

**MESSY BOUNDARIES - THE LIVED EXPERIENCE WHEN
YOUNGER CHILDREN'S NURSING STUDENTS ARE
REQUIRED TO CARE FOR YOUNG PEOPLE**

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requirements of the University of Greenwich
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DECLARATION

“I certify that this work has not been accepted in substance for any degree, and is not concurrently being submitted for any degree other than that of Doctorate in Education being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised the work of others.

SIGNATURE (STUDENT) DATE

SIGNATURE (SUPERVISOR) DATE

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ABSTRACT

It is acknowledged that caring interactions between younger, adolescent student nurses and young adolescent patients could precipitate particular difficulties and concerns for both parties during their journeys toward successful self-identity. The research undertaken identified two key dimensions: that of professional identity of the student nurses and that of illness identity for the young patients. These issues have been critically analysed using the theoretical underpinning of the seminal identity development theorists.

In order to understand the true meaning behind the lived experience of both groups of participants during these caring interactions, a hermeneutic, Heideggerian, phenomenological study was undertaken. In line with this methodology individual, unstructured interviews were undertaken with 11 student nurses (aged between seventeen years five months to eighteen years eleven months) and nine young patients (aged between thirteen years and seven months and eighteen years and one month).

Three main themes emerged from the data: (1) Messy boundaries; (2) Emotional security; (3) Being Younger making a difference. The findings highlight both concerns and benefits brought about by these caring situations. Concerns raised by the students relate to emotional distress, perceived lack of knowledge, confidence and professional identity. Also of concern is dealing with sensitive information disclosed by the young patients. Benefits identified by the students relate to being able to spend quality time with the young patients, being on the same level as them in informal 'normative' relationships, relieving their boredom and helping to momentarily distract them from their illness.

Concerns highlighted by the young patients centre around issues of trust and confidence in the students' professional abilities, the perceived lack of knowledge of the students in relation to their illness, and the students' lack of understanding of their feelings. In common with the students, the young patients felt that the opportunities afforded them to 'chill out', be normal young people, and to be able to forget about the business of getting better, were invaluable. The friendships formed represent crucial therapeutic relationships which were not explicitly recognised by either party.

The research has led to recommendations for improving student nurse education relating to young people/adolescents which it is anticipated will more appropriately meet the needs of the students and the patients. It has also enabled the creation of two models to support the unique engagement of the nurse-patient interaction, particularly in relation to the care of young people with a chronic illness:

- i) A Model for Processing Sensitive Information Revealed by Young Patients who may have a Chronic Illness
- ii) A Model of Adolescent Care Which Promotes Normalcy

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GLOSSARY OF TERMS:

Emotional Intelligence: A construct which defines a person's ability to perceive, understand and express emotions, which requires the ability to identify one's own and others' emotions, and to be able to regulate and modify one's mood adequately enough to improve one's state of mind.

Epistemology: This is a study of the source, nature and limitations of understanding knowledge.

Hermeneutics: The art, skill, or theory of understanding and classifying meaning. It is often applied to the interpretation of human actions, utterances, and experiences. A hermeneutic interpretation requires the individual to understand and sympathise with another's point of view.

Hermeneutical phenomenology: Is a research method that seeks understanding through the description of the lived experience but in addition an interpretive (hermeneutical) aspect is applied to the phenomena described.

Moratorium: This is a period of time in which there is a suspension of a specific activity until future events warrant a removal of the suspension or issues regarding the activity have been resolved. The "psychological moratorium" of adolescence refers to a period of exploring different roles, values, and skills.

Normalcy: Defined as a quality or condition of being within certain limits that define the range of normal functioning in terms of economic, political and social conditions of a nation or sub-culture.

Ontological: This is the philosophical assumption about the nature of reality. Being-in-the-world, one is thrust into the ontological contingency of "Being-in" an environment and "Being-with" others and with-oneself which underlies all participation, engagement, and concrete involvement with the world that is given in a person's immediate preoccupations and concerns.

Phenomenon: This is the central concept being examined by the phenomenologist. It is the concept being experienced by subjects in a study, psychological concepts such as grief, anger, or love.

Phenomenology: A qualitative research approach concerned with understanding certain group behaviours from that group's point of view

Phenomenological study: A study which examines human experiences through the descriptions of the meanings of these experiences provided by the people involved. The study describes the meaning of experiences of a phenomenon for several individuals.

Purposive Sampling: A non-probability sampling procedure in which the researcher uses personal judgment to select subjects that are considered to be representative of the population and phenomenon being studied.

Reflexivity: Is the open acknowledgement by the researcher of the central role they play in the research process. A reflexive approach considers and makes explicit the effect the researcher may have had on the research findings.

CHAPTER ONE

INTRODUCTION TO THE RESEARCH

This study, as a partial requirement of the Doctorate in Education (EdD), will investigate the lived experience of children's nursing students (between the ages of seventeen years five months and eighteen years eleven months), categorised as 'older adolescents', during caring interactions with 'adolescent' patients (between the ages thirteen years and seven months and eighteen years and one month). The lived experience of the young adolescent patients during these caring interactions will also be investigated.

Subject to meeting academic course requirements, there is no minimum or maximum age for entry onto a pre-registration children's nursing programme although most educational institutions will restrict the age on entry to a minimum of 17.5 years.

The trend in children's nursing is for students to be younger than students on other pre-registration nursing programmes (Buchan & Seccombe 2005). At the case study university this trend is replicated. For example, child branch degree students for the year 2005-6 between the ages of eighteen and twenty years was 69% compared to 32.1% for adult branch, 22.2% mental health branch and 26% midwifery.

Despite the popularity of the child branch programmes, student attrition remains high, and concern has been expressed regarding the recruitment and retention of registered children's nurses in the National Health Service (Eaton et al. 2000; Price 2002; Glossop 2002). Research indicates that the youngest students on entry are significantly less likely to complete than students of more mature years and that

students between the ages of 17-21 years are more likely to fail than other age groups (DH 2006).

There have been many changes in nursing since the beginning of the twentieth century which has affected both the patient population within children's nursing and the student nurse population. In 1919 a Register for Children's Nurses was created simultaneously with the General Nursing Register. The Platt Report (Ministry of Health 1959) formally endorsed the need for nurses registered in the care of sick children, Registered Sick Children's Nurses (RSCN) to be responsible for both delivering and overseeing the care of children in hospital (Miles 1984). 'Direct entry' was retained in Scotland and Northern Ireland until the late 1980s. Child nurse education then became a post-registered course in England. Nurses undertook a three year general nurse education and then, after gaining experience on the children's wards, undertook a post-registration course to become RSCN. In the late 1980s the Project 2000 curriculum was introduced which resulted in nurse education being delivered within four branches; adult branch, mental health branch, learning disability branch and child branch. The Project 2000 curriculum resulted in it again being possible to gain single registration into the care of the sick child (United Kingdom Central Council (UKCC), 1986). However, concerns were raised by service colleagues that newly qualified nurses were not demonstrating satisfactory practical skills, possibly due to shortened clinical placements associated with the Project 2000 curriculum design. This prompted an enquiry by the UKCC (the nursing and midwifery governing body at the time) who set up a commission for nursing and Midwifery Education in order to examine the needs of nursing education (UKCC

1999). This resulted in the Making a Difference curriculum being introduced nationally (DH 1999) which is a single registration programme and is the curriculum currently being followed.

From historical data obtained from the archive department of Great Ormond Street Hospital for Sick Children, it has been ascertained that the maximum age for children to be admitted to the children's wards prior to circa 1959 was twelve years (with a minimum age of two years). Further information obtained from the archive department of Great Ormond Street Hospital for Sick Children indicated that this age criterion was gradually relaxed between 1954 and 1975 when the age limit was raised to 14 years and beyond. Currently, children who are admitted to the children's wards throughout all hospital Trusts nationally are cared for by specialist trained children's nurses and the age range for admission is usually 0-16 years and in some cases 0-18 years.

Adolescent Transitions for both students and patients

The World Health Organisation defines adolescence as the period of life between 10-19 years; youth as between 15- 24 years and young people, as those between 10-24 years. That there are ambiguities within the definitions is perhaps to be anticipated as the terms 'youth' and 'adolescence' are used interchangeably to characterise/define the dynamic transitions of this stage of life that have as much to do with biological aspects as with socio-cultural conditions. Adolescence is a time of great change for young people encompassing physical, social/emotional and cognitive dimensions. Viner (2003) provides a more inclusive definition of adolescence as being that period

between the ages of ten and twenty-five years when bio-psychosocial maturation leads to functional independence in adult life. Adolescence is also viewed as consisting of three general developmental stages: (a) early adolescence from 10-13 years; (b) middle adolescence, from 14 to 17 years; and (c) late adolescence from 18 to 21 years (Radzik, Sherer, & Neinstein, 2002 - cited in Rew 2005). When considering the age ranges of the sub-stages of adolescence it can be seen that there is an age overlap between the patients and student nurses with the potential for young people as patients, and young people as student nurses to draw parallels in their experiences at this stage of their development. Hence a fifteen year old and a twenty year old may find themselves 'adolescing'.

A significant number of students therefore may be classified as 'older adolescents' when they embark on a children's nursing programme (Radzik, Sherer & Neinstein, 2002 in Rew (2005). Slavin (1996: 39) defines adolescence as a time to:

"Complete the transition from primary investment in the environment of the family to that of the larger, adult social world".

This conceptualises adolescence as a time of expanding relational roles and a tension between old familial links and new social challenges which many young people strive to resolve by leaving home and embarking on university life.

Universities could provide a psychosocial environment within which students can explore and experiment whilst experiencing identity formation and change. Higher education is particularly influential when its social milieu is different from students' home and community background. Peer influences play a normative role in this

development enabling students to explore options and possibilities before making permanent adult commitments (Gurin et al. 2002).

By embarking on a career that entails three years of intensive education, young nursing students could experience unexpected pressures that, by the very nature of their personal identity status, they may be inadequately prepared to deal with. Lack of preparedness for university life is a major influence at this transitional time and encompasses a range of factors which are influential on both attrition rates and poor achievement (Davies & Elias, 2003, Lowe & Cook 2003; Quinn 2004). These factors include teaching and learning styles, assessment strategies, peer group relationships and teacher/student relationships (McInnis, 2001; Tinto: 2002; York & Thomas 2003; McGivney 1996).

Health Services for Young People

The Platt Report (Ministry of Health 1959: 166) clearly states that there is a need for improvements in services for young people and pointed out that:

“The problem with adolescents in hospital is a subject which requires special study. In the planning of new hospitals their needs should be considered with a view to providing separate wards if the number of adolescents requiring admission warrants it”.

Adolescent care in hospitals and communities continues to be of concern and is failing to meet the needs of young people (House of Commons Select Committee 1997). Viner (2001) conducted a national survey of the use of hospital beds by adolescents which found that hospital bed usage by adolescents increased rather than decreased through adolescence. The survey showed that in contrast to North America and

Australia, there has been very little attention paid to the use of health services by adolescents in the United Kingdom. Viner (2001) recommended that whilst it is not always possible to provide dedicated wards for adolescents in most U.K. hospitals, the provision of more adolescent friendly facilities should be considered. In his continual efforts to improve health services for young people, Viner (2005) reiterates that the health of young people appears to have little priority in the United Kingdom where, aside from the teenage pregnancy strategy, few public health initiatives focus on adolescent health.

More recent research undertaken by Viner (2007) involving secondary analyses of the National English Young Patient Survey (2004) comprising 8855 subjects aged 12 to 17 years, highlights the fact that only ten percent of 12-14 year-olds and eighteen percent of 15-17 year-olds were nursed in an adolescent ward; the majority of 12-15 year-olds was nursed on children's wards and sixteen percent of 15-17 year olds nursed in adult wards. He concluded that dedicated adolescent in-patient wards improve aspects of quality of care for young people compared with child or adult wards particularly for older adolescents. This is further supported by a report by Norwich Union Healthcare (2001) which highlights the fact that although the average nurse spends twenty percent of their time caring for teenage patients only one in five nurses has received any specific education in this area. The aspects of care reported by the adolescents as being excellent in the adolescent wards were: feeling secure; having confidentiality maintained; feeling treated with respect; confidence in staff; appropriate information transmission; appropriate involvement in own care and appropriate leisure facilities.

Whilst there is a plethora of post registration courses being offered by education institutions for child and adolescent mental health services, there is a real dearth of courses being offered for general adolescent health.

Professional Context

In my role as the programme leader for children's nursing at the Case Study University, I was required to monitor and evaluate the experience of the child branch student nurses. When student nurses experienced problems or difficulties whilst undertaking the programme of studies, it was my responsibility to interview them in order to determine what the issues were, and where possible, help them to overcome their problems. I became increasingly aware that it was the younger students (usually under 20 years of age) who were more likely to experience problems with maintaining a commitment to the programme. This provoked an interest in trying to establish what factors were influential in preventing younger students being committed to the children's nursing programme which sometimes resulted in them leaving. Preliminary pilot interviews which were undertaken as part of the taught aspect of my doctoral studies indicated that one of the challenges faced by the younger children's nursing students was caring for young patients whom they perceived to be of a similar age to them. After researching the literature it became evident that there was a dearth of research regarding caring situations of this nature. This motivated me to undertake a research project which would focus on achieving an in depth understanding of what it is like for younger students when they are required to care for young patients who are of a similar age to themselves. It is equally important to investigate the reality of this

experience for the young patients when they are being cared for by younger student nurses whom they also perceive to be of a similar age to them. Allowing their voices to be heard is of vital importance as The United Nations Rights of the Child (1989) explicitly states:

“Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child” (Article 12).

NHS policies including The Platt Report (Ministry of Health 1959) (improving care for adolescents); Listening to young people - the National Service Framework for Children Young People and Maternity Services (DH 2004); Tackling Teenage Health (CMO 2007); Making Health Services Young People Friendly (2007); all state that it is especially important that the voices of the young patients are heard if improvements are to be made to services currently being provided for them. Politically, Sir Al Aynsley Green, who was appointed as the Children and Young People’s Commissioner for England from 2005-2010, was a driving force behind the rights of young people, particularly in respect of them having their voices heard.

Original Contribution to Knowledge

Whilst anecdotally within the case study institution, discussion has taken place as to why it may be that there are high attrition rates within children’s nursing; this has not formally been investigated. Preliminary enquiries led the researcher to consider this issue from a specific focus. An extensive search of the literature revealed that research focused specifically on younger children’s nursing students caring for young

people within a professional context, could not be found. Therefore, exploring this has produced original knowledge and understanding of the issues and benefits brought about by these ontological caring experiences

The Study

The findings of this research may contribute to curriculum development in respect of caring for young people and ultimately ensure that the provision of services to this client group will effectively meet their needs. It is also anticipated that any identified education needs of the students will be addressed.

The phenomenon being investigated in this study is ‘the lived experience of younger children’s nursing students (under 20 years of age) during caring interactions with adolescent patients, and the lived experience of young patients (over 12 years of age) when they are being cared for by younger student nurses’. These caring interactions are located in the specific ‘lifeworlds’ of the students and the young people in a hospital environment and must be related to their ontological structures of concerns that shape their being-in-the-world (Spichiger et al. 2005).

In order to investigate this a Heideggerian, hermeneutic phenomenological approach has been adopted because Heidegger was not concerned with discovering the source of knowledge in order to explain a situation, but with exploring and understanding what the meaning was behind a human experience and how that experience was embedded in everyday activity (Koch, 1996).

The questions this research aims to answer are:

1. What issues are of concern to the younger students during these caring experiences?
2. What benefits do the younger students feel their age brings to these caring experiences?
3. What issues are of concern to the young patients during these caring experiences?
4. What benefits do the young patients feel younger students bring to these caring experiences?
5. What are the commonalities and differences in these caring experiences between the two groups of participants?
6. How can an in depth understanding of the lived experience of all participants during these caring experiences inform children's nursing practice?

CHAPTER TWO

CRITICAL REVIEW OF THE LITERATURE

Background

There is a dearth of literature relating to younger student nurses caring for young people. An extensive review of the literature revealed no relevant papers. To address this, the literature review will examine fundamental concepts essential for understanding the emergence of the phenomenon being explored, namely: adolescence as a stage of development; identity development; professionalism; professional nurse identity; professional boundaries; caring in nursing; coping strategies; psychological impact of a chronic illness on young people. A discussion of adolescence prefaces this chapter as it sets the context for this research.

The review of the literature was undertaken using various search engines; Swetswise; Cinahl; British Nursing Index; Cochrane Library; Medline; ERIC; Google Scholar; University library database. A hand search of the literature in relation to following up cited authors was also conducted. Keywords included, adolescence, adolescents, identity development, professional identity, nursing, professional boundaries, caring in nursing, emotions and nursing, student nurses and emotions, emotional labour, coping and nursing, affects chronic illness and young people.

Younger student nurses caring for young people is an under-researched area so it has been necessary to draw on a number of different literatures to capture the literature which melds together the strands of the phenomenon being researched in order to create a literature base for this research. Both groups of participants are at varying stages of adolescence, therefore the over-arching theoretical perspective is identity

development which underpins and explains the phenomenon of their lived experience during these caring interactions. During this developmental period the student nurses will be exploring their personal and professional identity. It is impossible to separate the caring aspects from the professional aspects of this journey for the student nurses, so literature in relation to caring and coping in nursing terms has also been included in this review. Underpinning the whole thesis is the very strong theme of ‘messy boundaries’ in relation to gaining professional identity during these particular ontological caring experiences. It has, therefore, been necessary to explore this concept in order to make the appropriate links. For the young patients who are on a similar journey in respect of developing their personal identity, they have the added task during this developmental period of melding their personal self with their illness identity. It has therefore been necessary to review the literature in relation to the psychological impact of having a chronic or life limiting/life threatening illness in order to conceptualise the phenomenon from the perspective of the young patients.

Nature of Adolescence

Havinghurst (1951) proposed that adolescence was a stage of development that involved young people in several tasks; e.g. higher cognitive thought processes involving adult decision making and judgement; coping mechanisms; higher education or work force; mature relationships; and independence from parents for financial and emotional support. Rutter & Rutter (1993) explain the concept of adolescence as natural stage in the lifespan development and as a period of transition from childhood to adulthood which is characterised by dramatic changes in identity, self-

consciousness and cognitive flexibility. Adolescence is a time when a young person moves from dependency to independence, autonomy and maturity and eventually standing alone as an adult (Hutton 2005). Identity development is assumed to vary according to the influence of a person's biological or genetic inheritance. This is combined with the influences of the social, ecological status, parental influences, kinship interactions, family and church traditions and rituals, schools, neighbourhood and community experiences, as well as the larger socio-political context in which young people grow up (Cross & Fhagen-Smith 2001). Different adolescents react differently to the same situation, they have different coping styles, different vulnerabilities and different degrees of resilience all influenced by temperament, intelligence, peer-group support age and gender. There are also some features which are common to all adolescents particularly in relation to physical development, influenced by hormones, cognitive thinking and age related laws (Shooter 2007).

Theoretical Perspectives of Identity Development and Transition to Adult Life

The study of the self and of identity has been ongoing for more than a century. James (1890) and Cooley (1902) were among the first psychologists to theorise about the self (see appendix five). Psychoanalyst Erik Erikson (1959) is well known for his work on ego identity and subsequently identity of self, his work being influenced by among others, the psychosexual analyst Sigmund Freud (1923/1961).

Several theories and models have been applied to self identity evolving from Erik Erikson's 'Identity and the Life Cycle' (Erikson 1959) which he refined in later publications (Erikson, 1964; 1969).

Erikson's (1959) construct of identity formation is conceptualized as a psychosocial task, a time of conflict between identity and role confusion. Erikson's theory explores human development of the ego as a series of psychosocial crises. He proposes that it is only in adolescence that the individual has sufficient physical growth, mental maturation and social responsibility to experience and pass through a crisis of identity. However, Schwartz, (2001) argued that a lack of clearly defined concepts and a basic lack of theoretical precision brought about by metaphorical descriptions within his writings make it difficult to test Erikson's theory. Schwartz (2001) felt that Erikson's theory was 'eloquent' and 'artistic' but that it was difficult to extract any operational definitions from it.

Expanding upon Erikson's work Marcia (1966) proposed that exploration and commitment were the two key processes of identity formation. Exploration is about the extent to which adolescents consider various alternative commitments in the relevant identity domain. Commitment refers to the extent to which the adolescent has made choices in important identity domains and are thus committed to those choices. Based on the amount of exploration and commitment Marcia (1966: 1976: 1980) proposed an identity status model that referred to four qualitatively different statuses by way of which adolescents resolve the identity crisis which are diffusion, moratorium, foreclosure and identity achievement.

According to Marcia (1966), the status of diffusion could be pathological and may be the way young people who have experienced difficulties with early attachments, or with mental health problems such as schizophrenia, or psychotic behaviour, may experience this transition to adulthood, dwelling within this status for long periods of

time without any real commitment to establishing their own set of values and beliefs. Identity crisis will be absent within this status of transition and young people going through this experience could engage in anti-social behaviour. Young people who experience transition into adulthood within the status of moratorium are more likely to experience the general experimentation phases of adolescence and after a period of time reach an identity crisis until their true identity has been achieved. The third status of transition is that of 'foreclosure'. This label or status is usually applied to young people who are very heavily influenced by significant others and who do not engage in the usual experimentation and will readily adopt the values and beliefs that are imposed upon them without any real identity crisis. Identity 'statuses' are also flexible and open to restructuring and Marcia (1980) saw identity development as being cyclical, fluctuating from the status of moratorium to achievement at different stages in a person's life. Identity can also be viewed in phenomenological terms allowing individuals to experience themselves as having a core or centre that gives meaning and significance to one's 'lifeworld' (Marcia 1993 Cited in Meeus et al 2008).

In order to allow for greater variability within the four statuses and to enable a better understanding of the pathways of identity formation, Archer and Waterman (1990) expanded on Marcia's work and created sub-categories of foreclosure and diffusion. For example some of the subdivisions of Diffusion were; apathetic; pathological; and commitment-avoiding types. Some of the sub-categories for foreclosure included open, closed, premature and late developing types.

Marcia's theory has also been tested by Schwartz (2002), and Shutz and Schultz (2001) who overall concluded that their findings supported Marcia's theoretical explanations.

Grotevant (1987, 1992, and 1997) also extended Marcia's theory of identity status by adding the dimension of the process. The purpose of this Identity Exploration Process Model was to explore components and concurrent processes involved in the exploration of identity (Rew 2005). The two major concepts of this model are 'ability' and 'orientation', which are assumed to be independent components of the exploration process. Ability refers to a person's critical thinking, problem solving and perspective taking skills. Orientation refers to the attitudes which influence an individual's willingness to engage in exploration (Grotevant 1987). Furthermore, it is proposed that identity is developed through exploration over time, encompassing the whole lifespan and is not just an achievement of identity in any one stage of life.

Meeus et al. (2002) found that commitment (degree of personal investment in establishing their beliefs of decisions) and in-depth exploration are intertwined processes in identity formation and that strongly committed adolescents continue to intensively explore the domains of their choices, whereas adolescents characterised by a low degree of exploration are weakly committed. The level of commitment demonstrated by adolescents is also linked with a variety of personality and social factors. Luycks, Soenens & Goossens (2006) have linked commitment with the personality dimensions of extroversion, agreeableness, conscientiousness and emotional stability. Commitment is also positively associated with psychological well-being and adjustment (Luycks et al. 2005, Meeus 1996; Meeus et al. 1999). In

their more recent work Crocetti et al. (2008) have expanded on the original model of commitment to include a third element of reconsideration of commitment, a process they describe whereby adolescents make comparisons between current commitments and possible alternatives, and efforts they may make to change present commitments because they no longer satisfy.

Based on the works of Erikson and Marcia, Beronsky (1989) proposed a process model of human development and conceptualized the four statuses proposed by Marcia in terms of personal problem solving and decision making. Berzonsky (1992, 1993a, 1993b, 1997) conceptualizes identity as the way in which people construct a theory about themselves, how they will adapt and cope with the world rather than an exploration and discovery model. The three identity styles proposed by Berzonsky (1992) are, (a) informational or actively seeking information and thoroughly evaluating that information before making a decision; (b) normative or expressing greater concern for conforming to expectations of others, i.e. parents; (c) diffuse-avoidant or tending to avoid dealing with problems directly, procrastinating and only finally making decisions when other rewards or consequences are close at hand. Berzonsky (1992) argues that this theory is very useful in identifying coping strategies used by late adolescent college students.

Markus & Wurf (1987) propose that developing a sense of self refers to the enduring nature of the individual that distinguishes that individual from others and gives them a sense of sameness or continued being over time and space. Harter's (1999) description of the construction of self reflects the influences of William James, symbolic interactionists (including George Herbert Mead) and cognitive

developmental theorists like Jean Piaget (see appendix five). Harter (1999) asserts that self-development proceeds through predictable stages that begin at birth and those cognitive changes in development affect both an objective and subjective sense of self. Harter (1999) particularly stresses that self-worth is constructed out of competencies developed by a person in various aspects of their life, along with the approval and support of ‘significant others’. She further identifies the concept of ‘authenticity of the self’, when adolescents develop multiple selves in response to a variety of socialising interactions and begin to question who they really are.

