to resolve the problem of aligning spirituality with the clinical environment but were unsure of where to turn.

> *It's very personal to the individual and they don't like to disclose that. And I found that amongst nursing staff – very rarely people talk about their own personal views and perception of life and death (AM. Interview 1: 7: 3-5)*
>
> *You can't be free and express how – your views – in case you offend someone or you are judged (AM, Interview 1: 35: 6-7)*
>
> *But I didn't discuss it with um my mentor or anything because I thought – I don't know, I just assumed they wouldn't understand; it's not something you can really talk about. It's not really part of the job – maybe…* (D, Interview 1: 4: 26-28)

J was the only male pre-registration nursing student that volunteered for the study. J described himself as having no particular faith, although J revealed that as a young boy he had attended a Catholic church with his grandmother. J had initially agreed to participate in both focus groups, but did not attend. He agreed to participate in an interview on several occasions but again then did not appear at the allotted time and day. When J finally did come to be interviewed he was midway through year three of pre-registration education. Like the female participants J expressed insecurities regarding getting it wrong and being judged.

> *It's probably because ...um ...sometimes I struggle when I don't know enough about something so if somebody wants to know something about for example the heart, if I'm not quite sure on it then I feel really awkward and not quite um – I can't really… I couldn't articulate about it because I'd be slightly nervous that I'd say something wrong. It's the same with the religion – I'd be more scared about saying something wrong than saying something that would benefit that person*. (J, Interview 1:5; 9-15).

Fearing for J was also associated with getting it right even when a patient he had been caring for was dying.

> *Errr. I tried not to let it get to me because it… you know, the fact that he was bright and everything that night and in the space of a couple of hours he was very very bad so er – I tried to put it behind me. I bottle things up so I just kinda bottled it up and stayed there. Because you've got to be strong for him – rather than if I was bad then my outward reflection would be a negative one on him you know.* (J, Interview 1. 7: 10-15)

J was particularly concerned around revealing any emotion and upsetting the dying patient. Within the concept of fearing for spirituality was a property, which I coded as 'being allowed'. Being allowed was associated with a fear of *getting it wrong, uncertainty* and being '*found out*'. These participants were wary that any outward portrayal of spirituality and spiritual 'self' would be seen as inappropriate. Being allowed caused particular trepidation for the participants who describe themselves as having a Christian faith. In the winter of 2008/09 the press widely publicised the case of Caroline Petrie, a

nurse who was suspended by her employing organisation for offering spiritual support to a patient in the form of prayer. Ms Petrie was later reinstated after her employer's acknowledged that she was acting in the best interests of her patients (Gammell 2009). The appropriateness of prayer and 'being allowed' and whether or not this practice should be curtailed was brought into question within both Phases and student R was especially cognizant of the public controversy surrounding the case of Ms Petrie.

> *I think it is maybe just because of the media making examples of nurses who have shared their faith and got into trouble for just kind of – I'm just kind of thinking, don't do it, don't ever do it. I can't really think why else I wouldn't… Um…* (R, Interview 1. 10: 24-26)

R and D were the two students who, during the study, openly divulged their Christian faith. As Christians these participants disclosed anxieties surrounding the appropriateness of imposing their faith/belief on others via prayer.

> *…like you can't, you can't impose your own faith on other people, um (Pause 0.03) I could pray for them in my head or when I'm not with them. I'd pray for me to know what to do, or the right words to say to them, and it's not always something that you're told or taught how to do when you're a student.* (Group 2: Student D 10: 27-31)

This anxiety led to a curtailing of a natural and personal custom, which in turn, led to internal conflict and stress. Both D and R appeared to struggle with loyalty to their personal identity: '*self as Christian*' vs. *'self as nurse'*.

> *I know I don't share it* [faith] *because of fear. You hear so much about nurses getting into trouble through sharing their faith and things so I just kind of separate it I suppose. I mean it's not separate in me but it's separate – I don't see it as being professional by talking about that.* (R, Interview 1, 10: 16-19)

The concept of 'self' is central to symbolic interactionism (Blumer 1969). Blumer (1969) citing Mead (1934) states that Mead's view of 'self' was fluid and unique to human being. Formation of 'self' relies on perceptions, conceptions, communications and actions of an individual human being (Blumer 1969). The development of self is a process dependent upon reflexivity and informed action, which pivots upon human interaction with the world. These interactions involve symbols that accompany body language, and other communication and exchanges (Blumer 1969). Therefore, 'self' is able to formulate a social identity and acquire meaning through interaction with other human beings. The excerpts from the D and R above indicated that while in the clinical environment spirituality became essential for them and an integral and necessary element of 'self as

nurse'. The data in my study revealed that for the participants with a Christian faith their internal desire to pray openly but feeling that they were breaking some 'rule' caused them confusion and apprehension surrounding the legitimacy of this practice.

> *I would have liked to have said, "is there" –well I don't know if I'll get into trouble for saying this –"but would it help if I prayed with you" or… but I didn't think I, you know obviously it wasn't appropriate to say that. And also I didn't know how people would react to that. And also if the patient is – there was one thing when I thought if the patient approached me, am I then allowed to say anything or not?.* (D Interview 1: 2: 33-34 and 3: 1-4)

The students with a Christian faith tended to keep their belief system hidden or private from service users and other members of staff.

> *Yea. Or like, there was one family who sort of like I gathered that they did share the same set of beliefs but even then I thought no, I don't know if I'm allowed to do this* [pray] *or if I'm allowed to say anything. Then how much of myself can I – can I tell them?* (D Interview 1: 3: 9-12)

The participants kept spiritual identity hidden, secret and not revealed to others, bar the 'trusted' few. This finding is reflected in a study undertaken by Wilf McSherry on behalf of the Royal College of Nursing [RCN] in 2010. In this study McSherry noted that when it came to personal and professional boundaries those respondents with a Christian faith were almost 'apologetic' and "embarrassed about and wary of expressing their beliefs" (McSherry 2010:23). McSherry (2010) identified that in the nursing workforce there appears to be a sensitivity and a particularly consciousness of controversy surrounding political incorrectness and spirituality. Likewise I recall that research papers, articles and books connected to spirituality would appear from time to time on my desk at work. Sometimes accompanying these items was a brief 'post-it' note, but often there was no indication regarding who had 'gifted' me this literature, they kept their identity hidden from me. The tension and fear I had identified between 'self' and 'self as nurse' triggered me to review the literature surrounding the relationship between the self-identity of pre-registration students and their experiences in the clinical environment. Stockhausen (2005) suggests that reconciling personal identity with that of a new professional identity is essential to nursing students' particularly in relation to the student nurses' development of confidence and the integration of knowledge. Jenny Spouse has written widely on the experience of student nurses in clinical practice (Spouse 2000a and 2000b). Spouse's study into pre-registration nursing students' images of the profession suggests

that on entering nurse education an individual holds preconceived images about the role of the nurse and that reflect personal beliefs about the profession (Spouse 2000b). Included in such images are what it will be like to be a nurse and what the student will be doing as a nurse. Spouse (2000b) suggests this perception can be founded on media portrayal of the profession or previous personal experience, and occasionally both. Spouse (2000b) maintains that throughout nurse education, despite adjustment and consolidation, students maintain a deep-rooted obligation to view these images as an indicator for the type of nurse they hope to become. Both Spouse (2000) and Stockhausen (2005) suggest that student perceptions are influenced by experiences in the clinical area and the individuals with whom they come into contact.

Lathlean and Levett-Jones (2008) examined student nurses' experiences of conformity and compliance in clinical practice. Lathlean and Levett-Jones suggest that to foster acceptance and inclusion by qualified nurses, nursing students often adopt and adapt to the clinical environments overarching culture. This need to '*fit in and be accepted'* (Lathlean and Levett-Jones 2008:344) is identified as an integral belief of the nursing students and is essential in protecting them from any disapproval from qualified practitioners. As a consequence the nursing students in Lathlean and Levett-Jones' study exhibit three themes of behaviour expressed as: '*don't rock the boat'* - avoiding questioning poor clinical practice and potential alienation; '*getting the RN* (Registered Nurse) *offside*'- avoiding damaging their relationship with the qualified nurses; and, finally '*speaking up'*- having the confidence to challenge poor clinical practice (Lathlean and Levett-Jones 2008; 346-347). This final theme was only evident when the student felt established as a member of the nursing team. Lathlean and Levett-Jones (2008) hypothesize that student nurses wittingly conform and comply with a negative nursing culture. This conforming and complying avoids alienation and accompanying stigma from the nursing staff. Such strategies also enabled the pre-registration nurse student to feel belonging in the clinical environment.

My findings are contrary to those of Lathlean and Levett-Jones (2008). The process of fear and *fearing* associated with disclosing spiritual belief is not suggestive of an active consciousness of trying to conform, comply or be accepted. The *fearing* and *hiding* fit more closely with those of Randle (2001). In her grounded theory study on self-esteem,

Randle (2001) discusses that the extent to which the student nurse's 'whole self' becomes fragmented, causing them to adopt *'strategies such as depersonalization and passivity'* (Randle 2001: 298). Goffman's (1963) seminal work on stigma identified that the individual subject to stigma feels alienation from the 'norms' of humanity. Stigma results in the individual undertaking processes by which he or she learns to reconstruct personal behaviour to prevent overt obtrusiveness. The findings of this study into awareness of personal spirituality suggest it is more likely that during the students' first year they metaphorically stand on the side-line of an alien environment that does not reflect the images they had imagined. As they stand on this side-line, an outsider looking in, they are struggling to make sense of what they are seeing. Consequently, they seemed to be trying to place an identity of 'spiritual self' within the context of the unknown, unfamiliar clinical environment. The students were attempting to conduct themselves professionally under an umbrella of impending uncertainty and personal vs. professional identity conflict. This would explain why, notwithstanding their fear, those students who professed a strong Christian faith DID pray *for* their patients, consciously making a decision to keep the act of praying hidden, keeping this spiritual practice safe and secret. Praying was undertaken surreptitiously as disclosed by R:

> *I am quite frightened to pray actually – or for anyone to hear me - but if someone's in a lot of pain I'll pray because I just find it so distressing and um, if someone dies then when I'm getting the body ready, when I'm washing them I'll pray as well but I kind of pray very quietly so no-one can hear me…* (R Interview 1: 8: 18-21).

R also raised the notion of superstition, not only needing to pray for the patient, but praying for self. This need was associated with the experience of death or dying.

> *Um, I mean I'm praying for the patient really, that they're peaceful, that God can help them with their pain. Um, I mean, I don't know – my friend who was brought up as a Catholic said – he's a nurse - and he says he always prays when someone dies because, um, for protection, because he's heard that… spirits… like… can enter you and things like that. I'm really not sure what to think about that but I do pray for protection sometimes just in – just to make sure that like, I mean, I'm safe and the people with me are safe and that they – um – and the patient is kind of peaceful and things*. (R. Interview 1. 8: 27-32 7 9: 1-2)
>
> MEMO: again associated with death the need to protect self…almost primeval…superstition Prayer protects …keeps you safe…touching wood…

The brief memo that followed this excerpt from R's transcript indicates how this continuing concept of fear associated with other properties such as, superstition,

insecurity and secrecy was beginning to emerge from the data. In response it appeared participants undertook processes to prepare them and to help them to cope spiritually.

6.3 Spiritual preparing and coping

For people who hold a strong Christian faith, prayer is an important part of a day-to-day expression of personal spirituality. Prayer is integral to a Christian's personal identity and is often used as a form of meditation, essential as a coping mechanism in times of adversity and uncertainty (Ainsworth-Smith and Speck 1982; Carson 1989; Davies 2003; Ross 1994; 2002; 2006 and Narayanasamy et al 2004). I discovered the extent to which prayer played an important role in the lives of the two Christian students. The process of praying was integral to their life outside of nurse education and they were attempting to bring this part of their outside world to their education. Prayer was an essential element that sustained and directed them while in practice:

> *If I was, if I was going to do something I'm not sure if that is the right thing for me to do, I would pray about it…* (Group 1: Student D: 4: 30-31) … *Or, actually knowing that other people are praying for me as well…* (Group 1: Student D: 13: 31-32)

The busyness and unpredictability of the hospital environment seemed to have a negative impact on all the students, even those without a Christian faith needed 'something' as K disclosed during the discussions of group two:

> *…it's, it's harder because it depends whether you put stock on having a quiet moment or on taking yourself off for a prayer or whether you need to go and briefly touch some sort of sign or physical prop or something. We're not allowed to wear crosses round our necks anymore, if you nip off to your locker you can hold something comfort-wise for a moment and then off you go again… (Group 2: Student K: 13: 14-18)*

K's comments reminded me of a verbal expression often used in the English language "touch wood". This spoken idiom and custom is associated with the superstitious and used to avoid tempting fate often when speaking about illness and death. Campbell (1996) describes the ritual as a reaffirmation of faith often associated with crossing the fingers. Interestingly the touching wood may also be associated with the notion the Christian 'wooden' cross (Opie and Tatem 1992).

While writing these findings I spent a week in the Isles of Scilly with friends, one of who became unwell with a virulent vomiting virus. The sufferer of this affliction was an older

gentleman and his wife (Mrs P) had many years previously been a State Registered Nurse [SRN]. As the virus made its cruel progress through her husband and onto another member of the party, the retired SRN gave report regarding the progression of the illness to the other members of the group: *'not been sick again', 'looks perkier', 'I still seem to be OK'*. Each of these comments was followed in quick succession by the verbal expression "*touch wood*" and the simultaneous action of reaching out to touch the nearest wooden surface. When I asked Mrs P about this action, Mrs P recalled that as a young student nurse in the early 60s she and her compatriots were often frightened, not only about what might 'come through the door', but also that they would have the clinical skills to cope. It would appear that the ritual of 'touching wood' has been identified in nursing previously and has been documented by Cleary (2004:55) who found that for nursing staff caught up in the unpredictability of a mental health unit the metaphor "touch wood" was associated with "*anticipating the need to be prepared*". Being prepared, coping and security were articulated by AM, who revealed that when she had commenced the pre-registration nursing programme that she did not identify with a particular faith. Because of her upbringing AM had looked to the teachings of Buddhism in an attempt to identify a belief system to which she could relate and that would help her cope. AM described to me a moving and traumatic situation she experienced in her third clinical placement and tried to explain how she called upon her *'system'* to control the emotion she was experiencing:

> *I found that incident… I was so angry at this man that had done that to her. I know nothing about her, nothing about him or what had gone on in their life but I was so… oh, it just wasn't fair. That's when I went home – all the way home I was fuming [laughs] and asking "why?" And then I started thinking, oh, my system's failing me. Like, I'm getting angry again.* (AM Interview 1: 23, 24-33)

D, the Christian student who had attended group two, also volunteered for interviews as part of Phase 2. Again, during her first interview D revealed the need to shield herself by the use of prayer and this disclosure caused her further conflict and self-reproach:

> *But then I – afterwards I thought to myself, was it [prayer] – did I do it [pray] to make myself feel better? Or was it, you know, I felt quite bad for not doing it [praying], for not sharing.* (D Interview 1: 4: 18-20)

While J the male student nurse claimed no religious affiliation or belief and did not pray, he expressed regret that he did not attend a church nor hold any particular religious belief as this may have somehow offer him some security or shield should he ever need it.

> *I don't know. I think sometimes I er - it's quite nice to have a belief – if you've got something that you can then draw on. You know what I mean? Then like during the week I'll be a bit – you know what I mean? – I'll just think I want to go on Sunday and then it just never happens. I never get round to it. And um, yes… Sometimes I feel quite envious of people that have got a belief and then I think I should do something about it and then I never do*. (J, Interview 1. 4:1-6)

The artefacts I received as part of my data collection also revealed a need to seek security and protection. Shortly after K took part in the second focus group, she sent me a long email a section of which is detailed in appendix 8. K's email to me revealed what she felt she had not been able to share in a group situation. K had been brought up in the Christian faith. In adolescence and early adult life she had experienced poor mental health. K shared that in her youth she had rebelled against her parents and a family background of medicine, eventually come to nursing as a means to finding her 'self'. Attached to the email was a picture K had drawn, figure 6.2 (overleaf) and with it with the following explanation:

> *I have had to work towards personal emotional development as part of my self-healing process. I have always had a fast and consuming mind. I see spirituality, especially spirituality in work, as part of that. I enclose a picture I drew of how I see my 'Divinehood': the God clasps my head: logic, thought and reason. The Goddess has the embrace of my body: visceral, tangible and emotional.* [Sic: K email)

Figure 6:2 K's picture of '*Divinehood*'[sic]

Shortly after receiving K's picture and email, I was exploring the concept of superstition and touching wood I came across the image overleaf (Figure 6:3). I was surprised that it was representative of 'Treebeard' a character in the second book of the Tolkien Trilogy, The Two Towers (Tolkien 1955). Tolkien (1955) portrays 'Treebeard' as a 'protector', an *Ent*, a curious looking being neither tree nor man. *Ents* are familiar in folklore and are thought to protect the forests and the inhabitants therein (Anderson 2003). I realised that the image in figure 6:3 is similar in visual interpretation of protection and safety to K's pictorial representation of 'Divinehood' [sic].

The preciousness of spirituality to 'self' and associated need to be prepared for the unpredictable was fundamental to all the students. The students also felt a strong compulsion to identify a mechanism that would help them cope with the uncertainty that any altered image nursing might impose. The participants in this study were seeking ways to safeguard themselves from the traumas experienced in clinical practice and to

continue through and endure their pre-registration nurse education. This process was particularly stressful for those students who professed a strong Christian faith, who could not risk humiliation or compromise from their spirituality that had called them into nursing.

Figure 6:3 Tom Loback (2007): Hobbits and the Ent

6.4 Summary

These findings identify that in the early stages of their pre-registration education, nursing students are struggling to define and explain spirituality and they feel fear and uncertainty associated with the 'unimagined' experiences in the clinical environment. This fear and uncertainty manifests itself as a strong desire to hide spiritual practices and identify methods to cope and prepare self in adverse experiences. This chapter has explored elements of fantasy, folklore and superstition and the relevance of these concepts to spirituality and the participants' experiences in practice. The next chapter will explore the processes involved in safeguarding spirituality from loss. The notion of dualism within the context of health care will be introduced and examined and the opposing sides of good and bad health care are exposed. As a result of these opposing

elements a model of spiritual safeguarding processes is presented that seek to explain spiritual burn out.

Chapter 7 : Safeguarding

7.1 Introduction

Chapter 6 introduced the concepts of preparing and coping as the participants were struggling with defining and identifying spirituality and reconciling spirituality to their image of the nursing profession. Evident was a need to prepare and protect from adverse experiences. As the findings developed through theoretical sampling and constant comparison the process and category 'safeguarding' began to emerge. Without an ability to protect 'self' the students were powerless to safeguard 'other', their patients. In the previous chapter theoretical sampling of folklore, fantasy and superstition were interwoven to illuminate the fact that the participants' images of nursing became disjointed from their real world experiences in clinical practice. This resulted in the participants recounting surreptitious behaviour, keeping spiritual practices hidden while still relying on spirituality as part of coping with experiences in the clinical environment. Incidents and personal interactions with individuals that the participants had not anticipated nor fully reconciled will be explored in this chapter. Literature derived from theoretical sampling will be used to explore elements of the unimagined and quest in the findings. Revealed in this chapter are the profound and sometimes disturbing experiences encountered by pre-registration nursing students in the clinical environment. These experiences involve clinical practice, qualified practitioners and the patients for whom the students care. Explored in this chapter is the extent to which the participants' perceptions of some experiences as negative, initiate Basic Social Processes [BSPs] associated with *safeguarding*. These BSPs develop over time as the participants continue to grapple with their sense of *calling*, a sense of who they are and the nurse they hope to become. Concerns and perceptions surrounding *losing* spirituality and a recognition of two *opposing* images of the nurse; the image of a nurse the students aspire towards and the nurse they hope not to become. Subsequently, the findings in this chapter will present data that is evidence of the students' attempts to resolve their on-going struggle and align and *reveal* personal spirituality to the nursing profession. Finally a model of positive and negative safeguarding is presented.

7.2 Spiritual calling

The second focus group consisted of two female students (D and K) both of whom professed a personal spiritual belief and followed a faith. D shared with the group that that she had converted to Christianity from Sikhism in the last ten years. The other student K described her spiritual beliefs as Pagan. Unlike group one, the participants of group two were able to provide clarity surrounding the meaning of spirituality to them personally, particularly K:

> *There's a sort of dialectic at work in pagan thoughts that has the god and the goddess working together rather than just one deity so I have both of those different parts that they rule over as part of me; it's something that just walks beside me every day. I just know it's there.* (Group 2: K: 2: 22-26)

I found the dynamics between the participants of this focus group very different from the first group. K appeared self-assured, articulate and confident, while D was quiet and self-conscious. Bloor et al (2002) advise that a confident and articulate individual can easily dominate a focus group. I was aware that as the quieter member of the group D's voice might not be heard. Accordingly I found I needed to prompt her to share her meaning:

> *My meaning? I'm here for, I know I've been put here on this earth for a purpose; I don't know what it is still, but, um, I don't think you always need to know…* (Group 2: D: 4: 14-16)

The notion of calling was significant to the Christian participants. During the interviews in Phase 2, I met R. R was a young female student and an active Christian who was part way through year two of her pre-registration education when the interview took place. R had initially agreed to be part of Phase 1, but had been unable to attend either focus group. Like D, R also revealed that as a Christian she had been called to nursing.

> *I never really had much direction in my life but I really –I'm quite a practical person – and I really love people. Um, and I just kind of kept asking God what I was supposed to do. Quite a few occurrences happened that kind of pointed to the direction of nursing and I worked - I mean I'd heard from many people that it was the worst job in the world – but I went to work in a care home and I really enjoyed it and then it just – it was kind of like a confirmation that I was… like, oh,… like…, I'm using my personality and my skills and it's to the best of my ability and it just kind of like fitted; it just felt right. Then I kind of saw that as a calling; that's what I was kind of made to do...* (R, Interview 1. 3: 22-30)

Calling is defined as 'a *strong urge towards a particular way of life or career; a vocation*.' (Soanes and Stevenson 2006: 199). Calling and vocation have been traditionally

associated with the nursing profession (Lundmark 2007). Nightingale referred to *'calling'* as this '*precious gift'* and viewed this as the essential constituent of a good and worthy nurse (Nightingale 1860:327). 'Calling' is mentioned many times by Florence Nightingale in '*Notes on Nursing: What it is, and what it is not*' and is associated with the religious as in a call from God (Nightingale 1860). Florence Nightingale is viewed in the nursing literature as the as the founder of contemporary nursing theory (deGraaf 1989; Chinn and Kramer 1991; Lundmark 2007). Nightingale saw nursing as a common purpose and vocation for all respectable young women (Woodham-Smith 1950; deGraaf et al 1989; Lundmark 2007). Historical literature states that God called Florence Nightingale several times before she successfully managed to establish herself as a nurse (Nightingale 1915; Woodham-Smith 1950; deGraaf et al 1989). In her published collection of annual letters to the probationary nurses who trained under her leadership at St Thomas' Hospital, Nightingale was clear that the purpose of the nurse was to meaningfully serve mankind and in doing ultimately serve God (Nightingale 1860; 1915; Macdonald 1995). Nightingale's image of nursing as a feminine profession remained one that sat quite separately from the masculinity of medicine (Macdonald 1995). Nursing was depicted as a worthy occupation to which all young women should aspire and devote themselves in religious totality (Nightingale 1860; deGraaf 1989; Chinn and Kramer 1991; Macdonald 1995; Lundmark 2007). As a reflection of this ideology, the nursing profession held a "*spirit of unselfish devotion*" up until the mid-1950s (Chinn and Kramer 1991: 2) when a new era in nursing occurred. This era was driven by the profession's desire to seek scientific recognition (Chinn and Kramer 1991, Lundmark 2007). In today's modern world of nurse education the notion of 'calling' and vocation is rarely spoken. Yet, many who practise in health care would feel somehow called and continue to answer a 'calling' either spiritually, morally and ethically or otherwise (Kirschner 2003).

Lundmark (2007) suggests that it was in the mid-1900s that the UK nursing profession disassociated itself from concepts such as calling and vocation, a disassociation that was primarily based upon 'fear'. Fear that the concepts of vocation and calling may be construed as subservient and might expose nursing to manipulation by the medical profession and tie nursing to notions associated with femininity and motherhood (Lundmark 2007). Lundmark (2007) maintains that as a consequence of this fear the

response of the nursing fraternity was to establish nursing as a profession to be certificated via higher education. Thus securing the scientific recognition the profession sought (Lundmark 2007). Lundmark (2007) argues that the move to establish a scientific basis for nursing created reticence for some within a profession that had previously been content to narrate the identity of nursing with the notion of calling and vocation. Listening to and observing both D and R, I sensed this reticence. As Christians they assumed they would find a vocational home in nursing. In their early clinical experiences D and R were uncertain that their spiritual beliefs would be acceptable to the scientific side of the profession. Yet, in consideration of an ontology for the art and science of nursing, Paterson and Zderad (1988:29) describe the relationship of '*call and response'* as a dialogue between not only the nurse and the patient, but also the nurse and *purpose* of nursing. In humanistic nursing theory being the recipient of a 'call' is seen as an essential and existential experience, an awareness of 'self' and 'other'. Calling and response is a complex and long lasting sequence, all the while reflecting personal and professional interpretation and aspiration or hopefulness (Paterson and Zderad 1988).

An altruistic aspiration has been previously documented by Macdonald (1995) as an ideology that drives the caring professions. Smith and Godfrey (2002: 205) identified that 'the good nurse', holds admirable personal and professional characteristics, such as *'truly caring about people*' and a '*commitment to those she* [sic] *serves'*. Reflecting the relationship between the nurse and those for whom they care, Clark (2000: 21) describes spirituality as "*an experience of being in relationship with*". While in the previous chapter it is evident that the participants struggled to articulate the concept of spirituality as a single phenomenon, they were able to identify the constituents of spirituality in relation to a 'good nurse'. The students of focus group one identified themselves professionally and personally with a 'good nurse'. This group saw a good nurse as 'spiritual', one who identified with human values associated with empathy, kindness and compassionate understanding, as both Students A and B revealed:

> *B: Nursing? No, I'm the same as I was when I started. That's who I am. And funnily enough I'm, er, proud of it. I wouldn't have talked about it earlier, but being my age that's one of the reasons I know I'm a good nurse because I can see or feel more than meets the eye, and read into people's, um, feelings. And I, that's why I think, you know, I'm good at wellbeing and holism because I see past… I can't explain it; I don't know what you call that. It's not seeing things, but its feeling or understanding people's feelings*

> *A: almost empathy. It's being able to empathise with that person*
>
> *B: Yes. That's a funny word again. I don't know what the word for… I wouldn't say I know them, I wouldn't say I know their pain. That's empathy. I wouldn't say I know that. But I understand their basic fears. It's a very basic fact I think; a very basic fact of human being, that's hidden, that's dressed in a body. And that's what I think spirituality is. You know, seeing, reading that core, the core of a person's feelings, it's not a game whether they like something or not like something, it's an essential sort of feeling I think.* (Group 1, 3: 30-32. 4: 1-14)

Similar to the images of nursing that the students hold on entering the profession (Spouse 2000b), the participants assumed an image of how nurses should conduct themselves and likewise how they themselves should behave. The participants were vigilant, knowing that this image could be tested and cause personal challenge. K expressed this as uncertainty surrounding the unpredictability of human nature:

> *And I think humans are very scary creatures. There's nothing in the world that I actually genuinely fear except… human beings… because of what we're capable of. If you're somewhere wild and you get eaten or attacked by a wild beast, the beast will have a reason for it that you can understand – you're on their territory, close to their young, it's been a hard winter and they're hungry. But humans could just turn round and do something to you just because. Which seems like much less of a reason.* [K, Interview 1. 20: 1 -7]

In focus group one, A revealed her quandary that she had not expected nor was she prepared for the complexities of human life and death. Complexities to which she was exposed in the clinical environment and which would test her and that she would be challenged to accept:

> *So it's really difficult to… I think what I've realised is that I can't always make people happy and I think I came into nursing thinking make everyone happy and everybody better and you can't. You've got to accept that you can't make everybody happy and you can't make everyone well and that people are going to die and people are going to live; and people are going to live but not want to live*. (Group 1: A. 10, 20-25)

A also revealed how she was struggling to keep her nursing and home life separate and how the pressures of the clinical environment poised a threat to her spirituality.

> *I wouldn't want... I think you sometimes need a reality check and yes you are doing nursing and yes there are sick people but you have your own spirituality which is outside of this as well and I – my boyfriend actually arrived, he said to me the other day which was interesting, I'd got a bit worked up about something I'd experienced at work, and he said to me, "oh", like, "A, you can't get so involved in things" and that coming from somebody else, and actually that's true because I don't want to come home every night and worry about if a patient's going to be OK or if that nurse will be rude to that patient again and I kind of now -I learned that I had to switch on to these feelings and now I'm trying to learn*

> *how to switch off from them as well. So it's a bit of a roller coaster, like how to manage my spirituality, really. If that makes sense?* (Group 1, A, 21: 17-28).

In interview with AM, when I asked her if there was a particular incident in clinical practice that may have initiated a consideration of self and spirituality, AM revealed that for her too, all was not what she had expected:

> *No not particularly. Just when I went into practice and I realised that this is what nursing's all about and this is what I was going to be expecting to deal with for the rest of my career [laughs]. And like I said lots of suffering in the end- mortality. It was no particular incident. Since then I've had certain incidents that have really shocked me and made me think a lot deeper about things but…yea, no…* (AM, Interview 1: 22, 12-22)

I then questioned AM a little further and she disclosed that there had been a particular incident the preceding circumstances of which made me feel extremely sad. This was AM's defining story, a concept that will be explored in the next chapter. The decision to include AM's recollection of this incident here is twofold. Firstly, the event highlights that all was not what had been imagined or expected by AM. Secondly, the sadness and confusion it invoked in AM is indicative of the emotional turmoil that pre-registration nurses are exposed to on a day-to-day basis and that as nurse educators we should be cognisant of:

> *OK. Um, there was one lady that was in intensive care; she was only twenty-five and she was in there because her partner had beaten her up and smashed her head against a wall. And um, she had a little four-year-old daughter and um every day – she wasn't very well at all. She was there – I think she was in there for about ten weeks – and she was eleven weeks pregnant as well. So she'd only just got pregnant. And um, there was a lot of debate on whether they should abort the baby or not – um -to give her a lot more of a fighting chance. And I found that quite emotive. And um every day the parents of the girl – the twenty-five year old – would come in and bring a video tape of her little four year old girl in and the little four year old girl would tell her all about her day at school. And they would play it right to her ear so she could hear. And the little girl would be, oh mummy, wake up mummy – you're being very lazy. And I was like, ooh, that really upset me and um, yea, a week after I started placement there – coz she'd already been there a long time – they decided to turn off the life support and it took her a week to die. And on one of the night shifts that I was caring for her, when she was on the Liverpool Care Pathway…* (AM, Interview 1, 22, 5-20).