Knafo & Schwatz (2004) researched the extent to which ‘parent-child value congruence’ influenced the transition status of young people and concluded that there is clear evidence that identity formation varies with parenting styles and that parent-child value congruence varies with parenting styles. There is also evidence that there is an aspect of the parent-child relationship which promotes acceptance of perceived parental values, and additionally, that the way adolescents go about constructing their identities may influence parenting styles (Knafo & Schwartz, 2003). For example, adolescents who engage in exploration may induce parents to reduce their conformity expectations or, alternatively, to increase their restrictiveness.

Boyes & Chandler (1992) proposed that there was a strong relationship between cognitive growth in adolescence and identity formation. Krettenauer (2005) has further argued that not only is the development of formal operational thinking directly linked to the process of identity formation, but there is also a link with the development of epistemic cognition or the individual’s understanding of the nature of knowledge and how they come to know this. His conclusion is that there is evidence

that cognitive development and identity processing styles contribute independently to the process of identity formation as far as the identity statuses of moratorium and identity achievement are concerned. These two identity statuses partly depended on the development of epistemic cognition and were considered to be developmentally more advanced than identity diffusion and foreclosure. These conclusions can only be applied to adolescents and there are likely to be many other factors which contribute to the process of adolescent identity formation (Krettenauer 2005). Drawing on many of the above studies and a more recent Meta analysis conducted by Kroger, Martinussen and Marcia (2010) who investigated development patterns of identity status changes, Meeus (2011) carried out a review of longitudinal research to determine whether identity develops along a continuum progressively. Meeus (2011) concluded that personal identity develops progressively during adolescence and that generally individuals do not change identity, particularly ethnic identity. He refutes the idea that the status of moratorium precedes identity achievement but that adolescents may follow two distinct sets of identity transitions along the continuum of diffusion, moratorium, foreclosure and achievement. They also found correlations with adolescents with a mature identity showing high levels of adjustment, positive personality profiles, living in warm loving families and performing well at school.

Professionalism

In recognising that adolescence is a stage of development that both groups of participants will be engaged with, it is also important to consider that for the student nurses they will not only be making transitions from young person to adult within their

personal life, they will also be making transitions from student child nurse to a qualified child nurse. It is therefore important to consider all aspects of what becoming a professional entails.

‘Professionalisation’ is a term used to explain the complex sequential process in which an occupation comes to exhibit a number of attributes which are essentially professional and are said to be the core elements of ‘professionalism’ (Johnson 1972). In a process of professionalisation, an occupation passes through predictable stages of organizational change, the end state of which is professionalism (Johnson 1972).

Public opinion asserts that certain occupations, for example legal and medical, are classified as true professions, this having been embedded in history. In consenting to act within the boundaries of these professions, members are morally and professionally responsible for any actions which are done in its name. In accepting this role they identify with the values of that profession and the rights and duties which go with the role. Also in taking on the role of a professional (Downie1990) includes as a criterion that a profession must be governed by a professional body so those individuals within that profession are authorised by those professional associations to act in certain ways, depending on the function of that profession. Schon (1987) on the other hand sees professional action as comprising distinctive, reflective, practical judgment rather than esoteric knowledge. Reflective practice has become a major influence for professional education in the fields of nursing, education and social work in the UK (Clegg 1999), despite the fact that Schon’s major works (1983 & 1987) have been criticised by feminist movements due to concerns regarding the legitimacy of male professional knowledge (Carroll et al. 2002). However

reflective practice is still heavily embedded within the nursing literature as well as nursing legislation (NMC 2008) even though it was argued that Schon failed to notice the extent to which the professions he described were predominantly male.

Larson (1977) includes the criterion of autonomy in practice as a distinguishing feature between professional practice and proletarian work. Autonomous practice is considered to be one of the main goals within the profession of nursing. Professional nurse autonomy is defined as belief in the centrality of the client when making responsible discretionary decisions, both independently and inter-dependently, that reflect advocacy for the client. Personal and educational qualities that promote professional nurse autonomy are essential components of professionalism (Wade 1999). In education in the early 1960s it was the insurgence of autonomous teaching that was the catalyst for the professionalisation of teaching (Hargreaves 2000). Teaching and nursing which have large female work forces have come under tighter governmental control and scrutiny externally, with new managerialist regimes internally, which limit the scope for professional autonomy (Carroll et al. 2002; Brooks 1999). Southon & Braithwaite (1998) argue these managerialist reforms affect health care systems worldwide (World Health Organisations 1996). Southon & Braithwaite further suggest that it is the task-related behaviours in relation to high levels of expertise, autonomy of practice or freedom to control the management of each task, commitment to the tasks of the profession, identification with peers, a system of ethics and a means of maintaining standards which are central to professionalism. It is these high levels of professionalism within professional organisations which enable professionals to support each other thus ensuring that the

standards of their colleagues as well as the standards of the profession are maintained thus protecting their collective reputation. It is, according to Southon & Braithwaite (1988), the complexity of these tasks which are at risk of being over-simplified within the current trend of health care reforms. The importance of recognising the complexity and uncertainty involved in health services and the nature of professionalism required should not be ignored within these reforms (Lazaro & Azcona, 1996). In light of the above reforms and acknowledging that nursing is predominantly a female occupation it is perhaps understandable that 'nursing' as a true profession is not immediately recognised. It has been necessary, therefore, to explore professional nurse identity in more detail.

Professional identity in nursing

For many years nurses have been striving to turn nursing into a profession (Allen 2007).

Styles (2005) used the term 'profession building' to refer to nursing's struggle for professionalisation. She refers to attributes such as university/higher education; a distinct service or practice discipline; a research-based body of knowledge; autonomy and accountability; code of ethics; and an association to organise, serve and speak for its members, as characterising a true profession. There are challenges in constructing a professional identity because members of the nursing population are from very diverse and complex backgrounds. What has emerged through these challenges is an occupational mandate based on a holistic bio-psycho-social model which places the

quality of relationships with clients at the heart of nursing's claims to specialist expertise (Styles 2005).

To address this, Ruddy (1998) argues that nurses must reconsider what the foundations and accomplishments of nursing philosophy really are and return to these original philosophies, knowledge and theories in order to attain professional status. She proposes that we need to know where we are now in professionalisation, and how we can move forward to achieve true professional status. It is imperative also that philosophy, knowledge and theory continue to be linked intrinsically to professionalism (Ruddy 1998).

The context within which nurses work is regarded as very important for the development of their professional identity, skills and expertise as nurses (Meleis 1975, Benner et al. 1996, Gerrish 2000). Nurses need opportunities to share their experiences with each other, to learn from each other's experiences as well as get support from each other when they need this (Benner et al. 1996). Shortage of nurses on the wards, particularly of experienced nurses, can lead to confusion over professional identity and increased levels of stress for inexperienced nurses (Gerrish 2000).

There are many theories that address how nurses acquire their identity. Fagermoen (1995) asserts that nurses come to understand and recognise their professional identity based on what is considered as meaningful in their work, which is further guided by their beliefs and values. Fagermoen (1995) further claims that experiencing professional identity has to do with how the nurse conceptualises what it means to act as, and be a nurse. In establishing a professional identity, nurses are guided by their

beliefs and values and therefore, what is meaningful in the nurse's work touches on the identity of being and doing as a nurse.

Shuval (1980) explored a three-stage process of professional socialisation: i) pre-socialisation, where the nature of the students and the cultural image of the nursing profession are considered; ii) formal socialisation, which encompasses one's schooling, where appropriate professional behaviour is learned; iii) post-socialisation, which lasts into retirement, where the individuals examine the outcomes of socialisation. The formation of nurses' professional identity can also be understood through their personal narratives (Chan, 2001, 2002, Lindsay 2001, 2006; Schwind 2003, 2004). Chan (2002) suggests that nursing students need to be socialised into the bicultural experience of natural science and human science, with the latter placing more emphasis on the uniqueness and individuality of both the patient and the nurse. As nurses, an understanding of who we are and who we were is integral to nursing culture. Understanding how our personal life stories shape our relationships with our patients and students is reflected in student nurses' continuous learning about the meaning of nursing as a profession (Schwind 2004). Chan & Schwind (2006) believe that our personal life experiences contribute not only to who we are personally, but also to who we are professionally.

Gregg & Magilvy (2001) in examining how Japanese and Swedish nurses developed a professional identity highlighted a state of "bonding into nursing" as a process nurses undergo in order to integrate being a nurse into self. In order to bond into nursing several categories of learning had to be achieved; learning from working experiences; recognizing the value of nursing; establishing one's own philosophy of nursing;

gaining influence from education; having a commitment to nursing and integrating a nurse into self. Integrating the nurse into 'self' culminated in the development of a professional identity as a nurse.

Apker et al. (2005) undertook a qualitative study to investigate different role expectations between practitioners within a hierarchical structure. Fifty healthcare workers who frequently interacted with each other in clinical practice including staff nurses, clinical nurse specialists, physicians and health care assistants were interviewed. This study found that teamwork, which is fundamental to nursing practice, can cause professional identity tensions in nurses' work roles when they encounter differing perceptions of professionalism from different team members. Doctor's expectations of professional behaviour from nurses was viewed as a more clinical and medical professionalism, a detached bio-medical model valuing objectivity. In contrast to this, nursing team members also expect nurses to exhibit attachment in the form of caring and concern for team relationships, highlighting traditional nursing values of empathy and compassion (Apker et al. 2005). Historically, nursing has been considered a profession focused on nurturing, yet nurses today experience contradiction in this belief when faced with new role expectations that diverge from the occupation's care giving tradition (Apker et al. 2005). The attached-detached role confusion created by what is felt important of professional identity is at the heart of this tension and there is also a contradiction between new and old meanings of professionalism (Apker et al. 2005). Findings from Apker et al.'s (2005) study also indicate that nurses navigate mixed interpretations of their professional identity in the way they communicate differently to different team

members' about what their nursing role is. Expectations regarding the nurse role identity were not consistent across team members, with some team members expecting detachment and objectivity and others expecting attachment, caring and concern. Thus nurses need to be cognisant of team members needs and segment their interactions accordingly in order to meet different role expectations. This strategy could enable nurses to manage varying role demands, which, in turn, may reduce workplace stressors such as role ambiguity and role conflict (Morgan 2002 Cited in Apker et al 2005). In a previous study by Apker, Ford & Fox (2003) it was found that nurses who feel socially supported by their co-workers are more likely to identify with their hospital and with the nursing profession and this can be influential in their remaining in their nursing positions. Therefore, hospitals should make every effort to promote a culture that recognises nurse professionalism (Apker et al. 2005).

Professional Boundaries

Nursing boundaries were first referred to by Florence Nightingale (1893) in the "Nightingale Pledge", which highlights our duties and responsibilities as nurses and the importance of maintaining standards and professional boundaries:

"I will abstain from whatever is deleterious and mischievous... maintain and elevate the standard of my profession...will hold in confidence matters committed to my keeping...in the practice of my calling...and devote myself to the welfare of those committed to my care". (Cited in Holder & Schenthal 2007:25)

Professional boundaries (NMC 2008) are the parameters by which qualified nurses and student nurses are bound to practice and which define appropriate relationships between nurses and the patients in their care. Rarely are violations of these boundaries

discussed because there is an assumption that professional healthcare personnel have the skills to manage professional boundary dilemmas with patients and clients (Fronek et al. 2009). They further report that ‘proficiency in ethical decision making is essential to the maintenance of healthy boundaries’ (Fronek et al. 2009:18).

Peternelj-Taylor & Yonge (2003) reviewed the literature on boundaries in the nurse-client relationships of psychiatric nurses. They concluded that whilst self awareness, supervision and education are important for setting and maintaining boundaries, they also noted that the nursing profession requires nurses who have the skills and ability to make decisions about boundaries based fundamentally on the best interests of the patient or client. They also drew clear distinctions between boundary crossing and boundary violation. Boundary crossing is about actions or relationships based on the best interest for the individual client and should not necessarily be harmful, whereas boundary violations, such as sexual transgressions, are clearly viewed as harmful and exploitive. Gutheil & Gabbard (2003) in their review of clinical vignettes support these findings by describing boundary violations as being harmful to the patient and exploiting the patient’s vulnerable position but suggest that there has been an over-reaction to boundary issues in some cases and that boundaries must be regarded as flexible standards of good practice rather than a list of generically forbidden behaviours.

Austin et al. (2006) have the view that the term ‘boundary’ determines what is ‘out of bounds’ in a relationship and aims to control, constrict and limit behaviour within the relationship. They propose that using the term boundary as a metaphor to describe and determine ethical connections in the relationship between client and carer is

problematic and that perhaps a different metaphor could provide a better way of approaching ethical problems in practice. They describe the image of a boundary as a line, defence or wall which is used to determine the limits of professional helping relationships. They further describe the notion of boundaries to help distinguish the difference between a “friendly” therapeutic relationships and friendship.

Wilstrand et al. (2007) conducted an interesting study examining nurses’ experiences of caring for patients who self harm. Two main themes emerged; the first was that of ‘being burdened with feelings’ and the second was ‘balancing professional boundaries’. These findings indicated that the nurses were aware of their feelings and were able to reflect on these feelings although at times they were so overburdened with their feelings that they interfered with their professional responsibility to care for the patients. In relation to balancing professional boundaries this was described as a challenge in this study especially in relation to managing their own personal feelings and being able to draw on support from co-workers during difficult and emotional caring encounters. This study particularly highlights the importance of clinical supervision for trained nurses when caring for a particularly challenging client group a view proposed by Menzies (1970; Franks et al. 1994; & Allan & Barber 2005; and Allan 2011).

Caring in Nursing

Caring is central to nursing practice and whilst the actual definition of caring remains somewhat ambiguous there are differing theoretical perspectives which attempt to explain this concept, the most renowned of these theories being Madeleine Leininger's

Theory of Culture Care and Jean Watson's Theory of Human Caring. Leininger's (1993) culture care theory which grew out of several ethnographic studies states that care is a fundamental human activity applying culturally sensitive care practices aimed at enhancing the health and wellbeing of individuals. Leininger (1993) further proposes three modes of action that guide nurses in providing this culturally congruent care: (a) cultural care preservation or maintenance, (b) cultural care accommodation or negotiation, (c) cultural care re-patterning and restructuring. In contrast, Watson's (1979: Cited in Lewis 2003) theory of caring was empirically developed from three phenomenological studies, and identified ten 'carative' factors involved in caring: formation of a humanistic/altruistic system of values; instillation of faith-hope; cultivation of sensitivity to self and others; development of a helping trust relationship; acceptance of positive and negative feelings; use of the scientific problem-solving method for decision-making; promotion of interpersonal teaching-learning; provision for a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment; assistance with gratification of human needs; and allowance of existential-phenomenological forces. She later refined this theory to emphasise the transpersonal caring relationship as a moral ideal in nursing that is a means of communication and release of human feelings through the co-participation of one's entire self in nursing (Watson 1985: Cited in Lewis 2003). Furthermore, professional identity is essential to caring because caring is the essence of nursing (Leininger, 1984: Watson 1996). Swanson in her theory of caring derived through a phenomenological study supports Watson's (1996) idealism of caring from a moral stance as a,

“nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (Swanson1993:354).

Whilst caring is still a difficult concept to explain and understand it is still held as being central to understanding what nurses do as well as being attributable to some extent to all human beings in society. There needs also to be clarity between what is meant by ‘caring for’ and ‘caring about’ in that ‘caring for’ implies giving care to someone, whereas ‘caring about’ is much more about having an emotional connection with another person, wanting them to be and do well and wanting to do good for them (Davies 1995 cited in Williamson et al. 2008). In nursing there is an expectation that in a caring relationship nurses are expected to give technically competent, evidence based practical professional care but at the same time engage in interpersonal caring relationships with their patients (Liu et al., 2006 and Van Hooft, 2006 Cited in Williamson et al. 2008). Engaging in these caring relationships can cause anxiety for the student nurses.

The cost of caring in nursing was recognised by Menzies (1960) in her seminal study of anxiety in nurses and how high levels of stress and anxiety impacted on student attrition and staff turnover and sickness. She also looked at the nature of anxiety for nurses and how this is managed in hospitals and education. Menzies (1960) further highlighted that anxieties are aroused for nurses and student nurses during caring interactions with patients, particularly when they are directly required to engage with patients’ emotions. From this case study Menzies (1960) concluded that a social defence system evolved in nursing that managed the anxiety of nurses by developing and deploying a set of social defences whereby nurses retreat from role, task, and

organisational boundaries i.e. distance themselves. However, she also recognised that tensions arose, particularly for students, between their own infantile psychic defence systems for example, life and death instincts as proposed by Freud and more recently Klein (1959), and the social defence system. More recent work looking at this psychodynamic approach to caring and emotions in nursing includes studies by Fabricius (1999) who introduced an argument that moving nurse education into the academic arena and universities encouraged nurses to further distance themselves as a way of reducing emotional anxiety. This understanding of psychodynamic theories is of particular relevance for nurses working in child health nursing in order for them to appreciate the difficulties faced, particularly by younger student nurses, when they are required to engage with patient's emotions and how this could impact upon student nurse attrition from the education programme. A Recent study by Allan (2011) also highlights the issues faced by student nurses when they are required to manage their feelings during emotional caring work, as was originally proposed by Menzies-Lyth (1970). Allan (2011) illustrates the importance of a psychodynamic approach in nurse education as a way of reducing the theory-practice gap for student nurses by providing a forum for them to reflect on emotional issues arising in clinical placements. She suggests that working in small groups with students, facilitated by tutors experienced in psychodynamic work, could help students integrate their theoretical and practical learning. This is particularly important as there is an expectation that nurses engage in emotional caring interactions.

Lewis (2003), however, questions whether caring is unique to nursing because although nurses hold and generate knowledge about the concept of caring, caring is a

basic human quality. In nursing, from an ontological perspective, 'being' is the lived experience of nurses in the nurse/patient relationship, the lived experience of caring in the nursing context. Caring is manifested as nurses and patients interact together. She further proposes that a caring ontology (being in ones world) and epistemology (knowledge of knowing) is critical in nursing, otherwise what would nursing be grounded in? In contrast to this, Roach (1997 cited in Lewis 2003:38) believes that

'caring is not necessarily a special quality or that it is a quality held by only a few but more that caring is what makes us all human.'

Lewis (2003:41) questions

'why it then is that caring is seen as a distinct nursing quality, as being a nurse?'

She provides further explanations of caring by likening it to love and spirituality, healing environments or "soulful consciousness". She believes that caring as being, a soulful caring consciousness is essential but not necessarily unique to the epistemology of nursing. She also feels that our ontology or way of being in nursing is uniquely co-created with each client for whom we consciously and intentionally manifest,

'transcendent aspects of being and becoming in the caring moment' (Watson 2002:13).

Is it therefore a ubiquitous quality or trait (happening everywhere) or is it the unique nature of "caring as being" in nursing? Lewis (2003) further states that all humans have a choice about caring as being, and it is through everyday choices that caring as being becomes uniquely lived in present moments in time and space.

Watson et al. (1999) explored student nurses' perceptions of caring in a longitudinal study which sought to discover whether or not students' perceptions of caring changed over time. This was a quantitative study which employed the Caring Dimensions Inventory and the Nursing Dimensions Inventory for data collection at entry into nurse education and again after twelve months. They found that changes in student nurses perceptions did occur after twelve months on the nursing programme. Most of the student nurses held very strong ideals about what nursing was and what caring was on entry to the programme. However, after twelve months on the programme there were significant changes in student nurses perceptions whereby their notion of nursing and caring became synonymous with the students seeing caring as having psychosocial and professional /technical dimensions. This demonstrated a loss of their idealism about caring in nursing after just twelve months on the programme. The researchers do not clearly state whether this change in idealism was influenced by theory or practical experiences. It is acknowledged that the research participants were from adult, mental health and midwifery with ages ranging from seventeen to forty-four years with no child branch nurses being included (Watson et al. 1999). However, in a previous study Watson & Lea (1997) did report that younger nursing students view caring in more psychosocial terms, whereas older student nurses incorporate more professional and technical aspects into their perception of caring.

From an ontological perspective Benner (2001) defines caring as being personal to what matters to the carer and hence what is stressful to us as individual carers. This in turn determines what coping strategies the carer can draw upon to deal with this stress. This then makes the carer vulnerable to experiencing loss and pain through the very

act of caring although it can also result in satisfaction and fulfilment for the carer. Caring enables the carer to focus on the one being cared for enabling the carer to recognise problems and possible solutions. Finally caring establishes ways in which giving and receiving help are feasible (Benner 2001; Benner 1989). Ontological care relates to the range of connectedness and concerns that human beings can experience in their “lifeworlds” (Benner 2001). The ontological form of care that is engaged with will depend upon a specific situation or person. Care located in specific ‘lifeworlds’ must be related to the person’s ontological structures of concerns that shape their being-in-the-world. This is termed ontic care giving and, in order for this to be perceived as nurturing and supportive, must be attuned to the person’s ontological concerns or structures of care. Being ill could disrupt a person’s taken-for-granted “lifeworld”; therefore, recovery involves not only a bodily cure but re-integrating the person back into their “lifeworld” (Benner 2001).

Spichiger et al.’s (2005 phenomenological study advocated a view of caring that considers how ontological concerns structure the person’s “lifeworld” and how specific ontic care giving practices must be attuned to the person’s “lifeworld” combined with a broader notion of practice that is culturally based and a shared activity. They highlight the importance of defining the person as being in their “lifeworld” at those particular moments in time when their “lifeworld” is disrupted by the onset of illness and that not only do they require medical care to cure the illness but also they need to be restored back into their otherwise taken for granted “lifeworld”. This they see as a caring practice eminently suited to nursing and allows

for a description of nurses' caring from both the nurses' and the patients' perspective in many care settings.

Coping strategies for student nurses

As previously discussed stress and anxiety may be experienced by the student nurses when they are engaged in caring relationships with young patients and because issues could arise due to the emotional cost of caring, it is important to consider how students cope with these events and the strategies for coping that they might employ.

Lazarus & Folkman (1984:141) in their seminal work define coping as

“Constantly changing cognitive and behavioural efforts to manage specific external and or internal demands that are appraised as taking or exceeding the resources of the person”.

Moos (2002) proposes that adolescents are at greater risk of problem behaviours and depression when they experience acute and chronic stressors, but have fewer problems and more self-confidence when they have increased social resources and coping skills characterized by *approach* (facing a problem directly) rather than *avoidance* (avoiding a problem). Evans and Kelly (2004) conducted a survey to examine the stress experiences of young Irish student nurses and found that the leading stressors were examinations, the level of intensity of academic workload, the theory-practice gap and poor relationships with clinical staff. Emotional reactions to stress included feeling exhausted and upset under pressure. Coping efforts are described as either being directed towards ameliorating a threat (problem-focused coping) or decreasing negatively toned emotions (emotion-focused coping). It was found that students adopted short-term emotion focused coping strategies when attempting to deal with

stress. A sense of achievement, and determination, were personal factors, which assisted students to continue in the event of stress being present. Hardiness also emerged as a positive mediating variable that could influence stress reactions and coping abilities of some student nurses (Antai-Ontong 2002: cited Evans & Kelly 2004). However in contrast Lindop (1999; cited in Evans & Kelly 2004) concluded that student nurses had minimum skills associated with coping in relation to clinical stress.

There has been a wealth of literature advocating the benefits of social support for a person's well being and health (Cobb 1976; Cohen 1992; Cohen et al 1985) and this applies to younger student nurses. Lamonthé et al. (1995) advocate that social support is vital for successful transitions to university life and this support can come from many different sources, such as peers, tutor and parents all playing different roles (Tao et al. 2000). Christiansen & Bell (2010) advocate peer learning environments and support for junior nursing students as an approach which could ensure enhanced student experience in clinical practice and smoother transitions from first to second year studies. Montes Berges & Augusto (2007) in their study examined the role of perceived emotional intelligence in the use of stress-coping strategies, in the quantity and quality of social support in the clinical environment in the mental health of nursing students. They define the construct of emotional intelligence as a person's skill to perceive, understand and express emotions. This requires the ability to identify ones own and others emotions and to be able to regulate and modify one's mood adequately enough to improve one's state of mind and thought about the situation.

Their results indicated positive correlations between clarity (in sharing knowledge with other students, own learning clarified) and social support, social support and emotional repair, and social support and mental health.

According to Moos (2002), it is important to understand the psychosocial adaptation of adolescents, the family climate and social resources in various domains. Young people have a particular need to belong to a peer group which is important for both social support and self esteem. During the transition to university life the integration into new social and peer groups is an important aspect of socialization and identity development and particularly the new “university student” identity. Wilcox et al. (2005) found that strong social support and being accepted into a peer group rated highly in respect of factors influencing student retention.

In a large scale study of over six hundred students attending twelve schools and colleges in the UK, Kniveton (2004) found that despite the fact that Marland, (2002), and Nelson and While, (2002), would argue that pastoral care has been an important development in schools and colleges since the 1950s, her study revealed that teachers ranked very low in the list of those to whom the students will turn for help to cope with their problems. Some students will cope by simply avoiding the challenge, but if this results in failure to make a satisfactory transition to the new academic and social demands of university life, the results are manifested in drop-out or under-achievement (Rickinson & Rutherford 1995; Moos 2002).

Psychological impact of a chronic illness on young people

Having reviewed the literature in relation to how student nurses obtain professional identity, because all of the young patients have a chronic illness, it is important to consider how they develop a sense of self when they are burdened with a life limiting or life threatening illness. Recent research has focussed on the impact of a chronic illness on the overall wellbeing and development of young people. Berntsson et al. (2007) conducted a qualitative study of young Swedish people with long-term chronic illness and disability to determine factors influencing their wellbeing. Whilst they concluded that adolescents with long term illness generally experienced episodes of wellbeing like other young people, three themes were found to be important in order for them to feel good. These were feelings of acceptance of the illness, feelings of support and feelings of personal growth. Essential for these feelings of wellbeing was being allowed to live as normal a life as possible and being integrated into society. Delmare et al. (2006) conducted a phenomenological study of young people and adults to determine patient's views of their health and illness in relation to their chronic illness and how significant these views were in managing everyday life. They found that independence, self-control and taking responsibility for one's own life and particularly their chronic illness to be an essential element of being human. They also highlight the importance of nurses being attentive to the specific needs of individual patients in order to determine the extent to which each patient can be expected to self manage their particular condition and when outside help may be needed.

Taylor et al. (2008) conducted a systematic review of the literature to explore the lived experience of adolescents with a chronic illness. They determined that whilst young

people with a chronic illness faced the same developmental issues as their healthy peers, they were subjected to disruptions of constant treatments and hospital admissions. From the twenty studies reviewed which were rated as good to fair, seven main themes evolved: developing and maintaining friendships; being normal and getting on with life; the importance of family; attitude to treatment; experiences of school; relationship with the healthcare professions; and the future. They also determined from this review that whilst young people's aspirations are constrained by their illness and treatment, the relationship between their illness and life cannot be viewed in isolation of their development. The constraints imposed by the illness can have an affect on the dynamics and relationships with friends and family. One of the main concerns for the young people is that of striving for normalcy and the need for healthcare professionals to focus on their wellness rather than their illness. The need to differentiate between the different stages of adolescence was highlighted with the importance of using developmentally appropriate strategies.

A phenomenological study undertaken by Li-Min Wu et al. (2009) explored coping experiences of adolescents with cancer. This study highlighted two main themes. The first theme related to loss of confidence being a feature of physical and psychological suffering and the second theme related to how in order to rebuild hope the young patients had to restructure and revalue what they have. Therefore a key area in nursing adolescents with cancer is assessing their levels of hope, especially during difficult, painful and vulnerable situations. Healthcare workers also need to be mindful of how symptom distress can seriously impede adolescents in their efforts to maintain hope. This is supported by Moore et al. (2003) and Aldridge & Roesch

(2007), who propose that active coping strategies, support-seeking strategies and distraction strategies can be associated with positive outcomes for adolescents (Cited in Li-Min Wue et al. 2009).

Ravert & Crowell (2008) undertook a qualitative content analysis study of adolescent's methods of disclosing their illness of cystic fibrosis to their peers. It emerged that younger adolescents most frequently expressed psychosocial concerns and enlisted social support whereas emerging adults tended to present cystic fibrosis as just one of many self-characteristics. Age-related differences were influential in the way adolescents will disclose their illness and web-based disclosures were preferred to face to face disclosures with their peers. The authors propose that disclosing one's cystic fibrosis can be purposeful and reflective of the psychosocial tasks and challenges of adolescence but that support and advice from peers is also important. Another finding from this study was that the second most commonly used web page was one intended to facilitate psychological support through interaction via discussion boards, guest books or other features that allowed users to post supportive messages (Ravert & Crowell 2008). Evidence also suggests that adolescents with cystic fibrosis do not always want to be reminded of their disease, answer questions about it, or by being reminded of it make comparisons between themselves and healthy others (Pfeffer et al. 2003).

Gender differences in relation to coping with cystic fibrosis are also recognised. Females rely more heavily on denial as a way of coping than do males with males integrating their physical disorder into their self concept more readily (Willis et al. 2001). It is important to note that Szyndler et al. (2005) found that due to the

increased life expectancy and better management of cystic fibrosis, the majority of young people with this disease perceive themselves to have a reasonably good quality of life and a positive future. This study also identified that having a degree of optimism about the future was positively correlated with good psychological functioning.

Anxiety can be evoked by the very existence of 'being'. Existential anxiety is a concept used to describe a person's apprehension about the meaning of life and death and how these concerns are important considerations in a person's psychological well-being (Berman et al. 2006). Westenberg et al. (2002) and Warren & Sroufe (2004) suggest that by adolescence, young people have the cognitive capacity for insight into mortality and broader issues that may give rise to existential concerns. Erikson's (1963, 1968) identity development theory establishes adolescence as a critical period in the development of life goals and values as well as a sense of direction and purpose in life which, in fit individuals could give rise to existential concerns so for the young person with a serious illness these concerns could become heightened (Berman et al. 2006).

Young people with life threatening illnesses have to deal with two issues, that of 'health and illness', and that of 'specialness and normalcy' (Chesler et al. 1987 p.154). Some disabling conditions render the young person unable to fully participate in normative activities with their peers and can attract stigmata and body image issues that may be socially and psychologically disabling to some adolescents (Viner & Keane 1998; Rew 2006). There is evidence that internalizing disorders, including anxiety and depression, are the most frequently identified problems in adapting to

chronic life threatening illnesses in adolescents (Garstein et al., 1999; Thomson et al., 2003; Alwash et al. 2000; Oguz 2002; DiNapoli & Murphy 2002) with anxiety disorders emerging as the most prevalent (Thompson et al. 1998). Studies also indicate that those adolescents with shy personalities or behavioural inhibitions are more likely to be at risk of anxiety and depressive disorders (Muris, Meesters, & Spinder, 2003). Carpenter et al. (2009) in their study found that adolescents with sickle cell disease who were classified as high on behavioural inhibition were more at risk of adverse psychological outcomes than those with low behavioural inhibitions.

CHAPTER THREE

RESEARCH METHODS

Exploring the phenomenon through an interpretive lens.

The interpretive view is that knowledge is established through the meanings attached to the phenomenon studied; researchers interact with the subjects of study to obtain data; inquiry changes both researcher and subject; and knowledge is context and time dependent (Coll & Chapman, 2000; Cousins, 2002). In interpretive approaches it is important to examine the situation or phenomenon through the eyes of the participants rather than the researcher (Cohen et al 2006).

In deciding on a research design it was important to establish exactly what would be investigated, and what phenomenon would be studied. Methodology links a particular philosophy to the appropriate research methods and bridges philosophical notions to practical and applicable research strategies. The nature of this enquiry is concerned with the participants own interpretation of a lived experience of a particular phenomenon which led to the researcher's belief that this could only be achieved by adopting a phenomenological hermeneutic approach as a methodology. Qualitative research examines life experiences (i.e., the lived experience) in an effort to understand and give the experience meaning. Phenomenology aims to determine how to interpret our own and others' actions in a meaningful way (Denzin & Lincoln 2003). Phenomenology is an ordered approach to social research in which humans attempt to put a name to things they encounter (phenomenon means – that which appears) as experienced in their 'lifeworld' (their experienced world) (Shutz 1962), before attempting to analyse and categorise them. It is therefore, an attempt to focus

on the moment of experiencing as the moment of knowing and to enable the researcher to hold their gaze on the phenomenon itself, the lived experience of some activity (Willis 2002). The phenomenological research tradition involves searching for meaning and the essences of experiences, rather than measurement and explanations (Moustakas 1994 cited in Kormanik 2006). To justify phenomenological qualitative enquiry as a means for my research, the philosophies of interpretivism, hermeneutics, phenomenology, ontology and existentialism were explored.

Philosophical Background

Phenomenology is a branch of philosophy, owing its origin to the work of Husserl and later writers such as Heidegger, Sartre, Merleau-Ponty, who extended the ideas into existentialism (Wilson 2002).

Edmond Husserl regarded by many as the founder of twentieth century phenomenology was concerned with analysing consciousness to examine how things appear directly to us rather than through the media of cultural and symbolic structures (Cohen et al. 2006). Husserl focused on the study of phenomenon as they appeared through consciousness, arguing that both minds and objects occur within experience, thus eliminating mind-body dualism (Lavery 2003). Edmond Husserl advocated 'putting the world in brackets' to free ourselves of our usual way of perceiving the world (epoche) in order to free ourselves of all of our preconceptions about the world. This entails setting aside all our previous knowledge, values and beliefs, thus eliminating the chance of imposing bias onto a situation or event.

Ontological philosophies are concerned with the nature of reality, of being. During the 'Enlightenment', the view of Rene Descartes that "cogito ergo sum" ("I think therefore I am") had prevailed, articulating a split between man's mental being and his physical being. Descartes being religious in his philosophy, also argued that "cogito ergo sum" proved the existence of God. Heidegger (1962) in his famous work 'Being and Time' further defines 'being' in terms of Dasein, literally being there (an analytic of existence), a being that is constituted by its temporality, explained as located in that particular time, culture, tradition.

Heidegger disagreed with Husserl's view of understanding 'being' or 'phenomenon' and focused on 'Dasein' the mode of being human or the situated meaning of a human in the world (Lavery 2003). Unlike Husserl, Heidegger does not believe it is possible to set aside one's own experiences and knowledge. He explains that within this phenomenological approach it is those presuppositions or expert knowledge on the part of the researcher that is fundamental to inquiry and, in fact, makes the inquiry a meaningful undertaking. Indeed, Heidegger (1962) emphasized that it is impossible to rid the mind of the background of understandings and that this is what led the researcher to consider a topic worthy of research in the first place (Koch, 1995). Hermeneutic phenomenology evolves as meanings of the phenomenon are uncovered by both the researcher and the participants during the research process and where the true meaning of the phenomenon are explained by the person experiencing the phenomenon (Cohen et al. 2006). Metaphorically when both the participants and the researcher come to a 'true' understanding of the phenomenon as experienced by and interpreted by the participant and the researcher, the term 'fusion of horizons' is used

(Gadamer 1976). This describes the capacity for looking at what is meant within a conversation or as a matter of negotiation between the researcher and participant in the hermeneutical dialogue such that the process of understanding can be seen as a matter of coming to an ‘agreement’ about the matter at issue (Gadamer 1976). Heideggerian hermeneutics

“seeks to reveal the frequently taken for granted shared practices and common meanings embedded in our day-to-day experiences” (Diekelmann 1992: 73).

It is proposed therefore that a phenomenological study would best enable the interpretation of the students’ and patients’ own experiences from which insight and knowledge could be gained in respect of the structures and consciousness of that human experience (Creswell 1998). The nature of the enquiry is about interpreting an experience and trying to understand the nature of the experience through the voices of the informants (Field & Morse 1985, Cited in Creswell, 1998).

As I am investigating and interpreting the lived experience of both the student nurses and the young patients, and because of my professional background as both a nurse and educator, I do not feel I can bracket out or set aside my own knowledge and experience. Therefore, a Heideggerian, hermeneutic phenomenological approach has been adopted (Denzin & Lincoln 2003).

Sample /Participants

In line with phenomenological methodology it is important to recognize that “the phenomenon dictates the method (not vice-versa)” (Hycner 1999:156 Cited by Groenewald 2004) and the phenomenon also dictate the category of participants. In

line with this methodology a non-probability purposive sample was necessary. Purposive sampling was considered in that it was important to involve participants who met the age criterion for my research and would have experienced the phenomenon (Cohen et al. 2006).

The aim in participant selection in phenomenological and hermeneutic phenomenological research is to select participants who have lived the experience that is the focus of the study, who are willing to talk about their experience, and who are diverse enough from one another to enhance possibilities of rich and unique stories of the particular experience (Polkinghorne 1983; van Manen, 1997).

Boyd (2001) regards 2-10 participants to be sufficient to ensure reaching saturation point, and Creswell (1998) recommends long interviews with up to ten people for phenomenological research. Therefore, eleven (as eleven students were interested in taking part and ethically I did not feel that I could exclude one student) student children's nurses who met the age criterion of being under twenty years when starting the children's nursing programme and who were attending the case study University were purposively selected as participants. Ten of the student nurses were females and one was male. The students ranged in age from seventeen years five months to eighteen years eleven months. Nine young patients who met the age criterion of being over the age of twelve years, had experienced at least three hospital admissions and who were patients attending the outpatients department at a local Trust were selected as participants. Six of the young patients were female and three were male. The age range of the young patients was between thirteen years and seven months and eighteen years and one month. Although not intentionally planned for, all of the young

patients have experienced (and may continue to experience) many hospital admissions due to the fact that they all have chronic, life threatening/life limiting illnesses. In line with ethical requirements and being cognisant of the vulnerability of this group of patients, none of the young patients had been admitted to hospital during the preceding three months. Participant information sheets were given to both groups who were given a period of one week within which to decide if they wished to take part. (See appendix one). Written consent was obtained from all participants and for those participants below the age of sixteen years the consent of their parent/guardian was also obtained (see appendix two).

Data Gathering

In line with a Heideggerian, hermeneutic phenomenological approach to research it is important that the data gathering method ensures the richness and depth of the data gathered, rather than the quantity of the data. This allows for the quality of this study to be judged by its power to draw the reader into the researcher's discoveries allowing the reader to see the worlds of others in new and deeper ways. The aim should be to illuminate the main details as well as more trivial aspects of the experience that may otherwise be taken for granted in our lives, with an overall goal of creating meaning and achieving a sense of shared understanding of the phenomenon (Wilson & Hutchinson 1991).

To allow the participants to tell the story of their lived experience of the phenomenon being investigated, unstructured individual interviews were conducted. The aim of the interview was to explore their individual and collective understandings of their

ontological experiences, at that particular time in their existence. Participants were asked to describe in detail their experience of the phenomenon being investigated. Kvale (1996:30) identified key characteristics of qualitative research interviews, one of which is 'Life World' where the topic of the qualitative research interview is the lived world of the subjects and their relation to it, where the interviewer aims to interpret the meaning of central themes in the life world of the subject. To facilitate this, the questions asked were open in nature, for example, "tell me about what it was like for you when...." and "can you expand upon this a little more...", with follow up discussion being led not so much by the researcher, but by the participant, an approach which is supported by (Koch 1996) who proposes that the exchange should be entirely open, with few direct questions asked. The reason for this is to encourage the interview process to stay as close to the lived experience as possible. Kvale (1996) cautioned, however, that it is important to look for not only what is 'implied', but what is said 'between the lines'. Hence, verbatim quotations do not necessarily capture all of what is 'really said' in interviews. Additionally, van Manen (1997) supported the importance of

'paying attention to silence, the absence of speaking, the silence of the unspeakable and the silence of being or life itself, as it is herein that one may find the taken for granted or the self-evident' (Cited in Lavery 2003;19).

Data representation and analysis

In order to prevent some of the pitfalls of transcribing, such as mistyped words due to unfamiliarity with the topic area, the interviews were transcribed by the researcher (Easton et al. 2000). Based on the Heideggerian interpretive tradition, Diekelmann et

al. (1989) describe a process for analysis of narrative texts (see table 1). This process has been adapted to analyse and gain a greater understanding and interpretation of the meaning behind the lived experience of the participants. Once all the transcripts had been read several times the researcher began to identify emerging themes. The data were then uploaded to QSR NVivo 7 to help organise and manage the data. The transcripts were read and re-read to ensure familiarity with the text and the data were coded using named nodes (a term specific to NVivo 7) which were identified as very broad, emergent themes. Two types of analyses were undertaken: manifest and latent. In manifest content analysis the transcripts were scrutinised to identify and quantify particular topics which were explicit within the data. Latent content analysis involved deeper interpretation as to the meaning of the text rather than frequency of occurrences of phrases and statements (Ruw 2005).

Process of data analysis

There were several layers of analysis conducted. The first layer of analysis, manifest content analysis, took place after several readings of the transcripts. The patient's transcripts and the student transcripts were initially analysed completely separately.

Very broad, first emergent themes began to evolve for both groups of participants and after more reading of the transcripts and attaching the first themes as coding nodes on QSR NVivo 7, it was possible to see how often reference was made in relation to each of the broad themes.

Relationships between the emergent themes were identified and the first groupings of the themes were made under more specific headings. Deeper analysis, latent content

analysis, revealed deeper meanings within the text with new sub themes emerging. The new emerging themes were also attached to coding nodes on QSR NViVo 7.

Deeper analysis made it possible to group the broad themes under more meaningful headings. Also emerging were some strong overall themes in relation to professional boundaries, emotional issues and those broad themes which related to the age of the participants.

Deeper analysis also revealed similarities and differences of the experience between both groups of participants but the three main themes eventually identified appeared to be appropriate for both groups of participants. Some of the broad themes identified were positive attributes of the interactions and some were more negative attributes.

The three main themes that eventually emerged were: Messy Boundaries, Emotional Security and Being Younger Making a Difference. Within these three main themes some of sub themes were similar for both groups of participants and some were different but after the final analysis it was decided that all of the relevant sub themes were appropriately matched with the three main themes. (See appendix three p.220)

Hermeneutic phenomenology adds another dimension to data analysis, a process involving one of co-construction of the data with the participant as they engage in a 'hermeneutic circle of understanding'. Adopting this approach involved a process which moved from the parts of experience, to the whole of experience and back and forth again and again to increase the depth of engagement with and the understanding of the texts (Heidegger 1962, Annells, 1996; Polkinghorne, 1983). Once a fairly exhaustive analysis of the data had been undertaken with emergent themes being identified, the researcher met with all the participants individually to ensure that there

was a mutual understanding of what was being said. The participants were asked to read through their transcripts. The researcher then engaged in discussion with the participant to explain what meaning had been attached to the transcript and how this was translated into themes. The transcripts were annotated during this process to identify where clarity of meaning had been sought with the participant, particularly where the participant did not agree with the way certain aspects of the transcript had been interpreted. A process of validation thus occurred in the noting of discrepancies and integrating new information throughout the process. The researcher and participants worked together to bring life to the phenomenon being explored, through the use of imagination, the hermeneutic circle and attention to language and writing. Koch (1996) stated hermeneutics invites participants into an ongoing conversation, but does not provide a set methodology. Understanding occurs through a ‘fusion of horizons’ which is dialectic between the pre-understandings of the research process, the interpretive framework and the sources of information” (Gadamer 1976:835). Kvale (1996) viewed the end of this spiralling through the hermeneutic circle as occurring when one has reached a place of sensible meaning, free of inner contradictions, for that moment in time.

When this agreed understanding was reached and it was felt that a ‘fusion of horizons’ was achieved between the researcher and the participants, meanings were formulated into cluster themes. In line with stage 7 of the framework, a colleague familiar with the methodology assisted by scrutinising the transcripts to verify the appropriateness of the interpretation of the identified themes.

In order to tell the story of the participants, data from the transcripts of the interviews are presented verbatim in the findings chapter, and in the context of the themes being discussed. The participant quotes are coded as S = Student and P = Patient. As recommended by Gibson & Brown (2009), to provide a clear presentation of the findings, the analysis has been structured in response to the research questions with a particular focus on the identified themes and sub themes.

Table 3:1 Method of data analysis in interpretive phenomenology based on the framework of Diekelmann et al. (1989)

Stage 1	Read all transcriptions for an overall understanding
Stage 2	Write interpretive summaries and coding for possible themes of all transcripts
Stage 3	Analyse transcripts as a group in order to identify themes
Stage 4	Return to the transcripts or to the participants for clarification or disagreements in interpreting and writing a composite analysis of each text
Stage 5	Compare and contrast texts to identify and describe shared practices and common meanings
Stage 6	Identify constitutive patterns that link the themes
Stage 7	Elicit responses and suggestions on a final draft from a colleague familiar with the content and or methods of the study

Rigour

When a phenomenological study has the power to draw the reader into the researcher's discoveries allowing the reader to see the worlds of others in new and deeper ways the quality of the study can be enhanced. Polkinghorne (1983) suggested that the four qualities that the reader could use to evaluate the power and trustworthiness of a phenomenological study are vividness, accuracy, richness and elegance. Is the

research vivid enough to generate a sense of reality and draw the reader in and are they able to recognise the phenomenon from their own experience? In terms of richness can the reader engage emotionally with the research and has the research been presented in a clear and graceful manner?

The rigour of interpretive phenomenology is an important issue which needs to be addressed, particularly in respect of maintaining the credibility of nursing science and research (de Witt & Ploeg 2006). In order to enhance rigour in qualitative research and enhance trustworthiness and authenticity (Denzin & Lincoln 2003) the qualitative criteria of rigour framework (de Witt & Ploeg 2006) was used (See table 2). Rather than applying 'criteria' of rigour that were developed for generic application to qualitative research (Cohen 1994) which do not effectively express the rigour of interpretive phenomenology, this framework ensures 'expressions' of rigour. In interpretive phenomenological studies attempting to apply 'criteria of rigour' is problematic because it is philosophically inconsistent with the methodology and it is not always possible to demonstrate full expression of rigour in such studies. De Witt & Ploeg (2006) have integrated and synthesised the phenomenological ideas of van Manen (1997a), theoretical interpretive phenomenological nursing literature, and Madison's (1988) criteria of rigour for hermeneutic phenomenology when developing their framework. De Witt & Ploeg's (2006) framework ensures 'expressions' of rigour for interpretive phenomenology in terms of balanced integration, openness, concreteness, resonance and actualization. This is more in keeping with the methodology of interpretive phenomenology and also uses a practical language rather than esoteric and philosophical language, which is easier to understand.

In order to demonstrate ‘balanced integration’ the findings of this study are presented in line with the philosophical underpinnings and methodology of hermeneutic phenomenology to ensure that it is the voices of the participants that are heard and that the meaning behind the voices is interpreted as accurately as possible drawing on the researcher’s experience and knowledge of the .

In relation to the element of ‘openness’, care was taken during the interview process to ensure that the participants understood that it was their voice that was important and their story that the researcher desired to hear. Open ended questions were used in order to afford the participants the opportunity of telling their stories. All the participants were consulted to clarify accuracy of the transcripts in order to achieve a ‘fusion of horizons’ in respect of the interpretation of the true meaning behind what was being said.

In respect of ‘concreteness’ it is anticipated that the findings from this research will be usefully applied to future children’s nursing practice at the case study university.

It is anticipated that when the study findings are disseminated the voices of the participants will bring life to their experiences and echo for the reader similarities in their field of work, a type of epiphany, in a manner which will encourage them to rethink their practices and effect change, thus demonstrating ‘resonance’

By publishing the results of this research it is anticipated that ‘actualization’ will be achieved by enabling a wider audience to apply the findings to their own clinical practice. It is especially anticipated that the realisation of the resonance of the findings of this study will continue to be appreciated by readers in the future.

Therefore, in line with Heideggerian hermeneutic phenomenology and to preserve the integrity and legitimacy of the philosophies of interpretive phenomenology rigour is expressed by complying with the philosophical assumptions underpinning the methodology at every step of the collection, analysis and interpretation of the data.

Reflexivity

It is important that the researcher demonstrates to their audience their own historical and geographic situatedness and personal investment in the research and any biases they bring to the work (Denzin & Lincoln 2003). It was in recognition of my own position of power and status as a programme leader, and how this might influence the openness, particularly of the students, during the interviews (Richards & Emslie 2000), that I decided to resign from this post prior to undertaking the research. Whilst the students were aware of my role as a lecturer, they had not known me during my role as the programme leader. Hermeneutic research demands self-reflexivity, an ongoing conversation about the experience while simultaneously living in the moment, actively constructing interpretations of the experience and questioning how those interpretations came about (Hertz, 1997). Reflexivity is a central component of hermeneutic phenomenology and qualitative research in general (Greatrex White 2009). In analysing and interpreting the data, and as part of my being in the world with my prior knowledge and understanding, it was impossible to set aside my knowledge of caring for young people in hospital or my knowledge of mentoring nursing students. This previous knowledge may well have influenced or enhanced my interpretation of the data. Heidegger (1962) proposes that there is no unbiased way of

entering into research and that indeed it is a bias which helps us to make sense of the things we experience and encounter which is why it is impossible for the researcher to bracket out previous knowledge and experiences of the phenomenon being studied. I recognise that some of the young patients may not have been as open with me during the interview process because they did not know me very well, or equally, because they did not know me very well, they may have felt safer in sharing their experiences. Philosophical hermeneutics affirms the position of the researcher in the hermeneutic circle in relation to getting as near to the true meaning of the data as possible (Koch & Harrington 1998). Getting into this hermeneutic circle properly relies on each person's background being equally important in the interpretation of the interview data. The researcher's background can influence the interpretation of the participants' stories, but their previous knowledge and experience can enhance the interpretation because we understand something better by comparing it to what we already know (Koch & Harrington 1998). Recognising this was what prompted me to meet with all the participants post interviews to ensure that clarity of meaning within the transcripts had been achieved.