The next sample of this transcript has been used in chapter 6 as indication of AM's desire to seek some form of shield. Later on revisiting the original transcript the following data sprung out at me:

> *"I was so **angry** at **this man** that had done that to her"* (AM, Interview 1: 23, 24)

AM wanted to find something that would protect her against the negative emotional responses she was experiencing. I am reminded of the young midwifery trainee Jennifer Worth in her memoires 'Call the Midwife' (Worth 2008). As Worth writes, she shares with the reader the emotional and moral turmoil she had to face as a young, innocent and middle class pupil midwife. All was not what she had expected nor imagined, particularly the clients, one of whom, with a syphilitic vaginal chancre she describes as "*the revolting creature*" (Worth 2008:74). The silent revulsion, irritation and anger felt by Worth in her experience of this pregnant woman are evident to the reader. Anger, irritation and revulsion are powerful emotional responses and antonyms of words associated with a 'good nurse' like kindness and calmness. Anger is an antonym to words depicting values such as compassion and tolerance to which those in a caring profession are presumed to aspire. Jean Vanier the Canadian Catholic philosopher and humanitarian worker bravely divulged the intense anger he experienced against an individual with a learning disability. This anger occurred at a particular moment of fatigue and stress (Vanier 1992). The internal hatred and darkness Vanier experienced alarmed him. Particularly as Vanier viewed his self-identity as kind and caring (Vanier 1992). Even K the participant who could be most upbeat and pragmatic in our discussions revealed how the behaviour of some patients tested her:

> *…or when your patients do something stupid. You see someone with a chest drain and they're going outside for a smoke. Yup. (Laughs). OK. Um… That was frustrating.* [K, Interview 1. 20:29-31]

Students' external and internal images about what nursing should be like and images of self as 'good' and 'caring' continued to be tested and dislocated. The consequence of this contradiction caused the students' stressors and emotions that they had not anticipated. It became evident to me as I sampled the literature and returned to the initial data that 'fearing' identified in chapter 6 could mutate into anger and stress[8], as R articulated:

> *I really suffer, like I get a lot more stressed. Um, I can't relax as much; I'm married, and my relationship with my husband suffers because I'm less patient and er – you're just tired really, just – you don't know how to communicate with people as well and, um, you just suffer in every area. I get more ill, just everything. Yea.* (R, Interview 1. 14: 4-8)

[8] " *The disruption of meanings, understanding and smooth functioning so that harm, loss or challenge are experienced, and sorrow, interpretation, or new skill acquisition is required*" (Benner and Wrubel 1989:412)

I questioned R further regarding this and the impact of this on her identity; again she revealed that all was not as she perceived it should be. The qualified staff representative of the very profession she had been called to serve did not respect her as a student.

> *People can um be quite - not abusive to students but don't really respect them very well, very much, um, so you're just always kind of vulnerable and don't really feel like yourself. And I'm just hoping that when I am qualified – say that I qualify and work in a hospice, I think I would be myself then 'coz it would be on my own terms…* (R, Interview 1. 14: 16-20)

Other participants also felt anger and stress. B was a mature student who had initially started her training as a young woman. B shared in focus group one that in her youth she had been naïve about the demands of nursing and had subsequently left the profession. B was now attempting to undertake her nurse education again at the age of fifty. B perceived a lack of respect or care by staff, particularly towards older people. This caused B distress and anger:

> *When I… err… finished that placement I didn't even know that anybody had chaplains or bothered about spirituality - except me. And I thought to myself, why don't they have counsellors; they don't have counsellors to make you feel better or spirituality to make you feel better – absolutely… It just left such an impression on me. And such anger in me. I haven't seen that again*. (B, Interview 1. 5: 29-33)

B also had a clear vision of what constituted a good nurse:

> *I see them as, um, err – maybe that's because that's the way my mind is – much more humble and much – that's the side… that's the side that directs their nursing and I read it as – it might never be always perfect but it's more special; much more special, especially when I see as well too cold directive – which is the way we have to be. You see what I'm saying? Which as a good nurse, a very good nurse who never fails, who probably never steps out of line or does anything wrong. (B, Interview 1. 6: 27-33)*

B's vision of a 'good nurse' surprised me. In particular her perception that a good nurse "*probably never steps out of line or does anything wrong"*. B's view was that the institution of nursing expected her to conform, not to push barriers and not to challenge. The reader will be further introduced to B as the findings develop. Suffice to say B was determined to do the right thing and challenge poor practice and at one point, she walked out of clinical placement prematurely. This action threatened to jeopardise the remainder of her pre-registration education. Of the participants in the study only three students contributed fully in both Phases 1 and 2 to the completion of their pre-registration nurse education. B was one of these students. As B and I met through a total

of one focus group and two interviews, her commitment to the nursing profession to which she had come later in her life, became wholly evident.

At this juncture I will add some reflexivity from my own position of nurse/researcher. I found B the most challenging of participants. In early interviews she appeared to me to avoid my questioning and in turn questioned me. When I listened to her speech via my iPod and PC audio, her voice, tone and inflection irritated me. Such was the extent of my irritation, that early in the study I had to force myself to engage thoroughly with transcripts from my interviews with her. Needless to say, I came to recognise that it was B during the first focus group of Phase 1 who provided verification that spirituality could be lost:

> A:…*but sometimes I've felt that some of the qualified nurses and other members of staff have overlooked that and they've almost lost their own spirituality somewhere along the way, they've lost their own…*
>
> *B: I think they've lost their spirituality* (Group 1, 11: 30-32; 12: 1)

This discovery led to loss, losing and burn out connected with spirituality to become significant concepts.

7.3 Losing spirituality

The losing of spirituality is a category that occurred within both Phases 1 and 2 of this study. *Lose* or *lost* is a word in the English language associate with the negative. To lose something is to be deprived, having ceased or failed to retain something (Soanes and Stevenson 2006). Consequently, the gerund '*losing*' suggests being disadvantaged in some way. Within the data the students' belief surrounding loss of spirituality frequently occurred. The students perceived a 'loss of spirituality' in the words and actions of qualified staff:

> *Um, and the first thing that I did was – I sort of noticed on – in – placement on my medical ward, I started noticing how people with sort of um, terminal diseases and things, especially cancer, they were sort of starting to almost resent their religion……* (AM, Interview 1: 3: 29-32) *…and the staff as well…If you ever got into group discussions with staff… Then I'd find the staff would say stuff like: "oh, how can you say there's a God when you've got all this round you?" I mean cancer and things like that.* (AM, Interview 1. 4: 1-3)
>
> *Um, but I found that a lot of – I don't know if I should say this… but a lot of the nurses didn't respect her* [a dying patient] *because of that decision that she'd made. Um, like, in*

> *private they were kind of like –um, I guess like laugh about it and think it's just ridiculous.* (R, Interview 1. 5: 5-8)

Other times students viewed this loss of spirituality as associated with burn out, an inevitable and predictable occurrence within the profession they had entered.

> *Especially in some of the older staff that have been in nursing for a long long time, they seem to have lost that - I don't know what it is…Maybe not that they've lost their spirituality but um, they just go to work, do the job and come home.* (AM, Interview 1. 19: 22-25)

> *…they've* [trained staff] *simply become more solidly pragmatic as time's gone on. Um, ….it's, there is I think – people are much more aware and accepting of the fact that if there's going to be burn out it'll be - it could well happen in a caring profession. Which is a shame because it's almost like you're accepting entering a career which could lead you to something as bad as that…* (Discussion group 2, Student K: 21: 18-24)

Through theoretical sampling I examined literature surrounding 'burn out'. Burn out associated with stress is a common occurrence in vocational professions such as teaching and nursing (McVicar 2003). A review of the literature undertaken by McVicar (2003) identified that workload, dealing with death and dying patients are significant stressors in the clinical environment. These stressors can impact negatively upon nurses and in the longer term, their emotional health and wellbeing. An earlier journal article by Farrington (1995) cites the work of Gray-Toft and Anderson (1981), who devised a nursing stress scale that includes the same stressors: workload, dealing with death and dying patients. McVicar (2003) identified that workload and time pressure was a significant stressor identified in eleven studies undertaken from 1985 – 2003. It would appear that in over 20 years stressors in nursing continue to haunt the profession and provide a backdrop of uncertainly and unpredictability to nurses, both qualified and student (O'Mahony 2011; Onder and Basim 2008; Moore 2006). The consequences of stress in clinical practice have a greater and potential longer lasting impact on those students embarking on a pre-registration education programme (Davey 2002). Davey (2002:193) warns of negative role models and students being '*thrown to the wolves'*, due to stressors experienced by qualified practitioners in the workforce. This is a contrary image to the one of caring and kindness that was held by the students who participated in this study. As the interviews progressed, students began to express a cynical resignation and perceived inevitability that their desire to reflect the image of a 'good nurse' would continue to be challenged as they progress through their education. B articulated this:

> [Pause0.0]…. *I… I'm – the sadness is, I think, that as I'm getting more senior, I'm going to have to close up…Not, not, er… enter into* [laughs] *conversations. Not enter into kind conversations… Not enter into this talk that patients love…I, I'm still, um – when I started I'd be doing it all the time and now I'm the end of my second year. When I've got my responsibilities – clinical responsibilities, black and white ones, and life and death ones – they have to take priority…* (B interview 1: 14: 17-26)

This resignation expressed by the students was associated with the busy unpredictable clinical environment in which there is very little time.

> *…And I'm thinking in the hurry of nurses these days there are – there's black and white… it's black and white. And it's death or life and no time, no time…* (B Interview 1: 5: 7-10)

Time to provide spiritual care and to give spirituality the consideration the students perceived the phenomenon to deserve. Finding time for spiritual care is identified in the findings of a survey commissioned by the RCN; giving good spiritual care requires time (McSherry 2010). The RCN survey acknowledges that time is a necessary resource in the provision of support and guidance for those who would seek to provide spiritual care as a respondent in the RCN survey acknowledges:

> *'"It would concern me if spiritual care were forced upon staff who were not comfortable with it – but I do feel that there is not enough support, guidance and time given to those who may have the skills and abilities to provide spiritual care."*
> Respondent 1391' (McSherry 2010:22)

Within the busy hospital environment time is a concept that is frequently felt to be the nemesis of providing spiritual care (Narayanasamy 1995; Ross and McSherry 2002; Murray, 2004; McSherry 2010; DH 2010). In her first interview with me, K commented ironically on the paradox that is health care provision in a hospital environment:

> *I mean it's a genius idea; let's stick all the really sick people that are the most demanding and stick them all in one building* (K Interview 1: 3: 31-33)

The student nurses in this study were acutely aware of the negative impact a lack of time had upon their qualified nursing colleagues, and subsequently the care these colleagues provided. D articulated this after she had recalled a traumatic situation observed in children's oncology. The nurse working with D was assisting the doctors attend to a very sick child. In her busyness the nurse did not notice the distressed father and following the procedure did not have time to comfort the mother. Compelling D to fill this gap she perceived in the provision of care:

> *And I just said to her* [the mother] *if there's anything you need I'll just be outside. And I told the nurse I was working with and she said something like "oh well, you know they're going to be going through all sorts now; I don't know what to do. I can't be in there. I've got to do this"*. (D, interview 1. 21: 36-37; 22:1-22)

D did not appear to be judging the nurse nor did she express anger as other participants had done. Rather D was perplexed and troubled as to how this had come to be, how a nurse who should care, could appear not to care as she explained:

> *Just a bit like you don't know really. I didn't know where I stood. She didn't say to me, oh you go in there or… It just made me feel like it's not as important as other things that need to be done. That's what I thought. I don't think that – but I thought that's the impression I got that – that the nurse thought it's not as important as other things that need to be done, as other things need to be done here as well.* (D, Interview 1. 22: 5-10)

These findings echo those of Corbin (2008) and Maben (2008) who have identified that limited resources like time impact upon nurses' ability to provide the care to which they and the profession would aspire.

By the second wave of interviews the participants had undertaken their community placement and were able to share their experience of this different clinical placement. Again time was mentioned, but as opposed to the negative, within the community context time is a positive concept:

> *Uum. It felt more like I was actually working as a person who could put that to one side for the time being because I'm feeling a lot less intensely challenged by the environment I'm in because I can sit down at their kitchen table with them and talk with them. Which – you don't have time to really sit down and talk with someone on a busy ward.* (K, Interview 2. 13: 28-32)

The outcome for the participants in perceiving 'more time' was that they felt safer and more in control. They had time to be a 'good nurse':

> *And in the community it's much more you're working – you know all the lip service to patient choice, the patient comes first and everything like that is more possible in the community where I didn't notice that need to protect myself so much because you are literally working with them, at their own speed, and you have the time to do that. So I don't think there's that need to protect so much but you're committing yourself to them still as a professional.* (K, Interview 2. 3: 28-32)

> *Yea. Yea. I've found that anyway. And in the types of placements I've been on – when I went to community where it's not so rushed, you have got time to spend longer with people actually that's the time when I don't draw on it* [spirituality] *more.* (D, Interview 2. 48: 23-25)

For the students in this study the community placement was not the unpredictable alien environment of the acute hospital. It was an environment that reflected their image of what nursing should be. As the study progressed and I undertook further interviews it became evident that the lack of time in the hospital environment held a more sinister and silent entity. During her first interview B talked about spirituality being squished:

> *It's valuing – the wonder of some… I don't know what it is and I – it's not nice to squish… It's hard to put a finger on, you know what I mean? You can step on people's spirits can't you…* (B, Interview 1. 10:21-23)

A also talked about being 'stamped over':

> *I think my inner feelings of how I view myself and everything could be quite easily… a decision I've made could be quite easily stamped all over and I could quite easily be back down at square one feeling like I can't do anything if I haven't gone to a placement and if… somebody made me feel bad about myself because being the person I am I will take things to heart and I will be wounded by things…* (A, Group 1. 19: 27-28 & 31-32. 20: 1-2)

B and A were trying to explain that spirituality was valuable and integral to life, but not only might spirituality become lost, it could also be 'squished' or 'stamped' out of someone. I prompted B about 'squishing' during her second interview six months later. She revealed to me the following:

> *...and responsibility and like um, you haven't got time to be this spiritual person; you just don't have the time. It's what I think I was saying to you last time…* (B, Interview 2. 9: 23-25)

> *You haven't got the time. Um, and it's knocked out of you because nobody is going to test it or you're not liable for it.* (B, Interview 2. 9: 29-30)

Time for spiritual care and the 'squishing' of spirituality had almost been the undoing of B. During the second interview B shared with me that she had '*walked off*' her last placement (B, Interview 2. 10: 33). When I probed her as to why she replied:

> *Um you know, they have bed managers running in: "out out out out out!"; in there for three days; got to be in and out. The nurses are running round like you know – this is the care pathway, three days for this, it's "out out out out!". No time for any niceties whatsoever!!!!. I can't – I couldn't ...er…* (B, Interview 2. 10: 21-23)

During her second interview it became evident that like the other pre-registration nursing students B had much invested in her programme. Unlike the other participants B was a mature student. In interviews with me B frequently referred to her age. This suggests that an awareness of time was a limited resource for B. A lack of time in the clinical

environment that caused stress and time associated with being 'older' was a potential threat to B achieving her goal. Timmins and Kaliszer (2002) and Nicholl and Timmins (2005) identified that mature aged undergraduate nursing students refined previously developed coping strategies and developed new coping strategies during their training to reduce stress. Drury et al's (2008) grounded theory study considered the impact of pre-registration nurse education on mature learners and identified negative themes of isolation, feeling alien, fear of failure and minimal confidence in academic abilities. These negative themes were juxtaposed with positive themes such as high levels of motivation and personal reasons for undertaking the course (Drury et al 2008). Within the data there was evidence that the participants saw the 'loss' of spirituality as negative to nursing care. This was oppositional to their reasons for entering the profession, which was to make a positive difference for themselves and for others.

7.4 Opposing spirituality

As discussed in chapter 5, the findings were established via data analysis that involved theoretical sampling and constant comparison. This technique included the conversion of first level codes into gerunds and the use of thesaurus to search for synonyms connected to the gerund. Whilst undertaking this sampling method the antonym of the gerund was also considered. This process revealed that dualism, two sides and antonyms are of significance to this study of pre-registration nursing students and spirituality. Dualism originates from the Latin meaning 'two' and denotes a state of two parts (Soanes and Stevenson 2006). 'Dualism' is the originally philosophical theory of Rene Descartes who surmised that the human mind and thought processes were independent of the human body, the two working together simultaneously to provide an understanding of the world (Warburton 2010). Theoretical dualism recognises that in addition to having physical presence, human beings are also spiritual. While the physical element cannot live forever, there is a belief that the spirit can continue after death (Ruether 1994). Moral dualism recognises the ideology of two parts as being at opposing poles for example good and evil (Macey 2010). Macey (2010) considers the two sides of father time, that which is associated with death and dying, and that which is associated with the benevolent Father Christmas, representative of giving hope and renewal. While theoretical dualism might be assumed to be of more relevance to this study, it is moral dualism that is of

significance to the findings in this chapter. Moral dualism surrounding the uncertainties and contradictions the students experience in clinical practice.

Many things in the world have two opposing sides as depicted in the Fables of Aesop (Anthony et al 2006). Many of Aesop's Fables contain elements of moral dualism: *two sides to every story*; *two wrongs don't make a right* (Antony et al 2006). Dualism occurs with regularity in the fantasy and stories of quest that were considered as part of theoretical sampling. Dualism represented by good and evil, creatures and beings that were once kindly, can become poisoned or changed (Anderson 2003; Garth 2011). When Jean Vanier experienced anger and hatred this experience evoked a realisation that his feelings were a reflection of his true self, a person he did not really know and disliked (Vanier 1992). Vanier (1992) states that he needed to be conscious at all times of the darker side of his character and be mindful of the potential negative influence of this other side of his personality. As a mature student, B had personal experience of the less palatable side of health care. Prior to her successful application for the pre-registration nurse programme, B had worked in the community as a carer for social services. Again B shared that she had been appalled by the care she witnessed, but felt powerless to do anything, accordingly she entered nursing to make a difference. As I listened some months later to the audio recording of B's second interview and read the transcript, I wrote the following memo:

> So here B is in what she wanted to so much and in what she has a lot invested...time and emotion and it's no different...the very thing she hoped would save her has become the monster ...this resonates with me from the lyrics of a song by U2 and just now I looked for the lyrics to remind myself ... (WPW in B, Interview 2:12, 29-33: 08/02/11*)*

The analogy of 'monster' has been seen in contemporary health care. One only need consider the cases of the nurse Beverley Allitt (Clothier et al 1991) and the doctor Harold Shipman (Smith et al 2005) to be cognisant that it is possible for a certain type of individual to enter the health care profession. Individuals who would wittingly harm the vulnerable and weak, a potential that is always ubiquitous within healthcare settings as O'Neil (2000:330) warns:

> *"…no guarantees can be given that any doctor, nurse, or other clinician could not if sufficiently determined and perverse repeat Shipman's crimes"*

The omnipresence of malevolence lurked within the findings of this study. It became clear that as the students progressed through each clinical experience they developed an awareness of the type of nurse they would hope to become. The cases of Allitt and Shipman represent the extreme of a continuum between the 'good' and 'bad' practitioner. The students in this study were acutely cognisant of the type of nurse they did not wish to become or by whom they might be influenced or tainted. B articulated this in our first interview after she had shared with me her story of the ward sister who instructed B to remove flowers given by one patient to another:

> *Because… I wouldn't behave like that. And I've realised you don't have to behave like that. Because I realise how important it is to a patient. Because the one with the flowers she was like on her last legs and… she'd wanted a window. She knew she was dying. She never did get to the window, be in the window. And she had her flowers. And I wasn't go to take them away. D'you know what I'm saying? So, er… and experiences of senior staff – they would go and tell somebody, do the dirty or be the nasty one but – you know what I'm saying*? (B, Interview 1. 18: 10-16)

It was during a later reading and listening of K's second interview that a dualism in nursing came to the fore. K was an intelligent and articulate participant. K was able to share with me the two types of nurses she perceived as she came into her third year of the programme. Firstly there was the *'functional'* nurse, who used functionality as a way of coping and preventing burn out:

> *It just – I mean you see nurses who have become functional as a way of coping because they're burning out and you think well what kind of coping mechanism do you have? Are you really in touch with yourself? And, you know, have you really asked yourself recently if this is what you need? Um. Have you asked yourself recently – have you reminded yourself - why you got into nursing in the first place? Cos it will tend to be the older nurses. I think it's a shame that burn out is um… because it gets mentioned so much as something we must prevent in all sort of local and national policies and things so it's almost like it's accepted that it will happen…* (K, Interview 2. 17:6-14)

> *And - the functional nurses are really good at doing things – some things. But I think they'll probably burn out faster than the ones who have managed to come to some sort of sense of self by admitting that there is this intangible side to themselves and their work*. *(K, Interview 2. 17: 33-36)*

K did not see these *'functional'* nurses' as *'bad'* nurses. It was simply that their journey through nursing was inevitable and predicable towards burn out, which made K perceive them as reckless and not 'good' nurses. During the interview K made reference several times to nursing as a religion, so I encouraged her to explore and explain this further. This initiated an image from K of the second type of nurse who thrives on their work:

> *Yes, I mean you do see nurses who are absolutely dedicated to it* [nursing] *and they burn with this zeal like fire and I have to say that I'm never going to be a nurse like that. I'm always going to have to want to do something else apart from nursing – I want to have a life. But some of them do. And possibly because they have become – they've become… they need to have the um approbation; they need to have that positiveness in their lives so they're working towards it. Um but you could say that about anyone who really works in their field towards – you know?* (K, Interview 2. 21: 27-34)

This section from the transcript demonstrates that whilst K was continuing towards her final placement, she was developing an understanding of the type of nurse she hoped to become. Like the other participants K was able to sense two faces of nursing.

Randle's (2001) grounded theory study into the effect of a three-year pre-registration training course on students' self-esteem identified a core category of 'power over' (Randle 2001:285). Randle (2001) observed that 'power over' explained the social processes that impacted upon the students' self-esteem as they progressed through their training. Two categories identified by Randle (2001) are of significance to this study on pre-registration nursing students' awareness of their spirituality. The first is *'nurse power over the patient*' (Randle 2001: 295) which causes the students to experience feelings such as disbelief that are uncomfortable and cause uncertainty. The second is '*moral power over the patient'* (Randle 2001:296), a perception that while they are not formally competent, student nurses intrinsically recognise when actions of qualified staff are wrong and do not sit well with the image of nursing. Randle (2001) affirms that this notion of power in the profession is representative of a self-imposed 'hierarchy' that ensures nursing maintains its status in society. A view supported by MacDonald (1995) and Clarke (2010) who recognise that knowledge of health care brings with it considerable hierarchical power over and within society. The students who participated in this study were cognisant of the hierarchy in nursing. During K's second interview she described the paralleling of hierarchical power in nursing with that of religious practice:

> *I think… it can also be a little bit like a religion because you put on special clothes for it and you're going to a special place and you're obeying a certain set of rules*. (K, Interview 2. 22: 2-4)

Whereas D was able to recognise that hierarchy could determine the extent to which spirituality was recognised as important on the wards:

> *Yea. I don't know. I think it really – it depends a lot on who is working, who it is. And actually I think who is at the top as well. If it's not important to them it's* [spirituality] *not going to come out in the staff*. (D, Interview 2. 47: 25-28)

Although the literary discourse suggests power in health care has connotations with the negative, the articulate K was able to explain how she perceived power as a positive concept. In her second interview K was able to share with me that she felt a sense of purpose and fulfilment. In having a power to help others she was sustaining the growth of spiritual self:

> *Um… and I think in that respect nurses have in a way this – this great power to help themselves develop as people so they can help others because that's precisely what it is. It is helping other people. And I think what is important in terms of its true to say that to help you develop as a person in any area, but developing as a full person including a spiritual side, one of the best ways of doing that is to put your ego to one side and be helping other people.* (K, Interview 2. 16:28-33)

K was still maturing as a nurse and finding her own pathway through the profession. Theoretical sampling revealed that fantasy and quest literature is rife with heroic avoidance of negative influences (Anderson 2003). Similarly the participants in this study were aware of the potential negative influences that power and hierarchy in health care could have over them as student nurses. The previous chapter identified that spirituality was initially hidden. Given the opposing faces of nursing, the participants demonstrated a developing awareness of who could be trusted and who could not, with regard to revealing their 'spiritual self'.

7.5 Revealing spirituality

In later interviews, as the students transitioned through their education into year three, the interpretation process revealed that they became aware of and could identify other nurses who were seen as 'safe'. It was with these nurses that they could share and reveal that which was precious to them, their spirituality:

> *I've met a few other Christian nurses on placement but it's taken me a long time to actually discover that they are and it's only when I've kind of… hinted about my faith… that they've kind of hinted about theirs. It's quite secretive…* (R Interview 1: 5: 8-11)

> *...And she said to me that she quite often walks around the cots at night and prays over the children. And I thought to myself, yea I do that as well but I wouldn't come out and say it because I'd think I might offend somebody. Yea. And she was saying, oh no I, I – once I did actually – one of the mums asked me what I was doing. I said – obviously it must have been visible what she was doing – and she said I just - I just told her. And she was*

> *completely fine about it. But she said to me: I don't know if I would be able to tell that to the senior people I work with. I don't know how they'd view it. And she'd been there for years. And I thought that was quite sad*. (D Interview 2: 6: 30-36 and 7; 1-2)

It seems appropriate to compare the students' experiences of revealing their religious belief in clinical practice to that of 'coming out' as a homosexual. *Coming out* has also been used to describe the launch of debutants into society. The phrase denotes casting off a personal metaphorical cloak to reveal ones 'true' nature (Waite 2009). Chapter 6 introduced the concept of stigma felt by the students who participated in this study, particularly those who professed a strong Christian faith. Goffman (1963) suggests that in the longer term as the stigmatised individual associates himself more readily with the norms of a culture, the less he feels alienated. It was interesting in this study to observe how this normalisation manifested in the participants. Coleman (1982) describes the identity development of homosexual individuals as they progress through to the stage of 'coming out'. Coming out involves the individual recognising that they are in some way slightly different from those around them (Coleman 1982). Coleman (1982) advises that this recognition can cause feelings of guilt and fear, not dissimilar to the findings of this study. Coleman (1982) suggests that to develop a positive self-concept, the individual requires the support and recognition of others. While there are no guarantees of acceptance, individuals at this stage in their identity development, are able to sense how others will respond, depending upon the preceding reactions of others (Coleman 1982).

As the students gained knowledge of their clinical environment and the characters of the qualified staff therein, they were able to sense nurses who were 'OK' with which to discuss spirituality:

> *I don't know what… coz there are certain people I would feel more comfortable – like members of staff – bringing up that conversation with. And the way that they care for their patients – you can tell. (AM. Interview 1: 7: 28-30)*

What was particularly interesting is that students viewed normalisation and identifying likeminded 'safe' individuals as mutually reciprocal between them and the patients for whom they cared:

> *Yea. I think it is a thing you can sense. And I think patients really feel that as well. I think… I definitely believe that patients can tell whether someone's spiritual or not and I think they can definitely tell who they can talk to and who they can't. And I sort of feel quite sort*

> *of honoured because lots of patients have sort of talked with me about that which makes me feel oh I must be approachable to talk to. And I think that by having an open mind about religion and spirituality really helps that because you're not judging them and they feel they can say what they like and you're not going to agree or disagree but comfort them (AM. Interview 1:8: 4-12)*

This reciprocation caused another dimension to the need to protect and shield, thus the category of safeguarding was created. As the students moved through their education they recognised that fear and need to protect impacted upon their role as carers for their clients. During the second interviews, while protective strategies for self were beginning to be reconciled, simultaneously the need to safeguard 'other' became significant in the clinical environment:

> *And this equilibrium. So I'm thinking in hospital – again, when I see the fear of the elderly and the… I mean you can read it every day in their eyes and it's the fear - and it's so awful I can't um – of falling off their equilibrium*. (B, Interview 2.12: 8-10)

> *I think when you're very low psychologically, for instance depressed or upset, and like I said before you can't see the wood for the trees, you're just so enclosed, so self-centred and it… it's a protective thing. It's like the clam closing its shell you know. Go away. Leave me alone. Let me get on with this. But that can become a self-repetitive, vicious cycle in itself. So that helping other people is a genuine – I've discovered - is a really good way of helping yourself* (K, Interview 2. 19: 8-13).

For D, safeguarding the clients in her care from unnecessary harm and knowing what to do was important:

> *They were some really poorly ones* [neonates] *but no, nobody died; oh yea… I was reading the policy one night of what to do if a baby dies and they* [qualified staff] *thought… they said what are reading that for? And I said well it could happen here couldn't it? It could. They said well it's quite depressing having to read that. But I was just interested in what they – in what happened and do they call anyone; it was all written down in the policy that they* [parents] *are entitled to call somebody of their particular faith and, if they want to, they can spend as long as they like with the baby and things like that. Yea*. (D, Interview 2. 38: 11-18)

It was important to D that she knew and understood the proper processes needed to positively support a family if a baby died on the neonatal unit.

7.6 Positive and Negative Safeguarding

Early on in the iterative process after coding the interview with AM I wrote down the following as free writing/memo surrounding spiritual 'burn out' (figure 7:1 overleaf)

Spiritual burn out.
There is something about 'burn out' here. The participants recognise that it is inevitable for some staff (they '*lose it*'). AM seemed to sense it was happening to her…or would happen, and so she put her own 'protective' strategies in place. She has been 'self-sufficient' and sought out support from those that she trusts to give herself some 'protective' armour to enable her to continue…to go on.
She has found an inner self-confidence and ability to monitor 'self' (see resilience) using her own "*self-belief*" system.
There seems to be positive protection: faith/spirituality. But also the students see negative protection from qualified nurses in practice: switching off/detachment…and they are fearful of this as they associate this with not being a 'good' nurse. Back to discussion group 1… good nurses '*have it*'.

Figure 7:1 Memo on burn out

I recognised that the students were trying to protect 'spiritual self' from burn out.

Fundamental to the spiritual safeguarding process is a model of positive and negative safeguarding. Figure 7:2 (overleaf) depicts this model.