Table 2: Framework of Rigor in Interpretive Phenomenological Nursing Research (deWitt & Ploeg 2006)

Balanced Integration	The intertwining of philosophical concepts in the study methods and findings and a balance between the voices of the study participants and the philosophical explanation
Openness	Related to a systematic, explicit process of accounting for the multiple decisions made throughout the study process
Concreteness	Relates to usefulness of practice for the study findings
Resonance	Encompasses the experiential or felt effect of reading the study findings upon the reader
Actualisation	Refers to the future realization of the resonance of the study findings
	<i>Intentional characteristics of the framework are that the unique features of interpretive phenomenology are highlighted in a phenomenological way. This means that they become expressions (Van Manen 1997a) rather than criteria of rigor.</i>

Ethics

This research involved young patients from a local National Health Service (NHS) Trust and younger student nurses studying at the Case Study University. In line with Research Governance and NHS requirements, full ethical approval was obtained through National Research Ethics Service (NRES; Reference No. 08/H0809/33) prior to undertaking the research. Ethical approval was also obtained from the Research and Development Office of the Local Trust (Refer to Appendix 4).

The patients who took part in the study were recruited by placing a notice in the outpatients' departments with information about the intended study and my contact details for further information. The name and contact details of the young patients were passed to me by those staff members who had been approached by the young patients with an expression of interest in taking part in the study. The same notice with

my contact details was forwarded to the student nurses' personal tutors at the case study institution and those students interested in taking part contacted me for further information. At the initial contact with all the participants they were given the participant information sheet and were contacted one week after being given the information sheet to determine that they were still interested in taking part in the study. In keeping with the principles of research ethics (Polit & Beck, 2006), the nursing students and the patients who took part in the study were selected through voluntary informed consent. Each individual was notified of their right to withdraw, without giving reasons, at any point in time. Care has been taken to handle the data in a manner that ensures that the students and patients cannot be recognised by others in any form of publication.

Despite the lengthy processes involved in obtaining ethical approval, particularly in relation to including young patients in the research, the importance of conforming to these processes is recognised by the researcher. When involving vulnerable young people in research their physical and emotional safety must be paramount and in light of this no patients who had experienced a hospital admission during the preceding three months were considered for inclusion. Most of the patients were interviewed within their home environment and with their parent/parents present in the home.

CHAPTER FOUR

FINDINGS

Introduction

Reaching an understanding of the ontological experiences of the young patients and the students during their 'lifeworlds' and in line with the methodology of Heideggerian hermeneutic phenomenology, is a lengthy process. Clarification of meaning was agreed between the participants and the researcher until a "fusion of horizons" (Gadamer 1976) was reached to confirm understanding and interpretation.

After extensive reading, re-reading and clarification of the true meaning of the spoken words in the interview transcripts of the young students and the young patients, three main themes emerged: (1) Messy Boundaries; (2) Emotional Safety; (3) Being Younger Making A difference. The term 'Messy Boundaries', which arose from one of the interviews with a student nurse, has been adapted as a theme and is used to capture the ambivalence in the student nurses' professional identity arising from the tasks given to them by senior nursing staff. This reflects the undefined and unclear boundaries in the professional/pastoral relationships that developed between the students and the patients. In some circumstances these undefined boundaries were viewed in a very positive light and in other circumstances in a more problematic light. Emotional safety has evolved as a theme throughout the data which is cognisant with the fact that due to the very nature of adolescence and the ambiguities and confusions brought about by these transitions, most adolescents experience a rollercoaster of emotions and feelings during this developmental period. Adolescence is a time of self-consciousness and egocentricism and is recognised as a developmental period

when a person's self esteem is probably at its lowest and renders them more vulnerable to emotional insecurity with heightened sensitivities to external stimuli.

The theme, Being Younger Making a Difference, arose from the many references made by both groups of participants in respect of their understanding or belief that it was the younger age of the student nurses that was a significant factor in relation to the issues and benefits identified.

The findings will be presented firstly from the perspective of the younger student nurses in relation to issues of concern and perceived benefits, and then from the perspective of the young patients in relation to issues of concern and perceived benefits of these caring interactions. Throughout the transcripts a code has been ascribed to the texts with S=Student and P=Patient.

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ISSUES OF CONCERN EXPRESSED BY THE YOUNGER STUDENTS

THEME ONE: Messy Boundaries:

One of the key issues highlighted by the students within the data related to role ambiguity. The term 'Messy Boundaries' has been used to characterise this tension. As some of the student nurses identified, there appear to be unfounded assumptions by trained, senior nurses, that when there is a young adolescent patient on the ward it is appropriate and beneficial to "send the young student in" to chat with them or do their basic clinical tasks. The following responses support this notion:

"I looked after one girl umm... who was on the oncology side and ummm... she was fifteen and she was newly diagnosed with a sort of terminal umm... tumour in her lung I think... and um..... actually... ummm. The head of oncology did ask me to go in because I was younger...had asked me just to go in a maybe chat with her and sort of see how she's feeling and stuff..." Student" S 10

“... um... my mentor and the staff nurses felt that you know... she was feeling a bit alone... feeling a bit sort of sad... and you do get asked to go in and stuff... often the staff nurses will say like you are young you go in there and see whether... you know ...see if she is alright and everything...” S.9

Within the transcripts, the students describe how difficult it is to maintain professional boundaries when they have been placed in emotionally charged situations with the young patients, some of whom may have a life threatening or serious illnesses.

The central theme highlighted by these experiences is one of ‘messy boundaries’ characterised by unclear and undefined boundaries. This theme will be structured under the following two sub-headings highlighting the concerns and issues faced by this group of student nurses during these caring experiences: building appropriate relationships; seeing me as their friend or mate / not being seen as a nurse or professional.

i) Building appropriate relationships

In telling their stories the students describe many situations where they were unsure of whether or not it was appropriate to develop personal friendly relationships with the young patients. This ambivalence at times caused them to feel awkward or uncomfortable with the situation, and as a consequence, it blurred boundaries between them being in a professional role and them being in a friendship. The students also appear to be at a loss to understand or fully explain the type of relationships they were engaging in:

“It’s hard because you don’t know what your boundaries are. It’s hard... I don’t know... you don’t want to talk to them too chatty,

because then they will think like he did and he thinks he can kick a football at me maybe I've been too chatty and been too comfortable I don't know, it's hard,, it's hard." S.9

"but then on the other hand I felt a little bit awkward because I am his friend but I am not his friend sort of thing... its quite hard to explain... but he's having that encouragement ... and having that relationship that you're not too involved... you are a friend but your are not a friend... I can't explain it really..." S.8

"so I guess I learned that perhaps ... be a little bit wary although its ok to form a friendship and relationship with a patient so that they can trust you and things like that alright, but going a step forward that is when it starts to affect care in that way I guess you have crossed the line almost..." S.7

"but when I am just sitting chatting to them and making them feel better sort of thing... it stops being nurse and patients it starts being a normal talking relationship, not really a friendship but a sort of civil situation where you can just talk to people sort of thing" S.1

One student highlighted a different perspective in relation to developing appropriate relationships when describing how she encountered young people within her working environment that she knew from her personal life environment:

"it was strange because she knew me from a personal perspective um and not only was she of the same age but then she knew someone I knew very well and obviously knew things about me that she would not know about other nurses and that added on a different dimension to that kind of relationship as well, and I felt extremely awkward..."S.2

ii) Seeing me as their friend or mate / Not being seen as a nurse or professional

As the stories unfolded and the student nurses shared their lived experiences, their narratives highlight the fact that at times being seen as a friend or mate was a good thing but at other times they felt that it compromised their professional status. It would appear that it is the blurring of the boundaries that is making it even more problematic for the students to fully understand what their role is. In describing how they are trying to be a friend one minute and then revert back to being a professional, they appear to

be unable to differentiate between a personal friend and a friendly professional relationship:

“She knew I was younger and would go and see her on that point of view not so much an in between, not quite a sort of member of staff, not quite a sort of best friend that she had... that was really nice.” S.10

“at certain points she didn’t see me as a student nurse... she just saw me more like her friend and she would talk to me about things and everything.... like with the other young boy I don’t think he saw me as a nurse...he probably just did not see me as anything...really... But with the young girl I think she wasn’t... she saw me as a student nurse sometimes...but sometimes she just saw me like... ok... she’s just like another teenager too...” S.11

“Yeh... oh they sort of see me less as a nurse and sort of almost like a friend like someone they can get support with” S.1

“I have looked after a few patients who had cancer who were about seventeen and I think when they have cancer you just have to be as normal with them as you can so that is why I treat them as a friend just like talk with them...” S.4

Although some of the students are beginning to understand that they should be acting in a professional role they still find it difficult to maintain that role when they want to build a trusting relationship with the young patients:

“I think you just kind of have to remind them that you’re there as a professional as well if they didn’t want to speak to older nurses as well, you are there as like another patient you have made friends with you are still in the same role as other people but you kind of feel...” S.9

“sometimes I don’t always want them to see me a nurse... I want them to see me as someone they can get support from... rather than the nurse/patient situation...more of just of somebody they know they can talk to if they have got any problems” S1

Clearly the right level of friendship is not entirely clear and the students are finding it difficult to manage the emotional wellbeing of the patients and maintain a professional boundary:

“which can be quite difficult because you are trying to keep professional with them but also trying to get them to trust you at the same time...

it can make it quite difficult when you are trying to care for them... they make it difficult in a way...you are trying to keep them happy like keep them feeling secure like psychologically secure, emotionally secure...you don't want them to completely freak out... but you don't want them to see you as their best friend”.. S3

“when normally he would have picked one of his other friends he was hanging around with to do things like respite things, like just play games and stuff and he sort of ditched his other little friends and wanted to do stuff with me which was quite nice... but then on the other hand I felt a little bit awkward because I am his friend but I am not his friend sort of thing... it's quite hard to explain... I felt there was a very thin line between me being there to be a professional and me being ... being his friend”. Like not a friend who went in and bathed him... and that was when I stopped being a friend and had to become professional which was quite hard for him to establish that I think.....um.....um” S.8

THEME TWO: Emotional Security:

The second theme to emerge related to emotional security. It is the constant fluctuation of boundaries and change in status that appears to occur during times when the students are either just sitting or chatting to the young patients or doing their basic observations that seems to bring confusion to the caring relationships. Some of the students describe very aptly how they felt in such situations and how difficult or awkward they felt at these times. As the relationships develop and the young patients become more trusting of the younger students they have attempted to take the discussions to a deeper, less superficial level and this appears to be where the issues

arise as the students do not appear to be emotionally or professionally mature enough to deal with this. This theme will be structured under three sub headings: death and dying; difficult situations; personalising situations.

i) Death and dying

One of the most emotionally provocative encounters described by the younger student nurses was when they were required to deal with young patients who have a life limiting illness or are known to be terminally ill. They describe these experiences as too difficult to face or even acknowledge. From the following narratives it can be seen that not only were the students finding it to be very difficult to face the reality of the imminent death of a young patient, they were also aware that they were not able to give the emotional support and care to the young patients that would be needed at this time but were continuing to treat them ‘as they would any other patient’:

“Thinking back to it I was aware at the time that this girl was ... it was advanced, and that the likelihood of a positive outcome was basically nil but I don’t think to be honest I don’t think that I ever, that is ... always with me I never thought of her as this person dying I always thought of her as someone who was alive and I never looked to the future because I never prepared myself for the fact that within weeks that she was going to be dead... I never... like I never recognised that in my head... so therefore I guess when I treated her, I treated her like I would the other patients on the ward... rightly or wrongly”. S.2

“consciously or unconsciously a barrier went up and I was just like noooo... she was just the same as everyone else and I did not foresee the fact that she was dying... so yeh... I think it was much more about protective mechanisms for myself more than anything which probably isn’t great because the patient didn’t get the care that I believe she should, you know emotionally I was not really in tune with it... I will be honest I just didn’t... I just kind of stamped that out, that was it gone... it wasn’t happening I was just doing what I had to do for now, so.” S.3

Several of the student nurses described emotionally how awkward and difficult it was for them during these ontological caring situations:

“Well she was thirteen - I just thought, she was completely fine before her car accident, it did really get to me, all the things she had done before so that felt kind of hard that she wouldn't be able to do any of those things anymore and her mum was really hopeful that she would get better and it was hard to not... you did not want to say to her that she was not going to be completely normal but you don't know that she might and so its kind of hard to know how to communicate with her as well, and I did feel awkward because maybe if she was younger I wouldn't have felt so awkward but I saw a picture of her and her friends before and I didn't even recognise her in the picture because her face was so expressionless if that is the word like now...” S.9

The students also expressed how difficult and challenging some of these caring interactions were for them and how it had affected them emotionally:

“... it is quite hard actually... especially if you have parents that are not really strong hearted... you know... obviously it gets to a certain stage where parents get frustrated because their child is not getting better...and then you are obviously trying to you know sympathise with them and be as caring as possible and they are taking out all their frustration on you and it can be really hard at times...sometimes not that I feel like breaking down emotionally... but then sometimes it really hurts because I think about it”...S11

“If they are oncology and they are deteriorating and I had got to know them and they are really deteriorating and if I'd been there for quite a while it would be quite challenging to see them deteriorating... after we had tried so hard to get them up... that could be quite challenging...” S.5

“especially if they aredying... they need to have a bit of normality with what they are doing really..... Um.....I know I could definitely listen to them... whether I can give the right advice is different... it depends what they want to talk about.... If it is about death then I could probably listen to that because I have had a lot of experience with grandparents and the like dying...but obviously I wouldn't know what it feels like... like actually being dying and know that I was dying... ..” S.4

ii) Difficult situations

There were also examples of other difficult situations which clearly the younger student nurses did not feel emotionally or professionally able to deal with. They described some specific situations which they felt were difficult for them and which they felt inadequately prepared to deal with:

“I was in A & E and I went into the resus room as well and someone in there had been in a car accident as well and they were giving them anaesthetic and everything to stop them from moving and that and..... I just stood there and didn't really know what to do”. S.9

“I don't really know about her mental state and stuff. ... the counselors were coming in to sort that out...so I just... my priority was to try to encourage her to eat and drink” S.6

“It's a bit difficult with some of the others who had toxic overdoses or alcohol... talking to the parents is a bit difficult with me... they did feel a bit angry but I sort of knew at the back of my mind it wasn't because of me it was because of what the child did... I did still feel a bit insecure that they came in...” S.5

“There was a young girl...I was looking after who was ... there had been quite a big family trauma and she was talking to me and one of the other students about it... and I thought is this the sort of person you should be talking to about it...” S.3

One student recognized that by feeling insecure about her ability to care for a patient had an impact on her self esteem:

“but I did find it a bit difficult because I felt like in his eyes everything I was doing was wrong so that's what made me feel a bit withdrawn and my nerves and low self esteem kind of kicked in again...” S.11

They also described some situations when they found it very difficult to engage in conversations or interactions which were too deep and meaningful, rather preferring to keep to light-hearted every day conversations:

“I did not want to probe too far in because I didn't feel too comfortable in asking him about how he was feeling and stuff like that we could

have a conversation about what he got up to at the weekends and stuff like that..." S.7

"When we talked it was not really anything to do with why she had taken the overdose...there was obviously a lot of reasons why she had taken the overdose. it was more casual things...what she liked doing... her hobbies..." S.1

One student nurse could not even bring herself to use the word "**death**"....

"Mind you... in respect of really deep emotional situations... it would be difficult for me because I don't know what to say in those situations... I am not really very good in awkward situations I do sort of not really know what to say... and I do think if people do start to speak to me about you know... *that*... I would really be there to listen but I would not know what to say... I am a good listener but am not very good on the feedback side...so I think that would be quite difficult for me". S.1

iii) Personalising Situations

There were times when the student nurses were clearly imagining themselves in the same situations as some of the patients which evoked emotional distress for them:

"I just stood there and didn't really know what to do... when they are near to your age, you do think kind of... if that's me... if they are younger you just kind of think its horrible, but its not the same if you think... you kind of block it out of your mind that could be you because it's not an illness it's an accident..." S.9

"and it can be really hard at times...sometimes not that I feel like breaking down emotionally... but then sometimes it really hurts because I think about it...what if I were in that same position what would I do... how would I feel... but everyone is different... everyone expresses themselves differently." S.11

"it was a very weird feeling... weird... because it was like it was just basically, she was like me and she.... Was just gone... just gone now and it was a really strange thing... it was like a ... in some respects and you just think well, that could have quite easily been me or my mate you know stuff like that..." S.2

"I think they probably think that because we are of a similar age we have similar problems... which quite a lot of time we have... which like this girl was obviously depressed because she took paracetamol... and I understand depression... I have been through depression..." S.4

By imagining them self in a situation that the patient was in and how they might have felt in that situation, also enabled the student to take actions on behalf of the patient in order to minimize the distress of the patient;

“...so I felt the easiest thing was to put myself in the girls shoes and think how would I feel if... there were a lot of people in the room and obviously her back was showing... she didn't have any clothes on they were trying to get the l.p. (lumbar puncture) done and things so I was just trying to keep her covered up and even though she wasn't a hundred percent with it...” S.10

THEME THREE: Being Younger Making a Difference

An issue faced by this group of student nurses was that they believed they were viewed negatively because of their age rather than being viewed negatively because they were students. This was in contrast to how they feel older student nurses are viewed. The younger students articulated that it was because of their younger age that the young patients and their parents behaved differently and more negatively towards them. This theme will be structured under the following sub themes: lack of knowledge and experience; treating older students differently/patients and parents reaction to them; gender and intimacy issues.

i) Lack of knowledge and experience

The younger students have described feeling inadequate due to a lack of knowledge and skills acquired at this particular time in their ‘student nurse lifeworld’. They

expressed concerns about their lack of life experience and how this has an impact on the perception of others regarding their ability to provide effective care:

“but no definitely as I was younger I didn’t feel that I could sort of comfort the mum...and I did not have at the time anyway I didn’t have the knowledge to say this and this was happening... I didn’t know... I didn’t think it was right to say anything... because what I was saying might not be true...” **also**

“like take it more that we don’t **know** something or you don’t **know** like... like... with an obs machine or something... like you are changing the cuff sometimes it might not be on right arm or the right fit or something but he might be more inclined to... I might feel more embarrassed in front of him than I might do someone else.” S.10

“I felt that like I was obviously of the same age as them or relatively the same age as them and I would go in a do their obs and think ...

God like I know they think I haven’t got a clue like they obviously know the ins and outs of their treatment and I am going in doing their obs and stuff and they have like had this done millions of times...and they think O God what is she doing ... they are looking down their nose at me like just I don’t have a clue or things...they are going to think well... she is roughly the same age as me, how much more are they going to know than me... basically nothing.. and what are they doing caring for me... they have no experience...S2

“so perhaps he did not feel he could say to me he wanted pain killers... I think he may have known that I couldn’t go and get them and administer them, I don’t know if he said it to me it would not have made much difference, but if he said it to someone who could actually go and get them administer them it would have made a bit of difference but I don’t know...uh.... Uh...it’s uh...” S.8

ii) *Treating older students differently/ Patients and Parents reaction to them*

Life experiences would perhaps more readily be acknowledged by the parents and patients in respect of the older student nurses. Life experiences are often correlated with learning by experience, hence the belief that older students are likely to know more. The younger student nurses described passionately how they believed it was

because of their age that the young patients and their parents view them differently from the older students thus undermining their sense of professional status:

“Also...in the same setting I felt that if they did anything wrong or naughty or they should not have done it... if I said something I would not have had the same reaction as the other staff or other person older than me...because I am coming at it ... I am young, she’s on our level she’s not any better than us sort of thing... and whereas if I had been older and I am telling them, its more of an adult figure having that authority over them.....whereas they feel that we are... there is only a couple of years between us some teenage boy towers above me and look older than me, and for me to turn round and say you can’t do that its naughty its not nice...they sort of look at me like what’s she to say sort of thing... I think if I had been older I would have more authority to back up and support what I said...” S.8

“I don’t know if it was because the nurses thought the older students got life experiences... and they have got children and will automatically know how to deal with situations... I did notice it that we are not able to do as much as the older students get to do, I know it sound paranoid but you do kind of feel like that...” S.9

“in that I felt young and I felt I didn’t know how to deal with that situation anyway like any first year would, but I feel that if I was a bit older I might have been able to link up with the mum a bit easier whereas I felt that because I was young if I went over to the mum and said are you all right...she might be of... like what do you know... who are you... whereas had I felt maybe had I been a bit older in that situation age would have been on my side she might have thought I could have at least sat there and said oh I have children at home and I can’t imagine if anything happened to my child...” S.10

“whereas if it’s an older nurse or an older student nurse they seem to feel much more comfortable with the idea because they seem to think parents seem to have the idea that because they are older they have more experience...” S.3

“On occasions I think sometimes parents think...and are a bit... ooh... she is a bit young...but after a while.... I remember I had one case when the mum said would I go and get a nurse sort of thing... and she would not talk to me....I don’t know whether that was because I was a student... or whether it was my age... but I do know that the student nurse who was looking after them the day before was a lot older than me and they were fine with her...I think it was a case of like I don’t want a little kid looking after my child...sort of thing... and that was quite hard to deal with...” S.1

They particularly resent the fact that being younger with lack of experience is often correlated with lack of knowledge.

“Some of the parents think you are trying your best because you are quite young but some of them think you are very naïve and quite stupid because you are younger... but just because you are younger doesn't mean you are stupid..... But yeh they have also got that thing of that you haven't got enough life experience so how would you know about these things like depression...” S.4

“The bad thing about it is that um for example a parent her daughter had CF and she came in with that and she was very anxious about that... I mean she would be anxious with that... because I am a second year student they kind of gave me... she was my patient basically...so I said if you have a problem I will try as much as possible to get help for you.... She said oh you are so young how are you supposed to help me... it came to the point where it was a little bit patronising that because I am young I cannot help her and I began to feel a bit incompetent like I couldn't do my job... S.6

iii) Gender and intimacy Issues

Concern is expressed by the student nurses relating to issues of gender brought about predominantly by their younger age and their not feeling entirely comfortable when having to deal with the personal hygiene needs of some of the young patients:

“he didn't speak to any of the younger nurses...like he spoke to the older nurses... I think he felt like um young nurses were too similar to his age and he was quite funny about young nurses being in the room when he was having dressings changed or he was getting changed or anything like that...

especially teenagers they seem to be quite worried about things like that and he just seemed to be.... quite like prefer it if it wasn't a junior or younger nurse but if it was someone older like older than him... yeh”. S.3

“because I went to see an ECG and she was nervous because she had to take off her top...but because I was young and was female she was fine with it... I think she thought I had to go through the same things that she had... but I think that if I was a male nurse of my age she wouldn't

have let me do it...let me watch...I think guy child nurses have it harder than we do..." S.4

"Because I felt he was so independent I did not think I needed to talk about if his bottom was sore.....but now I think about it I should have... but obviously he did feel uncomfortable.... Yeh... it would be a bit of an uncomfortable situation to talk about but if it had to be done it had to be done..... We did talk about being uncomfortable and that could have been a reason why he was uncomfortable but we didn't really get into it...it would have been more uncomfortable on his part than my part... yeh... yeh...." S6

One student nurse in her narrative again demonstrated issues in respect putting them self in the place of the patient and how this impacted on her emotional discomfort:

"I looked after a girl who was 13 as well, she had been in a car accident and she was completely brain damaged and couldn't talk or couldn't move or anything and um... I felt really awkward when I had to give her a bed bath and stuff, and I kind of... I didn't know how aware she was of me being there but I thought that if that was me and she was aware of what's going on around her it must be so horrible to be that age... and I don't know if she might have preferred having somebody nearer to her age caring for her... I found that really hard because me and my age and her are near my age and..." S.9

There were also concerns raised in relation to issues of intimacy and how sometimes due to their age the student nurses had felt uncomfortable in particular situations with some of the patients:

"Well, there was one patient he was quite old, he was like about seventeen years old and that... but he only came in because he had thalasaemia and he came in and out for blood... he was kind of laid back and talking to me... and he was kind flirtatious a little bit... (giggly) and I thought is this because of my age or does he do it to everyone.... Or was it just because I was a female... but I think actually that was just him he was just flirting and talking and I tried you know to keep it kind of professional. From that I did all you know talk to him but minded what I'd say." S. 6

“I do find it more difficult with boys...with a boy.... I don't know why... just I don't know why I do... maybe because sometimes I feel they might be...sort of ... sometimes they might make sort of inappropriate comments... not in a sort of rude way I think...” S.10

“Yes I'll be honest I feel a lot more comfortable about looking after girls of the same age than boys definitely...I know it sounds awful but I remember with one of the cancer patients that I was with the one that was sixteen and the one that was eighteen and I remember like doing the obs and doing all this stuff and I know its really bad and really awful but I know I am going to hate to say this... like.... I hope he doesn't think I fancy him or anything when I am touching his arm and stuff, really I don't know where that came from... (nervous giggle) to be honest but I did feel uncomfortable..... and I thought...um... I hope he doesn't think I am doing this because I like him or I am being nice because I like him.... I don't know what that was all about... but ha ha... I don't know why but yeh... definitely I did feel like that with the males, definitely, I don't know why but.....maybe it is because it is quite like caring isn't it... especially at that age if someone cares for you or even now you start to think oh, you do get attached, I am often like that especially at sixteen you are thinking like... because they care for you... you're supposed to like them or touch them or something like that, I don't know, its possible, I don't know, for that reason I think more than anything else. Yes. Yes.” S.2

BENEFITS EXPERIENCED BY THE YOUNGER STUDENTS

THEME ONE: Messy Boundaries

The students shared the belief that one of the main benefits of the messy boundaries was that this enabled them to set aside their 'nurse' or not yet formed, 'professional' identity and function on the same level as the young patients during the times they were either sent in to chat to them or took it upon themselves to spend time chatting with them. There was a very strong sense throughout all of the transcripts that being of a similar age to the young patients enabled them to relate to them easily. There were far too many references to 'relating to the young patients' to include them all. This theme will be deconstructed and analysed under the following two sub themes:

being on the same level/ relating to the patients making it easier to talk to them; being able to make a breakthrough, getting them to talk.

i) Being on the same level/ Relating to the patients making it easier to talk to them

The ambivalence in their professional status and their young age appears to have enabled the students to relate well to the young patients which they perceive has made it easier for the young patients to communicate with them on the same level:

“...and I found her quite open I like to think she was quite pleased I had gone in there and was able to speak to her and was able to be sort of just be on her level”. S.10

“at certain points she didn’t see me as a student nurse... she just saw me more like her friend and she would talk to me about things and everything...” S.11

“relate to that age and maybe look back and see how you felt about everything and sort of talk to them ...that could help... help them to calm down... get into their minds...see how they feel about the situation...” S.5

“but because of the small age gap there it was quite easy for me to talk to her because I could relate to how she was feeling and things like that and that quite easily...” S.1

“She was really lovely and we... I suppose me caring for her... I felt that I don’t know perhaps I was on the same level as her, you know I felt that she was not afraid of the staff nurse, but I was more, not like a friend but she could relate to me a bit more...” S.8

“just because I think sometimes they need to talk to people of a similar age to them that they can relate to... just talking about normal stuff...” S.4

In relating to the young patients this young student appears to recognise the fact that young people are often judged by older people which is a strong influencing factor in relation to effective communication:

“There are two sides about how I feel about being young in this profession... like the good bit is that obviously I feel I can relate to the younger ones I can talk to them,, they might not want to talk to the older adults they feel that they might be judged...”. S.6

Another young student has also included issues of culture and race into the discussion concerning factors which influence being able to relate to the young patients.

“plus she was from my country Nigeria...so then it was much easier to relate to her as well... she is another teenager like me too and I can relate to her one way or the other...” S.11

ii) Being able to make a breakthrough, getting them to tell

Engaging in the friendly interactions with the young patients helped the students to build trusting relationships. As these trusting relationships developed, the young patients would, in the students’ eyes, be much more likely to open up to them and tell them more about how they were feeling than they would with the older students or trained staff:

“There was another one who was sixteen and she had taken an overdose...and she wasn't talking to anybody but she was talking to me..... not deeply in conversation but she would sort of say a few words to me.....that was in a matter of minutes she would talk to me... but with the other nurses it took them quite a long time to build up a bit of a relationship as she was quite nervous and did not know them...” S.1

“I really enjoyed to go and chat and just to take five minutes out of doing all that and just to say how are you how are you feeling and stuff and often they do open up to you maybe I think a bit more than they might do a sort of an older staff nurse...I don't always know why...” S.10

“...like there was a seventeen year old in A & E and I was in triage when he came in and he had cut his head right across his forehead... and he said to the triage nurse oh I fell over... and when the triage nurse went to get something... he said to me actually I was drunk but I didn't want to tell them that because I am only seventeen...and he said you know, you seem like my age you must know what it is like...you just sort of think... you can tell them as well...but just seem to have more trust in you almost like because you are their age and they seem to think you can understand more where they are coming from...so to speak... as to what they are doing and why they are doing it...and that you will be more understanding but you will understand what they are saying to you or why they are doing something... they just seem to communicate a lot better with younger people for some reason most of them... I think teenagers when they open up to you...you sort of you feel quite happy...you feel like you have achieved something by them talking to you...when someone can be quite closed not say anything... you think they are talking to you... a breakthrough almost, they are talking to me... brilliant...” S.3

“I think this is the most rewarding thing with working with them... definitely... you see them come in and things aren't great and then you will get one little thing to breakthrough with... one little sentence... some word or something will happen... sometimes you just don't get it and you think I didn't get through... I don't like that at all... sometimes its just one little word, one little sentence... it's a breakthrough... its ... and then it all just comes out... it starts to fly... I think just to be there... They will probably still self harm, still be bulimic or anorexic but at least for that hour or two hours that you were there with them or you were popping in and out they weren't so uptight and they weren't so withdrawn as they were when they came in... yeh... yeh...” S.2

At times the students felt a natural empathy with the young patients due to being a similar age to them and felt that this would encourage the young patients to open up to them:

“it all depends how you interact with them... how you can talk to them... I think... I believe you have to know what they are going through be in that right sort of mind... think of what they are going through at their age and think how you felt at that age and felt different...compare issues and see what they are going through to be able to talk to them... maybe they will open up more and talk to you back. Yeh...yeh” S.5

“It was good to see that each time I cared for him he started to smile a bit more... he was a bit happier... He still had the problem but you know he knew he could come to me and talk to me... His parents were not really there either it was just basically me and him talking...

because like I know how they have been seen in society and I have actually experienced some of the things and they may be of a similar background to me so I start off talking about school and then how they socialise basically... like hobbies and things like that... not social social... I try if possible to get things... I know its distressing times in hospital and they want to be outside so I try to make it a bit enjoyable as much as I can...” S.6

It is recognized, however, that when the young patients opened up to the student nurses there were occasions when concerns were raised in respect of confidentiality issues:

“I had a patient who I was caring for ... it was the young man with the broken arm... he did smoke... his parents didn't know he smoked... it was really difficult... you know... you think he is quite young do I let him smoke... do I not let him smoke... his parents don't know...you sort of get so many issues of what can I do...or like if you've got teenagers who are sexually active at a young age and their parents don't know for example. .because obviously teenagers don't tend to tell their parents everything...you sort of think I've got to be so careful... at what I say... they might have told you in confidence... you think O God what if someone lets slip that... or if they turn out to be pregnant or something like that you think...” S.3

THEME TWO: Emotional Security

This theme will be structured under the following sub theme: relieving the boredom for young patients/letting them forget about their illness for a while.

i) Relieving the boredom for young patients/letting them forget about their illness for a while

The students were very positive within the narrative in respect of one of the advantages that messy boundaries afforded them. In developing friendly relationships with the young patients, they felt this enabled them to help the patients take time out from being ill and fill some of their time during long and boring days in hospital:

“sometimes if she was bored I would ask her does she want books to read... do any drawings... stuff like that...try and help her out with that... I remember going to one of the corner shops in the hospital because she likes reading magazines... being updated with the latest things in the media... I would get her a magazine to read as well...” S.11

“...she looked quite pleased that I had gone in there just to sort of speak to her and just to sort not even you know ask some questions just to chill out and be with her so see if she wanted any magazines or whether you know there were magazines and stuff if she wanted to look at anything...and I found her quite open I like to think she was quite pleased I had gone in there and was able to speak to her and was able to be sort of just be on her level and chat to her about things like music and again school...” S.10

The students recognise the fact that being on the same level as the patients and having similar interests makes it easier for them to engage with the young patients and socialise with them in order to fill some of the time voids the patients experience during long hospital admissions. The students recognise the contribution they can make to making the patients feel better for those moments in time:

“When I haven’t got anything to do and I see a patient of a similar age to me I often go over to talk to them... especially if they haven’t got a friend with them...just because I think sometimes they need to talk to people of a similar age to them that they can relate to... just talking about normal stuff...doesn’t have to be what they are in for... talk about music and stuff like that..... P2

“so I tried to make sure that I stayed with them quite a lot because their parents weren’t around so I tried to talk to them about things that would interest them like celebrities music films that were coming out what they would like, similar things that I am into so that they know...” S1

“I understand where they are coming from... I really like listening to them... to them because they like to tell stories like when they are at school and they like talking about different stories and stuff and I really like listening to them... I think and I feel that if you listen to them and communicate with them you make a lot of difference to their stay in hospital rather than let them sit in a room by themselves watching telly.” S4

ISSUES OF CONCERN EXPRESSED BY THE YOUNG PATIENTS

THEME ONE: Messy Boundaries:

Some of the concerns expressed by the young patients are similar in nature to those of the younger students. Messy boundaries appear to underpin most of the issues and it is in the blurring of these boundaries that the issues arise. Issues in respect of younger students not being perceived as professional or real nurses were frequently raised within the young patient’s narratives. Also the young patients discuss, what they perceive to be, their responsibility in respect of teaching the younger students about their condition. This theme has been structured under the following sub themes: not seeing younger students as real nurses or professionals; expectations of them (the patients) being teachers.

i) Not seeing younger students as real nurses or professionals

Within the narrative it is evident that the young patients do not see the younger students in a professional role or as real nurses, but do recognise that the students spend more time talking to them:

“whereas professional nurses, like proper nurses, seem to be everywhere at once...and they seem to be very busy. Like... I have had many young student nurses looking after me during my time and um most of them seem to have time... if they come round with the proper nurse and they introduce them to me... they just seem to come back when the normal nurses aren't around and when they are doing my blood pressure or something they will just sit around and just talk for a while.” P1

More significantly, there is even a suggestion that being a student and not being a ‘proper’ nurse equates to being more ‘caring’:

“but... I am just saying that the younger students tend to be more caring because they have not started being proper nurses yet...” P.1

Sometimes the lack of professional skills being demonstrated by some of the younger student nurses during what appear to be a variety of interactions is viewed in a negative light by some of the young patients:

“Mind you, some of the younger ones, some of them lack, I don't know what the word is, like decorum, like they don't really care what they come out with... like I have had a couple of younger ones that are not very professional, like I know that they are only training and that, some of them are really rude...”

“I know student nurses are not professionals...and like I said before some of them don't have any decorum and don't care what they come out with... I've had a couple of students where I have had to say to the nurses don't send them in to me because they really irritate me...”

“I see the role of students as being trainees...I don't really see them as a nurse nurse... more as a trainee... I wouldn't class them as a trainee... a student rather than a nurse” P.7.

“I think it is sometimes difficult for them to...um... I won't say be told... but know when someone is trying to get them to do the right thing...like you are in pain and you just need something to stop it from hurting... they just need to see the **nurse** and get something... sometimes they don't just see that... just get distracted they go off and do something else...” P.3.

“I think it is very irritating with younger students... Younger students would be near the same age as me and I can't imagine if we swapped roles, it's almost like the younger students are doing work experience, like working in the hospital doing training but not so really trained... umm...” P.9

“Like the student nurses, I am not dissing them... if they have just started ... and they have never had someone coming out of theatre...”

you are coming out of theatre and are drowsy and dry and stuff like that... they might not know how to handle me know what to do not like a proper nurse, know the symptoms, what is going wrong... not that the young student would be bad but a real nurse would have much more experience...not being horrible..." P.6

ii) Expectations of them (the patient) being teachers

Some of the patients felt it was their responsibility to explain about their illness to the student nurses and in fact the narrative indicates that some of the patients enjoy this and benefit from this. From the narrative it would appear that the patients feel a sense of responsibility for being teachers:

"There was someone who did come in and ask me questions about my health, it was a man, asking me questions about my health I think they were a student.... I thought it was OK... they were trying to learn about stuff so I thought I may as well answer their questions....

It's kind of good know that you are helping the younger students... I don't know if that makes sense... they have kind of got you to practice on... that's a bit far... yeah but I don't really see it as a problem... What I find annoying is when lots of people come into the room, take notes and walk off... staring at you not speaking to you and then just walk off when you are trying to get some sleep..." P.8

"Usually every time I have been in I have had at least one younger student nurse..... usually they ask me all sorts of questions...like to help with their learning... like if they do see something with me that they have not seen before they ask me about it like... my portacath, like asking me when did I have it and things like that... I don't mind them asking, I think it is ok"

"I sort of quite like talking to the students when they ask me questions... I feel like I am like teaching them, like helping them out.... Say..." P.5

"I don't mind helping and teaching them... I quite like helping them if they don't know something then if they go to another patient in another hospital and they have got the same thing I have got and they remember from me that I had that and they remember from me how to do it or how to cope with it then I feel that I have helped them in some way... I quite like that. as I get older I am doing more of it so I know more about my medication and I don't mind if the nurse wants to ask certain bits about my medication or condition, I don't mind helping and teaching them... I quite like helping them I they don't know something then if they go to another patient in another hospital and they have got the same thing I have got and they remember from me that I had that and they remember

from me how to do it or how to cope with it then I feel that I have helped them in some way... I quite like that.” P.4

“I don’t mind telling them about my condition... because the more people that knows about it the better...because especially the students its good for them to know about different people with different conditions... I don’t mind talking about it because I am used to talking about it to different people... I think it’s good for them to be educated by an actual person who is going through it rather than being told about it by some lecturer person who is standing in front of a whole crowd of people telling them about it...” P.1

“She would ask what it is like having CF and I would obviously tell them because they are interested and obviously need to know about it, so they would ask questions and that... questions like, what CF is, what the symptoms are, what I have to go through, what I feel like living with it.” P.7

However, for others they were not quite so happy about doing this and did not like to speak about their illness to people they did not feel they knew:

“I have to tell them what is about and how I cope with it... it’s a bit... when they ask me I don’t usually tell them very much because I don’t really know them I don’t tell them everything sort of as I would with other nurses I have known a long time.” P.9

“I think some student nurses may understand a little bit... know a little bit about my CF they might understand a little but, but they will ask me to explain it, not nastily like, but ask me nicely if I could explain it.... I am not really that good at explaining it but yeh I don’t mind...they don’t always ask me about it.... Probably I know more about it...” P6

And some patients will find it very distressing to have to discuss their illness with the students.

“They (the young students) don’t really ask about my illness, because I get quite upset sometimes over my illness and stuff and I don’t like to be asked questions about it and stuff... if they ask me I just think they are being... what’s the word... they are just being... I don’t really know the word...”

“I prefer not to talk about my illness because I really don’t like to talk about it..... Its not that I feel uncomfortable about talking about it, it’s just that sometimes I always think why me... why did I get it... I cope with it quite bad... ... I get to a point when I’m sick of having CF and I get into a real tantrum mode...” P.2

“I don’t really like it when they (the younger students) come in and ask you about your CF and stuff when you don’t know them... I know its about their research and stuff and I don’t really like to say no...you always have enough of talking about it because you are in hospital and you don’t want to keep going on about it in a way... I don’t mind but its just that when you are in hospital you are surrounded by it and then you get some stranger you don't really know randomly asking you.” P.9

One of the young patients felt quite strongly that personnel should read the notes to find out about his condition before they asked questions or examined him when he was feeling particularly unwell:

“When I was younger I hated being prodded and poked and being asked questions.... When I was younger I had time for it... but there is a time and place for it... when you are sick you don’t want to be prodded and poked...questions... questions... questions...When I was younger I had time for it...when you are sick you don’t want to be asked questions about your past or health... I think the notes are there... read them...” P.3

THEME TWO: Emotional Security

The young patients have identified issues in relation to their emotional security during some of the caring experiences with the younger student nurses. As mirrored by the student nurses the young patients will be engaging with adolescence as a time of self-consciousness and egocentricism and be more vulnerable to emotional insecurity due to heightened sensitivities to external stimuli. To explore these issues, this theme will be structured under the following sub themes: feeling safe and trusting the students; younger students not understanding how they might be feeling; gender and intimacy issues.

i) Feeling safe and trusting the students

In respect of their emotional wellbeing the young patients expressed worries and concerns about feeling safe and trusting the younger students in certain caring situations. A lot of their fears focused on the belief that being young equated to less experience and knowledge.

“younger students are still learning and I would be more nervous with that... they are still learning, just starting to learn... I would have to assume that the older student had been their longer than the younger one... It’s down to experience but with the older student I would probably trust them more than the younger students.” P.8

“When I had my transplant I didn’t feel great then I would not really like a younger student to be looking after me on their own... especially if they didn’t know what they were doing and something went wrong... I am not saying it would... but if they didn’t know what they were doing one hundred percent and if I were really really ill then I would prefer not to have a younger student.” P.4

They also appear to equate being younger with being more panicky:

“I think the students like the younger ones get quite panicky and stuff like that ... like stuff they haven’t seen before... they are all mostly all right though...” P5

There is a belief, in the young patient’s view, that being an older student equates to being more experienced:

“I think if I was feeling really ill I would prefer an older student because I feel like they have got more experience and that, some of the younger students don’t know very much and ask me a lot of questions and that and you think do they really know what to do... stuff like that ... like...” P.5

The young patients also raise issues of concern in respect of feeling safe and trusting the younger students with their care:

“I think that in a way its nice to have someone your age to talk to but then not I don’t feel as safe almost in thinking that they are giving you your medicines sort of and umm... and they might not have as much

experience as an older student ... I would feel safer with an older student... I think it is because they are so young... there is just something more... you feel more safe with an older person... I don't know why..." P.9

"Frankly I thought it was a bit weird being looked after by someone who was barely older than you are... because sometimes you felt like that they did not know as much as the more experienced nurses... I did not trust them with taking care of myself..." P.1

ii) Younger students not understanding how they might be feeling

When conversations involved engaging in deeper emotional exchanges, the young patients describe feelings of frustration and annoyance in respect of not really being listened to or understood. They have also indicated that their feelings were not always considered and that the student nurses were unaware of when they might have touched on sensitive issues clumsily by making light of a situation which might be very distressing to the young patient.

It may well have been that by the very nature of those ontological experiences being engaged in by the young student nurses and the young patients, that they may have made casual comments, as they might with a friend or mate, without realising the emotional distress this could have caused the young patients. In engaging with the student nurses in this way has blurred the boundaries for the young patients whereby there is confusion between being in a friendship and a friendly professional relationship and is an example of how messy boundaries has produced negative feelings:

"Mind you sometimes they like come in and sort of act older than what they are, they feel as they know more about your body than you actually do yourself and they try to tell you things that you know what it is... I know they do know what they are talking about... but sometimes they act as if they know how you are feeling like for instance if you are feeling upset and if it is for a certain reason... sometimes they tell you it

is not because of that it is because of something else...when I feel like... I don't like that...when they are trying to tell you something that I know. Like when I was really really tired one night and needed to have an x-ray and she was taking her time coming round and I was getting really annoyed about it and upset and one of the student nurses came round and was basically saying it was not because of that... I can't remember actually what she said but because I was already annoyed anyway it made me even more annoyed... yeh just silly things like that...it annoys me because I don't like being in hospital anyway... and I don't like students coming round and telling me things what I don't like." P.4

"they was like talking about how easy it is to do physio, but it's not easy when you've got cystic fibrosis, and they sort of put you down as in you should be able to do it and you can't because it is hard... and a couple of the young student nurses are a bit ... of come on don't moan that much... it's not that bad... but they don't know because they haven't got cf (cystic fibrosis)...and sometimes I don't really think that they think about what they come out with...they don't mean it in a horrible way, but they really should like think what they say..." P.7

There were also occasions when the young patients felt that the younger students may not have engaged with them in this friendly non professional way, that perhaps they were used to with other young students, and this also appears to have caused distress for the young patients. The young patients could become emotionally distressed by the lack of chatting and socialization and did not feel comfortable with the silences:

"Well I had this one younger student who was looking after me and she was really quiet and it made me feel really uncomfortable because she wasn't saying anything... she would just sit there in silence because usually other nurses say like I am going to do your obs and start to do you temperature, but she just was just like doing it all and she didn't like say anything and she didn't like look confident and it made me feel uncomfortable...It just makes you feel uncomfortable if they don't talk to you..."

"I get quite panicky when people come in to look after me anyway....in case... I just don't like it... it makes me feel uncomfortable if they don't talk or anything and are just silent... especially if I haven't seen them before and they are silent.... Some of the young student nurses I have seen them before... especially if I have not seen them before and they are silent it like I don't get to know them I feel really uncomfortable because they don't get to know me..." P.2

Sometimes the younger students may not be picking up on cues that might indicate that the young patients are feeling particularly low or distressed:

“it’s quite tiresome being in hospital...especially when you are like in one position for a long time...like when your leg is in traction...which my leg is normally... like when I have a fractured leg I am normally in traction so you can’t move about and you just lye there for hours and sometimes the TV doesn’t work for ages and you just have to sit there and be bored... like I have been in hospital when I have had both my arms fractured and my leg fractured...so I could not actually do anything... I was just lying there with only one leg that could move... I was just sitting there...” (said very sadly) P.1

“When I was younger I had no patience for that I thought students go away...when you are sick all the time... I don’t want to be prodded and poked I just want to get better and go home..... like I can’t relate to it...um... its like going shopping when you have a cold... you are cold already... you are going around the fridges..... your nose is running...it’s a really horrid feeling the last thing you want is something to make you feel worse and that is very much how it is... you are feeling shit and you don’t want to be doing something that makes you feel even more shit...that’s not the point... I really hated young students when I was about 14.... really hated them did not have no patience...”P.3

The young patients appeared to be caused emotional distress because they were not being listened to or because they felt that that their knowledge about their disease was not acknowledged, which may reflect the students’ lack of experience and understanding rendering the students to be somewhat inflexible:

“I say, no I have not eaten anything yet so I take it then, but they will say its on the chart.... your chart you have to take it now...no I have to take it at breakfast and I haven’t eaten breakfast yet.... I am not being funny but I know I am right, I know when I have to take it... I know what I have to do... I know they have to tell me what to do... but I know I am right, so they have to go away and ask someone else to say is this right when I know its right.... I am left waiting around for about ten minutes, I know its only ten minutes... but till they come back, it really annoys me and it really irritates me... I get really frustrated because I know what I have to do...it doesn’t matter how many times I tell them... I do it at home by myself... but they don’t want to listen...they don’t want to listen to what is right, they just want to listen

to what they have been told to do...at the end of the day I know they have to do their job but..... I know I am right.... I have to say it every day.... The next morning they will say it again... I say I told you yesterday and I am telling you today... they still say I have to take it now but I say no... and I won't. I say I haven't eaten breakfast so I won't take it now.... Sometimes they say OK then... but usually..." P.6

"Specifically when I was younger there was a time when I was being looked after this student who must have been about eighteen... I told her I need some pain killers I was in pain my back was really hurting...she said that was fine she would get me some pain killers and would speak to the other nurse... I told her and she went off... obviously when you are in bed in pain... it must have been half an hour later my back was really throbbing now... and I asked her again when she came back and I told her I was really in pain... sometimes when you are in pain and get frustrated your mouth does let lose a bit... I told her I needed some pain killers and to tell my nurse... she wandered off and eventually she did tell my nurse and get my pain killers..." P.3

iii) Gender and intimacy Issues

Another area that often caused the young patients emotional discomfort was in relation to being cared for by students of the opposite gender especially in relation to dealing with their personal hygiene needs:

"I would prefer the nurse to be a woman; I would feel a bit strange if it were a man... I don't know why, because I would feel like, I would prefer it if they were a woman and were more close to me I would feel more comfortable and relaxed." P.5 (female)

"There isn't much I would mind him doing but not my hygiene stuff because my mum is usually with me and I would get her to help me with that if I needed to." P.4 (female)

"I prefer female students because I would feel more comfortable with them than a male..." P.9 (female)

"If I wanted to release my bowels or something... that is when a male nurse would have been preferable because that is not the best situation to be in with a female nurse...but all the other things I think a female nurse would be better... but I think just in like the toiletry side of things I think it would be best for male nurses to be caring for male patients." P.2 (male)

The embarrassment and discomfort of the young patients brought about by being cared for by younger student nurses of the opposite gender is clearly articulated:

“Other times it would be easier to have a male student... I would not feel so embarrassed... you don’t want to feel embarrassed... even though you are sick you can still blush and feel embarrassed... sometimes you need to do male things it has been embarrassing... you just get on with it...especially when you are fourteen or fifteen... a male nurse can be very handy... that is when a male nurse can be very useful...” P3 (male)

“There was not anything in particular like with the male students, but if I said to a student can you get a doctor please because I want to ask *her* something... and they like said what’s the matter is there anything I can help you with...and there is a certain something that is wrong with you and you don’t want to tell them...just little things like that... I do feel comfortable telling a woman, rather than a man... woman things like, time of the month and that... and other symptoms I get with antibiotics I get problems like ... in areas, like I wouldn’t want to tell male nurses, especially young ones... I would tell the women... the young girls... but not the male ones.” P.7 (female)

The male presence was appreciated by male patients:

“he was the first male student I had looking after me and I was a bit more relaxed with him and he was a male nurse... and I would have been more relaxed with the male nurse... the interactions I had with him was more or less the same as I would have had with the female student... but I think I trusted him more than the female nurses...its not because I am sexist or anything...(laugh)... its just that I felt I could trust him more because he was a male so ...” P.2 (male)

“even though I have had countless experience with the nurses... you have good nurses... but nothing beats the male presence...that’s priceless... as a guy I can trust him in that way...you can’t beat that...” P.3 (male)

THEME THREE: Being Younger Making a Difference

It can be seen from the narrative that young age does make a difference in respect of how the younger students are viewed by the young patients. This theme will be

structured under the following sub themes: younger students do not know much/ lack experience; viewing older students differently.

i) Younger students do not know very much / lack experience

From the narrative it can be seen that the young patients clearly feel that the students, because of their age, do not know very much and have little clinical experience, which could have an impact on them trusting them with their care:

“Once I had a problem with my gastrostomy tube, like I think the bubble had burst and something that and the younger student did not know what to do and she did not know what to do and she used the wrong thing, like the replacement one instead of the right one...I didn't feel very happy about that... I had to wait for a doctor to come and change it and that...” P.5