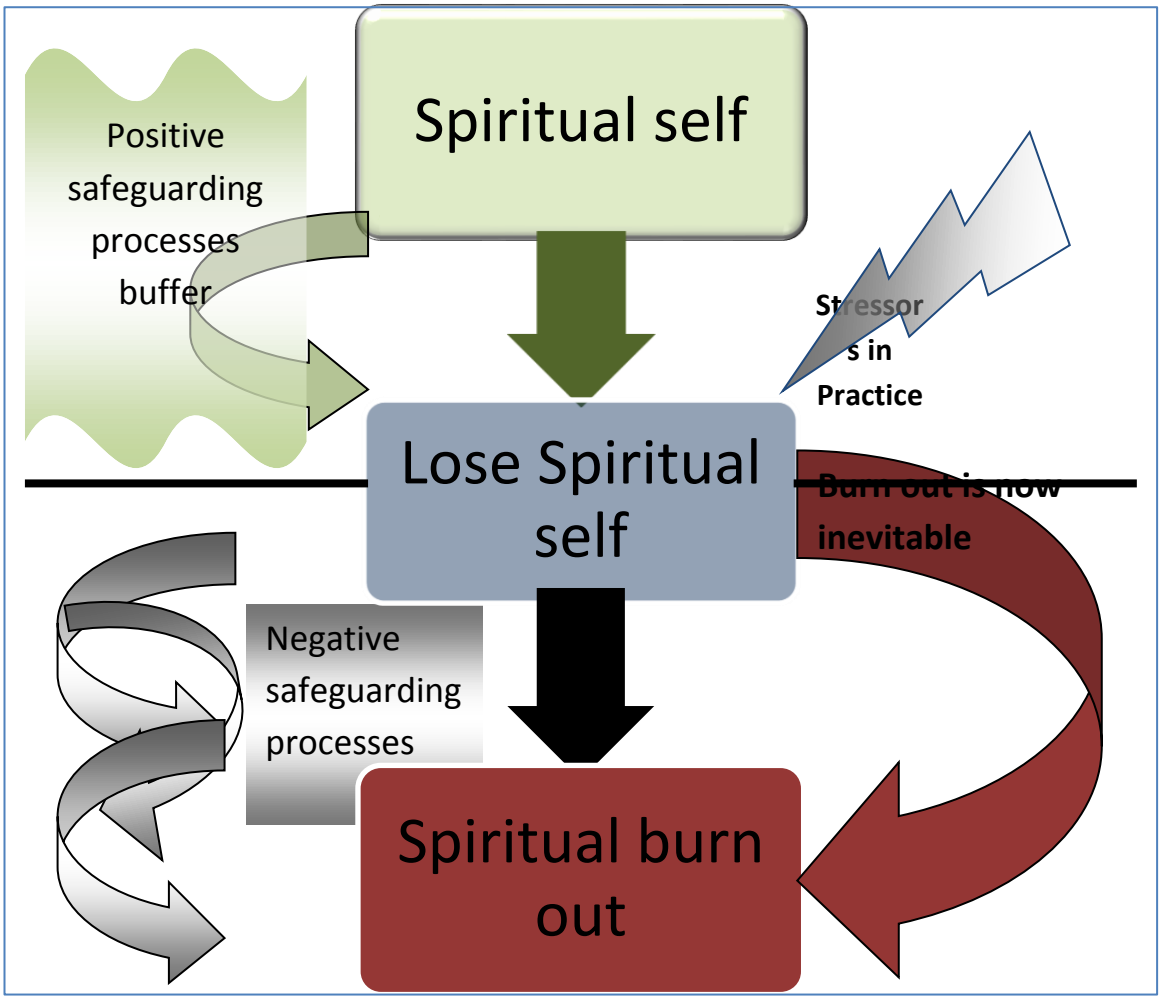


Figure 7:2 A model of spiritual safeguarding processes

The centre of the model depicts a downwards process from spiritual self, through to loss of spiritual self and finally spiritual burn out. There are two aspects to safeguarding of spiritual self, the positive and the negative. The right hand side of the model depicts that without any form of safeguarding the stressors in clinical practice will impact on spiritual self and spiritual burn out is inevitable. The left hand side of the model represents the two sides of a safeguarding process: positive and negative. Positive safeguarding processes such as believing, having a faith and utilising prayer provide a buffer and prevent the individual slipping over the black line and into negative safeguarding processes. While the students initially hide these positive safeguarding processes and struggle to utilise them openly, as they undertake more clinical experience they identify 'like-minded' nurses. This helps the students to develop the courage use these processes. Without this safeguarding buffer, the stressors in the clinical environment will lead to negative safeguarding processes. The 'functionality' described by K, the anger felt by AM

and B. Moreover the loss of spiritual care observed by B and a lack of spiritual respect observed by R in chapter 6. While negative processes offer some initial safeguarding. They are illustrated within this model as a downward spiral. If practitioners do not actively seek out positive processes, in the longer term negative processes will lead practitioners down towards spiritual and professional burn out.

7.7 Summary

This chapter has presented the findings with reference to the participants' continued challenge to complete three years of pre-registration nurse education. This chapter has outlined the complexities of dualism and the opposing elements of nursing care that feed into the emerging category of safeguarding. Safeguarding consists of two sides, negative and positive: the latter being associated with an aspiration and a hope to be a 'good nurse', the former resulting in loss of spiritual identity, hopelessness and ultimately spiritual burn out. The safeguarding category and the BSP it represents holds fear at bay, gives hope and prevents loss of 'spiritual self'. The students safeguarding of their developing spiritual identity as they journey towards the end of their pre-registration programme instigate these processes. The next chapter will explore BSPs connected to seeking these are, storytelling, hoping, developing resilience and being heard.

Chapter 8 : Seeking

8.1 Introduction

This chapter will continue to lead the reader through the journey undertaken by the pre-registration nursing students who participated in this study. This journey involves the Basic Social Process [BSP] of *seeking*, behaviours that help the participants' continuation through to their ultimate goal of becoming a qualified and competent nurse. A good nurse whom, in spite of the dilemmas of the health care setting, has the personal integrity to protect self from negative influence and safeguard those for whom they care. *Seeking* is a recognised element of spirituality (Runcorn 2006; Gillman 2007). This chapter will present properties associated with the process of *seeking* these are: *storytelling*, *hoping, developing resilience* and *being heard*. All of which accumulate to provide resolve to the problems the participants experience and enable them to continue through to qualification. Latterly this chapter will interpret findings concerning the participating students with whom I undertook a second interview. These students are K, B and D. While this chapter occurs towards the end of this body of work, the contents will reflect and revisit earlier occurrences in the study.

8.2 Storytelling

While story telling is identified in this chapter it is a process that I coded early in the data. During initial coding and prior to the subsequent gathering of data via theoretical sampling, I was asked to speak to my peers at a research day about my tentative findings. This required me to return to the participant data and revisit the initial codes. Chapter 6 presented findings to evidence that the students could not define spirituality. As I studied the transcripts from each participant I realised that each contained a narrative pattern. I equally noted that, when a student wanted to describe to me their understanding of spirituality or a dilemma associated with spirituality, they were struggling and grappling for words to explain what they meant. This struggle to explain was always followed by a 'story' from practice, which I coded as the 'defining story'. This process of storytelling

occurred in three stages. These stages are outlined below in tabular format from the transcripts of R and B (tables 8:1 and 8:2 overleaf).

The first stage of the process was 'struggling to articulate' and I could sense in the students an accumulation of frustration and uncertainty. Frustration that they could not articulate fully what they wanted to explain and uncertainty that what they were saying was going to be acceptable to me as researcher.

The second stage involved this accumulation 'gushing' forth as a story told from clinical practice. This storytelling involved an incident or occurrence the student as storyteller had witnessed or experienced in the clinical environment. The story was mostly associated with the negative. Sometimes this storytelling was long, complex and filled with dilemma, as can be seen in the process as applied to R in table 8:1 (overleaf). Other times the storytelling was short and factual, associated with defiance and determination as seen in a section of a transcript from B (table 8:2 overleaf). For D the student who had converted to Christianity her storytelling surrounded sadness, poignancy and the confusion she felt. For AM the young student who was on clinical practice in the Intensive Therapy Unit [ITU], her story concerned anger and frustration, whereas J's story had surrounded trying to do the 'right thing' for a dying patient. Remen (1996) advises that every individual's story is the unique property of the teller. Regardless of the reason for the story, during this second stage each student appeared self-confident and assured: this was 'their' truth, their experience. Once the defining story was told, the student would pull back, becoming tentative and uncertain again. They would then 'check' with me, asking me if I knew what they meant and testing to see if I had 'got it'. This was the third stage that I describe as seeking affirmation.

Table 8:1 R's Storytelling

R's Dilemma	Stages
But I do find it's quite lacking, um, on the wards, like it's not really the sort of thing people discuss and um, there's a Liverpool Care Pathway and there's this whole spiritual section which normally is left blank and I struggle [W1] with that because I don't feel like I have been trained to kind of go through that section with patients [W2] but, um, to me that was the most important thing on the pathway but it's not usually addressed. Um, yes. So I just kind of want to learn a bit more about that.	**[W1]Trying to make sense "struggle"** **[W2] Uncertain/unsure**
But there was one patient on my first placement who had liver cancer and who refused treatment because God had told her she was going to be healed and I mean – I saw her for about a month and her jaundice initially was – she was fluorescent yellow; before she was discharged and she was almost like the right colour and… she hadn't had treatment [W1]. Um, but I found that a lot of – I don't know if I should say this [W2] … but a lot of the nurses didn't respect her because of that decision that she'd made	**[W1]Defining story** **[W2]Apprehension about questioning what she has seen**
Well, um, I mean Christianity has got a lot of stick, mainly because the church tends to fight kind of evolution and science which I think is a big mistake because there's a lot to prove evolution and science - life science obviously. Um, and I think because they are so separate, because the church fights science and science always tries to prove evolution which disproves the world being made in seven days or whatever, um, then they have just become separate and science has a lot more respect I think. Yea... Um… Maybe I should research it more because I mean doctors have seen miracles happen – it is kind of a recognised phenomenon isn't it… miracles [W1] ?	**[W1]Seeking affirmation**

Table 8:2 B's Storytelling

B's determination	Stages
Because… I wouldn't behave like that. And I've realised you don't have to behave like that. Because I realise how important it is to a patient.	**Trying to explain**
Because the one with the flowers she was like on her last legs and… she'd wanted a window. She knew she was dying. She never did get to the window, be in the window. And she had her flowers. And I wasn't go to take them away	**Defining Story**
D'you know what I'm saying?	**Seeking affirmation**

The length of the storytelling process differed between the students, depending upon the extent to which the adverse emotional impact the event they were describing had upon them. The more I considered this pattern, the more it appeared to represent the pattern of a 'wave' (figure 8:1 below). Without exception as I analysed each one of the transcripts from the first round of interviews 'the wave' was revealed, to the extent that I could anticipate the pattern's arrival within the text.

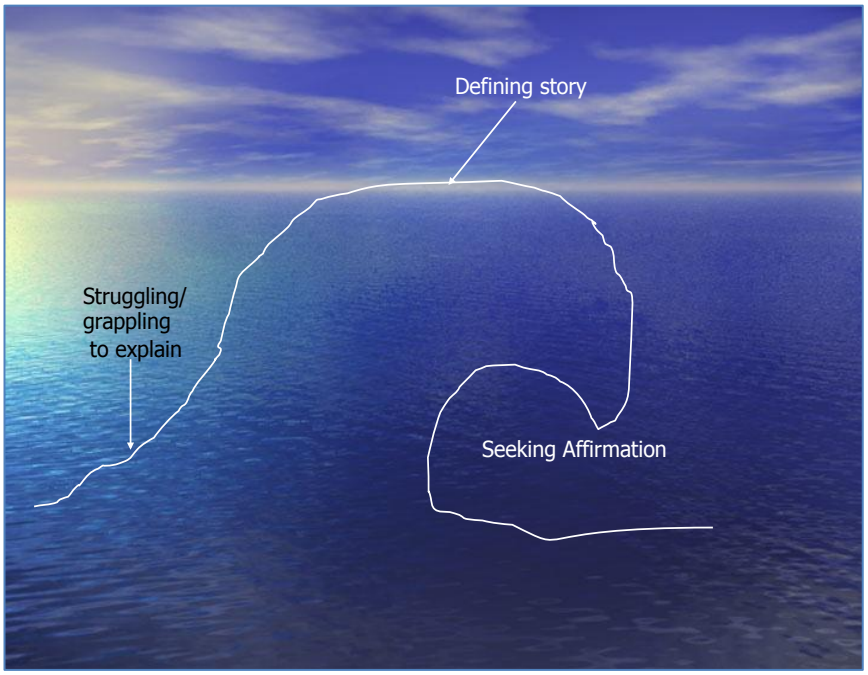


Figure 8:1 The Defining Story Wave

This wave became symbolic and representative of the participants' struggle to 'make sense' of their own feeling associated with spirituality. Sometimes the wave was huge, like a great tsunami, other times it was smaller. As the study developed I continued to look for the wave, and as I did I noticed a change in the pattern of the wave as the section below from a memo written in September 2011 as table 8:3 overleaf illustrates.

Table 8:3 Memo concerning the wave

In the first sets of data there were completely opposing beliefs between the students and their perceptions of the healthcare environment and profession they had entered and this was particularly noticeable in the students who had a strong Christian faith, what they thought they were 'called to' bore no resemblance to their experiences in the first 18 months. As they progress through their training the spiritual dissonance that I identified early on does lessen, they do adjust... Their stories are so significant in those first early days ...like the huge Tsunami I identified very early on in my analysis...These stories come like a great I wave of water, engulfing them and me, so powerful and emotional are they in their telling. *As the data develops these stories become less powerful, they still hold meaning but instead of leaving emotional debris when they retreat, there is more clarity in the meaning the student is trying to convey...like sand left smother when the tide has gone out.* [WPW: Memo on co variance. 09/11]

Stories and narratives are often used as data in phenomenology research. The method involves analysis of part or all of the text of a story and then comparing text to text to discover meaning from participants (Pursley-Crotteau et al 2001). At this juncture in presenting the findings of this study, I must make clear to the reader that it was not my intention to derive participant meaning from the content of the stories. In keeping with the premise of grounded theory what was of interest was the pattern and process (Glaser 1996) of the storytelling. Cognisant with grounded theory the hypothesis at this point is to explore and explain the purpose of the storytelling; why were the students telling me their stories?

Storytelling or narrative is a communication process intrinsic to human being and requires at least two persons, the teller of the story and the recipient of the story (Taylor and White 2000). Throughout history, humans have told stories to other humans, young and old alike. People tell stories to warn, stories to guide and stories to entertain, to the extent that storytelling has been correlated with the cultivation and totality of modern society (Salmon 2010). As far back as Grecian times, Aesop, a legendary Greek slave who became a Greek philosopher used storytelling to describe the moral dilemmas in life (Antony et al 2006). In the New Testament (New Revised Standard Version 1997) Jesus uses parables to help early followers to understand the principles of Christianity. Stories are used to explain the unexplainable and to make that which is complex and wholly personal easier for the recipient of the story, the listener or reader, to understand (Remen 1996, Frank 1997, Taylor and White 2000).

Chapter 8: Seeking

On sampling the literature I discovered the process of storytelling associated with healing and reconciliation had been well documented (Nouwen 1979, Remen 1996, Frank 1997). The work of Arthur Frank (1997) analyses the stories of those who have experienced illness and those who are journeying through illness. Taylor and White (2000) assert that storytelling follows a designated process: a beginning; a situating of persons and objects involved in time and place; a narrative of sequential events; and, finally a conclusion or indication that all is not resolved. Frank (1997), having himself experienced cancer and heart disease, claims that this is not always so. According to Frank (1997) there are three types of storytelling that can be attributed to individuals' experiences of illness and dilemma. The first is the "*restitution narrative*" (Frank 1997:77) in which the teller reflects that all was well, now it is not, but soon things will be better again. These stories portray the event concerned as an interruption in life, rather like the interruption of a television broadcast, a state of 'normal service will be resumed shortly'. This pattern of storytelling did not fit with the stories told by the students in this study. Their storytelling was not concerned with restitution; the Tsunami stories gave no sense that any positive normality over the negative could be gained. The students were frightened and fearful and nothing made any sense to them. The students' negative storytelling was more reflective of Franks (1997) second type of stories: "*chaos stories".* Frank (1997:97) suggests that chaos stories do not contain any '*coherent sequence.* Instead describing these stories as '*anti-narrative'* a lived experience played out in a tumble of words (Frank 1997:98). Interestingly, Frank cites an extract from the research of another grounded theorist, Kathy Charmaz (1991) as an exemplar of a chaos story. The full process of chaos storytelling is not evidenced by this citation, or Frank's (1997) discussion leaving the reader to ponder what came before the telling and what was left behind after the story was spent.

The findings of this study reveal that in telling me their chaos stories, the participating pre-registration nursing students were *seeking* to make some sense of order out of the chaos. The internal chaos the students felt had to be ousted and revealed to me was the reason for the telling: a confused recollection of events and feelings. Once the story was spent the students looked to me to 'check' that the telling was acceptable and that I understood. In turn, I responded with body language and vocalisms to encourage, to

comfort and to probe further. While this study is not an action research study, grounded theory explains what is happening in the data. In doing so, the students' chaos stories can be further explored and explained. Thus, this body of work can present them as the third type of story identified by Frank, that of '*quest*' (Frank 1997:115). Quest stories indicate to the listener or reader that as a result of the experience, the teller has gained something, that all is not lost, that there is still hope. This was evidenced in the stories told by K.

During concept development (section 5.3 of Data Analysis) I highlighted the significance of identifying negative cases that can refute an emerging hypothesis (Schreiber 2001). Initially I thought all the participants' storytelling was related to detrimental experiences. The only student for whom storytelling did not adopt the pattern of the wave was K. When I returned again to the data as part of constant comparison I identified the stories told by K were full of humour and positivity. Unlike the other students participating in the study, K's storytelling always was connected to, and explained, something good and positive that had happened in the clinical environment. K's storytelling pattern was different, throughout Phases 1 and 2; K's stories were upbeat, often contained humour and caused her (and me) to laugh:

> *And sometimes things, silly little things, can happen which just sort of light up your day making the most ghastly placement so much better. I think about a lady on one of my wards – a very confused lady, an older lady, she was always tottering off, wandering here, there and everywhere (laughs) and at one point one day we were going to tag her or something just to find out where she'd gone. Um, and then one of the senior HCAs brought in a teddy bear that she'd seen in one of the shops and that was it; after that everything was focused on the teddy bear for that lady. We thought it was fantastic. She was – it is a perfect example of an object lesson learnt, to have something for the patient to focus on, especially if they are confused and need that kind of focus but it just made everyone smile to see her talking to her bear and tell her bear off, and feed her bear and mothering her bear. Everyone on the ward thought that's so good, so cool.* [Group 2, K, 8: 11-25]

Finally Frank (1997:137) suggests that many stories stand as *'testimony'*. Roget's Thesaurus (Kirkpatrick 2000:167) places the noun 'testimony', under the classification: '*Intellect: the exercise of the mind, materials for reasoning'.* Verbs associated with testimony are evidencing, demonstrating and substantiating. While chapter 7 highlighted negative aspects of the clinical environment that were associated with stress and burn out, other research identifies positive experiences associated with practice (Stockhausen

2005). Comparable with the findings of Stockhausen (2005), K's storytelling stands as testament that all in nursing is not bad, that there is hope. K's story was evidence of her ability to see hope in the smallest of gestures and the most bizarre of stories, as this very long story demonstrates:

> *I think because even if you haven't really got it – like when MAU was very busy and you're feeling really grotty – you might have one or two shifts in a row when you go home thinking oh my god. But then the universe seems to chuck up something nice for you – someone says thank you, you manage to make a bond with a bit of banter with a patient; you can share a joke with someone. Or even better the hectic bit gets over and… I think the last night of that run… somehow the bed management – the bed managers had been working like rats to try and get everyone in and they managed. And we were all kind of sitting there looking a bit shell shocked at the nursing station. But that's when we realised it was over (laughs). Just for the time being. All the patients were actually asleep and everyone who should be somewhere was somewhere and there aren't people breaching in A&E and there aren't people in the corridor. It's like, phew, we did it. What all these things have in common is a sense of um triumph. And I think humans want to work towards triumph because it's a… it's a sense of something having been done, mustered and achieved. And achievement is a really good way of bolstering your confidence about carrying on.* [K, Interview 2. 19: 27-37; 20: 1-5]

As I read this extract, I focused on the words 'carry on' and theoretical sampling took me to the lyrics of the song, 'Hero' by Mariah Carey (1993):

> *And then a hero comes along*
> *With the strength to carry on*
> *And you cast your fears aside*
> *And you know you can survive*
> *So when you feel like hope is gone*
> *Look inside you and be strong*
> *And you'll finally see the truth*
> *That a hero lies in you*
> (Carey and Afanasieff 1993)

I wondered how K had come to this point, why was it that in adversity she had the ability to remain positive and to carry on when her peers were still struggling. K's stories were concerned with optimism, as opposed to her compatriots' stories of adversity. Like her peers she used storytelling to place me, the listener, in the here and now of her experiences. For the students who participated in this study, their storytelling was a method in which and through which they were *seeking* a way that enabled them to carry their hope, hope in life for the present, and hope that was integral to their spirituality. The students sought to use their stories and the storytelling process as symbolic, a

medium by which as individuals they interpreted and sought affirmation of their meanings (Blumer 1969), meanings that linked personal spirituality to hope.

8.3 Hoping

As I was undertaking my analysis I discovered that when the participants were struggling to explain spirituality. They were actually talking about hope, the frustration and hopelessness they experienced, particularly during their first year as articulated by A:

> *...but it's really hard if you've never experienced that, if you've never lost anybody or you've never lost like a limb or something coz I had a patient who just had an amputation and I was thinking I've no idea how to relate to that feeling so...* (A, Group 1. 5: 5-8)

The students expressed a realism of 'hope' for the present and the future as identified in this excerpt from AM's interview:

> *...being a nurse has changed the way that I live my life because, you know, it makes you realise how precious life is and how quickly it can be taken away from you. And how your family relationships are so important. I think when you're seeing that every day and you see some people with regrets – patients who have regrets or relatives with things they should have said or done, then it makes you think well at least if I stick by that rule now hopefully I won't have those regrets [laughs].* (AM, Interview 1. 30: 6-12)

Finally, the students articulated hope in their aspirations for themselves and the profession, all that they 'hoped' to become.

> *I hope when I finish this – if I get through – I don't want to be… I would really like to be in somewhere where it's trying to sort this problem* [lack of care in nursing] *out.* (B, Interview 2. 17: 34-36)

> *I would hope that I can from now and over the years as I'm working learn how to recognise defencelessness as opposed to just sort of calling on my strengths*. (K, Interview 2. 1: 1-3)

The concept of hope and hoping was evident in other data I sampled. While writing, and shortly after the holiday on the Isles of Scilly, I received an email from Mrs. P, the lady whose husband had been unwell:

> *How is your thesis going? I said I would pen a few words for you and here they are: -*
> *I qualified as an SRN at a London teaching hospital in the early sixties. The system was very hierarchical and during our training, we would often be anxious or even frightened as to whether we could cope with the next challenge. However we were young and lived in a nurses home, so there were always friends around with whom we could empathise, which was a great help in enabling us to come to terms with our lives. I do not recall any formal system for helping nurses to cope with traumatic situations. (Mrs. P, personal correspondence 26.07.12)*

The words 'empathise' and 'hope' both occur in Roget's thesaurus (Kirkpatrick 2000:309) under class six*: emotion, religion and mortality*. Mrs. P was explaining to me that fellow nursing students provided supportive friendships and hope in each other's lives. *Hope* is integral to definitions and discussions surrounding spirituality in health (Carson 1989; Bradshaw 1994; Ross 1994; 2002; 2006; Greasley et al 2000; McSherry and Ross 2002; Meyer 2003; Narayanasamy et al 2004; Narayanasamy 2006; Speck 2004; DH 2010; McSherry 2010). In nursing theory an aspiration of 'hope' has a connectedness to the spiritual (Travelbee 1971; Watson 1985; Eriksson 1987, *cited in* Lindstrom, Lindholm and Zetterlund 2009; Parse 1999). Hope is an integral element of human development providing meaning in life (Stephenson 1991) and enhancing psychological wellbeing and healing (Morse et al 1995; Deegan 1996). In addition:

> *"Hope prevents us from clinging to what we have and frees us to move away from the safe place and enter unknown and fearful territory"* (Nouwen 1979: 77)

Bradshaw (1994) acknowledges that in the context of Christianity, hope and spirituality are intrinsically linked, predominantly in association with resolve, salvation in death and a life thereafter. Ainsworth-Smith and Speck (1982) articulate this link between spirituality and hope more gently; stating simply that hope of life after death requires hope in life for the present.

In their 1995 paper '*Delineating the Concept of Hope*' Morse and Doberneck identified distinctive patterns of hope, associated with life changing events. Morse and Doberneck (1995:279) selected four client/patient groups, for which 'hope' played a significant, but differing, role in envisioning the future. These groups were: *patients waiting for heart transplants, spinal cord-injured patients, breast cancer survivors and breastfeeding working mothers*. Each group's experience of 'hoping' was placed alongside seven '*conceptual components of hope'* as detailed in table 8:4 (Morse and Doberneck 1995:281).

Table 8:4 Conceptual Components of Hope (Morse and Doberneck 1995)

1	Realistic assessment of threat or predicament
2	The envisioning of alternatives and setting of goals
3	Bracing for negative outcomes
4	A realistic assessment of personal resources
5	The solicitation of mutual supportive relationships
6	The continuous evaluation for signs that reinforce the selected goals
7	A determination to endure

In their discussion Morse and Doberneck (1995) identify patterns of hope associated with each individual group. Stating that several factors, including the onset of illness or personal resources such as time did not alter four patterns of hope they identified. These were: "*Hoping for a chance of a chance, incremental hope, hoping against hope and provisional hope*" (Morse and Doberneck 1995:283). Closer examination of Morse and Doberneck's (1995) study revealed that the ordering of conceptual components identified did not appear to fit within the phenomenon of spirituality and the category of *hope*. The crux of my dilemma with the work of Morse and Doberneck (1995) is that it did not account for what was happening to the participants' awareness of spirituality when the hope and 'imagined' is unrealistic and/or fails to deliver, becoming instead antonym: the 'unimagined'. In Morse and Doberneck's (1995) study 'threat' became a starting point for a journey of hope towards an imagined goal. Yet, this is in contrast to the findings from my study, which indicate that for the participants, hope was continuously under threat by the unimagined, unknown and unpredictable context of nursing. Travelbee (1971) advises that trust in another is an essential element of hope. Carson (1989:195) suggests that hope requires an expectation that there are significant elements of trust that can be called upon in times of need. Elements that include '*spiritual and human relationships*' that enable an individual to feel they are '*not alone*'. Deegan (1996:91) suggests that when people are losing hope they develop a '*hardened heart*' as a strategy for 'carrying on'. Deegan (1996) goes on to suggest that 'hope' is an essential survival mechanism. When there is 'no hope' then survival is put at risk.

Chapter 8: Seeking

My findings indicate that the participants had to continually struggle to readjust their personal awareness of spirituality and align it with a new identity of 'self as nurse' to maintain hope, particularly in response to the threats posed to their hope to become a good nurse. Their struggle initiated safeguarding processes to protect spiritual self and hope as they negotiated their way through clinical practice. This required participants to develop an awareness of influences that might impact negatively upon their spirituality, cause them to lose hope and impact on transition to qualification. Deegan (1996:95) advises that in mental health when a nurse comes into contact with a patient who has lost all hope, the nurse's role is to '*role model hope'* and to provide hope for the hopeless. Erickson et al (2010) defines role modelling in nursing as planning and implementing interventions that are unique for the client. Role models have complete acceptance of the individual, who they are, and where they are in their development. Role models gently nurture and facilitate personal growth in the individual, at the individual's own pace. My findings indicate that the participants struggled to seek out and identify role models in the clinical environment. Role models for spirituality and hope were not overtly visible amongst the qualified nurses, possibly because potential role models preferred to remain hidden to avoid being negatively judged (as discussed in chapter 6). More concerning is the possibility that qualified nurses who might have previously 'role modelled hope' and interpreted spirituality to pre-registration students have hardened their hearts and 'lost hope' as a protective mechanism to prevent burn out. Chapter 7 revealed that the participants were acutely aware of this. Hence, participants would attempt to seek out positive experiences and a vision of the nurse they would aspire to become. While I have argued that the conceptual components of Morse and Doberneck (1995) are not easily reconciled to explain the connection of hope to spiritual awareness of pre-registration nursing students, the final component, *'a determination* [seek ways] *to endure'*, was evident in the participants throughout the study, particularly in storytelling.

I am going to apply the analogy of carrying a bowl as a comparison to explore and return to the concept of *seeking* through storytelling in more depth. This association is derived from the practices of Buddhist monks. It was my brother, an Anglican Vicar, who drew my attention to the notion of the Buddhist bowl. As I was writing up my findings, my brother went through a particularly traumatic and chaotic personal crisis. One day during

supper at the kitchen table, my brother announced that he felt like a Buddhist monk who had had nothing but rubbish put in his bowl. I looked at him surprised, "*then give it back*," I said. *"I cannot,*" was his blank, sad and 'hopeless' reply. Buddhist monks carry a bowl, which is the most important item in their daily lives. The bowl is used for the collection of 'alms' offerings of either money or food from local people (Baroni 2002). Whatever is given must be taken with gratitude, even if it is of poor quality and not what was truly desired (Baroni 2002). Like my brother, the student participants whose storytelling was associated with the negative, carried adversity in their bowls, stories of dilemma, of defiance, of anger, sadness and uncertainty. In the early interviews that contained Tsunami storytelling, the students' only hope was to have me look in their bowls with them as they figuratively said, '*I know its rubbish, and its heavy, but can I make use of it*?' K on the other hand was able to symbolically say, '*look at the quality I have found in my bowl, even if at first I thought it was rubbish, how light and easy to carry is my bowl*'. While searching for data concerning storytelling, I came across the dialogue of Rachel Remen, an American physician whom, like Frank, has faced life changing illness, that has impacted upon her professionally as well as personally (Remen 1996). Her first book is called '*Kitchen Table Wisdom'*, and the title is derived from the following passage:

> *'My mother was a woman who was full of stories. As a public –health visiting nurse, she had sat at many kitchen tables, drinking tea and listening' (Remen 1996: xxxi)*

After reading these words, I remembered something K had said in one of the interviews regarding her experiences in a community placement. I returned to the data and found what I was looking for:

> *Uum. It felt more like I was actually working as a person who could put that* [fear] *to one side for the time being because I'm feeling a lot less intensely challenged by the environment I'm in because I can sit down at their kitchen table with them and talk with them. Which – you don't have time to really sit down and talk with someone on a busy ward…* (K, Interview 1. 13:28-32)

From my primary contact with K in the second focus group and throughout my interviews with her, I came to realize that for K 'hope' came from her pagan beliefs and her contact with other people. This belief, as evidenced in her picture of 'Divinehood' (chapter 6), is that each person is inherently held protectively through Mother Earth and Father God. In

the data gleaned from the students participating in this study, it was only K's who gave some indication of mutual support between nurses and with this, hope. K carried hope through her storytelling, telling the stories of herself as nurse and the stories of those she met as she journeyed through her nurse education. Hope for K provided a spiritual resilience that had been cultivated in her long before she had entered the nursing profession. K shared this resilience with me as an artefact in an email following the second focus group (Appendix 7). Storytelling about her personal positive spiritual experiences of nursing further sustained K's hope, helping her make sense of her situation and the situation of those around her.

8.4 Developing resilience

The positivity of K's stories indicated that she came into nursing with some resilience. K was able to reconcile her spirituality to nursing, to see that all was not lost, that the profession was not 'hard of heart'. If telling stories that contain positivity and hope are a process that provides resilience, what then happened to the other participants and that which they carried in their bowls? What are the processes they undergo for them that develop resilience? Chapter 7 identified the safeguarding behaviours undertaken by the participants. Developing resilience is a property that emerged from the codes associated with support and sustain and the gerunds supporting and sustaining. Support and sustenance are essential in carrying on and moving forward. The concept 'resilience' is a noun associated with resolve and spirit (Kirkpatrick 2000). Resilience is described by Clarke (2010:187) as '*a capacity for adaption that is the result of a complex, dynamic process involving a variety of internal and external factors*'. The findings of this study have demonstrated the complex and dynamic basic social processes associated with pre-registration nursing students' spiritual journey through three years of their educational programme. Basic social processes that involve struggling to define spirituality, identifying spirituality, preparing and coping, protecting spirituality, safeguarding spirituality from loss and seeking hope. These processes are evidenced within the telling of stories, which serve as a metaphorical vessel in which and through which the participants carried hope.

In chapter 7, I expressed to the reader the personal bias I had to overcome to analyse the transcripts of my first interview with B. My second interview with B was no less challenging than my first. To our second interview B brought with her a multitude of papers about spirituality and nursing care. B announced that that she had been thinking about spirituality and that it was not objective, it was subjective. The following is the extract from the start of a long and lengthy interview transcript and the field note/memo undertaken on the first read through and check of the transcript:

> *B: …and hence it is so difficult to audit or explain or... That's my feelings about it. And so I've got a lovely thing that I've found in writing here and I've got the people who quoted their names as well.*
>
> *W: Right.*
>
> *B: I thought you might like me to read it out.*
>
> *W: Yea. Go on. Do.*
>
> Memo: At this point I remember thinking 'oh no' again feeling slightly irritated that B 'felt' she had to explain to me...this is the thing with B and me and the interview process...see interview 1...its like I'm thinking 'stop will you B...I am the researcher and I do the asking'. (B, Interview 2. 1: 16-29)

B then proceeded to read me extracts from many articles and papers she had found that related to spirituality. Significant in the transcript of this interview, is not the dialogue of B, but the memos and notes I had made when re-reading the interview transcript and listening again to the audio recording as a part of constant comparison. These memos demonstrate that I could now see beyond B's voice and words and understand what she was trying to do:

> What is now so interesting is that while I was aware of the writings of Carson at this point I had not specifically sought her theory out to use in my own work...what is interesting is that I called on her work to explain the diverse nature of spirituality in chapter 1 of my interim report to help me explain and to enable me and other to recognise exactly what I meant...here it is clear that B was doing the same...searching for meaning (WPW, in B, Interview 2. 13: 20-25)

The first half of this second interview with B continued in this same manner. B trying to explain and retuning again to more of the research papers she had brought with her. When B had finally finished reading me extracts from all the papers, she said the following:

> *Um. The reason I sort of did the nursing was to actually make a difference; you know, have a … have a qualif – a profession. So that I can make a difference.* ***Not*** [emphasis added] *to go into a ward and run round after um, you know, but I don't know how to get there. That's been my problem and I – I'm disillusioned in how to get there. Because… well, I want to be able to speak up. I need… That's why I'm so into this research and stuff on this stuff. But I haven't got the eloquence – I'm not one of these er great communicators and very eloquent and… That's my downfall in life. You know some people just have it in trumps* [laughs] *but I'm just trying to get all my facts because I think it's such an important issue.* (B, Interview 2. 27: 33-36; 28: 1-5)

As I have substantiated previously, B had much to lose if she was not successful in completing her nurse education, earlier in this second interview she hinted at this:

> *…and now I'm trying desperately to get my facts and figures together. Because that's been one of my things in my third year – I got to my third year and I don't know if it's my age or my culture (I come from Africa) but …er… its* [spirituality] *sadly lacking*. (B, Interview 2. 5: 25-28)

MacVicar (1998) investigated student nurses' and midwives' experience of research in practice. At the commencement of their education, MacVicar (1998) identified that student nurses and midwives had not anticipated that research would be of any relevance for the tasks they were expecting to learn. Nurses and midwives had no conception of how research and evidence would be required in their chosen profession (MacVicar 1998). As the student nurses and midwives move through to year three of their education, they expressed equal disbelief that they had been so naïve as to not see that an understanding of research was essential in their clinical practice (MacVicar 1998). MacVicar (1998) identified that in year three the participants' appreciation of research fell into three typologies, dependent upon the students' level of intellectual development. These typologies are described as '*mergents, initiators* and *visionaries*'. *Mergents* value and have rudimentary intellectual grasp of research as related to ethical issues, they utilise research for assignments but do not initiate research. *Initiators* value and introduce research informed activities. The understanding of the initiator is greater than research awareness, meaning research is used as a 'yardstick' to measure clinical practice (MacVicar 1998:1309). *Visionaries* sit at the highest level of intellectual grasp demonstrating creativity vision and a desire for exploration that uses research (MacVicar 1998). If I apply these typologies to B at the time of our second interview, I would describe her as on the cusp, somewhere between *mergents* and *initiators*. A more fitting typology to reflect B's intellectual development and personality at that time would be the

'frustrated initiator'. Seeking and searching are natural and instinctual human occupations connected to the spiritual (Clark 2000). As a 'frustrated initiator' B was seeking to use research to make sense of what *should* be happening in the clinical environment, research and evidence that will become for her 'facts', truths and testimony regarding spirituality and nursing. All to be placed in B's metaphorical bowl affirming and evidencing that it was acceptable for her to feel the way she did. For B this bundle of papers was a new story she had sought out for the telling. In these papers, she identified hope. Hope that this evidence would support her aspirations as a qualified nurse. Often out of chaos and stress comes hope and resilience. Eustress is the term used to describe the positive reactions to stress. Responses that include heightened awareness, focussing of attention and rapid response (McVicar 2003). Gibbons et al, (2009) advises that eustress, or positive stressors, can enhance the learning experience, enabling students to identify coping strategies and, in turn, contribute to resilience.

In consideration of the environment and the impact on an individual, Garbarino (2001:362) suggests that while negative influences may reduce an individual to incapacity, positive, or '*salutogenic*' effects, can enhance cognitive development. Garbarino's (2001) discussion focuses on the effects war can have on a child's cognitive development; the extent to which war might develop resilience, or consume children in the violence, resulting in the child becoming part of the destructive pattern (Garbarino 2001). Chapter 7 explored the concept of safeguarding processes to protect spirituality. While pre-registration nursing students are not children, as explained previously, they enter the profession as novice, naïve to the expectations and experiences of the profession. Garbarino (2001) advises that children build 'social maps', containing elements of dualism as discussed previously, whom to trust and whom not to trust. External forces shape these social maps as do the child's internal sense making abilities. Similar to the adaptation processes in traumatised children described by Garbarino (2001), the student nurses participating in second interviews in this study were gaining resilience by using adaption processes. These processes included storytelling and seeking evidence to make sense and reconcile their experiences of clinical practice with personal spirituality and hope.

There was one further process undertaken by D, the participating student who had converted from Sikhism to Christianity, relatively recently in her adult life. I explain this process as homecoming. When D and I first met during the second focus group, she let it be known that this new faith was important to her, as were the rituals such as praying the practising of this faith involved. Below is a section of the transcript from focus group two. This section contains memos integrated during revisiting this transcript following analysis of the first interview with D some months later:

> *W: If you, D couldn't, you couldn't pray – how would you feel if you couldn't do those things?*
>
> *D: I don't think I could be myself.*
>
> Memo: D was very clear here and almost exasperated at the thought…being her 'self' is important to D and I wonder if this is why in the one to one interviews she became so distressed…not being 'allowed' means to D that she can't be herself …so 'self' is somehow altered, changed, made vulnerable by the circumstances she has found herself in se below…
>
> *W: Right.*
> *D: I don't know, how would I feel if I couldn't do those things? It's hard to say isn't it?*
> *W: But you've actually….*
> *D: You wouldn't be yourself at all.*
> *W: That's interesting you say that.*
> *D: Yeh. Its part of the way I am - the way I'm made up.*
> *W: Yeh*
> *D: And if I couldn't do it? I don't know – I don't think I'd want to do the job if I couldn't do it.*
> Memo… [See D interview 1] so this would explain further about D's distress…the 'job' she was called to do …stopped her from being 'herself' the very thing 'self' was called to became the threat….the protector becomes harmed?? (Group 2. 18: 2-24)

Following the focus group, during my first interview with D she became very distressed. D's mother had recently died during the time D's clinical placement was with children's oncology. The combination of personal grief, the traumatic experiences and suffering D witnessed in the clinical environment had a most overwhelming impact upon D and her view of 'self':

> *W: I think it was you who said in the discussion group, what would I do if I couldn't be myself?*
>
> *D: Yea. That's true. That's why I find it quite hard when you're – when you're on placement. I think perhaps if I knew I was there and that was my job I would be different. I*

> *still find it quite hard you can't totally be yourself when you're on placement.* (D, Interview 1. 25:16-19)

During this interview D would well up and cry. I felt ethically bound to temporary halt the audio recording and eventually stopped the interview prematurely. I found this interview extremely poignant and I began to despair at the nursing profession. It seemed to me that nowhere in a caring profession could this quiet, kind and unassuming individual seek solace. Even within the context of her newfound faith she was struggling to accept why life was playing out for her in this way. I worried that this emotional turmoil would consume D and that she would not make it through to the end of her education. Davey's (2002) paper '*Nurses eating nurses: the caring profession which fails to nurture its own*!' was of real relevance to D's predicament. Instead of other nurses devouring D it seemed that D was at risk of being engulfed and swept out of nursing by the whole health care system. Likewise, Deegan (2000) suggests that the dehumanising experiences of restraint, stigma and exclusion of individuals with mental illness breaks their spirit. I became concerned that D's 'spirit' was being broken by her perceived exclusion of Christianity from the 'caring' profession that 'called' her and that she would 'lose hope'.

I was pleasantly surprised when some months later D came forward for a second interview. As a student nurse who would specialise in child health, D had undertaken more community placements than the other participants. By the time we met for the second interview D was well into her third year and had undertaken another community placement. It was clear that D felt more 'at home' in the community environment:

> *Yea. I think it is as well. Yea. It is um… yea. More definitely in hospital, yea, people come to talk to you. They see you in a uniform and they think that you're a nurse and you know what's best. I think most people – most parents – probably feel like that. And I think when you're in community it – you sort of like can fit in more with the patients –not patients - with the clients you are working with.* (D, Interview 2. 19: 31-36)

I also noticed a tentative increase in D's confidence: she was becoming braver. Within her church, D now belonged to a 'home group', a place where in confidence and safety she could share her thoughts and feelings:

> *That* [home group] *helps. Yea. It does. And also there is – you know when you talk to friends. Not all the people I know, obviously –they're not all Christian – everyone I know, but… most of my close friends aren't but… they know I am. You know like when you don't know somebody really well and they keep saying something that you find quite offensive –*

> *I used to find it hard to say, to tell them but I find that I can now. And they're not offended whereas I was always worried I was going to hurt their feelings* [laughs]. *But actually they're hurting mine by the words that they choose to use.* (D, Interview 2. 25: 4-11)

D also disclosed that for her Professional Development Experience [PDE] she wanted to visit the hospital chaplaincy. This was because in clinical practice, even in children's oncology, the Chaplaincy service had not been visible to D and she perceived a non-existence of chaplaincy that she did not really understand. D had an image of what the chaplaincy role *should* entail and wanted to discover and evidence if that was really the case:

> *Just to see what it is, what sort of things they get involved with and what sort of people come to them and actually just what they're all about* (D, Interview 2. 40: 10-11)

Reference was made earlier to the cognitive development of children growing up in adversity. What is clear from the research is that where there is a significant other (parent, sibling, friend) (Garbarino 2001; Beckett 2002; Goodman and Gregg 2010) or positive opportunity and environment in which to belong (academic achievement and social responsibility) (Sprinthall and Collins 1995, Marsh et al 1996) or a fantasy that can provide the hope of triumph over evil (Garbarino 2001), only then, as indicated in K's story, can the negative impact of adversity be mitigated and hope restored.

D undertook her professional developmental placement with the chaplaincy service in her final year and found the experience incredibly rewarding. Not least because at the end of the three weeks spent with the chaplaincy team, they asked D to give a presentation on her vision of the service. D sent me the presentation as one of her artefacts: entitled "*My personal experience of the Chaplaincy Service*". The full presentation can be found in Appendix 9 of this thesis but the following two slides, numbers 11 and 12 (figures 8:2 overleaf) are of specific relevance to this chapter.

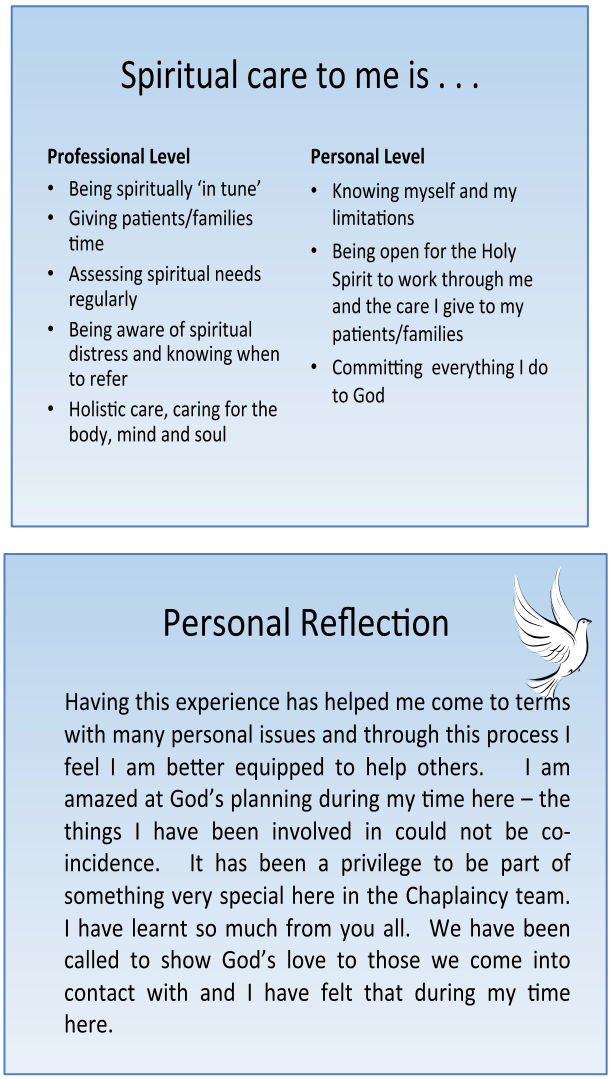


Figure 8:2 Slides 11 and 12 of D's presentation

D's experiences with the chaplaincy service had been the turning point in her pre-registration student nurse education and her transition towards qualification. The chaplaincy team contributed to a positive 'end' to D's final year. They had welcomed D to them, like the Good Samaritan who tended the injured Jew when everyone else had passed him by, the chaplaincy team cared for D. Like the people living alongside the Buddhist monks the chaplaincy team had filled D's bowl with good things and given her a positive story to carry. In asking D to undertake a presentation to and for them, they were giving her a purpose and welcoming her to a place where her beliefs had fit. They gave her belonging and hope. This hope meant that D was now able to see that she had a 'spiritual home' in nursing. Clark (2000) cites Eliot (1943/1971) "*the end is where we start*" suggesting that endings are often beginnings and part of life's transitions. Going

out and then returning home are cyclical processes associated with transition. The 'ordinary person' undertakes an experience and finds himself or herself changed by that experience. Campbell (1988) suggests these processes are associated with heroism and quest. That in all tales of quest there is a moment when the heroic need to call out for help, hoping someone will hear (Campbell 1988).

8.5 Being heard

In his discussion on spirituality and language, Gillman (2007:94) states '*we need others to hear our stories and to care'*. Talking and narrative therapies have been used in the treatment of mental health conditions for many years (White and Epston 1990). While undertaking theoretical sampling for burn out and loss used in the previous chapter I came across literature relating to being heard. Freeburn and Sinclair (2009) investigated stresses associated with the academic burden of mental health nursing students. Freeburn and Sinclair (2009:338) considered *the need for support* articulated by the students in their study to help '*preserve and to protect'* (Freeburn and Sinclair 2009:338). In keeping with the email I received from Mrs P, the students also found solace in others. More interestingly Freeman and Sinclair (2009) identified that not being listened to, not being heard, provided additional trauma, despair and hopelessness.

In my clinical experiences as a health visitor I have undertaken listening visits with women who have mild to moderate maternal depression. Within this context listening visits are intended to reveal, and then initiate, dialogue surrounding psychological issues the mother is experiencing (Cox and Holden 2003). The concept of maternal depression may appear a curious irrelevance to a study that focuses on pre-registration nursing students and spirituality. Nonetheless, there is great relevance to this study. A self-help book for mothers experiencing postnatal depression by Kleinman and Raskin's (1994) is entitled: "*This isn't what I expected*". The title of this book suggests that women new to motherhood face psychological dilemmas and confusion following the birth of their baby. This dilemma and confusion is not dissimilar to the experiences of the participants in this study. Again a much anticipated life transition, which has not delivered on expectations and 'hopes'. The imagined is now unimagined, hope is at risk of being lost.

Sprinthall and Collins (1996) discuss the developmental psychology of adolescents during the students' college years. While the participants in this study were not adolescents, like the theories of resilience in children, the considerations of Sprinthall and Collins have resonance with these findings. Sprinthall and Collins (1996) cite the work of Baxter-Marolda (1990) who undertook a study to 'measure' the thinking skills of college students. Students were asked to give answers to questions regarding their learning environment and the reason for their response. Sprinthall and Collins (1996) citation of this study is part of a broader discussion on the adolescents' cognitive development surrounding the complexities of learning. Citing Baxter-Marolda (1990), Sprinthall and Collins (1996) advise that during times of transition in education, female students are challenged by ambiguity associated with knowledge. Consequently, female students initially struggle with self-directed learning, eventually catching up with their male peers. Overall Sprinthall and Collins (1996:531) advise that those working with students in higher education: "*sharpen their ability to hear just where the student is 'coming from' as a basis for the kind of support he or she may need to manage the next hurdle*."

Throughout the study I was cognisant that the students wanted me to 'hear them', hear their stories of the turmoil and ambiguity in clinical practice. In response to 'seeking affirmation' I felt compelled to acknowledge their struggle, their confused understandings and attempts to articulate some sort of spiritual meaning within this new profession they had chosen. In all the basic social processes that emerged from this study, none of the participants ever requested a solution to their problems or challenges. The struggling to identify, the fear and uncertainty, the desire to safeguard, the seeking of evidence and sense making through the telling of stories, the expression of personal hurt and a need for recognition were central to them. All the participants required was an acknowledgement that I had heard them and that I understood. When presenting my findings to other students, they have concurred that all pre-registration nursing students should hear what this study has found: a theory of *carrying hope*.

8.6 Summary

This chapter has identified processes that the students seek to enable them to continue towards the end of their pre-registration nurse education. Associated with this process is

the construction of *resilience* and *being heard*. This chapter has determined the process of *storytelling* as a vessel in which and through which each participant is *seeking affirmation* and is enabled to *carry hope*. While this chapter considered the experiences of all participants, the findings predominantly focus on the three participants who continued through both phases of the study. The process of storytelling as applied uniquely to each individual participant has been considered and explained. The next chapter will explain the emergent theory '*carrying hope'* and the extent to which this theory explains the participants' resolve of spiritual self with their clinical experiences.

Chapter 9 : A theory of carrying hope

The previous chapter explored and explained the participants' awareness of spirituality as 'hope'. Hope that they would come through their education and make a successful transition to qualification. Chapter 8 explained that the participants used seeking to find other methods and opportunities that would help them make sense of their spirituality in relation to experiences in the clinical environment. These seeking processes increased their resilience and acted as metaphorical vessels in which and through which hope was carried throughout their pre-registration education. This chapter will explain a theory of *carrying hope*. This theory emerged from and is grounded in data obtained from an exploration of the Basic Social Processes [BSPs] by which pre-registration nursing students develop awareness and understanding of their own spirituality. The theory has been shaped by experiences of pre-registration nursing students in the clinical practice environment as they make the transition through three years of a higher education pre-registration nurse education. Theoretical sampling and constant comparison of data revealed the three significant BSPs of *struggling, safeguarding and seeking*. These BSPs have been presented previously in the three findings chapters to explain how the participants resolve the problems they encounter in clinical practice regarding their spirituality. These BSPs are conceptual components of the core category of *carrying hope*. These conceptual components and the core category are brought together and contextualised within the emergent theoretical context of *carrying hope*. This chapter will contain personal reflections regarding my journey throughout this study. These will include a consideration of the chosen research design and the extent to which my own insights as a nurse and educator have been influenced.

Figures 9.1 and 9.2 (overleaf) are a storyboard that portrays how each of the categories: *struggling, safeguarding* and *seeking* are essential conceptual components to the emergent theory of *carrying hope*.

Figure 9:1 Storyboard depicting the three concepts of Carrying Hope: Struggle, Safeguarding, and Seeking. © Tom Hobbs

Figure 9:2 Carrying Hope © Tom Hobbs

During the first eighteen months of their pre-registration nursing education, student nurses were *struggling* with the concept of spirituality in nursing and health care. They entered the profession, imagining a vocational and supportive context in which they would practice. The students' inability to define the phenomenon and to articulate a nursing context for spirituality made them uncertain and unsure of the phenomenon's context and permissibility within the profession. This was particularly evident in the participants who described a 'call' to nursing as the imagined positive calling began to morph into the unimagined associated with negative experiences. All the students had *hoped* for in entering the profession began to be challenged and they experienced

fearing. For participants who identified with a belief/faith, the spirituality associated with their faith acted as a talisman that would provide *hope* and protection in times of challenge or fear associated with the horrors and stresses of the profession that they observed. The students were cognisant of the hardening and complacency in their qualified compatriots. They articulated this as *losing* spirituality. The students viewed loss of personal spirituality as a direct result of stresses and pressure of working in the clinical environment. The students in this study experienced awareness that their spirit could also become marked and tainted by stress and as a result required *safeguarding. Seeking* through storytelling was evident throughout the study, particularly during the students first eighteen months of the programme. In these early stories, students recounted powerful images of their experiences in clinical practice. Personal spirit and hope are intertwined (Ainsworth-Smith and Speck 1982; Carson 1989; Bradshaw 1994). The storytelling enabled the students to address their problem of how to align and identify hope for 'spiritual self' with 'self as nurse' and all they hoped to become. The stories acted as a metaphorical vessel in which, and through which, the students could continue to *carry hope* through to the second eighteen months of their education.

By the end of their second year and into the third year of the pre-registration programme, the students were beginning to find an inner spiritual strength that augmented hope. The students with a Christian faith could identify qualified nurses who shared the same faith and who had experienced the same challenges. For these students there was realisation that it was acceptable to pray and to cautiously reveal spiritual self to others who they '*hoped*' would understand and support. All students in the study experienced a realisation that the patients might also feel the fear in the clinical hospital environment and also required safeguarding. The students were actively *seeking* answers for *safeguarding*, not only themselves but also the patients for whom they cared. In these answers the students could *carry hope*. The students were now growing in confidence. As the students made transition towards year three they seemed to demonstrate increased *resilience* and a sense of homecoming. A new identity of self as nurse began to form. They were braver and more able to challenge. By the third year the images recounted through stories in later interviews were less powerful. The students were *seeking* to make their own sense of their experiences in clinical practice. While *struggling* was still evident, they could now *seek* a resolve between their spirituality and their clinical

experiences as they progressed through to qualification. The students had learnt how to *safeguard* their spirituality by whatever means possible. Accordingly the students recognised that *safeguarding* must not necessitate the negative and detachment from what they perceived as the most important element of their spirituality, *hope*. Regardless of all they experience in the clinical environment the pre-registration nursing students participating in this study recognised spirituality as a fundamental element of nursing. Spirituality was precious to them as novices to nursing whose quest and hope was to make the successful transition to *carry* on becoming a qualified and good nurse.

9.1 Carrying hope

There are two elements to the process of carrying. Carrying associated with physical effort and movement and that which indicates 'motion through'. The verb 'carry' means to convey or transfer something from one place to another (Waite 2009). Within Roget's Thesaurus the verb 'carry' is placed within the classification of *'space'* under the section 'motion' and beneath the noun *'carrier'* (Kirkpatrick 2000:273). As a verb the word 'carry' can be converted into a noun by the addition of the gerundial 'ing'. To do so enables the reader to identify '*carrying*' as a named and concrete process associated with movement. While any philosophical debate surrounding 'carrying' could not be identified, theoretical sampling led to an examination of the concept of carrying in more detail.

Carrying as movement can be viewed as either voluntary or involuntary. Carrying can be a purposeful, meaningful action or a response to a stimulus (Kramer et al 2003) and is either a visible or invisible act. For example one may carry something that is evident such as a bag or a bowl. Alternatively the thing being carried may be small enough to be carried where it cannot be seen upon the person, for example in a pocket. A bag or a bowl can be carried openly and in turn, contain and carry within it something else, *something hidden*. On the other hand a person *may not have an awareness* of the potential significance of the thing they are carrying, for the example a virus or, indeed, spirituality.

Nursing within a Western context is primarily an altruistic vocation (Bolton 2000) based upon Christian values (Bradshaw 1994; Lundmark 2007). Accordingly, reference to carrying within the religious context is included here. Carrying is frequently referred to in

the Bible and other religious texts; it is known that Jesus carried his cross prior to his crucifixion. Carrying has been paralleled in the Bible with personal denial and burden (Matthew 16:24). Carrying is depicted in Christian art and *image* as the devotional. The fourteen Stations of the Cross (Sullivan 2004) represent Jesus carrying the weight of the cross, a burden *struggling* along the road to Calvary and to crucifixion. A person may be '*called*' upon to carry something, or they may have no choice in the carrying process. Station five is representative of Simon of Cyrene a man who unwittingly and unwillingly was c*alled* upon by Roman soldiers to help Jesus carry the cross (Sullivan 2004). Sometimes we resist carrying, carry something begrudgingly or reluctantly, only to find later on it was worthwhile carrying, and that somehow we have learnt from the experience.

In the poem '*a cross in my pocket*' the concept of carrying is connected to reminding, *protecting* and re*affirming* faith (Thomas n.d). Lacey (1977:129) refers to the religious population of America as carrying the word of God in their Bibles and throughout everyday life. Harrington-Watts (2002) also argues that the Bible carrying population of America has influence over the concepts of 'power' within the US. Stephens (2002:151) cites the Gospels of Mark and Luke to position the notion of carrying alongside the more sinister. In Matthew 4.5 and 4.8 (The Holy Bible 1997) Jesus is transported by the devil to the highest points, the pinnacle of a temple and to a mountain. Here the devil '*tests*' and '*challenges*' Jesus' devotion to God. Matthew (4.1) gives an assumption that Jesus had no choice in this transportation. Whether the carrying of Jesus by the devil was literal or hypothetical, or if Jesus was carried unknowingly and / or unwittingly, neither is certain. Therefore, the concept of carrying can be positioned against the *unimagined*, the unclear and *uncertainty*. During my analysis I wrote a long bizarre memo about a monster in the fridge (Appendix 10). This memo concerned my frustration of having lost my lunch. I could remember 'carrying it' in its plastic container. Yet, I could not recall where during the process in which I had intended to transport my lunch from the car to the fridge, I had mislaid the plastic container and in doing so, my lunch. Davies (2003:15) articulates the notion of *losing* something, *searching* for it and then finding that which is carried as a symbol of spiritual faith, her cross (table 9:1 below).

Table 9:1 'My Cross' (Davies 2003:15)

I lost my cross today, Lord. Yesterday I was wearing it, and today it is gone. I thought I'd find it, but as the day wore on, my searching became more frantic...I began to panic. My cross which I'd had for so many years, it was part of me my cross. *I found my cross today, Lord. It was lying in an unexpected place – yet right on top, ready for me to see it – if only I'd looked! I'm wearing it again now*.

Faith can be *lost* and *hope* can be *lost*. That which is carried, that which is symbolic can be *lost*, misplaced or forgotten. Carrying is a complex process (Dougherty and Lister 2011). As a physical human movement effective carrying requires on-going self-assessment, changes in posture and positioning and adjustment. The physical act of carrying requires careful monitoring, seeking support and assistance when needed to *protect* the carrier and that, which is being carried, particularly if the load that is being carried should become too heavy, or manoeuvring it becomes too complex. To physically carry something from one area to another requires *adequate time* to achieve the carrying purpose and goal. Yet, the carrying process can be positive, give a sense of achievement and provide 'hope'. Theoretical sampling for 'carrying hope' led to positioning the concept away from the religious and Christian and toward the spiritual.

The concept of *carrying hope* is connected to the positive and often associated with humanitarian work. In December 2012 an article appeared in the New York Times entitled "*A Factory on Bicycle Wheels, Carrying Hope of a Better Life*" (Cave 2012). The article tells of a Mexican artist who travels around Mexico City on a bicycle. This woman provided sewing materials free to the local community so that within their homes they can sew items of 'art' to be sold. As a consequence of this humanitarian initiative, the wage the workers receive is almost twice the minimum wage of other factory workers. The charity *Mountainchild* states that its vision is to 'carry hope'. By bringing food, medicine, education and love to the children of the Himalayas, many of whom die before their eighth birthday (http://mountainchild.org/about). The searching for images of 'carrying hope' revealed the beautiful artwork by William Kalwick, Jr. entitled *Carrying Hope* (figure 9:3 overleaf) http://houstoncivicarts.org/workszoom/725205/carrying-hope-by-william-kalwick-jr . Permission for the inclusion of this artwork has been formally requested (Appendix 11)

Figure 9:3 Carrying Hope by William Kalwick, Jr

This painting is significant to the findings of this study and the emergent theory. While the image above is not immediately reflective of pre-registration student nurses and clinical practice, it does depict the context of the young and vulnerable needing to be carried. The participants in this study were 'young' and naïve in the unimagined clinical environment. Consequently they were *struggling* with their spirituality. This led to *safeguarding* their spirituality and finally, *seeking* ways of *carrying hope* for their spirituality through to completion of their education and beyond. As nurses and educators we have a moral duty to support their spirituality; carry hope for our nursing students when, through fear, uncertainty and the unimagined, they are unable to do so. It is only then will we ensure that spiritual awareness in *hope* is safeguarded and continued through to the next generation of nurses.

Chapter 9: A theory of carrying hope

Carrying is a requirement of the many transitions in human life. We are carried before birth, we are born, we are carried until we can walk, and then life carries us along, through changes in childhood and into adulthood. Clark (2000) suggests that change is something that happens to us, whereas transition is a concept in which we have a choice and awareness. As adults we choose to work or not, we choose to marry or not, we choose to have children, or not. In each of these life transitions we have an imagined 'hope' of what our lives might be like as a result of this choice. But what happens when all that we hoped for goes wrong, when the marriage ends in divorce, when the longed for children do not come? As demonstrated by Spouse (2000b) student nurses choice to enter the profession is based upon an imagined idea of what the profession is like. What happens to when the profession fails to deliver the imagined? As Carson (1989) reflects, spirituality is bound in a search for self-actualisation and is an essential element in supporting life transitions. Transition is a conscious process that involves four elements of adaption '*physical, emotional, mental and spiritual'* (Clark 2000: 186). Likewise, the process of carrying can be physical, emotional, mentally challenging and require an adaption of spiritual self. As human beings we are called to adapt our image of who we are in light of new experiences, changing circumstances, shifts in values and beliefs and new understandings and knowledge (Carson 1989). Transition in life carries us down different paths towards self-actualisation. *Carrying* involves *struggling*. That which is *carried* requires *safeguarding*. The carrier needs to *seek* ways to ensure the process continues. As a consequence the problem for the students was how to *carry hope* for spiritual self within the clinical environment. Therefore, understanding and awareness of personal *spirituality* and the process of *carrying hope* are mutually dependent.

While the findings in this study are presented sequentially, *struggling, safeguarding* and *seeking* are not necessarily linear processes. Dependent upon context, and the particular problem for which a resolve is required, the pattern may differ. However, *struggling* is the initial process that causes the other processes to be called into action (figure 9:4 overleaf).