“after I had a bronchoscopy and was drowsy and that from the anaesthetic once... and he done my bms (blood sugars)... but it was the first time of him doing it and there was blood everywhere and the nurse had to help him clear it all up and he was getting really flustered... he didn't know what he was doing...there was blood everywhere... he kind of panicked a bit...” P.4

“I think if they are younger students they might make more mistakes because they are learning” P.9

“Especially with my condition that I have gone into hospital so many times that I know the procedure for everything.... So if I know that they are doing something not quite right I would tell them that it is not quite right and would they mind changing it...” P.1

“I am not dissing the younger student nurses, but they have not had much experience of taking the needles in and out...” P.6

“the young student nurses... even though you want to help them because they are students..... don't want to sound rude but sometimes they are slow on the uptake...” P.3

Sometimes the patients are expressing some more serious concerns in relation to lack of knowledge and skills, with one of the following incidents clearly indicating a drug error, which was followed up as such:

“there was a young student who was helping a senior nurse dish out the medication... the senior nurse left the trolley....and the younger student kept on dispensing the drugs to be signed off... I don't know if they are allowed to do this... and gave me my tablets...I said these are not my tablets. I know my tablets which ones are right and which ones are wrong...I have them all the time... I said these are not my tablets and I am not going to take them...” P.3

i) Viewing Older students differently

Clearly within the narrative it can be seen that the young patients appear to view the older students in a very different light. They appear to see them more as nurses and would trust them and feel safer with them:

“but I would panic if a young student were to try to take out a cannula... if it were a student nurse especially a younger student nurse I would panic even more... I would think o God they don't know what they are doing... I think an older student would know more....I would prefer an older student because... just because I think they would know more and they would probably be...you know... the younger student might be used to seeing someone really ill, but they would be more panicky and that and that would really panic me but the older student might not do that...” P.2

“It's down to experience but with the older student I would probably trust them more than the younger students.” P.8

“I would feel safer with older students... I think it is because they are so young... there is just something more... you feel more safe with an older person...” P.9

They are also equating being older with being more experienced:

“I think if I was feeling really ill I would prefer an older student because I feel like they have got more experience and that...” P.5

“if they are older you would feel more comfortable giving tablets etc... because the older students would have had more experience... they would have more experience umm... ummm...I don't know.” P.9

If they were older students and they had sort of children of their own they might be more like child friendly in a way rather than a younger student who wouldn't see you as... I don't know... I can't explain it... if the younger students do not have kids they might see you just as what they have to do at work and they might not put so much attention on you...” P.9

“If I were really poorly I would prefer an older student, a few times I have been really ill, and I feel I would definitely prefer an older student feel they know more about what they are doing probably because they have got more experience and are more reliable... not saying the younger students will not be but not so much as older students but would definitely prefer an older student...when I am unwell I definitely prefer an older student...” P.6

One young patient describes older nurses as having the qualities of a mother:

“older student nurses are softer and yet more experienced and harder at what they do...it's really strange... I would rather put up with or have a nurse who is older and warm than a younger nurse who does anything to what I say... anything is fine... even though the younger nurse may have more time with you like making you laugh and things... and older nurse is able to be calm and be supportive... more of a mothers warmth and settled... rather than you.... warmth and settled... that's what I think...” P.3

It would seem that the young patients acknowledge that the younger students are more chatty and friendly in their approach with them. However, they appear view the older students differently and see them more in the role of a nurse, particularly for undertaking nursing procedures, and in the way that they communicate with them. They are suggesting that the older students are not so chatty and probably are more knowledgeable than the young students:

“Older students talk to me not like that, they talk like with respect, but not like a mate, like a nurse, like how are you today, have you got a temperature, have you got a cough, I am like no... but younger students say how are you, what have you been up to... stuff like that... The older students come across more as a nurse... the younger students come across more as a friend... a nurse as well... As a nurse they take care of you more making sure you re fine and well, making sure you have not got a pain...the older students ask me more about me, how am I feeling, have I got a temperature (laughing) always ask me have I got a temperature... don't know why.” P.6

“I think overall umm... I'd prefer to have the older students doing all the procedures but it would be nice to see the younger students now and again to chat with...” P.8

The older ones seem to take it a bit more seriously, like, not more seriously, you know just get on and do it whereas the younger ones chat to you whilst they are doing it... the older ones just get on and do it. The older ones come across more as being a nurse, probably because I think they would know more and they would... yeh know more... yeh I think that is why I think they come across more as a nurse...” P.2

BENEFITS EXPERIENCED BY YOUNG PATIENTS

THEME ONE: Messy Boundaries

Whilst messy boundaries can give rise to some issues for the young patients, there is a strong indication in the patients' narratives that the ambivalence in the student nurses' professional identity is also perceived as a real benefit to them. The transient friendships that evolved between the students and the patients appear to be preferred to professional relationships. Seeing the students as friends or mates indicates that they see the students as peers more than professional nurses which is demonstrated in the narrative by the kind of interactions they had. This theme will be structured under the following sub theme: 'younger students as friends and mates/ being able to talk to them on the same level'.

i) Younger students as friends and mates/ Being able to talk to them on the same level

All of the young patients have commented freely on the fact that that really appreciate those moments in time when they have been able to relate to the younger students on a very friendly and relaxed level, having loads in common with them and seeing them more as substitute friends than nurses:

“it would be nice to see the younger students now and again to chat with... and I see them as nurses but you can be friends with them... why not...” P.8

“Umm... with the younger students I would talk to them about what I am doing at school and what I like doing at the weekends, sort of like your friend because they are like the same age, sort of like that... more as a friend because they are the same age as you...” P.9

“I quite like it with the younger students because you’ve got more in common because you are round about the same age... you know the same stuff... Know the same places where everyone goes... and we just talk about more in common because we are about the same age like someone you go to college with or are in school with like...you can have more of a laugh with them when they are younger and stuff. Um... um.... Not sure about the older students..... “We used to talk about telly, sometimes he would come in and watch telly with me and we would talk about all that sort of stuff.” P.4

“Younger students made me laugh...they are funny, they take my mind off being sick and it was easy to be silly... they remind you that you are a kid rather than a patient or what ever.... number so and so sitting on bed twelve...”P.3

“When you get to know them and they tell you more about their lives and I tell them more about mine... you do tend to become friends with them... and then they leave.”

“he still enjoys X boxes and play stations because he is barely out of his teenage years so its nice that he can relate back to that... whereas the older nurses might not be interested in that sort of thing.” P.1

“I have been in hospital quite a few times and been looked after by a young student nurse and its quite nice because I can’t be with my mates... they are a like a mate to me... they say like hello like are you OK, its quite nice to have like a friend, they have always been kind and helped me... Like.... They talk to me like a teenager, like when I talk

to my mates, they ask me like can I do anything, can I help with anything, anything I can get you, yeh yeh kind of like being a mate more than a nurse...I see the younger students more as friends the way they talk to me like a proper true friend... they are kind of like a friend to me when I am in there... its lovely that you can go in there and you have got a friend to talk to. They always take care of you, on time, but at the same time still as a friend.... Definitely both a friend and nurse..." P6

"Most of the younger students are really friendly and bubbly and I get along with them well.

.... its probably just the age because they are really bubbly and everything... they do act like nurses but they are like a friend... they come across really friendly... I would probably see them as a nurse but more as a friend..." P.2

"she would talk about every day stuff, like celebrity gossip, like being in hospital, like my illness, and that, anything really, anything that young people talk about." P.7

THEME TWO: Emotional Security

In relation to their emotional security the young patients frequently referred to the benefits of having younger students to engage with. All of the young patients have experienced extensive periods of time in hospital over the whole of their lifetimes which was considered to be both '*tiresome*' and '*boring*' but also reinforcing the fact that their illness was lifelong. Anything the younger students could do to relieve their boredom and give them respite from their illness was viewed positively. This theme will be structured under the following sub theme: 'relieving boredom/ enjoying their company/ letting them forget about their illness for a while'.

i) Relieving boredom / enjoying their company / Letting them forget about their illness for a while

There are numerous references to occasions when the young patients have been very glad to have the company of the young student nurses and to socialise with them in order to relieve their boredom:

“Yes I like it when they come to chat to you... like usually when you are in hospital if you’ve got no one there it gets really boring when you like, when the doctors come round they just talk about you, not chatty but about medicines and then go and you get really bored with that... it’s nice to have someone to come and chat to you, like you really miss your friends from school and that...” P.5

“... they just seem to come back when the normal nurses aren’t around and when they are doing my blood pressure or something they will just sit around and just talk for a while. It just makes a change from sitting there in bed for hours on end doing nothing... its nice to have someone to talk to other than your parents... its quite tiresome being in hospital...especially when you are like in one position for a long time...like when your leg is in traction...which my leg is normally... like when I have a fractured leg I am normally in traction so you can’t move about and you just lye there for hours and sometimes the TV doesn’t work for ages and you just have to sit there and be bored... like I have been in hospital when I have had both my arms fractured and my leg fractured...so I could not actually do anything... I was just lying there with only one leg that could move... I was just sitting there... so talking to people made a change to just lying there and staring into space... that was good... (said sadly)” P.1

“she sat with me for like 15 minutes and had like a normal every day chat and made me feel like I had company...and that would make me feel like that little bit better...P.7

“they would always pop in and say hello when she started and then like after they had finished say bye and that... she was probably eighteen or nineteen, at the time and I was sixteen so it was like having a mate to chat to...like when I was bored or if I wanted anything, yes it was nice.....” P.7

“I don’t mind it when the students come in and talk to me... I don’t really like being left alone.” P.7

“Student nurses help you have fun as well... when obviously you get better they can tell a joke and put a smile on your face, they are very good about that...where maybe mature students would be you are better now lets get on with the next one... whereas younger students are definitely more fun... definitely young student nurses are good at that... bring up morale for patients its very hard when you are on a ward...its little comments... like ...one time I was watching the Simpsons on the telly she said what if I had a skate board and turned this place into a skate park... and I said what are you talking about...I was hung up in a wheelchair...there was this massive corridor... there were these boxes and she made them into this like ramp section.... She said I could go up here and down there. It was hilarious... but that kind of thing putting that much effort into making one person happier... I think sometimes student nurses can do that... health is not just physical its mental as well... if you are sick you get very sick if you don't have the right sort of mind... so that is a benefit of the younger student because they can always make you smile which is good when you are in hospital.” P.3

One of the young patients was able to passionately articulate the real benefit of being able to take time out from being ill and the real benefit of those moments in time with the younger student nurses when he was able to forget the hard work of trying to get better and describes the effort that what was involved in getting better over a very protracted period of time. He was clearly able to articulate how important respite from this was in respect of his mental wellbeing:

“I think that is an important part about what younger student nurses are about... then can take away how bad it is for me to be sick... they can take your mind off it...and I believe personally... I have seen it with my own eyes... if you think too much about getting better... think about I have to do this... think too much about the work of getting better...then that has a detrimental effect on you getting better... the brain has a huge impact on how you react to medicine... if you are positive your body will recover quickly... if you have a younger student nurse who can take your mind off it for a five minutes... take that moment out of your day when you are not a sick boy.... then not only does that moment last for the five minutes you are thinking about it for a long time...you've got loads of time to think in hospital and it can have a long lasting effect and if she comes back tomorrow... another five minutes... if you are in for a week or months then it might help for that time... it might not get worse... it might get better... you wont die....you know what I mean... it will have a positive affect because you will always think of the silly times... a kid is a kid...that's important...” P.3

“but a nurse who can put a smile on your day but get you to drink when you don’t want to drink or take a pill what tastes horrible... or make you laugh when a doctor is putting in a cannula...they are the nurse you need to see... they are the nurses who are really important but if they can take your mind of being really ill... those are the important times... I think the younger students are very capable of taking the kids mind of things... when you are really sick ...understand being ill with all the machines going off... when the younger nurse can still have a positive effect on that one that is important... younger students have the key to that one... older students might have the ability to make you feel warm and safe but they must also be able to put a smile on your face...” P.3

“When I was in a wheel chair I was in for four weeks... then another month for an operation a total of two months in hospital...it’s gone... I can’t tell you what happened for those months...I had morphine...watched Jeremy Kyle at ridiculous times. I can’t say I did anything interesting... that’s the thing about hospital they... whilst they can make you better they don’t give time to your mind because just imagine a nurse coming in giving you your tablets and then going off for three hours... even though you are OK you are bored you walk around do whatever you need to you’ve got your phone but no other stimulation... even though some people come in you are on your own for long periods of time... even though my mum might come in before work for about half an hour and my sisters might come in after college... you’ve got a huge period during the day when it is just you and your brain...” P.3

“... hospital is like a prison mentally...first you start to ignore getting out and settle down nothing happens... to watching TV programmes doing this... getting into a routine of switching the light switch on and off...five times... it’s a bit like that routine wise doing certain things at certain times of the day... I remember I always have to get up really early... I don’t know why... I would start by reading my book... watch TV... wash... sleep... get up got to the shop... wash... you get into a routine of doing the same things every day... you know you are doing it but you can’t help it doing the same routine every day. That’s where younger students come into it they help you break out... make you laugh.... Make you forget about being sick...” P.3

This was also seen as a benefit by another young patient:

“ once when I had my portacath done I had two young student nurses watching how it was done... and they were like talking to me... because I get really panicky and am really needle phobic...they really took my mind off it... And they were standing either side of me and really taking my mind off of it...it was good.” P.2

Clearly there are issues and concerns faced by younger student nurses when they are engaged in these caring experiences with young patients as well as some perceived benefits. Whilst the young patients have identified some worries and concerns about these caring relationships, they have also highlighted significant benefits. These findings will be critically analysed in the discussions chapter.

CHAPTER FIVE

DISCUSSION AND ANALYSIS

This chapter will critically analyse the findings of this research in relation to relevant theory and literature. The discussion and analysis will be presented in line with the original questions posed at the beginning of this thesis and from the perspective of the identified themes.

Question 1: What issues are of concern to the younger students during these caring experiences?

THEME ONE: Messy Boundaries

i) Building appropriate relationships

One of the themes that have emerged from the data is that of unclear and undefined boundaries experienced by the student nurses. Clearly the student nurses had a rigid and inflexible perception of how a nurse should be and behave as a professional, and what a professional relationship entailed, and it was this professional relationship that was being challenged.

It is during caring interactions with the young patients that boundary dilemmas arose. Tensions arose particularly when, as the students described, gaining the trust of the young patients often, they believed, meant “*crossing the line almost*”. Also the students appear to be choosing to become a friend when saying “*you are a friend but you are not a friend*”, perhaps recognising that they should not be forming these emotional attachments. Compounding these tensions is the fact that by the very nature of them ‘being’ a student nurse and as Neville (2004) found in her study of adult and child degree nursing students, moral dilemmas can arise, and unlike more

experienced nurses the younger students may not intuitively know what is the right thing to do and may not be skilled enough to behave in a truly professional way during these times of personal dilemma. It should also be recognised that as Allan & Barber (2005) found, these dilemmas can also arise for more experienced adult branch nurses working in sensitive areas of practice.

ii) Seeing me as their friend or mate / Not being seen as a nurse or professional

The uncertainties in respect of appropriate behaviour and relationships with the young patients, being expressed by the young student nurses, emphasises the ambiguities relating to professional boundaries.

Whilst engaging in these ontological caring relationships with the patients the student nurses run the risk of crossing professional boundaries, especially when those caring relationships involve being friends or mates with the young patients. The student nurses from an ontological perspective of 'being' are experiencing the nurse/patient relationship, the lived experience of caring in the nursing context. Lewis (2003) conceptualises this caring as being manifest in the nurse patient interactions together, but the young students are unable to internalise and make sense of this. As Lewis (2003) proposes, a caring ontology (being in ones world) and epistemology (knowledge of knowing) is critical in nursing, otherwise what would nursing be grounded in? This 'knowledge of knowing' about their 'being' in the world in a caring professional relationship with the young patients has not yet been achieved by the young students. They do not yet appear to appreciate the true value of their unique relationships with the young patients, their 'being' in a caring

relationship with them. As Lewis (2003) explains, for nurses it can take years for this caring as ‘being’ in soulful caring consciousness to evolve, a long journey that the younger students are only at the very beginning of.

Wilstrand et al. (2007) highlight difficulties in balancing professional boundaries for trained nurses and Fronek et al. (2009) observed that professional boundaries are rarely discussed at the ‘coalface’ of practice, so it is not surprising that the student nurses do not recognise that such boundaries may exist or that they may be breaching these boundaries during these ontological caring moments. Fronek et al.’s (2009) research was based on the experiences of qualified practitioners which could indicate how much more difficult it is for inexperienced, unqualified nursing students to resist urges to relapse into unprofessional relationships with young patients which may result in boundary dilemmas that compromise the patient-client relationships.

Professional boundaries are the parameters which define relationships between healthcare professionals and their patients or clients (NMC 2008). Boundary dilemmas can occur when healthcare professionals experience conflicts of interest between the personal and professional aspects of their relationship with the client or patient (Fronek et al. 2009). It is further reported by Fronek et al. (2009:18) that:

“Proficiency in ethical decision making is essential for the maintenance of healthy boundaries”,

a skill that is unlikely to be effectively mastered by the young student nurses due to the early stage of their education programme. Blurring of these boundaries can occur when the younger student nurses experience a conflict of interest between

professional and personal aspects of their therapeutic relationships with the adolescent patients. For the relationship to be therapeutic the students need to have high quality communication and interpersonal skills as well as be able to build a trusting rapport with the young patients (McQueen 2000). The student nurses recognise how it is “*quite difficult because you are trying to keep professional with them but also trying to get them to trust you at the same time.*” Trust in relation to adolescents is of particular importance (Johns 1996). In many respects the younger student nurses are ideally placed to build such trusting relationships and ironically more so by the blurring of professional boundaries. It is in difficult and emotionally charged situations that younger student nurses may face the dilemma of trying to act in a professional manner, when actually they may feel more comfortable with, and that it is more appropriate to behave, in a manner which is more in keeping with their personal feelings and needs (Menzies 1960; Fronck et al. 2009). Austin et al. (2006), in challenging the term boundary as a metaphor to describe and determine ethical connections in the relationship between client and carer, have the view that the term ‘boundary’ determines what is ‘out of bounds’ in a relationship and aims to control, constrict and limit behaviour within the relationship. They propose that perhaps a different metaphor could provide a better way of approaching ethical problems in practice. They describe the image of a boundary as a line, defence or wall which is used to determine the limits of professional helping relationships. They further describe the notion of boundaries to help distinguish the difference between “friendly” therapeutic relationships and friendship, a crucial distinction that may not be readily apparent to the novice i.e. younger student nurses

for whom the processes involved in maintaining a therapeutic relationship, a relationship or interaction which promotes or maintains the health and wellbeing of the young patients, may not yet be well defined. Boundary crossing is further defined as those actions that might provoke feelings of discomfort for either patient or carer with boundary violations being more specifically described as actions that are clearly harmful or exploitive and could put either carer or patient at risk (Gutheil & Gabbard 2003; Peternej-Taylor & Yonge 2003). It is boundary crossing or blurring that is described by the student nurses, where they feel uncomfortable in certain situations, rather than boundary violations which could put themselves or the patients at risk.

In exploring student nurses' perceptions of being on the same level as the young patients, e.g. *"but sometimes she just saw me like... ok... she's just like another teenager too"*, it is important to consider how being at similar stages in their identity development could influence this. The young patients are predominantly in what is described as middle adolescence and the younger students in late adolescence (Radzik, Sherer, & Neinstein, 2002 - cited in Rew 2005). Erikson (1959) originally conceptualized identity formation during adolescence as a psychosocial task, a time of conflict between identity and role confusion. This status of role confusion, which Erikson (1959) defines, aptly describes the ambiguities being experienced by the student nurses in respect of their personal role identity and their professional role identity. This status of moratorium at this time in their lifeworld should be anticipated as this is also a time of exploration in order for young people to determine their true self.

Marcia (1966) has developed Erikson's work to propose four qualitatively different states of identity; achievement (a commitment made following exploration), foreclosure (a commitment adopted without much prior exploration), moratorium (ongoing exploration with little commitment), and diffusion (lack of commitment coupled with little exploration). Whilst these four states are not followed in discreet stages, most young people will engage in at least one of these states during adolescent transitions. Marcia (1966) focused very much on decision making processes young people went through during their explorations and discovery of self. Whilst identity achievement is considered to be the most developmentally mature status and diffusion the least mature status, there is no normative developmental pathway through which young people should progress because all people are individuals (van Hoof, 1999 Cited in Reis & Youniss 2004).

In relation to the younger students, it is likely that because they are immersed not only in explorations of their social identity, but also of their professional identity, this could result in extended periods in the status of moratorium, because of the increased decision making that is required of them. Engaging in comfortable interactions with the young patients, whom they perceive to be on the same level as themselves, could be explained in terms of normal exploration during this time.

Luyckx et al. (2006a) expanded the identity status model to include a two dimensional explanation of the differences between exploration and commitment. Breadth of exploration refers to the degree to which adolescents search for different alternatives in respect of their personal aspirations, values and beliefs before making commitments, with an alternate dimension of in-depth exploration before

commitments are made and how existing commitments are re-evaluated and revised on a continuous basis. These in-depth ongoing evaluations of one's existing commitments and choices are undertaken in order to ascertain the extent to which these commitments resemble the internal standards upheld by the individual (Meeus et al. 2002). Furthermore the status of moratorium, which entails extended exploration and lack of commitment, is a status which some younger students might occupy. This is due to the fact that they are likely to engage in more in-depth explorations (Luyckx et al. 2006a) in order to unify their personal internal aspirations, values and beliefs with those values and beliefs being thrust upon them in respect of their professional identity. Beronsky (1997) conceptualises identity as a way by which people construct a theory about themselves, how they will adapt and cope with the world, rather than an exploration and discovery model. The three identity styles proposed are; informational or actively seeking information and thoroughly evaluating the information before making a decision; normative or expressing greater concern for conforming to expectations of others, i.e. senior nurses or managers; diffuse-avoidant or tending to avoid dealing with problems directly, procrastinating and only finally making decisions when other rewards or consequences are close at hand. Beronsky (1992) proposes that this theory is very useful in identifying coping strategies used by late adolescent college students. Clearly, the student nurses are likely to be information seeking and evaluating their new knowledge to see how it fits with the expectations of the professional self and making their own decisions as to what being a professional means. They may also be more comfortable with

complying with or conforming to expectations of more senior staff in respect of what is meant by being professional. As can be seen within the narrative, for example, *“sometimes I don’t always want them to see me a nurse... I want them to see me as someone they can get support from... rather than the nurse/patient situation...more of just of somebody they know they can talk to if they have got any problems”*, they may be more comfortable with avoiding the issue of being professional altogether until such time as this status may be more meaningful and rewarding, which might not be until some time after they have qualified as a trained nurse. They may perceive the status of being, or acting as a professional, a hindrance and quite unrewarding in respect of the relationship and measure of trust that they can achieve by just being the young patient’s friend.

The expectation that because they are young and are likely to be better placed to cheer up the young patients or relate to them easily puts the students in a dilemma in respect of which side of the fence they should occupy. There are times when the students actually express the desire not to be treated as a nurse and to be viewed as a friend, for example: *“like when they have cancer try to be as normal with them as you can so that is why I treat them as a friend just like talk with them”*. Messy boundaries arise when the students feel the need to adopt the persona of the professional nurse when in reality the young patients and their parents do not view them in this light. At this stage in their development, the students are not in a position to bond fully with the nursing profession and integrate their professional self, or nursing self, with their personal self, which is crucial for attainment of true professional identity (Gregg & Magilvy 2001).

The students are exploring components and concurrent processes involved in the exploration of their identity (Grotevant 1987, 1992 and 1997). Depending on the support and supervisions the student nurses receive whilst in practice will influence how much of the essence of nursing's professional identity passes to the students by their mentors or significant other teachers and peers, an important aspect in relation to gaining professional identity (Benner et al. 1996). This in turn will influence their attitude towards wanting to explore what professional identity will mean to them in their 'lifeworld'. Furthermore, the individual cognitive skills of the students in relation to their critical thinking and problem solving will affect how they make sense of the information and ideas they are exposed to in respect of what others describe as the true meaning of professional identity in nursing (Grotevant, 1987, 1992 and 1997). As part of their learning in relation to their professional identity student nurses are required to have an understanding of external political influences and environment, time management, critical thinking and self reflection as well as effective interdisciplinary skills. These are critical competencies required to enable the students to become effective professionals (Adamson et al., 2001: Dalton et al. 2003: Harris et al. 1998: Huebler 1994). Not surprisingly, Randall (2003) correlates attaining nurse identity with a negative affect on students' global self esteem. Until the students have achieved a professional identity in nursing they will continue with their explorations, a process which is likely to continue until after they have completed their education programme successfully and become qualified nurses. Until this point it is unlikely that the students will have the skills to engage in

therapeutic interactions with the young patients that are supported by strong professional boundaries.