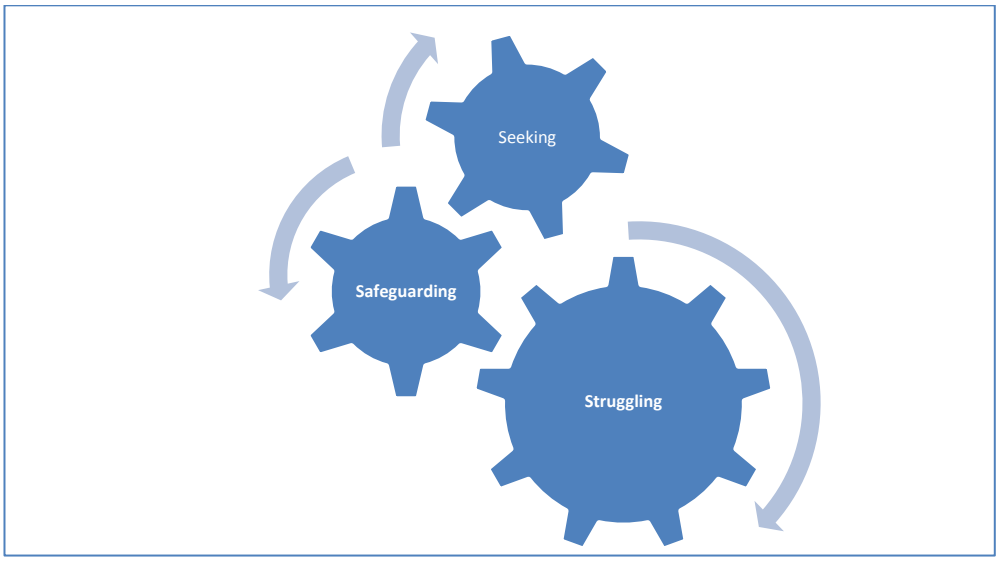


Figure 9:4 Diagram illustrating the interchangability between struggling, safeguarding and seeking

Figure 9:5 Carrying hope

Struggling, safeguarding and *seeking* are processes operating together within the single process of *carrying hope* (figure 9:5 above). A formal articulation of the substantive theory 'carrying *hope'* is expressed overleaf.

Carrying hope *is a theory to explain the basic social processes undertaken by human beings in times of transition. Carrying hope includes struggling, safeguarding and seeking. Carrying hope enables individuals, groups or communities to develop awareness of, and continually accommodate a vision of the positive, the expected, the anticipated and the imagined (all they had hoped for), when this vision of the positive threatens to morph into the negative: the unexpected, the unanticipated and the unimagined. If the process of carrying hope becomes too difficult, other(s) - individuals, groups or communities may need to offer support and assist in carrying hope.*

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9.2 Personal reflections on the study

This section will explore my personal thoughts regarding the study and the personal 'hope' I carried that this piece of academic work should come to fruition. I have chosen to use Carper's (1978) Fundamental Ways of Knowing (adapted from Johns 2003) and include White's (1995) additional element to frame the discussion in this section. A description of these ways of knowing can be seen in table 9.2 (below).

Table 9:2 Carper's (1978) Fundamental ways of knowing with the addition of White (1995)

Empirical Knowing – existing knowledge that provides the empirical basis for effective practice
Personal Knowing – knowledge held within the practitioner that influence the way the world is seen and responded to
Ethical Knowing – an appreciation of how best to respond in terms of societal benefit, expectations and norms
Aesthetic Knowing – the practical knowledge and skills: professional artistry used by the practitioner
Socio-Political Knowing (White 1995) – within the 'broader context in which nursing and healthcare take place' (White 1995: 83)

Personal Knowing: My own ontological understanding was the driver for this study. As a child I often wondered at the bigger picture of life and all that it held. My own life transitions thus far including personal and professional experiences have caused me to turn towards God and/or other higher being to seek meaning and hope. Having produced

this body of work I am now more aware that carrying hope was integral to each transition. Undertaking this journey over the past six years has caused transitions of my past, buried deep in my psyche to come to the fore. A concern for the reader may be the extent to which my own experience of transition may have biased the study. Throughout the process of undertaking the study and while writing up the findings I have been reassured by texts such as Schreiber and Stern (2001) and more recently Bryant and Charmaz (2011). These experts as second-generation grounded theorists recognise that in researching we cannot wipe away our past experiences. It is these experiences that so often bring us in search of the foundations of knowledge. Accordingly my personal and professional worldview has become part of the data that helped shape the study.

Aesthetic knowing was significant in my understanding the context in which the study took place. Particularly the tussles and tensions described by Morse et al (2009). It was Stern (2009:57) who helped me reconcile any aesthetic influence on the study, advising that it can be hard to take the 'nurse' out of the research. In the early days of this venture, not only did I naively seek out a framework into which to 'fit' this study, I really 'struggled' to think 'like a researcher' (how ever a researcher might think?) and not 'care' for the participants as a 'nurse'. This is a tension explored by Adler and Adler (1987:19) who suggest there is a danger that the researcher can find they become "*psychologically engulfed*". I wonder if, as nurse researchers, we document this tension sufficiently. Or like spirituality, is it a conflict we keep hidden for fear of being judged as inadequate in research terms? Reflection throughout the study and discussions with my supervisors and fellow peers enabled me to recognise when I was in danger of becoming biased in my approach to the study. *Ethical knowing* within the context of this study is tied to aesthetic knowing above. I really cared about the participants, particularly the three who were part of the whole study. Through my analysis I felt I came to know and understand them. I feel privileged to have heard these participants' experiences of clinical practice as they made their transition towards graduation and qualification. *Socio-Political Knowing* was a key driver for this study and is significant to the implications identified in the study. Nursing has been subject to several high profile media reports regarding poor care (Glaser 2012). Other authors have expressed concern that it may be 'compassion fatigue' that leads nurses to not raise their concerns, particularly unease about an insidious and detrimental culture that had developed within the institutions where patients were

severely harmed (West 2010). I was very privileged to be part of the team who developed an all graduate nursing and midwifery curriculum (NMC 2010). At the NMC review we won high praise for our 'values based curricula', based upon the concept of the Wizard of Oz, this ideology sees the student nurse as travelling the yellow brick road in search of a metaphorical heart, nerve and brain. It is our intention that students enter the profession with, and then sustain, a vision of who they wish to become 'as nurse'. Becoming is a key concept of this curriculum (*Dorothy and self-disco*very), and it is on their metaphorical three year journey that students are required to question their intrinsic motivation, what they value about their knowledge, skills and attitude to caring (*the heart*). *The nerve* is associated with self-belief and self-efficacy; who do they need to be, to become the person they hope to be as a caring professional. Finally *the brain* requires the student nurse to develop intellectual skills in critical analysis of their own practice and that of others and to carry this aspiration forward into the clinical environment. Much of the vision and impetus for this curriculum came from fruitful discussion within the team and sharing the findings that were coming from our individual doctoral studies, not least my own.

The greatest accumulation of knowledge I have gained since undertaking this study has been *empirical*. Before I embarked on this study I had a basic understanding of research, viewing myself as a novice, unsure and unconfident when considering the principles, processes and issues concerning research. The taught elements of the doctoral programme have enabled me to gain confidence personally, professionally and practically. Particularly in qualitative research and moreover, grounded theory. I find myself 'thinking' grounded theory and trying to solve problems using 'grounded theory'. Not conventional, nevertheless a good way of identifying solutions creatively and asking '*what's going on here then'.* I am now more objective about the situations and problems I encounter in my personal and professional life. Much of this confidence has been gained from dissemination by presenting at conferences nationally and internationally about the study and the findings that emerged from the data. The presentations I have given to date are detailed in table 9:3 overleaf.

Table 9:3 Presentations

Wigley, W (2011) *Student nurses perceptions of spiritual self and practice*. The Health Sciences Postgraduate Research Conference 2011. Faculty of Health Sciences, University of Southampton (Poster Presentation and speaker)
Wigley, W (2011) *Student nurses perceptions of spiritual self and practice*. RCN Annual International Nursing Research Conference, Harrogate (Visual Presentations with Expert Review [ViPER]).
Wigley, W (2010) *Student nurses' defining stories of spirituality*. Faculty of Medicine, Health and Life Sciences, Postgraduate Conference. University of Southampton (Presenter)
Wigley, W (2008) *What influence might practice experiences have on pre-registration nursing students' awareness and understanding of their own spirituality?* 8th Biennial International Nursing Conference in Brunei Darussalam (Presenter)

Most interestingly for me (but no longer a surprise) at these events I noted the reserved manner in which delegates and other presenters have approached me. These individuals have wanted to know about my study and have been curious about the philosophical stance the study was taking. When they felt safe to do so, these individuals often shared with me their innermost belief about spirituality and what it meant to them. This has been the greatest gift of this study because spirituality, that which will give hope to carry on in the face of adversity, is innate within us all; if we only pause for a moment in life to consider it.

Summary

This chapter has explained and presented the substantive theory of *carrying hope.* The theory explicates and highlights the problems pre-registration nursing students experience in trying to resolve their awareness of personal spirituality in clinical practice. A resolve that is present throughout three years of an NMC validated, higher education pre-registration nurse education programme. My own experiences as researcher during the study have also been explored. The next and final chapter will demonstrate the fit of the substantive theory of *carrying hope* with other vocational transitions. This final chapter will summarise the study, drawing conclusions and suggesting implications for

clinical practice. Recommendations for pre-registration nurse education will be highlighted and a model of pastoral care in pre-registration education identified. In addition suggestions for further empirical inquiry will be made.

Chapter 10 : Implications, recommendations and conclusion

10.1 Introduction

This chapter will conclude the study. The substantive theory of *carrying hope* will be positioned against other 'vocational' higher education programmes. National concerns regarding attrition from pre-registration nursing programmes will be highlighted and a model of pastoral care illustrated. Conclusions from the study will be presented along with recommendations for further inquiry.

The enterprise for this study arose from personal experience as a nurse and a nurse educator. The context and concept of the study was shaped by my experience of teaching spirituality and the associated learning by pre-registration nursing students about spirituality in nursing. At the commencement of the study I was the module lead for a module entitled 'Context of Care' in the pre-registration curriculum and part of the indicative teaching content of the module was spirituality. Every evaluation of the module over the five years the module ran revealed that the pre-registration nursing students understood neither the context nor concept of spirituality in nursing. This raised concerns for me that the learning needs of pre-registration nursing students with regard to spirituality are not being met. A concern that was reflected theoretically in the preliminary exploration of the literature associated with nursing and spirituality (chapter 2). Recent drivers from professional bodies such as the RCN (McSherry 2010) and policy guidance by the Department of Health (DH 2010) continue to position spirituality as fundamental in quality nursing care. Nonetheless, the nursing profession still perceives a lack of support and guidance in delivering spiritual care (McSherry 2010; McSherry and Jamieson 2011). Thus, there remains uncertainty in the profession surrounding engagement with religious and spiritual care practices (McSherry and Jamieson 2011). This uncertainty has caused numerous authors to question the effectiveness of spiritual teaching in nurse education (Narayanasamy 1993 and 2006; Ross 1996 and 2006; Meyer 2003, Milligan 2004; Mitchell et all 2006; McSherry 2008 and 2010; McSherry and Jamieson 2011). Very few studies have examined the effectiveness of spiritual teaching in

relation to pre-registration nursing programmes (Ross 2006), even though evidence suggests that a consideration of personal spirituality enhances awareness and understanding of spiritual need in others (Greenstreet 1999; Ross 2006; Mitchell et al 2006; McSherry 2010). At the commencement of this study and throughout its duration, there was an absent body of knowledge to explain how pre-registration nurses might gain an awareness and understanding of their own spirituality from their experiences in clinical practice. Hence, this study has sought to explore the phenomenon of spirituality as perceived by pre-registration nursing students and the relationship of any perception of spiritual self to experiences in the clinical environment.

As a result of conducting two focus groups at the start of the study, it became evident that the phenomenon of spirituality was hard for pre-registration students to define within a nursing context. Pre-registration nursing students viewed the phenomenon of spirituality as ethereal in nursing care and ephemeral within their formal education. Unlike the science of nursing, spirituality in nursing practice was viewed by the participants as having neither substance nor evidential grounding. The participants had entered the profession, imagining a vocational and supportive context in which they would practice. When the imagined and supportive context became challenged, the participants were *struggling* with their spirituality. All they had *hoped* for in entering the profession had to be confronted and they experienced *fear*. The participants who identified with a belief/faith, initially kept their spirituality *hidden*. Yet for these participants in particular, spirituality acted as a talisman to protect them from uncertainty and the unimagined. Spirituality afforded dual *safeguarding*; requiring safeguarding as it fulfilled a safeguarding purpose in times of challenge or *fear* associated with the clinical environment. The participants safeguarded that which kept them safe. In spite of *struggling, fearing* and uncertainty surrounding *revealing* spirituality, the pre-registration nursing students participating in this study understood spirituality as essential to nursing. Yet, they also recognised that *loss* of spirituality might lead to *loss* of *hope* and spiritual/professional burn out. This acknowledgment caused them to adopt *seeking* behaviours such as *storytelling* that, in the longer term, supported and sustained their spirituality, provided *resilience* and augmented *hope.* Spirituality was significant and essential to them as novices to nursing whose quest was to become a qualified and good nurse. This was the *hope* they *carried*. Regardless of their successful transition to

registration for the students who participated in this study, there were several points in the study where the participants began to doubt their ability to continue and carry on through the programme. Without a means or method of *carrying hope*, there was the potential for their spirit to be broken and burnt out, resulting in loss of *hope*. A broken, burnt out spirit and loss of hope in pre-registration nursing students is a significant problem for pre-registration nurse education that will be addressed in section 10.4. Firstly, as Glaser (1996) suggests that grounded theory concerns itself with the theoretical, not the descriptive, I would like to position 'carrying hope' against other vocational educational context. A grounded theory is about a process, not necessarily a particular population (Glaser 1996). Likewise, the theory holds implications in other substantive areas. *Carrying hope* is applicable to other vocational educational contexts, where transition requires the learner to come into contact with elements of human life that may be different from their own and not be what they had imagined.

As I was writing this thesis my daughter was undertaking a PGCE programme to enable her to qualify as a teacher of geography to children aged eleven to sixteen years. As she spoke to me of her quest to achieve this qualification I could see parallels to the findings in this study. Her biggest challenge was to come in her first teaching placement, a 'failing' school, subject to OFSTED special measures and intense monitoring. A school where three quarters of the student population come from disadvantaged homes. She 'struggled'. She found the children's behaviour challenging and she was tired. She struggled to comprehend the lives that some of the children were experiencing. My bright, beautiful and spirited girl began to lose hope. In that first term the Times Educational Supplement [TES] published an article by Tom Bennett (Bennett 2012). In this article Bennett speaks to the reader of the challenges trying to keep 'your distance' in teaching and of pupils who notwithstanding every disadvantage defy the odds. Bennett (2012) draws parallels with the stresses of being a new student nurse, the silent message of the article being to continue with a vocational spirit. Never give up an ambition to hope to make a difference, that teaching is worthwhile. A subtext, which my daughter found hugely comforting in those early dark days of the autumn term and lifted, her spirit and that gave her hope to carry on.

A friend's son was commencing his second year as a junior doctor in a busy inner city tertiary hospital. I was talking to my friend about my study and she became very animated and said "*Oh! Ben should hear this*". Remen (2001) considered the extent to which medics in the United States [US] were experiencing depression, dissolution and leaving the profession as a consequence. Like the participants in this study, they entered the medical profession with a purpose and hope to find meaning in their lives. Remen (2001) proposes that American medical students are transported from anticipation and enthusiasm through to '*cynicism and numbness'* (Remen 2001:4) during the four years of their education. Remen (2001:5) advises that medical training in the US should recognise '*the innate wholeness'* in each student and work to restore a sense of service, a sense of calling. Yet, in the US health care is predominantly privately funded, an opposing context to the UK and the National Health Service [NHS] organisations. It transpired that Ben[9] was disillusioned with his role and wondered if he could continue to practise medicine within the context of the NHS.

10.2 Implications for clinical practice

The discussion above suggests that the findings of this study have implications in other vocational learning contexts; this doctoral study is concerned with the immediate implications for clinical practice. The NHS continually undergoes upheaval and re-organisation as part of opposing policy measures and target incentives (Marks and Hunter 2005). Such upheaval and changes in management structure have been cited as one of the numerous causes of the inadequate care exposed by the recent Francis inquiry into health care provision at Mid Staffordshire NHS Foundation Trust (Her Majesties Government [HMG] 2010). Disturbing in the report is evidence that the culture within the Trust was not supportive of, and commensurate with, positive nursing care. There exists evidence from the US that 'moral courage' in nursing is reflective of personal characteristics. Characteristics such as challenging inappropriate care, acting as an advocate for patients and being prepared to take risks that are in the patients' best interest, are frequently reflective of structures and values within the employing health care organisation (LaSala and Bjarnason 2010). Positive and successful health care organisations within the US hold mission, vision and values, which are reflected in

[9] Name changed to maintain confidentiality

positive patient outcomes, low workforce turn over and a commitment to the workforce by recognising professional development (LaSala and Bjarnason 2010). LaSala and Bjarnason (2010) suggest that without adequate and clear organisational structures practitioners within the organisation encounter 'moral distress': the suffering an individual experiences when they are unable to do what they know to be right. The woeful omissions in care in Mid Staffordshire were forensically exposed in the Francis inquiry (HMG 2010). It might be argued that the nursing culture within Mid Staffordshire had gone beyond 'moral distress', losing moral courage and *losing hope* to complacency and indifference. Yet, there is no evidence to suggest that similar issues are not lurking within other NHS organisations. The participating pre-registration nursing students in this study alluded to negative traits and practices in the clinical environment. In a target driven NHS obsessed with completing the latest audit and risk report, a culture of 'watch your back', has developed. There is evidence to suggest that such defensive management techniques within public service are '*stultifying*' (Lapsley 2009:18) of any innovative spirit. Long gone are the days when as a profession we supported each other 'spiritually' and 'carried hope' for our compatriots. Davey's (2002) observation that '*Nurses are eating nurses'* seems to be a reality of nursing within the contemporary NHS. In response to media coverage regarding the quality of nursing care a 'new vision' for nursing has been proposed (DH 2012; Glaser 2012). This vision calls for nursing to (re)capture the values of nursing and focuses on '6Cs': *Care, Compassion, Competence, Communication, Courage and Commitment* (DH 2012). A 'call' that suggests that something held historically in nursing has been lost. It remains to be seen if the simplistic solution or recapturing 'six Cs' will be effective in the longer term. I would suggest what has been lost and is no longer carried by the profession, for the profession is 'hope'. A hope that encapsulates recognition and vision of a personal and professional spirituality which 'calls' not only to care for others but also to look after its own, a hope that recognises the potential fragility of our pre-registration nursing students, and nurtures them through to successful completion of their education and beyond.

Riel-Sisca (1989) suggests that nurse education unwittingly fractures the student experience of role models by using clinical experts to demonstrate theoretical concepts in the practice environment. The positive personal qualities and aspirations of these clinical

experts are not always reflective of those held by nurses working in the clinical environment. The historical role of a clinical tutor was replaced by that of clinical mentor as part of the Project 2000 Programme (UKCC 1986). While Barrett (2007) suggests that clinical credibility of nurse lecturers in HEIs is not necessary and that strong knowledge of subject areas is sufficient. The findings of this study suggest that detachment from the clinical environment may inadvertently cause detachment from the naivety of the student experience with regard to spirituality. Indeed, (Spouse 2001) advocates the need for mentors to be involved in an effective clinical teaching role to facilitate role modelling to student nurses, a role that would be valued by pre-registration nurses (Lee et al 2002). Perry (2008) identified that role modelling in clinical nurse education when used with supervision is known to be an effective teaching strategy (Perry 2008). The RCN (2012) suggests that the clinical environment should support, value and include nursing students in clinical supervision while acknowledging and ensuring their supernumerary status (RCN 2012). Given the findings by the Francis inquiry (HMG 2010), there is a need to re-visit and explore the additional benefits of a clinical educator, over and above that of the familiar and traditional mentorship model. This study demonstrated in chapter 8 that there is a need to look within the clinical environment for role models of 'hope', qualified nurses with the capacity and capability to recognise the fragility of human spirit. In the absence of such role models in the immediate future, co-ordinated learning and teaching strategies involving hospital chaplaincy in the clinical environment, could be implemented. Such strategies should focus on the importance of nurses' role modelling 'hope' to patients and to each other.

10.3 Implications and recommendations for pre-registration nurse education

In the publication '*Managing Attrition Rates For Student Nurses and Midwives: A Guide to Good Practice for Strategic Health Authorities and Higher Education Institutions*', the Department of Health [DH] claim that attrition rates for students on pre-registration nursing programmes is relatively good in comparison to other Higher Education Institution [HEI] programmes (DH 2006). Nonetheless, the DH (2006) recognises that the monitoring and management of attrition rates nationally is necessary for accurate workforce planning. Since the publication of the document (DH 2006) HEIs have consistently monitored recruitment and retention. All HEIs that provide nurse education

enter into a contract with their local Strategic Health Authorities [SHA][10] to deliver on specified numbers and percentages attributed to recruitment and retention. Attrition rates not only have consequences for workforce development, currently HEIs are monitored by SHAs. Any fluctuation in these numbers results in a significant financial penalty for the HEI. Clover (2011) and the RCN (2012) advise that there has been a considerable drop in attrition rates in first year nursing students nationally which in year 2010 – 2011 sat at 1.6%. However, the rates for students in their second year of pre-registration nursing programme remain higher at 8.3% of students who commenced their programme in 2009 -2010 (Clover 2011). This data is consistent with the impression I gained undertaking this study. Data obtained from the focus groups and interviews indicated that the 'struggle' the participants experienced is most acute in the first eighteen months of their programme. While the fundamental contexts of attrition are multi-faceted and complex (Orton 2011), Last and Fulbrook (2003) suggest that stress and unrealistic expectations and experiences can be a significant factor. Tools, such as restorative supervision have been noted as being useful in the management of anxiety and stress in the clinical environment (Wallbank and Robertson 2008), particularly in relation to '*caring for loss'* (Wallbank 2013: 11). However, Carver et al (2007) noted that mental health pre-registration nursing students hold uncertainties regarding the formality of clinical supervision. Pastoral care differs from formal supervision in that is does not necessarily provide a solution to problems (Swinton and Willows 2009). Pastoral care is often referred to as spiritual care and is frequently offered by chaplaincy services (DH 2003). Pastoral care involves listening, supporting, and encouraging. It is the spiritual dimension of any caring professional relationship (Swinton and Willows 2009). Adequate pastoral care in pre-registration nursing programmes is a requirement of the NMC (2010). The DH (2006) advises that those HEIs who provide comprehensive pastoral care in pre-registration nursing programmes are less likely to experience high rates of attrition. While many personal tutors of pre-registration nursing students view pastoral support as key to their role with students, one disadvantage of the 'traditional' personal tutor role is the tendency to focus upon academic performance and progression (Por and Barriball 2008). Por and Barriball (2008) identified that next to practical academic support with

[10] From 01 April 2013 SHAs are dissolved and the responsibility for health education will be held by Health Education England [HEE], with local planning and commissioning to be led by Local Education and Training Boards [LETBs]

assessments, students mostly require help with personal issues and problems requiring signposting to appropriate counselling services. This would suggest that effective pastoral support as recognised by Swinton and Willows (2009) is not identified as an essential role for the personal tutor in pre-registration nurse education. In which case, the question remains who best to serve the needs of the pre-registration student with regard to their personal pastoral and spiritual care; the chaplaincy, the counsellor or the personal tutor. Whichever the most appropriate individual might be, Por and Barriball (2008) suggest that good pastoral support requires adequate time and tutor autonomy.

The findings of this study suggest that the spiritual need of pre-registration nursing students is not always recognised. Yet, storytelling played a significant role in articulating the stage the participant was experiencing in their *carrying hope* and their awareness of spiritual self in the clinical environment. A model of pastoral care that utilised storytelling could enable personal tutors to guide students who require support to *carry hope*. The model is illustrated in figure 10:1 (below)

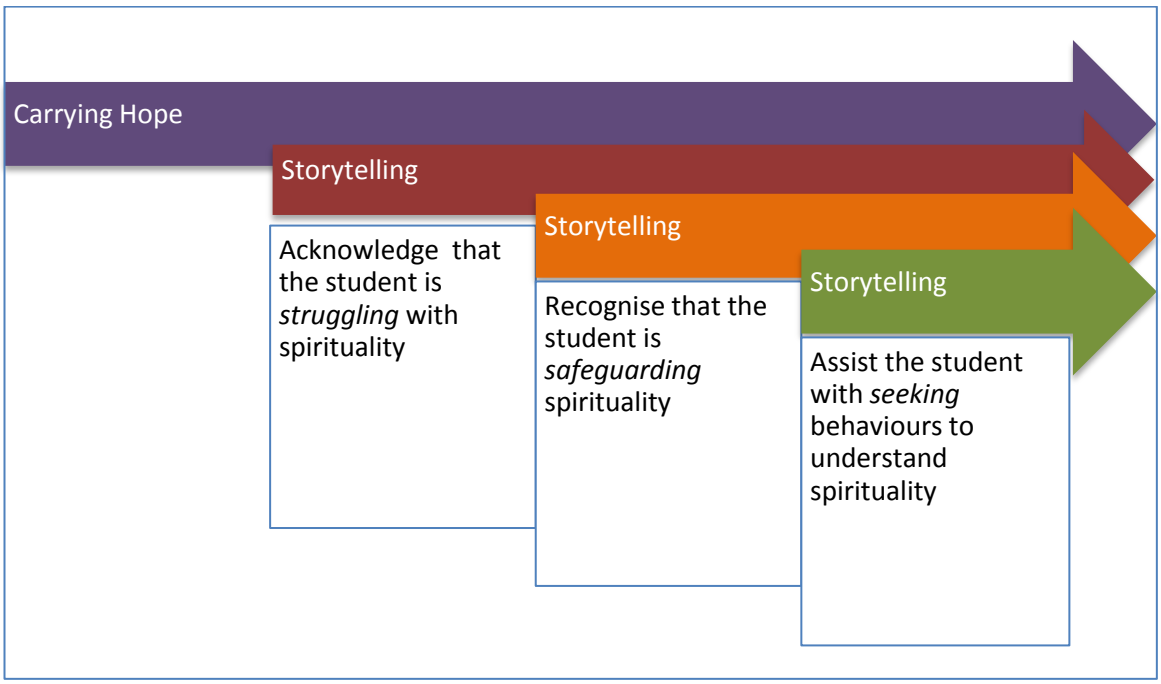

Figure 10:1 A model of pastoral care to support '*carrying hope*'

This model (figure 10:1) is intended to assist the tutor to understand through the student's story, which element of *carrying hope* and spiritual awareness the student might be experiencing difficulty with. The tutor's role would involve acknowledging areas of spirituality with which the student may be struggling, recognising when the student is

attempting to safeguard personal spirituality or that of others. Finally assisting, where appropriate, with seeking behaviours. Each of these elements can be identified in and through storytelling. The colour of each element as red, amber and green, highlights which elements carry the most risk with regard to the students progression throughout the programme. Red is suggestive that *struggling* is the most challenging aspect of *carrying* but the student might also require support when *safeguarding*. Once the student begins the '*seeking*' process they are more likely to manage *carrying* for themselves. With the teaching commitments of a full curriculum and other constraints, it appears that the pastoral care of students is being missed in relation to the students' developing spiritual needs. A model of pastoral care would highlight the spiritual needs of students and enable them to develop a personal awareness of spirituality.

Barnett (1994) suggests that higher education must concern itself with the holistic development of an individual. A personal and professional development that will enhance knowledge and values and complement both the operational and the academic aspects of higher education. These, in turn, will fund a competence for the individual's development beyond the effective operational (Barnett 1994). Barnett's (1994) text was written at a time when higher education was changing. Polytechnics were becoming universities and the vocational profession of nursing was moving into higher education. Almost twenty years later, nurse educators and educationalists continue to recognise that '*fitness for practice, fitness for purpose, fitness for award and fitness for professional standing'* (NMC 2004) are worthy and appropriate truisms to which the profession should aspire. Nonetheless, the findings of this study suggest that due to the demands a contemporary NHS places upon nurse education and clinical practice, creating an effective operational registered nurse has taken precedence. As a result, the vision for an overall holistic competence in the individual practitioner may have become lost. In the move towards an 'all graduate profession', the NMC Standards for Pre-registration nursing education (NMC 2010) lists '*professional values'* as the first domain of competence. The RCN acknowledge that the future graduate status of nursing should not impact negatively on care and compassion (RCN 2011) but the full consequences of an all-graduate profession in the UK context remains unknown until 2015. Professional values can only be fully acknowledged and obtained by pre-registration nursing students if role

modelling of hope in spirituality and spirituality in hope is overtly evidenced and carried throughout their nurse education.

10.4 Recommendations for further study

If education fails to fully prepare nurses (McSherry and Jamison 2011), and being attuned as a nurse to one's own spiritual needs helps identify the spiritual needs of others (Greenstreet 1999; Mitchell 2006 et al; McSherry 2010), then this study has gone some way to exploring this problem. This study has identified that spirituality is difficult to define and as a result difficult to teach, as an assumption is often made that spirituality is automatically affiliated to religion and religious practice. The learning and teaching strategies of pastoral care and role modelling could foster recognition of the link between 'hope' and 'spiritual awareness', not only for students but also those responsible for their education. Further empirical knowledge is required to appreciate the extent to which a model of pastoral care (figure 10:1) might enhance spiritual awareness in pre-registration nursing students. In the longer term, educators in the profession require a broader understanding regarding the effectiveness of role modelling within the context of spirituality and carrying hope.

Finally, the participants in this study all volunteered because they were interested in spirituality and it was important to who they were. There remains a gap in the evidence to explain spiritual awareness in pre-registration nursing students who have no religious affiliation, or do not see spirituality as an important aspect of who they are. A future study might explore the perceptions of pre-registration nursing students who claim no spiritual affiliation or spiritual awareness with regard to their understanding of spirituality within health care provision. Do they carry hope and experience the same issues as those students' with awareness of spirituality? Ultimately if pastoral support and role modelling is found to be effective, its use and efficacy with qualified staff in the clinical environment should be investigated. An evidential understanding is required in nursing as to how pastoral support and role modelling might, in the longer term, instil the importance of personal and professional hope and enhance spiritual care giving.

10.5 Conclusion

This study has identified the substantive theory of *carrying hope*. Prior to the emergent theory there was an absence of evidence-based knowledge that might explain how pre-registration nursing students may gain awareness of their spirituality from experiences in practice. *Carrying hope* is a basic social process undertaken by pre-registration nursing students during their transition to become qualified nurses. *Carrying hope* enables pre-registration nursing students to develop awareness of, and continually accommodate a vision of the positive, what they expected, anticipated and imagined in the profession they have entered. When their vision threatened to morph into the negative, the unexpected, unanticipated and unimagined, the students experienced *struggle* with spiritualty, they wanted to *safeguard* personal spirituality and needed to *seek* out methods to support and assist them in *carrying hope*.