THEME TWO: Emotional Security

i) Death and dying

Nursing is a very complex profession in a high-stress environment, involving interactions with many different individuals e.g. colleagues, peers, patients and families (Reeves 2005 Cited in Montes-Burges & Augusto 2007). Learning to control emotions in nursing also requires emotional intelligence (Mayer & Solovey (1997) cited by Montes-Burgess & Augusto 2007), a skill which varies between nurses because emotional intelligence can be linked to personality (Austin et al 2009). The construct of emotional intelligence deals with a person's ability to understand and express emotions; being able to identify one's own and others' emotions, and being able to regulate and modify our own mood adequately in order to improve our own thoughts about an emotional situation (Mayer & Salovey 1997). Emotional intelligence is not necessarily gained by having years of experience in practice with exposure to traumatic and emotional situations, and is less likely to be gained by inexperienced, young student nurses. What is reported, though, is that having high levels of emotional intelligence could equate to better management of the effects of stress by using more adaptive coping strategies (Montes-Burgess & Augusto 2007).

Therefore, the cost of caring and engaging in emotional interactions for the young students, who may not have acquired these adaptive coping strategies, could be very

costly to them. There is much written about the cost of caring in nursing, and emotional labour, with most of the literature and research being undertaken with qualified health care professionals. Hochschild (1983) first defined emotional labour as the induction or suppression of feelings in order to present a persona that enables others to feel a sense of being cared for in a safe place. The main three characteristics of emotional labour are described as: face to face or voice contact with the public; a requirement that the carer produces an emotional state in another; it allows the employer through training and supervision to take control over the emotional activities of his/her workers (Hochschild 1983), with (Smith 1992), linking emotional labour with caring. James (1993) stresses that emotional labour is skilled work, a skill which requires experience, as well as a recognised trait of women's work which is often rendered invisible and undervalued. Clearly it can take time for some students to develop these skills and it is important to consider how these skills are learned.

In the past emotional labour and learning to care was a skill passed on to students by sisters or charge nurses on the wards. Smith & Gray (2001) conducted an evaluative study to ascertain new patterns of how students learn to care, concluding that it is predominantly mentors and link lecturers who are now at the forefront of students' learning in relation to emotional labour. The importance of sharing experiences by way of story telling and reflections on practice was highlighted as ways of reinforcing for students what is involved in emotional labour and how it is central to the notion of caring in the National Health Service (NHS), although as Jenkinson (1997) points out, adolescent students may need further support and guidance in

respect of reflecting on their practice. Smith & Gray (2001) also highlighted the fact that the notion of emotional labour was more implicit than explicit within national educational policy and practice.

It is not surprising that inexperienced younger student nurses lacking in emotional intelligence, might more easily be affected by stress. The affects of stress are closely linked to illnesses and adverse behaviours as well as exhaustion and absenteeism (Lindop 1989: cited in Evans & Kelly 2004). In extreme circumstances, for example, the death or anticipated death of a patient is recognised as a cause of anxiety for student nurses (Knight and Field, 1981; Parkes, 1985; Clarke and Ruffin, 1992; Rhead, 1995: cited in Evans & Kelly 2004)) and the death of a child is also significantly stressful (Scullion, 1994 Cited in Evans & Kelly 2004). This kind of experience was described by a student: “*consciously or unconsciously a barrier went up and I was just like noooo... she was just the same as everyone else and I did not foresee the fact that she was dying*”. Furthermore, this description of anxiety about death highlights Menzies-Lyth’s (1970) description of the nurse-patient relationship and how caring for dying patients produces anxiety for the students and evokes emotions that are being denied (Allan 2011).

Maslach et al. (1996) identified emotional exhaustion as a variable that is directly related to burnout, a direct consequence of stress. Magnussen & Amundson (2003) in their literature review of stress and coping among Irish student nurses identified younger students, between seventeen and twenty five years of age, as experiencing greater emotional response to stress than older students, an issue which is clearly mirrored by the student nurses in this study.

ii) Difficult situations

There were other situations which the student nurses did not feel emotionally or professionally able to deal with for example, *“but I did find it a bit difficult because I felt like in his eyes everything I was doing was wrong so that’s what made me feel a bit withdrawn and my nerves and low self esteem kind of kicked in again.”*

Smith & Gray (2001) distinguished between the social elements of emotional labour, which included integrating patients and family into the environment and the psychological elements, which included friendship, intimacy and building trust. The social and psychological aspects of emotional labour are the key components of interpersonal relations in nurse/patient/family contact (Smith & Gray 2001).

Whilst the student nurses appear to be able to build friendships, engage in elements of intimacy and gain the trust of the young patients, they appear to be grappling with the complexities of what is involved in emotional labour and how this is embedded in the notion of caring. They could be suppressing their own feelings in order to present a persona of a person who cares for the patient, but in actual fact they are not responding to and acknowledging their own feelings, their authentic, conscious feelings, which would enable an element of reflexivity within the situation as proposed by (Allan 2006). This also further highlights lack of emotional intelligence as defined by Montes Burgess & Augusto (2007). Emotional labour facilitates and regulates the expression of emotion in the public domain and is a skill which requires experience (James 1993), something that the younger students may not yet have at this moment in their ‘lifeworlds’.

Within the data it is evident that the younger students are not always able to manage their own emotions and more importantly, the patients' emotions. Gray (2009) stresses the importance of analysing how nurses manage their own and the patients' emotions and more importantly, how the nurses come to terms with the difficult processes that can be an unavoidable part of patient care. These are skills which the young student nurses will need to learn about, and their learning will depend upon their exposure to the caring interactions which evoke uncomfortable and conflicting emotions in the nurses and the patients. In my small scale study, not all of the student nurses disclosed situations relating to their experiences of feeling inadequate in emotionally charged situations. This could be due to the fact that they had not at that particular moment in time for them experienced these emotional conflicts or, as Ontong (2002), cited in Evans & Kelly (2004) found, natural hardiness has emerged as a strong mediating variable that affects student nurses reactions to stress and their coping ability. However, for those students who had been affected by these experiences, for example: *"I think it was much more about protective mechanisms for myself more than anything which probably isn't great because the patient didn't get the care that I believe she should, you know emotionally I was not really in tune with it"*, it appears that they found it difficult to engage in emotional exchanges and preferred to keep the interaction very much on a superficial level, and not daring to engage with the patients in a therapeutic way. This distancing of themselves as a defence against anxiety is recognised within the literature (Menzies (1960); Fabricius (1995); & Allan (2006). By describing feelings of being comfortable with being on the same level as the patients they appear to be engaging with them in this way that avoids them becoming involved in more emotional,

therapeutic interactions. Gray (2009) highlights the importance that trained nurses put on the therapeutic value of emotional labour but it is unclear that the student nurses are developmentally at this stage in their learning. What they are lacking is the experience and skills which will enable them to deal with these emotional interactions and help limit the cost to them of emotional labour i.e. emotional exhaustion (Huynh, et al 2009; Henderson 2001).

iii) Personalising Situations

One student at the point when we were reaching a ‘fusion of horizons’ about her experience, passionately stated that when she was in an emotional encounter with a very seriously ill patient she felt that it made her *‘feel very vulnerable’*. She felt the experience led her to relate to all her own life experiences since being the same age as the young patient and how she *‘felt helpless’* in the situation by not being able to do anything to change the situation for the young patient. She recalled that this had caused her quite a lot of distress. The relationship that had developed between the student and the young patient clearly rendered the student nurse vulnerable. Unfortunately, in such situations the students are not always aware of what is happening and are unable to draw on adequate coping strategies or counselling skills to enable them to deal with such situations (Fabricius 1995; Evans 2007). Lazarus & Folkman’s (1984:141) definition of coping as:

“Constantly changing cognitive and behavioural efforts to manage specific external and or internal demands that are appraised as taking or exceeding the resources of the person.”

These are higher level coping skills than could reasonably be expected of all student nurses, let alone the younger student nurses. As can be seen within the transcripts there will always be those students who are not so negatively affected by distressing and emotional situations, i.e.

“I think they probably think that because we are of a similar age we have similar problems... which quite a lot of time we have... which like this girl was obviously depressed because she took paracetamol... and I understand depression... I have been through depression.”

This could be due to natural hardiness influencing their stress reactions and coping ability (Antai-Ontong, 2002: cited in Evans & Kelly 2004).

Part of the journey to a professional identity is about understanding how personal life stories shape our relationships with our patients which are reflected in the student nurses’ continuous learning about the meaning of nursing as a profession (Schwind 2004). Chan & Schwind (2006) believe that our personal life experiences contribute not only to who we are personally, but also to who we are professionally. It is important to enable the student nurses to debrief about such situations and make provision for personal reflection in and on practice and also to receive the support they may need in relation to personal reflection (Allan 2011; Jenkinson 1997), in order to strengthen their coping abilities by knowing how to deal with similar situations in a less distressing way in the future. During the transition to university life and upon engaging with the demands of the education programme, the integration into new social peer groups is an important aspect of socialisation and identity development and particularly the new “university nursing student” identity. Wilcox et al. (2005) found that strong social support and being accepted into a peer

group rated highly in respect of factors influencing student retention. It is important for those providing pastoral support to students to be aware of different approaches to coping that students may adopt.

It is also important to understand the coping responses of either *approach* (facing a problem directly), or *avoidance* (avoiding a problem). Moos (2002) proposes that adolescents are at greater risk of problem behaviours and depression when they experience acute and chronic stressors, but have fewer problems and more self-confidence when they have increased social resources and coping skills characterised by *approach* rather than *avoidance*. Assessing student nurses' strength of social support and their approach to emotional problems is therefore important to emotionally prepare the students to deal with such difficult interactions.

THEME THREE: Being Younger making a difference

i) Lack of knowledge and experience

In their journey of exploration of self identity and professional identity, the students appear to have experienced some uncomfortable and difficult situations that they perceive as a negative aspect of being a younger student.

Part of this is about their level of knowledge which is attributed to their stage of learning on the children's nursing programme. Lindop (1999: cited in Evans & Kelly 2004) aptly describes the theory/practice gap as being instrumental as a real source of stress for students. The lack of knowledge and lack of life experiences they describe is linked closely with their age inasmuch as they would naturally be lacking in life experiences at that time in their life. Glackin and Glackin (1998) concluded

that the maturity of older student nurses is influential in enabling them to cope better than the younger nursing students in clinical practice. Evans & Kelly (2004) in their study of student nurses' coping effectiveness also found that younger student nurses had noticeably greater emotional responses to stress in clinical practice than did older students who, due to their age, may have had previous caring experience that had increased their level of confidence. From a psychodynamic perspective the older students may have learnt to ignore the emotions of others as a defence mechanism against the cost to themselves of emotional labour (Menzies 1960; Fabricius 1995). The unconscious repression of painful emotions during clinical interactions could also explain how older student nurses manage their feelings and the emotional cost to them of emotional labour (Allan 2010).

i) Treating older students differently/Patients and parents reaction to them

As the students themselves describe, being on the same level as the patients involves messy boundaries making it difficult to make those transitions from being a friend to the patient and then becoming the professional nurse. These difficult transitions are what the students are experiencing when they feel they are not being treated as a knowledgeable professional, something they are expecting the parents and the patients to see them as.

The context within which the students work is regarded as very important for the development of their professional identity, skills and expertise as nurses (Meleis 1975; Benner et al. 1996; Gerrish 2000). It is crucial that during these difficult encounters that the students get opportunities to share their experiences with each

other, to learn from each other's experiences as well as get support from each other when they need this (Benner et al. 1996). As Evans & Kelly (2004) point out, it is also important that the students are afforded protected reflective time to encourage them to reflect on practice, with the aim of improving outcomes for future practice.

When nursing students start their education they begin the process of transition into their new role as a nurse (Fagerberg & Ekman 1998). It is during this transitional process that students could experience difficulties with integrating their personal identity with the new professional identity (Klaich 1990, Walter et al. 1999), especially as it is evident that the students are still immersed in their personal identity journey. Randall (2003) reports that the process of attaining a nurse identity can have a negative affect on student nurses' global self esteem which is apparent within the narrative. Apker et al. (2005) highlight tensions that nurses encounter in the workplace when perceptions of professionalism differ between team members and how they are expected to behave differently with different personnel. Not surprisingly the students are experiencing tensions in their professional ability when on the one hand they are expected to behave professionally but by the very nature of their age they are also expected to relate to the patients, be more on the level of the patient and get them talking in order to develop trusting relationships. The student nurses will come to understand who they are professionally, based on what is considered meaningful in their work, Fagermoen (1995), and as Chan (2002) suggests, the nursing students need to be socialised into the bicultural experience of natural science and human science, with the latter placing more emphasis on the uniqueness and individuality of both the patient and the nurse. An understanding of

who we are and who we were is integral to nursing culture (Chan 2002), which makes the younger students on the one hand ideally placed to understand the uniqueness of the young patients but on the other hand this could create tensions with developing a professional identity. Understanding how our personal life stories shape our relationships with our patients is reflected in student nurses' continuous learning about the meaning of nursing as a profession (Schwind 2004). Chan & Schwind (2006) believe that our personal life experiences contribute not only to who we are personally, but also to who we are professionally.

Gender and intimacy issues

In relation to the students concerns regarding dealing with the young patient's personal hygiene needs, this concern of nursing care is an issue that is mirrored throughout the various branches of nursing. Chur-Hansen (2002) in her follow up study determined that little has changed since the previous studies undertaken in the 1980s in respect of patients' gender preference of carers in intimate and sensitive situations. The degree of intimacy in clinical situations was found to be predictive with same gender preferences by patients. In this same study it was also found that young females, particularly, experience more embarrassment in revealing their bodies to health care professionals of the opposite gender which might be indicative of sexual overtones that compound their discomfort (Chur-Hansen 2002). Issues in relation to male genital related care can be complicated and may be related to privacy, intimacy, sexuality, dirty work and emotional discomfort (Zang et al. 2008). Whilst students are taught the clinical requirements with regard to meeting patients'

hygiene needs, children's nursing students usually relate this practically to caring for babies and children and from a purely physical perspective which involves mainly cross infection issues and issues of safety and dignity. Dealing explicitly with the emotional and psychological context of personal hygiene care is not addressed fully within the curriculum particularly in respect of adolescents and young people. Lawler (1991) debated in detail issues in relation to embarrassment and discomfort felt by student nurses upon their first encounters of caring for bodily parts, highlighting specifically how privacy and dignity for patients was paramount but that little was discussed in relation to what went on behind the curtains emotionally between student and patient. In fact, showing emotions in caring during this period of time were viewed as a weakness or lack of professionalism (Lawler 1991).

In respect of the students concerns regarding issues of intimacy, namely, "*he was kind flirtatious a little bit, and I thought is this because of my age or does he do it to everyone.... Or was it just because I was a female... but I think actually that was just him he was just flirting and talking and I tried you know to keep it kind of professional*"; whilst there are implicit professional expectations of nurse-patient interactions and encounters being completely asexual (Gray 2009; Higgins et al. 2009), issues in relation to appropriately modest communications and interactions between nurse and patient are not explicitly addressed within the literature, particularly in relation to the kind of interactions these younger students and patients find themselves in. As a safety net, Higgins et al. (2009) suggest that the younger students try to adopt a professional persona during such encounters, but due to the previously experienced messy boundaries, the ambivalence of their professional identity becomes clear.

Furthermore, one of the major components of developing a sense of self is that of developing a sexual self. Moore & Rosenthal (1993) (cited by Horseman 2005) suggest that all developmental theories identify sexuality as being at the centre of the transition from childhood to adulthood. Sexual identity for both the patients and the younger student nurses will be heightened at this time and could render them more sensitive to cues and messages which could be interpreted as sexual.

SUMMARY

There appear to be several issues of concern for the students, which largely centre on emotional difficulties when caring for the young patients. Friendly interactions with the patients, which can create messy professional boundaries for them, can expose them to emotional engagements with the young patients which they appear to be inadequately prepared to deal with. There also appears to be a perception that they are treated differently from older students which has caused some students distress. This has implications for children's nursing education which are discussed later. (See pages 165-168)

Question 2: What benefits do the younger students feel their age brings to these caring experiences?

THEME ONE: Messy Boundaries

i) Being on the same level/Relating to the patients making it easier to talk to them

Adolescence is a time when peer relationships are of paramount importance to young people. Friendships in adolescence have a high priority and are grounded on

reciprocity (Reis & Youniss 2004). In their interpretations of their lived experiences with the young patients and in light of their shared interests and hobbies, the students appear to be much more comfortable in the role of fellow adolescent or friend rather than in what they perceive to be their professional role. This perceived sense of shared experiences, being on the same level or relating well to the young patients appears to break down barriers in communication with them and this is seen as a positive aspect of messy boundaries by the students. In arriving at a 'fusion of horizons' of understanding with one of the students, it was clearly pointed out that for younger students *'it doesn't work to have strict boundaries, you have to give a bit to get a bit back'*. It was further commented that *'you have to have a similarity to trust someone'*, with the younger student it was her age that was the similarity. Younger students see their age and stage of development as an advantage over older students or trained nurses, who they feel invoke barriers to communication (Drury 2003), by the very nature of their age and command of authority i.e. *"obviously I feel I can relate to the younger ones I can talk to them, they might not want to talk to the older adult, they feel that they might be judged"*.

Drury (2003) highlights the concerns that young people have in respect of power imbalances and lack of respect shown by adults in authority as causing problems in communication. Christie & Viner (2005) support this notion stating that communication between young people and medical professionals is highly problematic. In order to take an accurate medical history, specialised clinical communication skills are needed in light of new life domains, such as sex and drugs, which young people may be immersed in (Christie & Viner 2005). The students commented that their age was an advantage when engaging in communications with

the young patients, i.e. “*but because of the small age gap there it was quite easy for me to talk to her because I could relate to how she was feeling and things like that quite easily*” and “*just because I think sometimes they need to talk to people of a similar age to them that they can relate to... just talking about normal stuff* “. As Salter & Stallard (2004) and Rutishauser (2003) propose, age appropriate communication skills are important for engaging young people in communication. Younger student nurses being immersed in similar life domains and being familiar with the language and interests of the young patients, make them ideally placed to be accepted by the young patients as a friend or peer with whom they can engage in meaningful non-judgmental dialogues but conversely they are not then viewed as an authority figure.

ii) Being able to make a breakthrough, getting them to tell

Within the narrative the student nurses are recognizing that one of the benefits of being younger is that they can more easily ‘*make a breakthrough*’ with the young patients and get them to ‘*open up to them*’. It is at this time in their ‘lifeworlds’, in their journey of self identity, that the student nurses are more likely to be motivated in the honing of communication skills as it helps them to:

“Develop self-identity, establish social relationships with others, and provide the basis for collective social activity”
(Haslett and Bowen 1989:27).

Lefevre et al. (2008) in their taxonomy of conditions and skills define the important aspects of effective communications with young people as ‘knowing’, ‘being’ and ‘doing’. Although this study was targeted at social work students it is relevant to the student nurses. In respect of ‘knowing’, within the context of their professional

practice, professionals need to have an understanding of the young person's capabilities or impairments which might influence the communication process as well as have a clear understanding of the purpose of the communication. Explicit within this is having the knowledge of young people's stage of development and particular crisis they may be going through. 'Being' is more values/ethics based and is about treating young people as being competent with a right to participate, providing them with relevant explanations and taking their views into account. A young-person-centred, anti-oppressive approach is needed which includes being respectful, providing time and ensuring confidentiality as well as the person centred qualities of empathy, congruence, sincerity, honesty and openness. Within the nature of 'being' attention also needs to be paid to the emotional and personal capacity of the individual in recognising their own feelings when dealing with the strong feelings of the young people and this may illicit feelings of emotional distress especially if a real person-to-person level of warm, friendly and caring interactions are to occur (Evans 2007). The 'doing' aspect is about providing the right environment for effective communication and is about going at the pace of the young person whilst incorporating good verbal and non-verbal expressive techniques as well as good listening skills (Lefevre et al. 2008). Clearly if this level of communication is to be achieved with young patients then the student nurses will need to be equipped with the skills to do this. The student nurses are demonstrating a good sense of 'being' in terms of how they are interacting with the young patients, the amount of time they are able to invest in them and the level of trust they are managing to achieve. Empathy appears to be a quality which the young students

have by their perception that by the very nature of 'being' at a similar development stage as the young patients this should, through practical experience, enable them to understand what issues are involved at this stage of development for the young patients. In regard to communication being a two way action, whilst the student nurses appear to be adequately placed to engage the young patients in communication, it is not evident that once the patients have divulged or disclosed their feelings or concerns, that they are adequately prepared to deal with this from an ethical, values based and knowledge based perspective, as might be the case for trained nurses.

Confidentiality is another important factor which will influence whether young patients engage in communication as this is very high on their list of essentials for effective health care (Viner 2007; Viner & Barker 2005; Christie & Viner 2005). An important issue to be addressed here is that of confidentiality and the students' responsibility in respect of the NMC Code of Professional Practice (NMC 2008) in relation to issues of confidentiality and knowing when confidentiality in relation to disclosures cannot be assured to the young patients. This is particularly important when not sharing important information with senior nurses would not be in the best interests of the young person. Thus whilst there are clear advantages of the 'messy boundaries', there could also be disadvantages for the students if they are not entirely clear about their professional responsibilities in this respect.

THEME TWO: Emotional Security

i) Relieving the boredom for young patients/letting them forget about their illness for a while

One of the issues about being in hospital for long periods of time, especially for young people, is how boring it can be (Hutton 2005), and how much time they can spend just thinking about their problems. One of the real benefits of the 'messy boundaries' as perceived by the students, is the ease at which they are afforded the time to spend with the young patients and by the very nature of the friendly relationships they build with them, can just chill out with them talking about every day things thus allowing them to be ordinary young people for those moments in time. The importance of these moments cannot be overstressed because the young patients need these times of identity exploration in order to fulfil the tasks of adolescence (Erikson 1968).

The benefits of social support are well documented and this is relevant to young people with a long term chronic life limiting illness who value friendships (Berntsson et al. 2007). In order to facilitate optimal functioning it is important to have an understanding of the dynamic variables of the psychosocial aspects of a long term illness with an awareness of the importance of psychosocial support (Abraham et al. 1999). Although they may not necessarily be aware of it, in spending time with the young patients the students are able to offer distraction from their illness and offer some degree of social support which is positively correlated with improved coping for patients with oncology problems (Moore et al. 2003, Adlreidge & Roesch 2007, Cited in Li-Min Wue et al. 2009). Young people with life threatening

illnesses have to deal with two 'lifeworlds', that of 'health and illness', and that of 'specialness and normalcy' (Chesler et al. 1987:154). The student nurses feel that they can fulfil the role of providing an element of normalcy and specialness during these moments in time when they are just chilling out. As Saewyc (2000:120) argues, because caring interactions with adolescents are important for building therapeutic relationships, nurses who care for adolescents must have a 'passion for the population'. Conversely, in the high stress environment of nursing (Reeves 2005 Cited in Montes-Burges & Augusto 2007) student nurses are easily affected by stress. The reciprocal social support the students could be experiencing by the social encounters they have in those moments of time with the young patients could actually improve their self esteem and be an aid to building their emotional intelligence (Montes-Burges & Augusto 2007). In light of the fact that clinical placements can be a factor influencing stress, engaging in these interactions could increase the student's satisfaction levels thus reducing the risk of attrition (Hughes 1998), as it is reported that negative experiences in clinical placements can demotivate students and impact on their academic success (Last & Fullbrook 2003; Robshaw & Smith 2004). Similarly, some students enjoy the challenges that clinical practice presents to them with the challenges seen in a positive light thus enhancing satisfaction (Howard 2001; Prymachuk & Richards 2007a). As it is known that engaging with the child branch of nursing, and particularly being a younger student, can have a negative effect on attrition levels (DOH 2006; Price 2002; Prymachuk 2009), it is crucial to ensure strategies are in place to ensure that younger child branch students enjoy and learn from their clinical placements and do not experience

stress at unreasonable levels whilst on placement. Clearly the student nurses have discussed many of the challenges that caring for young adolescent patients present to them, but these particular interactions appear to be viewed in a very positive light thus enhancing their satisfaction levels.

The role the students play during these caring interactions is important as it is well documented that wards and units designed specifically for the care of adolescents in hospital are scarce with services and facilities being evaluated poorly (House of Commons Select Committee 1997; Viner 2001; 2005; 2007; Young Patient Survey 2004). Therefore, the opportunities for distraction from their illness are limited and occasions when the young patients can engage in social, age appropriate activities with their peers on the wards are restricted. The student nurses appear to be bridging these gaps successfully.

SUMMARY:

In contrast to some of the issues of concern for the students, there are several areas of perceived benefit. The students recognise that because of their age they are able to communicate well with the patients and get them to open up to them. They also recognise the fact that they can help to relieve the boredom of the patients, particularly because they feel they are more on their level and can engage in friendly normal interactions with them. The benefits gained by these interactions need to be honed and will be considered under implications for children's nursing education later on in the thesis. (See pages 165-168)

Question 3. What issues are of concern to the young patients during these caring experiences?

THEME ONE: Messy Boundaries

i) Not seeing younger students as professionals

Messy boundaries appear to underpin the issues expressed by the young patients, both in respect of their relationships with the student nurses and how they do not really see them as real nurses or professionals e.g. “*I don’t really see them as a nurse nurse*”. In a critical review of the literature, Taylor et al. (2009) identify relationships with healthcare professionals as being an important aspect of healthcare for young people with a chronic illness. They draw on the work of Rechner (1990) who found that one of the most important people was their nurse (trained), someone who would focus on them rather than their illness. Rechner (1990) outlines the importance of this relational support with their nurse in enabling young people to come to terms with their illness. By not recognising the younger student nurses as professional nurses they may be making comparisons between them and the professional trained nurses that they have had caring for them over a period of many years.