The findings from this study indicate that the spiritual needs of nursing students are not necessarily recognised by others. In addition, strategies that support and nurture the spiritual needs of pre-registration nursing students and assist and support with carrying hope are not readily available in the educational or clinical environment. As a result pre-registration nursing students are *struggling* to *safeguard* their spirituality and are *seeking* ways in which to align personal spirituality to their *hope* to become good nurses. This study provides evidence that pre-registration nursing students have an awareness of their spirituality and spiritual needs. As part of this awareness they endeavour to *carry hope* for spiritual self to make sense of their experiences in clinical practice. McSherry and Jamieson (2011) identified that education is failing to prepare nurses to adequately meet the spiritual needs of patients and their carers. In this observation lies the ultimate paradox. Understanding, recognising and meeting spiritual needs of those for whom they care is a fundamental aspect of nursing and was recognised as such by the pre-registration nursing students who participated in this study. Pre-registration nursing students are in close contact with patients, they are the patients' main carers. Pre-registration nursing students' entitlement to receive spiritual care is no lesser or greater than any other individual. As a nursing profession we ignore this need at our peril. Not only can loss of hope and disillusion in their education and clinical experiences cause pre-registration nursing students to leave the profession, but the stresses of the health care

environment, lack of role models and personal disenchantment can lead to professional complacency, cynicism, a lack of quality nursing care and personal burn out. An absent concern for the spiritual needs of pre-registration nursing students will become a self-fulfilling prophecy, leading to a lack of spiritual care for patients, their carers and their families. This study suggests that the value and caring of nursing and the *hope* the profession inspired in itself and in others has become at best muted, and at worst lost. This study has identified that there is a need in pre-registration nursing programmes to openly provide spiritual sustenance: a model of pastoral care and role modelling in clinical practice is proposed. If students are enabled to understand their own spirituality, they will be more attuned to this need in those for whom they care. Nurse education needs to provide spiritual care for our future nurses. Without support for, and nurturing of their awareness of spirituality, pre-registration student nurses will continue to struggle to '*carry hope'* within the profession.

'The Journey' By Tom Hobbs (2011)©

Appendix 1: Appraisal of studies on spirituality

Appraisal of spirituality studies on nurses = 8 (Adapted from Crombie 1996)

Author	Research focus	Population	Sample size	Design and description of data	Findings	Issues pertaining to my study	Implications for practice
Ross, L. (1994)	Nurses perception of spiritual needs and care	Full time qualified nurses working in elderly care wards in 12 out of 15 health boards in Scotland	N=685 (quantitative questionnaire) N=12 (in-depth interviews)	Quantitative: purpose design postal questionnaire (67.8% response rate) analysed using SPSS Qualitative: in-depth semi-structured interviews	Questionnaires – spirituality seen as belief, faith and religion. Spiritual needs hard to identify, but nurses saw themselves as responsible in responding to, yet >50% refer to chaplain or other. Some nurses feel inadequate in providing spiritual care.	Qualified nurses Awareness of spiritual dimension of own lives had experienced crisis, willing to give of themselves at deep personal level. Nurses claiming religious affiliations more likely to identify spiritual needs.	Personal characteristics of the nurse seem important in determining whether or not and how nurses give spiritual care.

Author	Research focus	Population	Sample size	Design and description of data	Findings	Issues pertaining to my study	Implications for practice
McSherry (1998)	Nurse's perception of spiritual needs and care. Development of Spirituality and Spiritual Care Rating Scale (SSCRS)	Ward based nurses of all grades in one NHS Trust	N=559	Quantitative: purpose designed postal questionnaire (55.3% response rate). Factor analysis was used to analyse relationships which existed between statements (variables) in the SSCRS	Nurses feel hesitant and unsure about the effectiveness in provision of spiritual care. More action is needed to empower nurse and increase confidence in providing spiritual care.	More research is required to investigate nurses perceptions of spirituality in order to validate existing findings and to generate new knowledge and understanding of spirituality within the UK	Spiritual dimension needs to be placed firmly within existing nursing curriculum Nurses perceive spirituality as a universal concept relevant to all individuals No individual member of the MDT should hold the *monopoly* in providing spiritual care

Author	Research focus	Population	Sample size	Design and description of data	Findings	Issues pertaining to my study	Implications for practice
Narayanasamy and Owens (2001)	Nurses' perceptions of and responses to spiritual needs	Nurses practicing in mixed settings attending a post registration course at University of Nottingham	N=115	Qualitative critical incidents (88% response rate) Content analysis for emerging categories	Confusion over the notion of spirituality and the nurse's role in providing spiritual care. Nurses derived satisfaction from the provision of spiritual care	Qualified nurses. The use of interviews with nurses may have established comparability between oral and written accounts of incidents relating to spiritual care.	Response to spiritual care giving is largely haphazard and unstructured.
Carroll (2001)	Nurses' perceptions of spiritual needs and care.	Convenience sample of hospice nurses	N=15	Qualitative; Phenomenological heuristic approach of semi-structured interviews	Meeting the spiritual needs of patients with cancer requires a team approach. The hospice provided adequate resources to meet patients spiritual needs	Fundamental need for research into the provision of spirituality in nurse educational programmes	To achieve holistic care that includes meeting spiritual care needs the assistance of the MDT is required

Author	Research focus	Population	Sample size	Design and description of data	Findings	Issues pertaining to my study	Implications for educational and nursing practice
McSherry and Watson (2002)	Student nurses' and patients' awareness of the importance of spiritual care.	A cohort of pre-registration student nurses. (St/N Convenience sample of diabetic out patients	Entry St/N n=168 Year 1 St/N n= 124 Year 2 St/N n=90 Patients n=206	Quantitative: Longitudinal panel survey of one question on Nursing Dimensions Inventory (NDI) using a Likert scale analysed using ANOVA. Paired *t*-tests and Bonferroni correction (p<0.017)	Education may increase student nurses' awareness of the spiritual needs of patients. Yet the concept of spiritual need does not seem to be considered particularly important to patients.	The extent to which student nurses exposure to spiritual dimensions in practice may have impacted upon the findings is unknown.	Potential widening of the theory-practice gap between nurse education on spirituality and experience in practice.
Narayanasamy et al (2002)	Nurses' ability to construct and respond to spiritual needs	Learning disability nurses	N=10	Qualitative critical incident analysis and construction of inferences.	Information about the clients' religious background initiated action that considered spiritual need	Nurses' personal belief system influenced the recognition of spiritual care. Some nurses defined spiritual needs in non-religious terms	Nurses more attuned to recognise religious needs as opposed to holistic spirituality. Spiritual care interventions produced a positive effect on clients and nurses themselves.

Author	Research focus	Population	Sample size	Design and description of data	Findings	Issues pertaining to my study	Implications for educational and nursing practice
Narayanasamy et al (2004)	Responses to spiritual needs	Convenience sample of registered nurses attending post-registration courses in elderly care	N=52	Qualitative: critical incidents	Nurses reported that patients' religious background, spiritual/religiously loaded conversation and diagnosis acted as prompters for them to identify, plan and implement nursing interventions. Nurses perceived such interventions to be spiritual care.	Participants believed that searching for meaning and purpose was a particular spiritual need in clients. Other findings congruent to Narayanasamy et al (2002)	Vocabulary about spirituality in nursing is confusing and interchangeable used to refer to spiritual and religious needs. This ambiguity and confusion may mean that spiritual care is inconsistently applied to the care of older people.

Author	Research focus	Population	Sample size	Design and description of data	Findings	Issues pertaining to my study	Implications for practice
Milligan (2004)	Nurses' perception of their role in spiritual care giving	Registered nurses undertaking a palliative care course	N=59	Quantitative, questionnaire: Closed questions using a 5 point Likert scale. And Multiple choice questions subject to frequency analysis and expressed as p% in total. Open questions (answered using free text) analysed using thematic analysis.	Nurses considered spiritual care needs to be important and met them in a variety of ways. However, there were areas in which the nurses lacked appropriate knowledge to meet the needs of their patients	Inadequate training or education and inadequate experience were cited as factors that affected spiritual care giving	Nurses need to be aware when to refer on to appropriate specialist input to help meet the spiritual needs of patients

Appraisal of studies on nurse education = 2 (adapted from Crombie 1996)

Reference	**Research focus**	**Population**	**Sample size**	**Design and description of data**	**Findings**	**Issues pertaining to my study**	**Implications for educational and nursing practice**
Narayanasamy, A. (1993)	Nurses' awareness and preparation to meet spiritual needs	RGNs attending Care of the Elderly course in U.K	N=33	Quantitative questionnaire (100% response rate) Presented in tabular form given in % and compared to Chadwick (1973)	While nurses aware of spiritual needs of patients, these are poorly met. Competence should be improved by further education in spiritual care	Self-perception of spirituality not considered	Nurse educators should incorporate spiritual care teaching and learning strategies into educational nursing programmes
Ross (1996)	Educational Preparation	Registered Nurses working in care of the Elderly	N=685	Mixed methods Qualitative: interviews Quantitative: questionnaires	Nurses had limited recall of training in spirituality. Yet some nurses seem better able to give spiritual care than others	Clarity is lacking on how spirituality should be taught or how effective any such teaching is in helping nurses to give spiritual care	Other, more effective methods should be explored for teaching spirituality.

Appendix 2: Invitation to participate

Student invitation (version 4)

Study number: **SONAM/016/2007**

Study name: What influence might practice experiences have on pre-registration nursing students' awareness and understanding of their own spirituality?

Name of researcher: Wendy Wigley

Supervisors: Dr Magi Sque and Professor André le May

Dear Student

My name is Wendy Wigley I am a member of the teaching staff within the School of Nursing and Midwifery and like you, I am also a student, currently studying towards a Doctorate in Clinical Practice.

I would like to invite you to take part in a research study that explores how practice experiences might influence pre-registration nursing students' awareness and understanding of their own spirituality?

I enclose:

- An information sheet describing the study.
- A reply slip which you can return to me, the researcher if you would like to take part in the study.
- An addressed envelope so that you can return the reply slip to me.

Thank you for taking time to read the enclosed information

Kind regards

Wendy Wigley

Doctorate in Clinical Practice Student

Appendix 3: Information sheet

Pre-registration student information sheet (version 5)

Study number: SONAM/016/2007

Study Name: What influence might practice experiences have on pre-registration nursing students' awareness and understanding of their own spirituality?

Name of researcher: Wendy Wigley

Supervisors: Dr Magi Sque and Professor Andree le May

I would like to invite you to take part in a research study that explores the way in which pre-registration student nurses might make sense of their own spirituality as they progress through their three years of training.

Your group has been chosen from the list of the 2007 pre-registration nursing students learning groups based here at XXX. I am working down this list week by week over 6 weeks, approaching one group per week until I have recruited enough volunteers to participate. Before you decide, it is important for you to understand why the research is being done and what it would involve for you.

Please consider the following information carefully and take time to decide whether or not you would like to take part. This information sheet will describe the study.

Thank you for taking time to read this

What is the purpose of the study?

The purpose of this study is to explore the way that pre-registration nursing students might make sense of their own spirituality from their experiences in practice. This information will be used to:

- Explore pre-registration nursing students' personal meaning of spirituality.
- Identify how pre-registration nursing students might 'make sense' of their own spirituality.
- To enhance the learning and teaching of spirituality in nursing.
- Contribute to a Doctorate in Clinical Practice for which I am studying.

In addition information and data from the study may be used for:

a) teaching research students
b) secondary analysis

How will the study be undertaken?

The study will take place in 2 phases:

Phase 1: The focus group: a group of up to 8 other pre-registration nursing students who will meet with me and explore belief systems, views and meaning about their own spirituality and their nursing practice. The focus groups will last no longer than one hour and be held at a venue either on the campus or close to the campus.

Phase 2: One to one interviews: these will be held with me every six months throughout the three years of your pre-registration training. The initial interview process will encompass topics and issues that were discussed in the focus groups. The interviews will be held in a

place of your own choice. What I hope to talk about are your experiences from practice and how these might make you consider your own spirituality. To help you do this I have suggested some activities that I am calling 'vehicles' that might help you describe what you want to say about how you feel. To help this happen between interviews you might use pictures, art, poems, or things you might have written to bring to the next interview. We will then talk about your vehicles so that I can begin to learn about your views, feelings, experiences, beliefs and actions about how you see your spiritual 'self' and how it connects to your nursing practice.

Which Phase of the study can I take part in?

You can take part in *either* Phase 1 or Phase 2 or *both* Phases of the study and it is up to you which phase(s) you choose:

Who has been invited to take part?

2007 intake of Diploma, Advanced Diploma and Bachelor of Nursing pre-registration nursing students based at XXX Campus

Who is undertaking the study?

The study is being undertaken by me; Wendy Wigley, a Deputy Programme Leader and Lecturer in the School of Nursing and Midwifery. I am undertaking this study as part of my Doctorate in Clinical Practice research and **not** as part of my Lecturer or Deputy Award Leader role to the Public Health Awards, which are concerned with learning beyond initial registration.

Do I have to take part?

No. It is up to you to decide if you want to take part or not. If you do decide to take part you will be asked to sign a consent form to say that you agree to take part in the study. If you decide you don't want to take part in the study that is OK, you won't have to give a reason and your decision will not affect any part of your pre-registration nurse training.

Will my academic tutor know I am taking part?

The academic tutors have been informed that their learning group members may be approached to take part. Any information that you share as part of the study will be confidential and will not be shared with your Academic Tutor.

What will happen if I decide to take part?

I will contact you and confirm and explain arrangements for the phase(s) you would like to be part of.

If you decide you would like to take part in *both* phases 1 and 2 you will receive the invitation, information sheet and consent form to take part in the focus group **first.**

If you decide you would like to take part in Phase 1: focus groups I will contact you and you will be sent:

- a detailed information sheet about what to expect in the focus group,
- the date time and venue of the focus group;

This information will be for you to keep. You will also be sent a consent form for your information and to bring with you to sign before the focus group.

Please note that focus groups will be held at the University Campus either in the morning or the afternoon but no later than 4pm and not during lecture or practice time.

If you decide you would like to take part in Phase 2: one to one interviews with me the researcher, I will contact you ***after*** the focus groups are completed in October 2008. You will be sent

- An information sheet about what to expect from the interviews; this information will be for you to keep.

You will also be sent a consent form for your information and to bring with you to sign before the first interview. I will then contact you personally to arrange a convenient time and venue.

Why do I need to sign a consent form?

A consent form is written confirmation that you agree to take part in either Phase 1 or Phase 2 of the study and that you agree to your voice being audio (sound) recorded and for notes to be taken.

What will happen if I decide not to take part?

You will not be contacted again about this study. If you decide you don't want to take part in the study that is OK, you won't have to give a reason and will not affect any part of your pre-registration training.

What are the benefits of taking part?

Knowing that the views and experiences you have contributed to this study will add to a body of knowledge about spirituality, so that teachers of nursing are better able to provide the teaching and learning experiences necessary to help student nurses, like you understand spirituality in nursing care.

What are the possible disadvantages of taking part?

The focus group will take no longer than one hour of your time.

The one to one interviews with me will take no longer than one hour of your time every 6 months for the 3 years of your pre-registration training.

Who is providing sponsorship and professional indemnity (insurance) for the study?

Sponsorship and professional indemnity (insurance) is being provided by the University Legal Services.

Who had reviewed the study?

The study proposal and accompanying information has been seen and approved by the School of Nursing and Midwifery Ethics Committee.

What if I have a concern or complaint?

If you have a concern or a complaint about this study you should contact XXXX Academic Adviser & Co-ordinator, in the Research Support Office at the School of Nursing and Midwifery XXXX If you remain unhappy and wish to complain formally XXXX can provide you with details of the XXXX Complaints Procedure.

Will my involvement in this study be kept strictly confidential?

Yes. The procedures for handling, processing, storage and destruction of the data comply with the 1998 Data Protection Act. This means that all information about your contact details will be kept in a secure place and separate from the information collected during the focus group and the one to one interviews.

You may or may not know others taking part in either Phase 1 (focus group) or Phase 2 (interviews) of the study. All those taking part in Phase 1 must make sure that information

from the focus group discussion is not shared with anyone outside the group so that the rest of the group and your own confidentiality are maintained.

All information you share with me, whichever Phase of the research you chose to participate in, will be confidential and will only be seen by myself and my two supervisors, at all times your identity as a participant in the study will be protected by me.

In keeping with the NMC code of Conduct (2008), in the very unlikely event of evidence that vulnerable adults, children or yourself are at risk of significant harm, I would have to share relevant information with an appropriate third party.

There will be no individual identifiable material in the transcripts (written account) from either the focus group or the one to one interview.

Both the audio recordings and transcripts (written account) will be stored anonymously using a fictitious name and not your real name or anything that would identify you. All documentation will be stored in a computer file that is password protected.

After the study has finished any information relating to the study will be stored securely for 15 years and then destroyed as confidential waste in line with the University information storage policy.

What will happen to the findings of the study?

The findings of the study will form part of my thesis and may be published in academic journals relating to nursing and nurse education. No participants will be identified in any publications and seminars.

At the end of my research I would like to invite participants back together so that I can share with my findings with them.

What do I do if I am interested in taking part or would like further information?

If you would like to take part in the study, please:

- Complete the reply slip
- Place it in the addressed envelope provided
- Place the envelope in the box at reception on the ground floor of the Building XXXX
- Please do this within 7 days of receiving this invitation

If you think you would like to take part in this study but would first like to talk to me, my contact number is: XXXX and my email address is: XXXX

Contact details of researcher:

Wendy Wigley: Doctorate in Clinical Practice Student. School of Nursing & Midwifery, University XXXX

Tel: XXXX

Thank you very much for considering taking part in this study

Appendix 4: Focus group information sheet

Participant information sheet [Focus group] (version 6)

Study number: **SONAM/016/2007**

Study Name: What influence might practice experiences have on pre-registration nursing students' awareness and understanding of their own spirituality?

Name of researcher: Wendy Wigley

Supervisors: Dr Magi Sque and Professor Andree le May

Dear…….

From the list of the 2007 pre-registration nursing students learning groups based here at [redacted] learning groups have been selected one after another. Your learning group was selected from this list and you have been invited to participate as you expressed an interest on the first information sheet to take part in a focus group for the above study, thank you. Please keep this sheet for your information.

Your focus group will take place at [insert address venue] on [insert date] at [insert time]. Refreshments will be available.

I enclose a consent form for your information and to bring with you to the focus group.

The actual focus group is expected to last no longer than one hour, but it is probably best to allow one hour and a half, as I would ask you to arrive early so that your contact details can be confirmed, I can answer any questions you might have before the focus group begins and to check that you understand what will happen before you sign the consent form

What is the purpose of the focus group?

The purpose of the focus group is to explore, belief systems, views and meaning about participants' own spirituality and their nursing practice. The themes and issues that are identified will be used to guide Phase 2 (interviews) of the study.

The findings obtained from this study will add to a body of knowledge about spirituality, so that teachers of nursing are better able to provide the experiences necessary to help student nurses, such as you, learn about spirituality in nursing care and for this reason you will be asked to consent that information and data from the study may be used for:

- teaching research students
- secondary analysis

Who will take part?

All the other members of the group will be 2007 intake pre-registration students and like you, they will have volunteered to meet and share their beliefs about themselves, awareness of what spirituality might be and what it means to them**.** I will act as a facilitator for the focus group to encourage the discussion and to make sure that those that wish to contribute to the discussion are able to do so.

My colleague [name] will act as an observer, to make notes about where people are seated which will help me recognise who is speaking when I listen to the voice recordings; record any key points from the discussion and any non verbal reactions. My colleague will assist with welcoming the group and attending to their needs such as refreshments.

What will happen when I take part?

You do not have to disclose your personal experiences in the focus group if you do not wish to, but you will be encouraged to share your beliefs and views about spirituality and your practice experiences and what it means to you.

There are no right or wrong answers and everybody's view is important so I will ask all participants to listen to each other and respect each other's views and beliefs, even if they may be different from your own.

I will be available half an hour after the discussion to if you want to talk about anything else this group made you think about or how you felt during the focus group. I would also be happy to receive anything you would like to share with me in writing before or after the group discussion.

Will the focus group be recorded?

Yes, the focus group will be audio (sound) recorded with your permission so that an accurate written account of the discussion can be made.

Will what I say be confidential?

Yes. The procedures for handling, processing, storage and destruction of the data comply with the 1998 Data Protection Act. This means that all information about your contact details will be kept in a secure place and separate from the information collected during the focus group

You may or may not know others taking part in Phase 1 (focus group) of the study. All those taking part in Phase 1 must make sure that information from the focus group discussion is not shared with anyone outside the group so that the rest of the group and your own confidentiality are maintained.

All information you share with me will be confidential and will only be seen by myself and my two supervisors, at all times your identity as a participant in the study will be protected by me.

In keeping with the NMC Code of Conduct (2004), in the very unlikely event of evidence that vulnerable adults, children or yourself are at risk of significant harm, I would have to share relevant information with an appropriate third party. There will be no individual identifiable material in the transcripts (written account) from either the focus group or the one to one interview.

Both the audio recordings and transcripts (written account) will be stored anonymously using a fictitious name and not your real name or anything that would identify you. All documentation will be stored in a computer file that is password protected.

After the study has finished any information relating to the study will be stored securely for 15 years and then destroyed as confidential waste in line with XXXX information storage policy.

What if I have a concern or complaint?

If you have a concern or a complaint about this study you should contact Dr XXXX Academic Adviser & Co-ordinator, in the Research Support Office at the School of Nursing and Midwifery (Address: XXXX. If you remain unhappy and wish to complain formally Dr XXXX can provide you with details of the University Complaints Procedure.

If, as a consequence of your participation in the focus groups you become distressed, you can contact the **Wellbeing Team** at the University Student Services Tel . This service offers

confidential support for students who are emotionally or psychological affected by an incident or occurrence.

What if I change my mind about the focus group?

If you consent to being part of the focus group you can change your mind and leave the group by contacting me either by email or telephone; you won't have to give a reason and this will not affect your pre-registration training. However should you choose to withdraw you will be sent a form to return in a stamped addressed envelope asking you to clarify if you are still happy for data collected from you to that point to be used in the study or withdrawn.

If you think you would like to take part in the focus group but would first like to talk to me, my contact number is; XXXX and my email address is:XXXX

Thank you for taking time to read this. Wendy Wigley: Doctorate in Clinical Practice Student

Appendix 5: Focus group schedule

Planned procedure for focus groups (version 2)

Item Type	Item number	Item
Opening	1	We would like to welcome you all here today and to break the ice, invite you to introduce yourselves.
Introduction	2	You have been invited here today because I am interested in knowing how you think about your own spirituality.
Transition	3	Could you take a minute to think about what spirituality means to you.
Key	4	How would you describe this meaning?
Prompt	5	How do you feel about this meaning?
Key	6	What things do you do to get in touch with your spirituality?
Prompt	7	In practice or outside of practice?
Key	7	Why do these things make you get in touch with your spirituality?
Prompt	8	How do they make you feel?
Key	9	If you couldn't do these things how would you feel?
Prompt	10	How would you know you felt this way?
Prompt	11	What would you do or not do?
Ending	12	What is the most important point that we have discovered today?
Summary		
Ending	13	Have we missed anything?

Appendix 6: Interview information sheet

Participant information sheet [interviews] (version 6)

Study number: **SONAM/016/2007**

Study Name: What influence might practice experiences have on pre-registration nursing students' awareness and understanding of their own spirituality?

Name of researcher: Wendy Wigley

Supervisors: Dr Magi Sque and Professor Andree le May

Dear…….

From the list of the 2007 pre-registration nursing students learning groups based here at XXXX learning groups have been selected one after another. Your learning group was selected from this list and you have been invited to participate as you expressed an interest on the first information sheet to take part in the interviews for the above study, thank you. Please keep this sheet for your information.

What is the purpose of the one to one interviews?

The purpose of the interviews is for me to be able to collect detailed stories and descriptions about your experiences, beliefs and awareness of spirituality from your nursing practice and then to explore these with you in conversation.

From my interviews with you and others I hope to be able to be able to add to a body of knowledge about of how pre-registration nursing students 'make sense' of their own spirituality so that teachers of nursing are better able to provide the experiences necessary to help student nurses such as yourself learn about spirituality in nursing care, for this reason you will be asked to consent that information and data from the study may be used for:

- teaching research students
- secondary analysis

What will happen when I take part?

The interviews will involve you talking with me one to one every six months over the three years of your pre-registration nurse training.

The initial interview process will encompass topics and issues that were discussed in the focus groups, however it is probable that over the three years of the study new and altered ideas or topics may be identified that would warrant exploring with you.

After each interview we will spend a few minutes talking about how you felt during the interview process.

What if I don't know what to say?

Sometimes it might be difficult to tell your story, or you might forget it by the time we meet for an interview.

Therefore, between the six monthly interviews, it would be helpful if you consider and look for your own spirituality, what it means to you, how it helps you to 'make sense' or understand your nursing practice.

To help you do this I have suggested some activities that I am calling 'vehicles' that might help you describe what you want to say about how you feel. These are some suggestions of vehicle, but you might find some of your own:

1. Write about your feelings and why you think you are feeling them.
2. Identify pictures paintings or drawings that might represent what you feel.
3. Create pictures paintings or drawings of your own.

You can show these to me at the next interview. We will then talk about your vehicles so that I can begin to learn about your views, feelings, experiences, beliefs and actions about how you see your spiritual 'self' and how it connects to your nursing practice.

Will the interview be recorded?

Yes, each interview will be audio (sound) recorded with your permission so that an accurate written account of the discussion can be made.

Will what I say be confidential?

Yes. The procedures for handling, processing, storage and destruction of the data comply with the 1998 Data Protection Act. This means that all information about your contact details will be kept in a secure place and separate from the information collected during the one to one interviews.

You may or may not know others taking part in Phase 2 (interviews) of the study. All information you share with me, will be confidential and will only be seen by myself and my two supervisors, at all times your identity as a participant in the study will be protected by me.

In keeping with the NMC code of Conduct (2008), in the very unlikely event of evidence that vulnerable adults, children or yourself are at risk of significant harm, I would have to share relevant information with an appropriate third party. There will be no individual identifiable material in the transcripts (written account) from either the focus group or the one to one interview.

Both the audio recordings and transcripts (written account) will be stored anonymously using a fictitious name and not your real name or anything that would identify you. All documentation will be stored in a computer file that is password protected.

After the study has finished any information relating to the study will be stored securely for 15 years and then destroyed as confidential waste in line with University information storage policy.

What if I have a concern or complaint?

If you have a concern or a complaint about this study you should contact Dr XXXX, Academic Adviser & Co-ordinator, in the Research Support Office at the School of Nursing and Midwifery XXXX (If you remain unhappy and wish to complain formally Dr XXXX can provide you with details of the University Complaints Procedure.

If, as a consequence of the interview you become distressed, you can contact the **Wellbeing Team** at the University. This service offers confidential support for students who are emotionally or psychological affected by an incident or occurrence.

What if I change my mind about being interviewed?

If you consent to take part you will still be able to change your mind at any time by contacting me either by email or telephone; you won't have to give me any reason and this will not affect your pre-registration training. However should you choose to withdraw you will be sent a form to return in a stamped addressed envelope asking you to clarify if you are still happy for data collected from you to that point to be used in the study or withdrawn.

If you think you would like to take part in the interviews but would first like to talk to me, my contact number is; Tel: XXXX and my email address is: XXXX

Thank you for taking time to read this.

Wendy Wigley: Doctorate in Clinical Practice Student

Appendix 7: Emails from participants K and B

Hi

I've had some thoughts since the initial interview session. I felt now that they have consolidated into something approximating order, I would write, as you have encouraged me to do so!
*For me, the question of spirituality has become very important. What I felt I could not say in front of a third person, I will say here. I started as Christian, became rabidly so around 14, feeling 'driven'. I was confirmed; at the touch of thr Bishop's holy-oil-daubed thumb and I lost all Xian religious sensibility. I spent 4 years being an angry teenager(!), and at 18 did some research into what I *did* believe, and realised I was, by default, a Pagan. I don't follow a Pagan template, such as Wiccan or Norse, but the rather more fluid Druidical model: observer and witness, again by default, due to my thoughts and beliefs following that pattern more than any other.*
At age 16 I had what turned into a minor breakdown and an inevitible sliode into clinical depression. Due to a rather highly strung chord in my make-up, I have never shaklen this condition off; it will always be with me. I have dealt with it medically and counsellor-wise since, but in the last year I have felt a need to reconnect with a sense of 'self', and discovered this through examining what I believe as faith instead of intellectually (although I find the two inextricably tangled), and I have had some very good conversations with the university Chaplin; a very open character I feel I can trust in speaking of such things without coming across as 'airy fairy'!
I find now that I am asking myself:
Am I integrating a sense of self and belief into my work as:
I learn more?
I accept my choices with greater mmaturity and confidence and mould my training and life around me with more assurity?
(Perhaps due to both of the above) I find more purpose in life?
Certainly it comes and goes- the passion and commitment. With a curious, subject-hopping, taste-testing sort of mind, I would expect variation, and no human being is ever the same, on one level, forever. I am also slowly accepting myself. I always said when I was young, watching my medical parents, "I'll never be a nurse"! Now I have that ingrained idea to work against and soothe.
*Is *knowing* self and appreciating self is a form of spiritual development? I see it as linked inexorably to mental development, training and growth.*
Is 'spirituality' an attempt to describe self to self to accept self and live with it? Religion I see as a conformity to a pattern as a form of structured support, but spirituality is a developmental process.
if one outgrows or questions the bounds of a religion one is in, it doesn't devalue the religion; it just might not be the be-all, end-all for them.
I have had to work towards personal emotional development as part of my self-healing process. I have always had a fast and consuming mind. I see spirituality, especially spirituality in work, as part of that.
I enclose a picture I drew of how I see my 'divinehood': the God clasps my head: logic, thought and reason. The Goddess has the embrace of my body: visceral, tangible and emotional.

http://www.themogwai.eclipse.co.uk/pagan.JPG

best, K

06/02/10

Hi

After I last met with you re your spirituality research, and when I spoke to you about the subject of my latest essay about an HCA who said no, I went even further with all my research.

It led me onto experience-based design in healthcare improvements and two Americans called Paul Bate and Glenn Robert who first wrote an article, and have since written a book, on the subject.

They were discussing the inclusion of creative people and subjective issues which were as important as scientific and objective problem solving for future improvements. It particularly caught my attention because the couple of girls I have met undertaking your research, and myself, come from creative backgrounds, and I wondered about the connection between our creative minds and your subject of spirituality.

Since I last saw you I did a small power point presentation to the rest of my group on the subject of including professional design teams in experience-based research in healthcare improvements, because such individuals possessed the ability, or it could be the training, to realize the importance of subjective issues in any new improvements in the NHS.

I have attached a written copy of the talk I gave because I thought you might be interested. It is all about the importance of caring and brightening the 'spirit' of people.

I have come to a point where I am beginning to wonder whether it is because I am creative, or it could be that my background before now was in graphic design, I might have the ability to be aware, or perhaps the brain has been trained to be aware or rather 'in tune', to the importance of 'spiritual' issues in care. 'Spiritual' meaning the issues I mentioned in my attached document and those I spoke about at our last meeting, and not religious ones.

Brown and Libberton (2007) wrote a paragraph in their book 'Principles of Professional Studies in Nursing', which really stood out to me. I thought I would share it with you.

'There is a need for professionals to learn and understand the need to think subjectively in their dealings with people because people exist in their own worlds of multiple meanings which are not always as logical as the world of science promotes. There needs to be a balance between objectivity and subjectivity. The world has forged ahead in the area of science and technology, but there is a fear that spirituality may become dimmer with the passage of time'.

I hope your spirituality research does some good in promoting kindness to our fellow human beings, and never allows 'spirituality' to become dimmer with the passage of time.

You loaned me a book, which I still have safely. I so want to find the time to read it before returning it to you.

Kind regards

****
*

Brightening the Spirit

by B

January 2010

The government announced that from 2010 the National Health Service (NHS) needs to start concentrating on the quality of care that it gives Brown (2008). The word quality not only refers to clinical care, but it is also about the human experience of care.

Brightening the spirit and improving the human experience in health care systems is the subject of my presentation.

On behalf of the charity organisation The Kings Fund , a review paper was written called 'Seeing the person in the patient' for the 'Point of Care Programme', a programme set up to transform patients' experience of care in hospital and to enable health care staff to deliver high-quality care. It is both immoral and inhuman not to do one's best to protect people when they are weak and vulnerable, but the difficulty of achieving this within complex systems and institutions is a major challenge. It is important though, to find the right solutions Goodrich and Cornwall (2008).

It is much easier to measure and make changes to the physical aspects of quality in care because this can be seen and measured and acted upon. It is an objective subject and what science is all about. Whereas measuring psychological and emotional aspects is very subjective and difficult to measure and act upon Brown and Libberton (2007).

The world is becoming user-driven and for some time now other institutions and organisations such as hoteliers, bankers, car manufacturers, and politicians have used information about the public's views of their services to improve their systems. Improvements in healthcare are as important as in any other industry. Those they serve can make important suggestions as individuals, generate worthy hypotheses in small groups, and provide data through surveys that describe what is, and is not going well in the health care service Delbanco (1993).

Patient and staff involvement in new healthcare systems is part of a wider trend towards more 'bottom-up' public participation in the NHS. The NHS Institute for Innovation and Improvement have been involved in bringing the two together as co-partners to work with researchers and designers in re-designing services to help frontline NHS teams make the improvements that patients really want and need. The concept is known as Experience Based Design (EBD) NHS Institute for Innovation and Improvement (2010).

Improving the patient experience is a necessity for the NHS and there is already a huge amount of effort being put into it. Not only is it humane to do our best to protect people when they are weak and vulnerable, but there is an ever increasing choice of health care organisations to compete against. And in addition, from 2010 the government will be linking hospital income to quality experience and patient satisfaction. For the past 10 years government funding has been linked to quantity, so this will involve a huge culture change in the NHS The Kings Fund (2009).

With the ever increasing pressure to become user-centred the NHS will have to manage the 'customer experience' with the same importance as it does its 'functional' and 'operational' components. It is on the strength of experience in terms of reliability, technical quality, appearance and presentation, and the interactive quality of the service, that customers judge an overall experience on, and decide whether to stay with, or switch to a new provider in the future Bate and Robert (2007).

In 2008 the Kings Fund charity and the Department of Health wrote that patients increasingly use the internet to share information about their experiences in hospital. There is some evidence that where they have a choice and the information is available, rates of hospital-acquired infections, perceptions of cleanliness and staff attitudes will affect where patients want to be referred. So it seems likely that, as patients begin to exercise choice, hospitals that do not focus on patients'

experience will have poorer reputations, fewer patients and thus less income Goodrich and Cornwall (2008) and Department of Health (2008).

Bate and Robert put forward a broad suggestion that the design sciences might have much to offer those leading changes in the NHS. The pair put forward the case that the 'human experience' is one of the most important elements of good design. Pleasing peoples' feelings and senses by making the subject or object of design look good and feel good has to be incorporated into any design if it is to succeed. This element is known as the aesthetic appeal Bate and Robert (2007).

In design the word aesthetics is used to describe the beauty or emotion experienced by the design. No matter how good a service or product may be, the aesthetics is what is seen and felt by customers and what impresses them the most The Design Council UK (2009).

In a more general sense, aesthetics, as a philosophy refers to the study of sensory values. Aesthetics is interested in ways of seeing, and sensing the world. As a field of study, aesthetics involves ways of seeing and perceiving the world. Aesthetics assumes an ability to judge on a sensory level, as well as a collective agreement about ideals of beauty Ford (2010).

Kant described the aesthetic judgement as a judgement of feeling, distinct from cognitive and moral judgement. To let oneself be governed by the beautiful or by a feeling of beauty is nothing else than to have a tendency to make everything whole, to bring everything to perfection Schaper (1964).

Bate and Robert make the statement that 'good design' of healthcare services is essentially no different from good design in any other sphere, be it a product or a service. Design is the process of originating and developing a plan for a product, a structure or a system. A design can be a proposal, drawing, model or description. The three elements involved in the process of design are:

Performance *(Functionality**)***	***Engineering*** *(Safety)*	***The aesthetics of experience*** *(Usability)*
How well it does the job/is fit for the purpose	*How safe, well engineered and reliable it is*	*How the whole interaction with the product/service 'feels'/is experienced*

*Healthcare, they say, has always been quite deeply involved with the first two elements of design: '**performance**' in terms of the use of evidence-based practice, pathways and process design to ensure the clinical intervention is right; and '**engineering**' in terms of clinical governance and standards, to make it safer and more reliable. However what healthcare hasn't engaged in is designing human experiences (as distinct from designing processes). The two questions 'How can we make our patients' experiences better?' and 'How would it feel if it was me or my elderly mum?' are to do with human experiences. They were questions asked by the Secretary of State for Health in 2005 to the NHS Department of Health (2005), and refer to the **aesthetics** of the experience Bate and Robert (2007).*

*Bate and Robert wrote that these three magic ingredients of great design were best articulated by a designer Scott Berkun, who uses the example of the Brooklyn Bridge, and John Roebling its designer, to express this 'noble idea' of design as **performance** and **engineering** and **aesthetics** Bate and Robert (2007.*

'Brooklyn Bridge had to be beautiful, reliable and functional. They saw their role not just to build something that would transport people, or last 50 years or 200, but to contribute to the landscape and the human experience of everyone that came into contact with their creation. Every sketch and diagram John Roebling made considered not only its physical purpose and structure, but also its visual appearance to those walking on the bridge, and those looking at it from across the river' Scott Berkin cited in Bate and Robert (2007.

This sentiment reminds us of the power of design to deal not only with the purpose, but also the spirit of a thing. 'It is the spirit behind the Brooklyn Bridge, and the spirit in the structure itself, the spirit that you anticipate and appreciate even if you've never studied engineering, even if you've never studied aesthetics Bate and Robert (2007).

Few healthcare practitioners would probably disagree with the idea that 'spirit' is just as important in healthcare, if not more so Bate and Robert (2007).

Appendix 8: Classifying gerunds using Roget's

*denotes a new gerund found during this process

Class	Section	Gerund	Original code	Antonym	Notes
Abstract Relations	Existence	*Being*	*Fragility (of life)*	*Strong/sound*	*1-existence*
	Relation	*Allowing* *conflicting*	*Being allowed (D & B)* *Being yourself (K,D, & B)* *Conflict*	*Denying* *Non existence* *harmony*	*8-circumstance relative condition* *7-difference*
	Quantity	*Needing/wanting*	*…to be accepted*		*55-incompleteness*
	Order				
	Number				
	Time	*Existing*	*Fragility (of life)* *Own mortality (AM, J)*		*114-Transience* *114-Transience*
	Change	*Enchant(ing)* **withdrawing*	*Witchcraft*(K)* *Switching off (AM)*	*engaging*	*147-convertion:change to something different* **research craft* *145-cessation: change from action to rest*
	Causation	*Ruling* *Enchanting* **weakling* **weakening* **impending*	*Hierarchy* *Witchcraft* *Fragile* *Squished/squashed (K)* *inevitable*	*Subsidiary/minor (students as minor)* *strong*	*178-influence* *160-power* *163-weakness* *165-destruction* *155-destiny:future events*
Space	Space in general				
	Dimensions	*Sustaining* **sufficing* *crossing*	*Sustain* *Crossing boundaries*	*insufficient*	*218-support* *222-crossing-intertexture*
	Form				
	Motion	*crossing*	*Crossing boundaries*		*305-Passage: motion through*
Matter	Matter in general				
	Inorganic matter	*Defying*	*Resilience*	*Vulnerable*	*328-elastic Giving and*

Class	Section	Gerund	Original code	Antonym	Notes
		**Weak(ling)*	*(Fragility) life*	*Strength*	*forgiving??? In giving was K strong?* *330-brittleness*
	Organic matter	*Living* *Breathing* *Dying/leaving*	*(Fragility) life* *(Fragility) life* *Death/leave(B)* *Own mortality (AM,J)*	*Dying* *Birth/Life*	*360-life* *360-life* *361-death*
Intellect: the exercise of the mind					
Division 1: Formation of ideas	General	**Transcending judging*	*Own mortality (D, J, R & AM)* *A good nurse*		*447-Intellect* *Also contains SOUL & SPIRIT*
	Precursory conditions and operation	*Cherishing* *Losing* *Seeking/searching*	*Precious* *Losing /lost (B, K, D and R* *Seeking affirmation* *Seeking answers (year 2)*	*Carelessness* *Worthless* *Cheap*	*457-carefulness links to protection nurse as carer, sentinel guard* *458-negligence* *459-enquiry*
	Materials for reasoning				
	Reasoning processes	*Doubting* *Bewildering* *predicting*	*Uncertain/unconfident* *Confusion* *inevitability*	*Trusting*	*474-uncertainty* *473-certainty*
	Results of reasoning	*Finding* *Believing/accepting /trusting*	*Finding strength* *Believing (in God/something)*	*Lost/losing* *Doubting*	*484-discovery* *485-belief*
	Extension of thought	*Disappointing/disheartening* **demoralizing*	*disillusioned*		*509-disappointment*
Division 2: Communication of ideas	Creative Thought				
	Nature of ideas communicated	**Telling*	*Story(ies)*		*520-Interpretation*
	Modes of	**Telling*	*Story(ies)*		*524-Information*

Class	Section	Gerund	Original code	Antonym	Notes
	communication	*Hiding* **duping*	*Hidden* *Hospital as bubble-artificial (K)*		*525-concealment* *542-deception*
	Means of communicating ideas	*Defining* *Confusing*	*Defining Spirituality* *Confusion*		*590-Description narrative* *568-imperspicuity*
Volition: The exercise of the will					
Division 1: individual volition	Volition in general	*Willing* *Calling* **necessitating*	*Dedication* *Calling* *inevitability*	*Reluctant*	*597-willingness* *612-motive* *596-necessity*
	Prospective volition	*Protection(ing)* **sustaining* *Helping/serving* *Calling* *Valuing* *Demanding* **sinking*	*Protect* *Sustain* *Making a difference* **craft (witch)* *Precious(spirituality as)* *Time* *Helpless/vulnerable*	*Insufficient* *Irrelevance* *Worthlessness (badness)*	*660-safety/safeguard* *666-preservation, salvation, safekeeping* *635-sufficiency* *628-instrumental* *622-business: vocation* *644-goodness* *627-requirement* *661-danger*
	Voluntary action	*Attempting* *Struggling/striving* *tiring*	*Struggle* *Time/busyness of hospital*	*Unmotivated, not keen*	*671 attempt* *684-fatigue (burn out)*
	Antagonism	*Defending* *Defying* *helping* *struggling*	*Protect* *Resilience* *Making a difference* *Struggling*	*aggressive* *obey* *accept*	*713-defend* *703-aid* *716-contention*
	Results of actions				
Division 2: Social volition	General social volition	*Leading* *compelling*	*Figurehead and leadership (seeking) K* *inevitable*	*Following* *unconvinced*	*733-authority* *740-compulsion*
	Special social volition				
	Conditional social volition				

Class	Section	Gerund	Original code	Antonym	Notes
	Possessive relations	*Loving* *Finding*	*Precious* *Finding strength*	*Worthless/cheap* *Loss/losing*	*811-dearness* *771-acquisition*
Emotion, religion and morality	General	*desensitizing*	*desensitizing*	*responsive*	*820-insensibility*
	Personal emotion	*Oppressing* *Fearing* *Needing/wanting* *Discouraging/dejecting* *Hoping* *Distressing* *Suffering* *worrying*	*Squish/squash/erase self as Christian* *Fear of being judged (D & J: 1)* *Fear of being found out (R & D)* *Fear of burn out (K, AM & B)* *Monster (K:1 and B:2)* *To be normal (R)* *Despondent /hopeless* *Hope (K & AM) "having faith in something" (K:1)* *Distress(of self)* *Suffering (self) (R:1)* *apprehension*	*Free* *encouraged*	*854-fear* *859-desire* *834-dejection* *853-hopeless* *852-hope* *825-suffering*
	Impersonal emotion				
	Morality	*Forgiving* *blaming*	*Resilience* *guilt*	*Vulnerable* *pure*	*See matter* *909-forgiveness* *936-guilt*
	Religion				

Not sure about these codes
Dedication (K interview 1, comment w19 and K's comment interview 2:21:28)??Negative & again...add to table and see
Transcend
Ephemeral
Desensitize
volition

Appendix 9: D's presentation

My personal experience of the Chaplaincy Service
D
Final Year Nursing Student (Child Health)
May 2010

Preconceived Ideas
•Chaplains are called upon for patients who are "religious" and ask to see a chaplain.
•Chaplains are primarily contacted by nurses when a patient dies in hospital.
•The services of Chaplaincy are limited to patients.

Why did I choose to do my elective placement with Chaplaincy?
•I wanted to know what Chaplaincy had to offer so that in turn I could use this to enhance my own practice once qualified.
•I wanted to able to recognise when a patient would benefit from a chaplaincy referral.
•My questions were not being answered by nurses I had come into contact with during placements.

Spiritual Care
•Religious care is a part of but not the whole
•Being there for someone
•Listening
•Asking the patient if they would like to talk with anyone else
•Showing respect for their beliefs and values (no matter what faith group/no faith)
•Letting the patient lead the way (moving at their own pace)
•Everybody's business (not just chaplaincy)
•**Spiritual care involves taking care of ourselves**

Self Awareness
•Being self aware benefits the people you are caring for.
•Tears are acceptable as long as they do not take the focus off the person you are there to support and cause them more distress.
•Tears are healing and often they are more uncomfortable for others than the one shedding them.
•Having time out when you need it is important.

Why is spiritual care important?
•People in hospital are at their most vulnerable.
•They are suddenly dependent on others.
•Their identity has been stripped away.
•They may feel fear, anxiety, grief/loss, anger.
•As nurses, being aware of this is vital to assess spiritual care needs (which nurses should be doing for each patient they care for).

Visits
Visiting on the wards with different members of the Chaplaincy team has been interesting . . .
•Patients have been happy to talk to someone who is neutral (not family, not staff).
•Sometimes the perception of nursing staff has been totally different to that of chaplaincy.
•Active listening is key.

•In all of the visits where I have been present, the patient has appreciated time spent with them. Staff Support
•Staff having access to spiritual support is beneficial both to them and to the Trust as it is a means of reducing stress, letting off steam or just having someone there to talk to (someone non-judgemental and removed from the situation).
•Cost effective to the Trust

Volunteers
• The volunteers are crucial. It would be impossible to run the service without their input.
• Concerns of the volunteers -
Publicising the volunteer service amongst younger people could be improved.

The Funeral Emotional
Closure Peace
Unfinished business Visualisation
Aiding the grieving process (Denial, Anger, Bargaining, Depression, Acceptance) Spiritual care to me is . . .

Professional Level
•Being spiritually 'in tune'
•Giving patients/families time
•Assessing spiritual needs regularly
•Being aware of spiritual distress and knowing when to refer
•Holistic care, caring for the body, mind and soul

Personal Level
•Knowing myself and my limitations
•Being open for the Holy Spirit to work through me and the care I give to my patients/families
•Committing everything I do to God

Personal Reflection

Having this experience has helped me come to terms with many personal issues and through this process I feel I am better equipped to help others. I am amazed at God's planning during my time here – the things I have been involved in could not be co-incidence. It has been a privilege to be part of something very special here in the Chaplaincy team. I have learnt so much from you all. We have been called to show God's love to those we come into contact with and I have felt that during my time here.

Appendix 10: Memo on losing lunch

June 2011

I am trying to look at philosophy to see where my research fits ...I know I have looked a bit at Heidegger (as I have discovered he was a Nazi...I am liking him less) and questioned his notion of being...arguing that one cannot 'be' until you have arrived (perhaps he thought that the arriving business was far too messy and complicated and somehow assumed that people are born/ bred 'being') and these students in my study are trying to get somewhere...even if it is up a huge mountain.

And now I am thinking journeys are complicated (Andre you know how I love talking about journeys)...well not all journeys...but can you recall driving somewhere and bits of your journey not resonating with you...normally after a night shift...you know...not remembering to 'see' bits of a journey you are familiar with...we just 'do it'.

I put my prawn stir fry in the fridge, in the kitchen at work the other day. I then 'lost it' what I mean was as I couldn't find it in my bag...on my desk...I even went back to the car and looked for it ... not there...maybe I thought I had left it at home on the side when I went back in to collect something...I then wondered to myself just before going home...did I put it in the fridge???...and I had.

Now had a large monster jumped out of the fridge at me that morning and punched me on the nose you can bet your bottom dollar that I would have remembered that I had put my prawn stir fry in the fridge...In fact I may have even developed some kind of fridge phobia...and needed something to protect me from the monster each time I went to the fridge...so I would seek something out....and the whole journey of going to the fridge would be etched on my very being...the "What happens if I go to the fridge and don't have something to protect me" journey...not a story...(although I have made it a story in its telling)...but it is an action... and journeying is an action...(back to gerunds again) ...but we don't always know we are in the middle of an action.

Now, this is not the same as decision making ...because decision making requires a consciousness of action associated with a hope that it will be successful...and hope usually occurs simultaneously with fear, coming after the initial event (fridge, monster, nose).

I may make the decision that I need protecting...I buy a nose protector, I carry tazzor...I get someone to come to the fridge with me and distract said monster ...I may do all of these or one of these...I may first try them all out and see which one is

the most effective... But this will require a certain amount of bravery (hope) and the potential risk that one or none will be effective.

Or...I may chose to ask someone if they have had a similar experience of the monster in the fridge and they may tell me that they found that the nose protector helped prevent injury...but did nothing for the fear... So suggest I take them along with me and while I wear the nose protector, they can tazzor the monster (well I had already thought of that and now two of us will be frightened...hope is beginning to disappear)

I could try another fridge...but monsters could lurk there...what to do?? Someone can't help me...I have to help myself...but I don't know how, I have no hope...so I leave all fridges well alone and buy lunch at the shop....ATTRITION ... I attrite myself from all things to do with the fridge.

So what I am trying to say in all of this (it's very hard to have deep philosophical thoughts and maintain them when a sad daughter brings you coffee).

The action of journeying requires a consciousness but an informed consciousness as opposed to a uniformed consciousness. ..It requires knowledge and a knowing and none of these can exist without 'hope'

But the need for knowing is only sparked by something happening on the journey...and then you have to find the knowledge you seek...and if by now you are completely freaked by the thought of the monster in the fridge, you do not want to start knowing...you have no 'hope' of knowing ....you just want the journey to be easy and unmemorable the way it always was.

I spent all day hoping I would find my stir fry...mostly because I hate waste and I hated the thought of it going off somewhere (in the decomposing way...not in the "I am leaving to start a new life" way) ...most of all I hated the fact that my mind had played this dirty trick on me and I hoped this was not the start of dementia!

Had the monster in the fridge existed then I would have hoped that it was just a figment of my philosophical imagination...and I would have sought knowledge and knowing about the positioning of monsters in fridges.

So as said daughter has just read this and said "*you lost me Mum with the whole fridge and the monster thing"...* I tried explaining that when you are in a dark place and have no hope you will not seek out the knowledge you may need to help yourself... to make sense of what you are feeling...Or worst still you will become the monster ready to scare anyone who looks in a fridge.

And now here is a conundrum...if (As Bertie Russell says) "philosophy is the no-man's land between science and theology...exposed to attack from both

sides”...where does this leave a research study on spirituality... Hmmmmm tricky.....

Knowing is a conscious action...you can’t know something until something has happened to make you know...you can’t do deciding until you know what you are deciding upon. You can’t do journeying without starting somewhere and arriving...and you can’t do ‘being’ until you have done arriving...and know you are there!

Appendix 11: Permission request to Houston Civic Arts Association

Thank you, the following information has been sent:	
Name	Wendy Wigley
Email	ww1@soton.ac.uk
Phone	
Comments	Dear Sirs I would very much like to use a copy of the beautiful artwork by William Kalwick, Jr. entitled Carrying Hope, in my doctoral thesis: Carrying Hope: A Grounded Theory Study of Pre-Registration Nursing Students' Understanding and Awareness of Their Spirituality from Experiences in Practice. I have already contacted William Kalwick, Jr. but have had no response. Please be advised that this study is for an academic award of Clinical Doctorate from the University of Southampton and is not for formal publication. Thanking you in anticipation Wendy Wigley Doctoral Student
Captcha	025830

Appendix 12: Participant demographics

Assigned Identifying letter	Disclosed personal belief/faith	Branch of nursing study	Participated in focus group (Phase 1)	Number of interviews (Phase 2)
A	Christian	Adult	Yes	None
AM	Buddhist	Adult	No	One
B	None	Adult	Yes	Two
D	Christianity (Converted from Sikhism)	Child	Yes	Two
J	None	Adult	No	One
K	Pagan	Adult	Yes	Two
R	Christian	Adult	No	One

Glossary of Terms

Antonym:	A word opposite in meaning to another
Artefacts:	A collection of additional data such as written text, creative materials or objects (drawings and other imagery or symbolisms) to provide the researcher with ideas and insights into the personal structures and cultural influences of participants.
Basic Social Processes [BSPs]:	Fluctuating actions demonstrated by individuals as part of their interaction and relationship with an environment and individuals therein (Glaser 1978).
Calling:	A strong urge towards a particular way of life or career; a vocation (Soanes and Stevenson 2006: 199)
Category:	A concept that is derived from and grounded in an accumulation of coded data
Code:	The 'name' given to a particular type or section of data during initial analysis
Concept:	See category
Constant comparison:	An analytical process comparing data with data so that more theoretical concepts are generated (Charmaz 2006)
Core:	The one category into which lesser categories, their properties and the codes relating to the properties, all fit
Drugless trip:	See 'in-phenomenon' below
Emergence:	A process in which categories relating to the properties and grounded in the data are discovered by the researcher
Formal theory:	A theory developed from comparison of several substantive theories to propose a theory that concerns a conceptual area,

	grounded in the data from several substantive theories (Glaser and Strauss 1967)
Freewriting:	A writing style used during analysis that liberates the researcher's thoughts and feelings about their research and enables the transference of ideas into text (Charmaz 2006).
Gerund:	An English verb which ends in *'ing'* but that primarily functioned is as a noun (Soanes and Stevenson 2006). Useful in identifying BSPs
In-phenomenon:	Sparks of discovery and conception of ideas in the iterative process also referred to as a '*drugless trip'* (Glaser 1978:127).
Memos:	Flexible data authored by the researcher and useful for helping the researcher to put into context different observations acquired during the other data collection methods (Schreiber 2001; Charmaz 2006)
Negative cases:	Illustrations used in grounded theory to improve theoretical sensitivity and thus guard against potential bias (Schreiber 2001). Negative cases can appear to be saying the opposite of the emerging theory.
Property:	Derives from a selection of codes and fits within a given category
Service user:	A contemporary term used to describe individuals who receive care or whose relatives/friends receive care within health care provision i.e. Patient, Client or Carer
Spirituality:	Wider than religion, the inner 'self' that arouses feelings of love, faith, hope and trust that provides meaning, inner peace and purpose in life.
Stress:	The disruption of meanings, understanding and smooth functioning so that harm, loss or challenge are experienced, and sorrow,

	interpretation, or new skill acquisition is required (Benner and Wrubel 1989:412)
Substantive theory:	A theory that is developed as part of an empirical enquiry into a substantive area and grounded in the data (Glaser and Strauss 1967)
Synonyms:	Words with the same or similar meanings
Theoretical sampling:	Often used in tandem with constant comparison, a process in which further data is generated. This process is controlled by the emerging theory (Glaser and Strauss 1967). The researcher concurrently moves between collection of data, coding and then analysing the data (Glaser 2004; Schreiber 2001; Glaser 1978)
Theoretical saturation:	The point when the researcher cannot find any new insights, perceptions and meaningful properties from theoretical sampling and data collection (Milliken and Schreiber 2001)
Theoretical sorting:	An essential element of grounded theory that integrates and brings back together data that has been broken into many constituents (Glaser 1992; 2004)

References

Abdellah F G et al (1960) Patient-centred approaches to nursing New York: Macmillan CITED IN: Heath HBM (2002) *Foundations in Nursing Theory and Practice* London: Mosby

Alder P A and Alder P (1987) *Membership roles in field research: Qualitative research methods series 6* London: Sage University Press

Alligood M R and Marriner Tomey A (2009) *Nursing Theorists and Their Work* (7th Edition) St Louis: Mosby

Anderson D A (2003) *Tales Before Tolkien: The Roots of Modern Fantasy* New York: Ballantine Books

Ainsworth-Smith I and Speck P (1986*) Letting Go: Caring for the Dying and Bereaved* London: New Library of Pastoral Care

Anthony M, Miller M A and Muscarella G (2006) *The Legendary Life And Fables of Aesop* Toronto: Mayant Press

Ayliffe Poole G (2010) *The Anglo-Catholic use of two lights upon the altar (1840)* London: Kessinger Publishing

Backman K and Kyngäs H A (1999) Challenges of the Grounded theory approach to a novice researcher *Nursing and Health Sciences* 1: 147-153

Baldacchino D R and Buhagiar A (2003) Psychometric evaluation of Spiritual Coping Strategies scale in English, Maltese, black-translation and bilingual versions *Journal of Advanced Nursing* 42 (6): 558-570

Baroni H J (2002) *The Illustrated Encyclopaedia of Zen Buddhism* New York: The Rosen Publishing Group

Barnett R (1999) *The limits of Competence: Knowledge, Higher Education and Society London*: The Society for Research into Higher Education & Open University Press

Baxter-Magolda M (1990) Gender differences in epistemological development. Journal of Colleges Student Development 31: 555-561 CITED IN: Sprinthall N A and Collins W A (1995) *Adolescent Psychology: A developmental View* New York: McGraw-Hill Inc.

Beckett C (2004) *Human Growth and Development* London: Sage Publications

Benner P (1984) *From Novice to Expert: Excellence and Power in Clinical Practice* (commemorative edition 2001) New Jersey: Prentice Hall

Benner P and Wrubel J (1989) *The Primacy of Caring: Stress and Coping in Health and Illness* California: Addison Wesley

References

Bennett T (2012) Under your skin *Times Educational Supplement* 5009: 26-30

Benzies KM and Allen MN (2001) Symbolic interactionism as a theoretical perspective for multiple method research *Journal of Advanced Nursing* 33 (4): 541-547

Biggs J (2005) *Teaching for Quality Learning at University* (2nd Edition) Buckingham: Open University Press

Birks J and Mills J (2011) *Grounded theory: A practical guide* Sage: London

Blackwell's *Dictionary of nursing* (1998) Oxford: Blackwell Science

Bloor M, Frankland J, Thomas M and Robson K (2002) *Focus Groups in Social Research* London: Sage Publications

Blumer H (1986) *Symbolic Interactionism: Perspective and Method* Berkeley: University of California Press

Bolton G E J (2010) *Reflective Practice: Writing and Professional Development* London: Sage

Bolton S C (2000) Who cares? Offering emotion work as a `gift' in the nursing labour process, *Journal of Advanced Nursing* 32 (3): 580-586

Bowling A (2004) *Research methods in health: Investigating health and health services* Maidenhead: Open University Press

Bradshaw A (1994) *Lighting the Lamp. The spiritual Dimension of Nursing Care* Harrow: Scutari Press

Briggs K (1978) *The vanishing people: a study of traditional fairy beliefs* London: Batsford

Brown P G and Garver G (2009) *Right Relationship: Building a Whole Earth Economy* Berrett-Koehler Publishers, Inc.: San Francisco

Brownlow C V (1945) *Gould's Medical Dictionary* London: Lewis and Co. LTD

Brosche T A (2003) Death, Dying, and the ICU Nurse *Dimensions of Critical Care Nursing:* 22 (4):173-179

Bryant A and Charmaz K (2011) *The Sage Handbook of Grounded Theory* London: Sage

Bryant A (2003) A Constructivist Response to Glaser *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* 4 (1). Available at: http://www.qualitative-research.net/fqs-texte/1-03/1-03bryant-e.htm [July 31 2007]

Bryant A (2002) Re-Grounding Grounded Theory. *The Journal of Information Technology Theory and Application* 4 (1): 25-42

Burns N and Groves SK (2001) *The Practice of Nursing Research: Conduct, Critique & Utilization* (4th Edition) Philadelphia: W.B. Saunders Company

Campbell J (1988) *The Power of Myth* New York*:* Bantam Doubleday Dell Publishing Group

Campbell C (1996) Half-Belief and the paradox of Ritual Instrumental Activism: A theory of Modern Superstition *British Journal of Sociology* 47 (1): 151-166

Carper BA (1978) Fundamental patterns of knowing in nursing. *Advances in Nursing Science* 1(1): 13-23

Carroll B (2001) A Phenomenological exploration of the nature of spirituality and spiritual care *Mortality* 6 (1): 81-98

Carroll R and Prickett S (2008) *The Bible: Authorized King James Version* Oxford: Oxford Paperbacks

Carson BV (1989) *Spiritual Dimensions of Nursing Practice* Philadelphia: W.B. Saunders Company

Carver N, Ashmore R and Clibbens N (2007) Group clinical supervision in pre-registration nurse training: The views of mental health nursing students. *Nurse Education Today* 27: 768-776

Cave D (2012) A Factory on Bicycle Wheels, Carrying Hope of a Better Life. *The New York Times* Available at: http://www.nytimes.com/2012/12/31/world/americas/mobile-factory-with-hope-for-a-better-life-mexico-city-journal.html?_r=0 [Accessed: 10 February 2013]

Charmaz K (2009) Shifting the Grounds: Constructivist Grounded Theory Methods IN: Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K and Clarke AE (eds) *Developing Grounded Theory: The Second Generation.* California: Left Coast Press 127-193

Charmaz K (2006) *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* London: Sage Publications

Charmaz K (1991) Good days, Bad Days: The Self in Chronic Illness and Time Berkeley: University of California Press: 173 CITED IN: Frank AW (1997) *The Wounded Storyteller: Body, Illness, and Ethics* Chicago: The University of Chicago Press

Chinn PL and Kramer MK (1991) *Theory and Nursing: a systematic approach* (3rd Edition) St Louis: Mosby Year Book

Chuengsatiansup K (2003) Spirituality and health: an initial proposal to incorporate spiritual health in health impact assessment *Environmental Impact Assessment Review* 23: 3 –15

Clark MB (2000) Characteristics of faith Communities IN: Clark MB and Olson JK (2000) *Nursing within a Faith Community: Promoting Health in Times of Transition* Thousand Oaks: Sage 17-29

Clark MB and Olson JK (2000) *Nursing within a Faith Community: Promoting Health in Times of Transition* Thousand Oaks: Sage

References

Clarke A (2010) *The Sociology of Healthcare* Harlow: Livingstone

Cleary M (2004) The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing* 13*:* 53–60

Clothier C, MacDonald CA and Shaw DA (1994) *The Allitt inquiry: independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991*. London: HMSO publishers

Clover B (2011) *Huge fall in nurses dropping out of nursing courses* NursingTimes.Net. Available from: http://www.nursingtimes.net/whats-new-in-nursing/news-topics/nursing-education/huge-fall-in-nurses-dropping-out-of-nursing-courses/5035504.article [Accessed 28 October 2012]

Cluett E and Bluff R (2000*) Principles and Practice of Research in Midwifery* London: Bailliere Tindall

Coleman E (1982) Developmental stages of the coming out process *Journal of homosexuality* 7 (2): 9-17

Corbin J (2008) Is caring a lost art in nursing? *International Journal of Nursing Studies* 45: 163-165.

Costello J (2001) Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards *Journal of Advanced Nursing* 35 (1): 59-68

Cowman S (1998) The approaches to learning of student nurses in the Republic of Ireland and Northern Ireland *Journal of Advanced Nursing* 28 (4): 899–910

Crombie IK (1996) *The pocket guide to critical appraisal* London: BMJ Publishing

Cox J and Holden J (2003) *Perinatal Mental Health: A Guide to the Edinburgh Postnatal Depression Scale (Epds)* London: RCPsych Publications

Davey L (2002) Nurses eating nurses: the caring profession which fails to nurture its own! *Contemporary Nurse* 13 (2-3):192-7

Deegan P (1996) Recovery as a journey of the heart Psychiatric *Rehabilitation Journal* 19 (3):91-97

Deegan P (2000) Spirit Breaking: When the Helping Professions Hurt. *The Humanistic Psychologist*
28 (1-3) 194-209

deGraaf K R, Marriner-Tomey A, Mossman C L and Slebodnik M (1989) '*Florence Nightingale*: *Modern Nursing'* in Marriner-Tomey A (eds) *Nursing Theorists and Their Work (*2nd Edition) St Louis: Mosby Company 59-57

Davies J (2003) *Touching the Hem, Encounters with Jesus by those who knew him* Suffolk: Kevin Mayhew

Data Protection Act (1998) Available at: http://www.legislation.gov.uk/ukpga/1998 [Accessed: 02 December 2010]

Department of Health [DH] (2003) *NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff: Guidance for managers and those involved in the provision of chaplaincy-spiritual care* London: DH Publications

Department of Health [DH] (2009) *Religion or belief: A practical guide for the NHS* London: DH Publications

Department of Health [DH] (2011) *Spiritual Care at the End of Life: a systematic review of the literature* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123804.pdf [accessed 12 June 2012]

Department of Health [DH] (2012) *Compassion in Practice Nursing, Midwifery and Care Staff Our Vision and Strategy* http://www.commisioningboard.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf [accessed 02 April 2013]

Dey I (1999) *Grounding grounded theory* San Diego: Academic Press

Dey I (1993) *Qualitative data analysis* Thousand Oaks: Sage CITED IN: Schreiber R S and Stern PN (2001) Using Grounded Theory in Nursing: New York: Springer Publishing Company

Donabedian A (1989) Institutional and professional responsibilities in quality assurance *Quality Assurance in Health Care* 1 (1): 3 – 11

Dougherty L and Lister S (2011) *The Royal Hospital Manual of Clinical Nursing Procedures* (8th Edition) Chichester: Wiley-Blackwell

Drury V, Francis K and Chapman Y (2008) Mature learners becoming registered nurses: a grounded theory model. *Australian Journal of Advanced Nursing* 26 (2): 39-45

Elliot R (2011) Spirituality, mental health nursing and assessment *Journal of Community Nursing* 25 (3): 4 -10

Erickson H C, Tomlin E.M and Swain M A P (2010) Modeling and Role Modeling IN: Alligood M R and Marriner Tomey A (2010) *Nursing Theorists and Their Work* (7th Edition) St Louis: Mosby 537-559

Eriksson K (1987) Vardandets ide. Stockholm: Almqvist & Wiksell [The idea of caring. Stockholm: Almqvist & Wiksell] CITED IN Lindstrom U A, Lindholm L and Zetterlund J E (2009) Theory of Caritative Caring IN Alligood M R and Marriner Tomey A (2010) *Nursing Theorists and Their Work* (7th Edition) St Louis: Mosby 191-223

Farrington A (1995) Stress and Nursing. *British Journal of Nursing* 4 (10): 374-378

Fisher D, Fairclough L and Wakeham, M (2001) *Finding and Using Information. London*: Distance Learning Centre, South Bank University

Flemming K and Fenton M (2007) Making sense of research evidence to inform decision making IN: Thompson C and Dowding D (eds*) Clinical Decision Making and Judgement in Nursing*. Edinburgh: Churchill Livingstone 109-129

Frank A W (1997) *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: The University of Chicago Press

Freeman M and Sinclair M (2009) Mental health nursing students' experience of stress: burdened by a heavy work load'. *Journal of Psychiatric and Mental Health Nursing* 16:335-342

Gammell C (2009) 'If I'm Nursing, I'll continue to offer prayers. It's a natural thing for me to do. Nurse suspended over her beliefs explains why she will not change'. *The Daily Telegraph* 7 February. 11

Garth J (2011) *Tolkien and the Great War: The Threshold of Middle-earth* London: HarperCollins

Gibson B (2011) Accommodating Critical Theory IN: Bryant, A and Charmaz, K (2011) *The Sage Handbook of Grounded Theory* London: Sage 436-453

Gillman H (2007) *Consider the Blackbird, Reflections on Spirituality and Language*. London: Quaker Books

Glaser B G (2002) Conceptualization: On Theory and Theorizing Using Grounded Theory. *International Journal of Qualitative Methods* 1 (2): 23-28

Glaser B G (2002) Constructivist Grounded Theory? *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* 3 (3). Available at: http://www.qualitative-research.net/fqs/fqs-ebg.htm [Accessed 31 July 2007]

Glaser B G and Holton J (2004) Remodelling Grounded Theory *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* 5 (2). Available at: http://www.qualitative-research.net/index.php/fqs/article/viewArticle/607/1315 [Accessed 16 August 2011]

Glaser B G (2001) *The Grounded theory Perspective: Conceptualization Contrasted with Description*. Mill Valley: Sociology Press

Glaser B G (1998) *Doing Grounded Theory: Issues and Discussions* Mill Valley: Sociology Press

Glaser B G (1996) *Gerund grounded theory: The Basic Social Process Dissertation*. Mill Valley: Sociology Press

Glaser B G (1992) *Basics of Grounded Theory Analysis* Mill Valley: Sociology Press

Glaser B G (1978) *Theoretical sensitivity* Mill Valley: Sociology Press

Glaser B G and Strauss A L (1967) *The discovery of grounded theory* Chicago: Aldine

Glasper E A (2012) This is Nursing: an initiative to reshape the vision of nursing. *British Journal of Nursing* 21 (18): 1104 – 1105

Glen S and Parker P (2003) *Supporting learning in nursing practice: a guide for practitioners*. Basingstoke: Palgrave Macmillan

Goffman E (1963) *Stigma: Notes on the Management of Spoiled Identity* Englewood Cliffs: Prentice-Hall

Goffman E (1969) *The Presentation of Self in Everyday Life* Middlesex: Penguin Books

Goldberg B (1998) Connection: an exploration of spirituality in nursing care. *Journal of Advanced Nursing* 27:836-842

Goodman A and Gregg P (2010) *The importance of attitudes and behaviour for poorer children's educational attainment.* Joseph Roundtree Foundation Available at: http://www.jrf.org.uk/publications/educational-attainment-poor-children [Accessed: 09 August 2012]

Greasley P, Chiu L F and Gartland RM (2001) The concept of spiritual care in mental health nursing. *Journal of Advanced Nursing* 33(5): 629-637

Greenhalgh T (2006) *How to Read a Paper: The Basics of Evidence-Based Medicine*. Chichester: John Wiley & Sons

Greenstreet W (1999) Teaching spirituality in nursing: a literature review, *Nurse Education Today* 19: 649-658

Guba E G and Lincoln Y S (1985) *Effective Evaluation* San Francisco (US): Josey-Bass Publishers

Handy C (1999) *Understanding Organizations* (4th Edition) London: Penguin Books

Hardacre J (2001) *Leadership at every level: a practical guide for managers*. London: Public Sector Management

Harry B, Sturges K M and Klingner JK (2005) Mapping the Process: An Exemplar of Process and Challenge in Grounded theory Analysis. *Educational Researcher* 34 (2): 3-13

Heath H B M (2002) *Foundations in Nursing Theory and Practice* London: Mosby CITING*:* Abdellah F G et al *[sic]* (1960) Patient-centred approaches to nursing. New York: Macmillan AND Levine, M.C. (1973) *An Introduction to clinical nursing*: New York Macmillan

Her Majesties Government [HMG] (2010) *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009* Volume I and Volume 2. Available at: http://www.midstaffsinquiry.com/pressrelease.html [Accessed: 10 February 2010]

Hero (1993) [song] (From the Album Music Box) Written by Carey M and Afanasieff N Columbia Records

References

Holton J (2011) The Coding Process and Its Challenges IN: Bryant A and Charmaz K *The Sage Handbook of Grounded Theory* London: Sage 265-289

Jeon Y (2004) The application of grounded theory and symbolic interactionism *Scandinavian Journal of Caring Science* 18: 249-256

Johns C (2003) Opening the Doors of Perception IN: Johns C and Freshwater D (Eds) *Transforming Nursing Through Reflective Practice* Oxford: Blackwell Publishing 1-20

Kalwick W (n.d) Carrying Hope (painting) *Houston Civic Arts Association*. Available at: http://houstoncivicarts.org/workszoom/725205/carrying-hope-by-william-kalwick-jr [Accessed 10 February 2012]

Katz E and Lazarsfeld P (1955) *Personal Influence: The Part Played by People in the Flow of Mass Communications* New Jersey: Transaction Publishers

Kearney M H (2001) New Directions in Grounded Formal Theory IN: Schreiber R S and Stern PN (eds) *Using Grounded Theory in Nursing*: New York: Springer Publishing Company 227-246

King M, Speck P and Thomas A (1995) The Royal Free Interview for Religious and Spiritual Beliefs: development and standardization. *Psychological Medicine* 25: 1125-1134

Kirkpatrick B (2000) *Roget's Thesaurus of English Words & Phrases* London: Penguin

Kirschner M H (2003) Spirituality and Health. *American Journal of Public Health* 93 (2): 185

Kleinman K R and Raskin V D (1994) *This isn't what I expected: Overcoming Postpartum Depression* New York: Bantam Books

Kramer P, Hinojosa J and Royeen CB (2003) *Perspectives in Human Occupation* Philadelphia: Lippincott Williams and Wilkins

Lacey C (1977) *The word-carrying giant: the growth of the American Bible Society (1816-1966)* Wisconsin: William Carey Library

Laing R D (1972) *Knots* Hammondsworth: Penguin Books

Lapsley I (2009) New Public Management: The Cruellest Invention of the Human Spirit? ABACUS 45 (1): 1-21

LaSala C A and Bjarnason D (2010) "Creating Workplace Environments that Support Moral Courage" *OJIN: The Online Journal of Issues in Nursing* 15 (3). Available at: http://gm6.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol152010/No3-Sept-2010/Workplace-Environments-and-Moral-Courage.aspx [Accessed 10 February 2012]

Last L and Fulbrook P (2003) Why do student nurses leave? Suggestions from a Delphi study. *Nurse Education Today 23*(6): 449-458

Lee R M (1995) *Doing Research on Sensitive Topics* London: Sage Publications

Lee W, Cholowski K and Williams A (2002) Nursing students' and clinical educators' perceptions of characteristics of effective clinical educators in an Australian university school of nursing. *Journal of Advanced Nursing* 39 (5): 412–420

Levett-Jones T and J (2008) Don't rock the boat: Nursing students' experiences of conformity and compliance. *Nurses Education Today* 29:342-349

Levine M C (1973) An Introduction to clinical nursing: New York Macmillan CITED IN Heath H B M (2002) *Foundations in Nursing Theory and Practice* St Louis: Mosby

Lindstrom U A, Lindholm L and Zetterlund J E (2009) Theory of Caritative Caring IN Alligood M R and Marriner Tomey A (2009) *Nursing Theorists and Their Work* (7th Edition) St Louis: Mosby 191-223

Locke K (2011) Rational Control and Irrational Free-play: Dual thinking modes as Necessary Tension in Grounded Theorizing IN Bryant A and Charmaz K (2011*) The Sage Handbook of Grounded Theory* London: Sage

Lord M (2002) Making a Difference: the implications for nurse education. *Nursing Times .Net*. Available at http://www.nursingtimes.net/nursing-practice-clinical-research/making-a-difference-the-implications-for-nurse-education/206457.article [Accessed 11 June 2012]

Lundmark M (2007) Vocation in Theology-Based Nursing Theories *Nursing Ethics* 14 (6): 767-780

MacDonald K (1995) *The Sociology of the Professions* London: Sage

Maben J (2008) The art of caring: Invisible and subordinated? A response to Juliet Corbin: 'Is caring a lost art in nursing?' *International Journal of Nursing Studies* 45: 335-338

Macey S L (2010) *Patriarchs of Time: Dualism in Saturn-Cronus, Father Time, the Watchmaker God, and Father Christmas* Athens: University of Georgia Press

MacVicar M H M (1998) Intellectual Development and research: student nurses' and student midwives' accounts. *Journal of Advanced Nursing* 27, 1305-1316

Marks L and Hunter D J (2005) Moving upstream or muddying the waters? Incentives for managing health *Public Health* 119: 974-980

Marriner-Tomey A (1989) *Nursing Theorists and Their Work* (2nd edition) St Lois: The C.V. Mosby Company

Marsh I, Keating M, Eyre A, Campbell R, McKenzie J and Finnegan (1997) *Making Sense of Society* Harlow: Addison Wesley Longman Ltd

Martsolf D S and Mickley J R (1998) The concept of spirituality in nursing theories: differing world-views and extent of focus *Journal of Advanced Nursing* 27: 294-303

References

Maslow A R (1968) Towards a Psychology of Being *(*2nd edition) New York: D. Van Nostrand *CITED IN:* Carson B V (1989) *Spiritual Dimensions of Nursing Practice* Philadelphia: W.B. Saunders Company

Maxwell R and Maxwell E K (1980) Search and Research in Ethnology: Continuous Comparative Analysis1. *Cross-Cultural Research* 15:219-243

McFarlane J K (1970) *The Proper Study of the Nurse* London: Royal College of Nursing and National Council of Nurses of the United Kingdom

McSherry W (1998) Nurses' perceptions of spirituality and spiritual care *Nursing Standard* 13: 36-40

McSherry W (2000) Education issues surrounding the teaching of spirituality *Nursing Standard* 14: 40-43

McSherry W and Ross L (2002) Dilemmas of spiritual assessment: considerations for nursing practice. *Journal of Advanced Nursing* 28 (5): 479-488

McSherry W and Watson R (2002) Spirituality in nursing care: evidence of a gap between theory and practice *Journal of Clinical Nursing* 11: 843-844

McSherry W, Cash K and Ross L (2004) Meaning of Spirituality: implications for nursing practice. *Journal of Clinical Nursing* 13: 934-941

McSherry W (2010) *RCN spirituality survey 2010: A report by the Royal College of Nursing on members' views on spirituality and spiritual care in nursing practice* London: Royal College of Nursing [RCN] Publishing

McSherry W and Jamieson S (2011) An online survey of nurses' perception of spirituality and spiritual care *Journal of Clinical Nursing* 20 (11-12): 1757–1767

McVicar A (2003) *Workplace stress in nursing: a literature review*. Journal of Advanced Nursing 44 (6): 633-642

Meyer C L (2003) How Effectively Are Nurse Educators Preparing Students to Provide Spiritual Care? *Nurse Educator* 28 (4): 185-190

Milligan S (2004) Perceptions of spiritual care among nurses undertaking postregistration education *International Journal of Palliative Nursing* 10 (4): 162-171

Mills J, Bonner A and Francis K (2006) The development of constructivist grounded theory *International Journal of Qualitative Methods* 5 (1): 1-10 Available at: http://www.ualberta.ca/~iiqm/backissues/5_1/pdf/mills.pdf [Accessed 2 December 2010]

Mitchell D L, Bennett, M J and Manfrin-Ledet L (2006) Spiritual Development of Nursing Students: Developing Competence to Provide Spiritual Care to patients at the End of Life. *Journal of Nurse Education* 45 (9): 365-370

Moore C (2006) The transition from student to qualified nurse: a military perspective**.** *British Journal of Nursing* (DEFENCE NURSING FOCUS) 15 (10): 540-542

Morse J M and Doberneck B (1995) Delineating the Concept of Hope. *Journal of Nursing Scholarship* 27: 277-285

Morse J M, Stern PN, Corbin J, Bowers B, Charmaz, K and Clarke AE (2009) *Developing Grounded Theory*: The Second Generation California: Left Coast Press

Morten H and Taylor F (1944) *The Nurses Dictionary* London: Faber and Faber

Mothers Union (2011) *Children & Spirituality* London: Mothers Union

Murray S A, Kendall M, Boyd K, Worth A and Benton T F (2004) Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers. *Palliative Medicine* 18: 39-45

Narayanasamy A (1993) Nurses awareness and educational preparation to meet their patients' spiritual needs *Nurse Education Today* 13: 196-20

Narayanasamy A (1995) Spiritual care of chronically ill patients *Journal of Clinical Nursing* 4: 397-398

Narayanasamy A and Owens J (2001) A critical incident study of nurses' responses to the spiritual needs of their patients' *Journal of Advanced Nursing* 33 (4): 446-455

Narayanasamy A, Gates B and Swinton J (2002) Spirituality and learning disabilities: a qualitative study. *British Journal of Nursing* 11 (14): 446-455

Narayanasamy A, Clissett P, Parurmal L, Thompson D, Annasamy S and Edge R (2004) Responses to spiritual needs of older people *Journal of Advanced Nursing* 48 (1): 6-16

Narayanasamy A (2006) The impact of empirical studies of spirituality and culture on nurse education *Journal of Advanced Nursing* 15 (7): 840-851

Nathaniel A K and Andrews T (2007) How Grounded theory can Improve Nursing Care Quality *Journal of Nursing Care Quality* 22 (4): 350-357

Neuman B (1989) *The Neuman Systems Model* (2nd Edition) Norwalk, Connecticut: Appleton and Lange

Newman M A (1986) *Health as Expanding Consciousness* St Louis: Mosby

Nicholl H and Timmins F (2005) Programme-related stressors among part-time undergraduate students *Journal of Advanced Nursing* 50(1): 93-100

Nightingale F (1915) *Florence Nightingale to her Nurses* London: Macmillan & Co
Re print (2007) Kessinger Publishing's Rare Reprints

Nightingale F (1860) *Notes on Nursing, what it is and what it is not* America: D. Appleton and Company. Re print (2005) iBooks: Public Domain Books

Nouwen H J M (1979) *The Wounded Healer* London: Darton: Longman and Todd Ltd

Nursing and Midwifery Council [NMC] (2002) *Code of professional conduct*. London: NMC

Nursing and Midwifery Council [NMC] (2004a) *Standards of proficiency for pre-registration nursing education*: London: NMC

Nursing and Midwifery Council [NMC] (2004b) *The NMC code of professional conduct: Standards for conduct, performance and ethics*: London: NMC

Nursing and Midwifery Council [NMC] (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives*. London: NMC

Nursing and Midwifery Council [NMC] (2009) *Guidance for the care of older people.* London: NMC

Nursing and Midwifery Council [NMC] (2010) *Standards for pre-registration nursing education.* London: NMC

O'Connor N (1993) *Paterson and Zderad: Humanistic Nursing Theory* Newbury Park: Sage Publications

O'Donnell H (2008) The emotional impact of nursing student attrition rates *British Journal of Nursing* 17(12): 745-754

O'Mahony N (2011) Nurse burn out and the working environment *Emergency Nurse* 19 (5): 30-37.

O'Neil B (2000) Doctor as Murderer *BMJ* 320: 329-330

Office of National Statistics [ONS] (2011) *Integrated Household Survey April 2010 to March 2011: Experimental Statistics*. Available at: http://www.ons.gov.uk/ons/rel/integrated-household-survey/integrated-household-survey/april-2010-to-march-2011/stb---integrated-household-survey-april-2010-to-march-2011.html [Accessed: 23 October 2012]

Olson J K (2000) Health, Healing, Wholeness and Health Promotion Clark MB and Olson J K (eds) *Nursing within a Faith Community: Promoting Health in Times of Transition* (Chapter 3) Thousand Oaks: Sage 31-41

Onder C and Basim N (2008) Examination of developmental models of occupational burn out using burn out profiles of nurses *Journal of Advanced Nursing* 64(5): 514–523

Opie I and Tatem M (1992) *A Dictionary of Superstitions* Oxford: Oxford University Press

Orton S (2011) Re-thinking attrition in student nurses. Journal of Health and Social Care Improvement 1: 1-7

Osborne R (1992) *Philosophy for Beginners* New York: Writers and Readers Publishing Incorporated

Parahoo K (1997) *Nursing Research: Principles, Process and Issues* Basingstoke: Macmillan.

Parry K W (1998) Grounded theory and social process: A new direction for leadership research *Leadership Quarterly* 9 (1): 85-105

Parse R R (1981) *Man-Living-Health theory of nursing* New York: Wiley

Parse R R (1999) *Hope: An international human becoming perspective* Sudbury MA: Jones and Bartlett

Paterson J G and Zderad L T (1988) *Humanistic Nursing* New York: National League for Nursing

Peace on Earth (2000) [song] (from the album: All That You Can't Leave Behind) Written by Bono. Island/Interscope Records

Perry B (2009) Role modeling excellence in clinical nursing practice *Nurse Education in Practice*, 9: 36–44

Pizzorno A (2008) *Rationality and Recognition* IN: Porta D and Keating M (eds) *Approaches and methodologies in the social sciences: A Pluralist perspective* Cambridge: Cambridge University Press 162-173

Por J and Barriball L (2008) The personal tutor's role in pre-registration nursing education. British Journal of Nursing, 17 (2): 99- 103

Porta D and Keating M (2008) *Approaches and methodologies in the social sciences: A Pluralist perspective* Cambridge: Cambridge University Press

Randle J (2001) The effect of a 3-year pre-registration training course on students' self-esteem *Journal of Clinical Nursing* 10:293-300

Riehl J P and Roy C (1980) *Conceptual models for nursing practice* (2nd Edition) New York: Appleton-Century-Crofts

Riehl-Sisca J (1989) *Conceptual models for nursing practice* (3rd Edition) Norwalk: Appleton & Lange

Remen R N (1996) *Kitchen Table Wisdom: Stories That Heal* New York: River Head Books

Remen R N (2001) Recapturing the soul of medicine *Western Journal of Medicine* (WJM) 174: 4-5. Available from http://www.rachelremen.com/recapturing.html [Accessed 23 November 2012]

Rogers A (2002) Teaching Adults (3rd Edition) Maidenhead: Open University Press

Rogers C (1983) *Freedom to Learn for the 80's* London: Charles E. Merrill Publishing Company

Rogers M E (1980) Nursing: a science of unitary man IN: Riehl J P and Roy C (eds) *Conceptual models for nursing Practice* (2nd Edition) New York: Appleton-Century-Crofts 181-188

References

Ross L A (1994) Spiritual aspects of nursing *Journal of Advanced Nursing* 19: 439-447

Ross L A (1996) Teaching spiritual care to nurses *Nurse Education Today* 16: 38-43

Ross L (2006) Spiritual care in nursing and overview of the research to date *Journal of Clinical Nursing* 15: 852-862

Roy C (1980) *The Roy adaptation model* IN: Riehl J P and Roy C (eds) Conceptual models for nursing practice (2nd Edition) New York: Appleton-Century-Crofts 105-114

Royal College of Nursing [RCN] (2012) *Quality with compassion: the future of nursing education* Report of the Willis Commission on Nursing Education, London. RCN Publishing

Ruether R R (1994) *Gaia and God: An Ecofeminist Theology of Earth Healing* London**:** Harper Collins

Runcorn D (2006) *Spirituality workbook: A guided for explorers, Pilgrims and Seekers*. London: Society for Promoting Christian Knowledge

Salmon C (2010) *Storytelling: Bewitching the Modern Mind*. Paris: Verso

Schreiber R S and Stern PN (2001) *Using Grounded Theory in Nursing*: New York: Springer Publishing Company

Shih F J, Gau M L, Mao H C, Chen, C H and Lo C H K (2001) Empirical validation of a teaching course on spiritual care in Taiwan *Journal of Advanced Nursing* 36 (3): 133-346

Smith J (2005) *The Shipman Inquiry: final report* Available at: http://www.shipman-inquiry.org.uk/home.asp [Accessed: 05 August 2012]

Smith K V and Godfrey N S (2002) Being a Good Nurse and Doing the Right Thing: A Qualitative Study. *Nursing Ethics*, 9 (3): 201-312

Soanes C and Stevenson A (2006) *Concise Oxford English Dictionary* (11th Edition) Oxford: Oxford University Press.

Speck P, Higginson I and Addington-Hall, J (2004) *Spiritual Health Needs* Editorial BMJ 329 (7458): 123-124

Speck P W (1978) *Loss and grief in medicine* London: Baillière Tindall

Speziale H J and Carpenter D (2007) *Qualitative Research in Nursing: Advancing the Humanistic Imperative* (4th Edition) Philadelphia: Lippincott Williams and Wilkins

Spouse J (2000a) Talking Pictures – investigating personal knowledge through illuminative art work *Nursing Times Research* 5:253-261

Spouse J (2000b) An impossible dream? Images of nursing held by pre-registration students and their effect on sustaining motivation to become nurses *Journal of advanced Nursing* 32 (3): 730-739

Spouse J (2001) Bridging theory and practice in the supervisory relationship: a sociocultural perspective. *Journal of Advanced Nursing* 33 (4): 512–522

Sprinthall N A and Collins W A (1995) *Adolescent Psychology: A developmental View* New York: McGraw-Hill Inc.

Star S L (2011) Living Grounded theory: Cognitive and Emotional Forms of Pragmatism IN: Bryant A and Charmaz K *The Sage Handbook of Grounded Theory* London: Sage 75-91

Stephenson C (1991) The concept of hope revisited for nursing *Journal of Advanced Nursing* 16:1456-1461

Stern N S and Covan E K (2001) Early Grounded Theory: Its Processes and Products IN: Schreiber R S and Stern PN *Using Grounded Theory in Nursing*: New York: Springer Publishing Company 17-34

Stern P N (2009) Glaserian Grounded Theory IN*:* Morse J M, Stern PN, Corbin J, Bower B, Charmaz, K and Clarke A E (eds) *Developing Grounded Theory: The Second Generation* California: Left Coast Press 55-85

Stephens W (2002) *Demon Lovers: Witchcraft, Sex, and the Crisis of Belief* Chicago: University of Chicago Press

Stockhausen L J (2005) Learning to become a nurse: Students' reflections on their clinical experiences *Australian Journal of Advanced Nursing* 22 (3): 8-14

Strauss A and Corbin J (1998) *Basics of Qualitative Research; Technique and Procedures for developing Grounded Theory* (2nd Edition) London: Sage Publications

Struther J (1986) When a knight won his spurs IN Moore G *Hymns Old and New* Suffolk: Kevin Mayhew Ltd

Sullivan J (2004) *Carrying the Cross with Christ* New Jersey: Paulist Press International

Swinton J and Willows D (2009) *Spiritual Dimensions of Pastoral Care: Practical Theology in a Multidisciplinary Context.* London: Jessica Kingsley Publishers

Tanyi R A (2006) Spirituality and family nursing: spiritual assessment and interventions for families *Journal of Advanced Nursing* 53 (3):287-294

Taylor C and White S (2000) *Practising reflexivity in health and welfare: Making Knowledge*. Buckingham: Open University Press

The Holy Bible (1997) *New Revised Standard Version [NRSV]* New York: World Publishing

Thomas V M (n/d) A *Cross in My Pocket* Available at: http://www.fulwoodmethodist.org.uk/fmcmag/easter%202007/cross/cross_in_my_pocket.htm [Accessed 20/10/12]

Timmins F and Kaliszer M (2002) Aspects of nurse education programmes that frequently cause stress to nursing students - fact finding survey *Nurse Education Today* 22: 203-211

Tolkien J R R (1954) *The Fellowship of the Ring* London: George Allen & Urwin

Tolkien J R R (1954) *The Two Towers* London: George Allen & Urwin

Tolkien J R R (1955) *The Return of the King* London: George Allen & Urwin

Trauth E M (2001) *Qualitative Research: Issues and Trends* London: Idea Group Publishing

Travelbee J (1971) *Interpersonal aspects of nursing* (2nd Edition) Philadelphia: F. A. Davies

United Kingdom Central Council for Nurses, Midwives and Health Visitors [UKCC] (1986) *Project 2000 – A New Preparation for Practice* London: UKCC

United Kingdom Central Council for Nurses, Midwives and Health Visitors [UKCC] (2000) *Requirements for Pre-registration Nursing Programmes* London: UKCC

University of Southampton (2010) *Research Integrity and Academic Conduct Policy* Available at: http://www.soton.ac.uk/ris/policies/integrity.html [Accessed 02 December 2010]

Urquhart C (2001) An Encounter with Grounded Theory: Tackling the Practical and Philosophical Issues IN: Trauth E M (ed) *Qualitative Research: Issues and Trends* London: Idea Group Publishing 104-140

Urquhart C (2011) The Evolving Nature of Grounded theory Method: The Case of The Information Systems Discipline IN: Bryant A and Charmaz K *The Sage Handbook of Grounded Theory* London: Sage 339-359

Vale-Taylor P (2009) "We will remember them": a mixed-method study to explore which post-funeral remembrance activities are most significant and important to bereaved people living with loss, and why those particular activities are chosen *Palliative Medicine* 23:537–544

Vallis J and Boyd K (2002) *Ethics and end-of-life decision- making* IN*:* Hockley J and Clark D (eds) *Palliative Care for Older People in Care Homes* Buckingham: Open University Press 120-135

van Leeuwen R, Tiesinga L J, Post D P and Jochemsen H (2006) Spiritual care: implications for nurses' professional responsibility *Journal of Clinical Nursing* 15: 875-884

Vanier J (1992) From Brokenness to Community *The Wit Lectures* New York: Paulist Press

Waite M (2009) *Oxford Thesaurus of English* (3rd Edition) Oxford: Oxford University Press

Wallbank S and Robertson N (2008) Midwife and nurses responses to miscarriage, stillbirth and neonatal death. *Evidenced Based Midwifery* 6 (3): 100-106

Wallbank S (2013) Recognising stressors and using restorative supervision to support healthier maternity workforce: a retrospective, cross-sectional, questionnaire survey. *Evidenced Based Midwifery* 11 (1): 4-9

Warburton N (2010) *Philosophy: the basics* (4th Edition) London: Routledge

Watson J (1985) *Nursing: Human Science and Human Care: A Theory of Nursing* New York: Appleton-Century-Crofts

West D (2012) Nurses at risk of 'compassion fatigue' Available at: http://www.nursingtimes.net/whats-new-in-nursing/acute-care/nurses-at-risk-of-compassion-fatigue/5012327.article [Accessed 02 November 12]

White J (1995) Patterns of knowing: Review, critique, and update *Journal of Advanced Nursing* 17 (4): 73-86

Wiener C (2011) Making Teams Work in Conducting Grounded Theory IN: Bryant A and Charmaz K (eds) *The Sage Handbook of Grounded Theory* London: Sage 293-310.

World Health Organisation [WHO] (1948) Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (*Official Records of the World Health Organization* 2: 100)

Worth J (2008) *Call the Midwife* London: Phoenix

Wuest J and Merritt-Gray (2001) Feminist Grounded Theory Revisited: Practical Issues and New Understandings IN Schreiber R S and Stern PN (2001) *Using Grounded Theory in Nursing*: New York: Springer Publishing Company