By engaging with the young student nurses as friends and mates and being able to relate to them due to their perceived ‘sameness’ or ‘similarities of interests’ professional boundaries are being blurred.

The skill of ethical decision making is crucial for practitioners to make sense of and determine suitable course of action when faced with boundary dilemmas (Rothman

2005), with proficiency in ethical decision making being essential to the maintenance of healthy boundaries. Unlike the more experienced nurse the students may not intuitively know what the right thing to do is and may not be skilled enough to behave in a truly professional way during these times of personal dilemma (Benner 1984).

The title of 'student nurse' implies that for them there is a period of learning being undertaken in order to understand what is involved in becoming a professional nurse. As Shuval (1980) suggests students are still in the pre-socialisation stage of engaging with the image of the nursing profession so it cannot be expected that they will develop the critical competencies required (Adamson et al., 2001; Dalton et al. 2003; Harris et al. 1998; Huebler, 1994) to enable them to become effective professionals until the latter part of their programme or until they have made the transition from student to professional or qualified nurse. The term 'professional' encompasses all of the above discussions as to what constitutes being a professional. Incumbent in developing a sense of self is the emergence of ones own values, beliefs and moral/ethical principles. The NMC code of professional conduct: A standard for conduct, performance and ethics (2004) clearly indicates what is required of nurses in respect of their professional practice.

Neville (2004) evaluated the nursing curriculum to ascertain student nurses' perceptions of moral dilemmas experienced during their training. The moral, legal and professional contexts of nursing being inextricably linked rendered the student nurses to be immersed in situations that they were unable to deal with. This appears to be recognised by the young patients. The expert nurse as defined by Benner

(1984) might intuitively know what the right thing is to do in a given situation. For these less experienced student nurses, the way is not always so clear. Kelly (1993) argues that when students are involved in real life situations, moral distress results because their actions cannot be reconciled with their moral convictions and their standards of what a good nurse would do. Neville (2004) states that being a nurse is a moral dilemma and that student nurses experience moral dilemmas in respect of truth telling; informed consent; withholding or withdrawal of treatment and resuscitation decisions.

Student nurses may not become proficient in these skills until after they have become qualified nurses thus making it very difficult for them to maintain professional boundaries. It is perhaps not surprising that the young patients in their narrative describe their perceptions of young students as not being real nurses and not considering them to be professionals. The student nurses perceived lack of knowledge in respect of their care appears to compound these feelings.

ii) Expectations of them (the patient) being teachers

The young patients discuss 'being teachers' as if they feel it is their responsibility to fulfill this role and that by educating the students they will enable them to care for others with the same condition more effectively, which in essence is an added burden of having such an illness.

Adolescent patients and especially those who have been burdened with their illness since birth, which is the case for all the young patient participants in this study, will experience unique transitions into adulthood. One of the major developmental tasks

of adolescence is assuming responsibility for self (Arnett, 1998, 2000, Arnett & Galambos 2003). Achieving this developmental task in relation to their illness is critical (Hannah & Decker 2009). In exploring their personal identities, they will undoubtedly need to meld their illness identity with their self identity. Erikson's (1968) psychosocial theory provides a very good framework for understanding how integration of illness as part of self-identity might develop across the lifespan. The young adolescent patients will at some point during these transitions experience identity versus role confusion, which is one of Erikson's sub stages and at this time of natural crisis be immersed in resolving issues between their normal psychosocial self and those in respect of their 'ill' self. Part of the psychosocial development of the young patients is about gaining autonomy and social maturation and explicit within this is achieving autonomy in their own physical care (Arnett & Galambos 2003). Berntsson et al. (2007) found that adolescents need to have knowledge of how their body works and reacts to various treatments in order to cope with the stressors caused by their illness. In acting as teachers and being able to demonstrate knowledge and independence in respect of their illness could be viewed as part of the natural process for them in achieving self identity.

However, there is an incongruence in this because, apart from the usual tensions and difficulties of adolescent transitions, the young patients, according to Christian & D'Auria (1997), prefer to keep their illness a secret as a protective strategy for reducing the sense of being different from their peers with the intentions of demanding more stability and respect in later young adult life (Gjengedal et al. 2003). Not surprisingly there are tensions described by some of the young patients,

who clearly see the student nurses more as their peers than as nurses, but at the same time they are expected to declare all in respect of their illness to these particular peers, thus reinforcing their differences. The issues of disclosure about chronic illness are explored in detail by Ravert & Crowell (2008) in their study of individuals with cystic fibrosis across the age span; the findings of which they felt could be applied to any chronic illness. They found that adolescents (13-18 years) more than any other age group, frequently disclosed about their illness on web pages designed to share support and enable them to express psychosocial concerns associated with their illness. These findings were consistent with the descriptions of adolescence as a time of identity formation, when peers and social comparisons hold special salience (Ell & Reardon 1990 Cited in Ravert & Crowell 2008; Christian & D'Auria 1997). The importance of support and advice from peers was highlighted by Ravert & Crowell (2008) whereas maintaining normalcy for adolescents is also reliant on their peers. The messy boundaries highlight issues for the young patients who may not be comfortable with disclosing and discussing details about their illness to those students whom they perceive to be more their peers than their real nurses or health care professionals. So on the one hand acting as teachers could be a vehicle for enabling the tasks of adolescence, but on the other hand could be a hindrance in respect of maintaining some sense of normalcy.

THEME TWO: Emotional Security

i) Feeling safe and trusting the students

In relation to the young patients not really trusting the younger students with their care, especially regarding surgery and more specific treatments, it is acknowledged that in most Trusts, students are supervised by a trained mentor (NMC 1020), and it is unlikely that they would be left to take care of seriously ill patients independently. However, when the students reach their third year of education, if they are assessed as being proficient at collecting patients from theatre and returning them to the ward, they might be expected to do this with the support of their mentor. To this extent it is important that these students are aware of the emotional impact this may have on the young patients. Whilst engaging with the student nurses on the same level as themselves, being their friends or mates and not clearly seeing the students as real nurses, the young patients may have developed a relationship with the students that is unlike any relationship they might have engaged in with those older students or trained nurses whom they perceive as being professionals or more trustworthy. Messy boundaries under these circumstances appear to have reinforced the ambivalence in respect of the student nurses' professional identity.

Existential anxiety is involved with a person's apprehension about the meaning of life and death and how these concerns are important considerations in a person's psychological well being (Berman et al. 2006). If anxiety can be evoked by the very existence of being, then one must assume that having a chronic illness will enhance this for the young patients. Westenberg et al. (2001) and Warren & Sroufe (2004) suggest that by adolescence, youth have the cognitive capacity for insight into

mortality and broader issues that may give rise to existential concerns. In not trusting the younger students, it is highly likely that the young patients are very aware of consequences of their illness; their likely prognosis and life expectancy; the importance of minimizing risks imposed by inadequate care; and how all the complications of their illness impacts on achieving a sense of normalcy. Erikson's (1963, 1968) identity development theory establishes adolescence as a critical period in the development of life goals and values as well as a sense of direction and purpose in life, which in healthy individuals could give rise to existential concerns. For the young person with a serious illness these concerns could become heightened resulting in mistrust of younger personnel (Berman et al. 2006). Marcia (1966) suggests four statuses of identity development involving two basic dimensions, exploration and commitment. It is possible that young people with a serious illness spend longer in active exploration which is a status identified with existential concern and could be associated with symptoms of anxiety and depression as well as psychological distress related to identity problems (Berman et al. 2006).

ii) Younger students not understanding how they might be feeling

Having a life threatening or life-limiting disease is a big enough cross to bear without the burden of having to deal with extraneous issues brought about by seemingly unintended misplaced comments or actions by those personnel charged with caring for and improving the lived experienced of those individuals. Having a chronic health problem involves three main characteristics (a) they have a biological, psychological or cognitive basis; (b) the condition is expected to last at least twelve

months and (c) the sufferer will experience functional limitations that require a reliance on compensatory assistance (Rew 2006). Such disabling conditions render the young person unable to fully participate in normative activities with their peers and can attract stigma and body image issues that may be socially and psychologically disabling to some adolescents (Viner & Keane 1998; Rew 2006). Therefore, these young patients are engaged in a juggling act trying to balance the pressures of managing their illness, with the desire to achieve autonomy and a real sense of self-worth which is enhanced by elements of normalcy. There is evidence that internalizing disorders, including anxiety and depression, are the most frequently identified problems in adapting to chronic life-threatening illnesses in adolescents (Garstein et al., 1999; Thomson et al., 2003; Alwash et al. 2000; Oguz 2002; DiNapoli & Murphy 2002) with anxiety disorders emerging as the most prevalent (Thompson et al. 1998). It is crucial, therefore, that the young patients are able to express their feelings and that healthcare professionals are skilled at recognising cues that all is not well for them emotionally. Studies also indicate that those adolescents with shy personalities or behavioural inhibitions are more likely to be at risk of anxiety and depressive disorders (Muris, Meesters, & Spinder, 2003). Carpenter et al. (2009) in their study found that adolescents with sickle cell disease, who were classified as high on behavioural inhibition, were more at risk of adverse psychological outcomes than those with low behavioural inhibitions. Evidence suggests that adolescents with cystic fibrosis do not always want to be reminded of their disease, answer questions about it, or by being reminded of it make comparisons between themselves and healthy others (Pfeffer et al. 2003).

What is important to remember is that for most patients with a chronic or life threatening disease, as they mature into adolescence or young adulthood part of their life journey towards gaining a self identity will involve them having a knowledge of not only the clinical management of their condition, but also the prognosis their condition is likely to hold for them. They will need to have a solid understanding of their condition in order to be self managing and develop a sense of autonomy not only within their family situation but also when they are hospitalised. In order to reach a true self identity gaining autonomy and independence is crucial and part of the normal crisis (Erikson 1959) that will be experienced during this transitional time in their 'lifeworlds'. Delmar et al. (2006) found that certain existential values such as independence, self-responsibility and self-control become meaningful when living with a chronic illness. Delmar et al. (2006) also stress the importance of nurses being attentive towards the patient's effort to become the master of their own life by picking up on important cues in relation to what is important for the patient in regard to choices and responsibilities in managing their illness. It is not surprising, therefore, that the young patients get upset or angry when healthcare professionals, whom they perceive to have limited knowledge about their condition, try to demonstrate superior knowledge or skills in the management of their care and do not readily take notice of what the young patients are saying in respect of how their condition should be managed. Clearly the messy boundaries have resulted in situations where the younger students, in their efforts to be seen as knowledgeable in relation to caring for the young patients, have clumsily not been skilled enough to

acknowledge openly that the patients probably know much more about how their condition should be managed.

Family centred holistic care is purported to be the framework used to guide practice in almost all children and young peoples' clinical areas although evidence shows that family centred care and family nursing are not favourably evaluated (Casey 1995; Coyne 1995b; Callery 1997; Kirk 2001; Smith et al. 2002; Reeves et al. 2006). Holistic care includes caring not only for the child or young person's physical needs but most importantly their psychological and emotional needs. This is even more important when caring for a young person with a serious life limiting or life threatening condition which impacts on their psychosocial and emotional wellbeing (Garstein et al., 1999; Thomson et al., 2003; Alwash et al. 2000; Oguz 2002).

The discomfort or distress caused to the young patients could so easily have been avoided had the younger students had a better understanding of the psychological impact of a chronic life-threatening illness.

iii) Gender and intimacy issues

The young patients highlighted issues in respect of how they feel about having their personal needs attended to by personnel of the opposite gender. Not surprisingly this is also an issue for some of the younger student nurses. Key work in this area was undertaken by Lawler (1991), where issues of embarrassment for nurses in respect of being exposed to naked bodies are explored. Lawler (1991) and later Meerabeau (1999) highlight strategies that nurses employ to minimise embarrassment levels for both themselves and the patients. Reference is made to

the skills involved in constructing a context within which it is permissible to see other people's nakedness and genitalia and to handle other people's bodies. Clearly this is a highly sophisticated skill which younger students may not yet have mastered. It is also a time during a young patient's physical development when they will naturally be very self conscious about their bodies especially when their illness causes issues in relation to body image (Viner & Keane 1998; Rew 2006).

The young patient's preference for same gender nurses is in line with the findings of Chur-Hansen (2002), particularly in intimate and sensitive situations, with young female patients being more embarrassed about revealing their bodies to nurses and other health care professionals of the opposite gender. This was mirrored in the narrative of the younger student nurses.

THEME THREE: Being Younger making a difference

i) Young students do not know much/ lack experience:

The notion that the younger students, by reason of their age, do not know very much is reiterated throughout the narrative of the young patients:

“some of the younger students don't know very much and ask me a lot of questions and that and you think do they really know what to do..”

and

“she did not really know a lot and I had to sometimes tell her what to do”.

and

“the young student nurses... even though you want to help them because they are students..... don't want to sound rude but sometimes they are slow on the uptake.”

This is of particular importance since the knowledge base of the student is central to their role as a professional nurse. This is an important area of the relationship between the patients and the students which appears to be viewed more negatively and could be emotionally distressing for them.

Murphy et al. (2009) found that student nurses and particularly younger student nurses demonstrated more caring attributes when they first embarked on the nurse education programme than they did by the end. This core, valuable attribute of caring exhibited by the younger students appeared to become diminished as the educational process progressed and their knowledge base increased. That the younger student nurses in this study are able to relate well to the young patients and demonstrate caring friendly relationships with them; i.e. *“but... I am just saying that the younger students tend to be more caring because they have not started being proper nurses yet”* is demonstrated throughout the narrative; what is lacking, according to the patients, are their skills and knowledge.

Berman et al. (2006) in their study of existential anxiety in adolescents identified youth as a prime time for comprehending the meaning of life and death with broader life issues becoming more salient (Warren & Sroufe 2004; Westenberg et al. 2001). Also, in light of their age, the young patients are likely to be fully cognizant with their disease, thus heightening their anxiety in relation to the detrimental impact that a lack of knowledge and experience on the part of the students, could have on outcomes for them.

Trust, and high quality communication and interpersonal skills are valued components of therapeutic relationships for adolescents (Johns 1996, McQueen 2000). Whilst it is clear that the messy boundaries enable the young patients to

relate well to the younger students by engaging in friendly 'normal' encounters, they are clearly not ready to place their trust in them in respect of their clinical care. This may be due to their belief that the students do not know very much at this stage of their education. Developing a trusting relationship with an adolescent takes time before they are likely to disclose feelings of concern about their illness as this kind of openness takes 'time, courage and trust' (Delmar et al 2006) .

Building such a trust is something that cannot be hurried. Shooter (2007) found that there are times when some issues are of such immediacy that there is no time for trust to be developed with someone who is perceived as being a knowledgeable and experienced therapist. It is at these times of immediacy when the adolescent cannot be put off. Because of the natural peer relationship that has developed with the younger students and the fact that they are likely to be able to spend more time in their company, the young patient may open up and tell them something they are concerned about even though they may feel that they do not know very much.

With the extraneous pressures incumbent on the young patients by the nature of their illness, achieving the tasks of adolescence will be challenging for them (Viner & Keane 1998; Ritchie 2001), therefore, they are bound to be cautious of those personnel whom they consider not to be as knowledgeable as themselves in relation to their care. Berman et al. (2006) propose that by the very nature of striving for a sense of identity the young patients will consequently experience heightened existential anxiety which is particularly salient for those young people who are in the status of moratorium where they will be experiencing a crisis due to active exploration prior to identity development (Marcia 1966). Adolescence is also a time

of cognitive growth which is essential for identity formation (Boyes & Chandler 1992). The young patients in achieving cognitive growth and developing formal operational thinking, which is directly linked to the process of identity formation, will be developing epistemic cognition and grappling in their understanding of the nature of knowledge and how they come to know this, reinforcing their belief that the younger students are not very knowledgeable (Krettenauer 2005).

In relation to young patient's emotional wellbeing it is important that they are not burdened with anxieties about trusting those personnel to care for them if they do not feel safe with this, but rather that they are listened to and reassured that only proficient staff will be managing their care. As there is evidence that internalising disorders, including anxiety and depression, are the most frequently identified problems in adapting to chronic life threatening illnesses in adolescents (Garstein et al., 1999; Thomson et al., 2003; Alwash et al. 2000; Oguz 2002; DiNapoli & Murphy 2002), it is important that further pressures are not put on the young patients which could increase the likelihood of psychological problems particularly anxiety disorders (Thompson et al 1998).

ii) Viewing older students differently

There is a real strength of feeling within the narratives that there are certain times when the young patients would prefer to be cared for by an older student nurse:

"I think if I was feeling really ill I would prefer an older student because I feel like they have got more experience and that..."

and:

“If I were really poorly I would prefer an older student, a few times I have been really ill, and I feel I would definitely prefer an older student feel they know more about what they are doing”.

From the comments made by the young patients it is not surprising that the younger students themselves picked up on the fact that the older students are viewed differently from them in respect of their professional capabilities. There are many references to the fact that the young patients clearly equate being older with experience and greater knowledge. They appear to assume that being older might mean that the older student would probably have children themselves and know more about caring for them, thus making them feel safer.

Care and caring are conceptualised within the literature in terms of professional attitude, sense of responsibility, skills and competence (Liu et al. 2006) which may be why the above assumptions are being made by the young patients. However, because of their own stage of development they may not yet be ready to see the broader picture, whereby care and the ability to care may simply be the result of one's own culture values and beliefs as in (Leininger's 1991; 1995) theory of cultural care or the theory of caring that relates more to the humanistic side of caring as proposed by Watson (1985: Cited in Lewis 2003). Vanhanen & Janhonen (2000) investigated student nurses orientation into the profession in terms of orientation to caring, what nursing work meant to them and what their expectations were in respect of nurse education and future career in nursing. They found that students entered the profession for a variety of reasons which ranged from engaging with an altruistic service, becoming an expert in health care, as an instrument for achieving a personal goal or simply economic security in life. In the personal and friendly interactions

which occurred between the students and the young patients in this study, information being shared could have led the young patients to view the younger students as not being truly professional nurses but being more like themselves at those particular ontological moments in time thus clouding the issue of their caring ability or professional proficiency. The patients have commented on the fact that *'the older ones seem to take it a bit more seriously, like, not more seriously, you know just get on and do it'*, they felt that the older student nurses tended to get on with the job of nursing more and talk to them more about their health and wellbeing, rather than engaging in lighthearted conversations as reported by Watson & Lea (1997). Interestingly, Vanhanen & Janhonen (2000) also found that male student nurses, particularly when associated with psychiatric and anaesthetics nursing, were more caring-orientated than female students, a factor which does not appear to have been reported by the young patients.

Satisfaction with work is an important factor for student retention, and it is reported that attrition rates are higher for children's nursing students, particularly younger students, than other branches of nursing (White et al. 1999; Price 2002; Glossop 2002; DOH 2006). Prymachuk et al. (2009) in their more recent research into student nurse attrition also found that older students were more likely to complete the course and that child branch students were more at risk of attrition. Eaton et al. (2000) reported that one of the main reasons for attrition amongst child branch students after family and personal problems is that of disillusionment (White et al. 1999). It is important, therefore, that students on the children's nursing programme

feel valued and supported in order to redress the issue of attrition thus preventing negative feelings of self worth and failure (Sheffler 1997; Last and Fulbrook 2003).

SUMMARY:

There are several issues of concern for the young patients which may have been brought about by the ambiguity in the students' professional status. The patients commented on having to be teachers in relation to their illness and have felt that cues in relation to their feelings have not always been picked up on, and their ability to be self caring, recognised. The patients have also highlighted issues of concern in respect of their emotional security in relation to trusting younger students with their care, particularly when they are feeling really unwell. There are implications for practice which will be discussed later in the thesis.

Question 4: What benefits do the young patients feel young students bring to these caring experiences?

THEME ONE: Messy Boundaries

i) Younger students as friends and mates/ Being able to talk to them on the same level

As previously discussed, adolescence is a developmental stage which is strongly influenced by peer relationships and is a unique period in life that requires the achievement of many developmental tasks (Havinghurst 1951). An important task of adolescent is developing relationships with peers and feeling part of a recognised

peer group (Zimmerman 2004; Reis & Youniss 2004). Because of the issues previously discussed in respect of communicating with adolescents (Drury 2003; Christie & Viner 2005) young people prefer engaging in conversation with people of their own age because they feel less likely to be judged by their peers. In describing their relationship with the young students as being on the same level and being friends and mates, clearly indicates that the young patients see them as peers rather than professional nurses. Messy boundaries appear to provide benefits for the young patients in respect of providing an element of normalcy for them whilst in hospital. Although visiting times are very relaxed on children's units, during term time, visits from peers are naturally restricted by their own commitments to school or college. Young people are more likely to be surrounded by young children whilst on the children's wards so the company and friendship of those students whom they perceive to be more their friends or mates is a welcome relief for them.

Friendships and social support are important buffers for young people with chronic life threatening illnesses. Empathetic engagements, validation of opinions about oneself and current life experiences are seen as salient characteristics of friendships during adolescence that promote the development of self-worth (Bigelow 1977; Youniss & Smollar 1985 cited in Zimmerman 2004).

The therapeutic benefit of these encounters needs to be measured against the perceived lack of professional identity and professional relationship the young students have with the young patients, which might otherwise be recognised in the older, more experienced student nurses. As Erikson (1968) strongly argues, the key to identity formation in adolescence lies very much in their interactions with others.

Self identity and developing a sense of autonomy are important tasks of adolescence, and as is noted within the narrative the young patients see themselves at a similar stage in their development to the student nurses charged with their care: *“I quite like it with the younger students because you’ve got more in common because you are round about the same age”* and *“Like.... They talk to me like a teenager, like when I talk to my mates”*. These parallels in development should not be viewed negatively as the benefits of these ‘unprofessional’ encounters appear to outweigh the costs. These interactions appear to be facilitating the young patients in respect of the normal explorations related to developing a personal identity (Erikson 1963; 1968; Marcia 1966). The amount of time some of these patients have spent in hospital (one patient spent six months in hospital on one occasion) can have a devastating effect on their psychosocial development resulting in internalizing disorders such as anxiety and depression (Garstein et al., 1999; Thomson et al., 2003; Alwash et al. 2000; Oguz 2002; DiNapoli & Murphy 2002). Being a young person with cystic fibrosis can have a negative impact on physical functioning affecting their quality of life and psychosocial wellbeing (Pfeffer et al. 2003). Any actions on the part of the students that can promote normalcy for the young patients should be encouraged because psychosocial support is a positive indicator for better psychological outcomes for patients with a long term illness (Anderson et al. 2001). With any serious chronic illness adolescent patients may face greater challenges in achieving their goals in respect of psychosocial and identity development due to increased social isolation, change in body image and the physical effects of their treatment regimens (Viner & Keane 1998; Ritchie 2001). Therefore, any strategies that can be employed by the

student nurses to support the young patients in achieving their psychosocial and cognitive developmental tasks should be seen as a benefit. Healthcare providers need to be mindful of the gains adolescents receive from healthy peer relationships which are not usually afforded by relationships with older people (Ritchie 2001). Spirito et al. (1991) in their study found that peers have a major influence on the psychosocial functioning of adolescent oncology patients. Furthermore, Olssen et al. (2003), cited by Sawyer & Aroni (2005) found that negotiating relationships with peers is an important part of managing chronic illness in adolescence. Sawyer & Aroni (2005) also promote peer support as being highly rated by young people with a chronic illness who particularly value social support of other young people as in the case of the younger students, albeit rather transitory in nature.

In relation to nursing theory, Leininger (1989), cited in Saewyc (2000) with reference to her cultural care theory, refers to adolescents as not only coming from different cultural and ethnic backgrounds that might influence their response to caring actions but she also points out that adolescence is in itself a sub-culture. By emphasizing the importance of nurses being knowledgeable about adolescents (Leininger 1989, cited in Saewyc 2000), especially how they interpret caring practices, the younger student nurses are ideally placed to demonstrate credible caring responses due to the fact that they themselves are immersed in the same sub-culture. Saewyc (2000) reinforces the notion that adolescents often view teaching or health promotion by senior staff as being 'parental' or 'judgmental' of their lifestyles which is detrimental to forming caring relationships. Watson (1997) in advocating her concept of transpersonal caring relationships highlights the importance for

adolescents of the authenticity of 'being' in terms of the real ability of nurses to be present and in a mutual state of being with the young patients in order for them to appreciate a real sense of being cared for. She makes reference to the egocentricism of adolescence and the importance of adolescent identity development and how very tuned in adolescents are in respect of recognising when nurses are not truly 'present' during caring interactions. Again the younger students are very much seen by the young patients as being on their level and tuned in with them in caring friendly relationships. Watson (1997) in exploring her fourth carative factor of the development of helping-trust relationships raises the issue of adolescents not easily trusting adults because they see them in positions of power and judgment. This again places the younger students, due to their perceived 'sameness', at a point of advantage when it comes to gaining the trust and friendship of the young patients thus facilitating caring relationships.

THEME TWO: Emotional security

i) Relieving boredom/ enjoying their company / Letting them forget about their illness for a while

For young people, having friends and being accepted as part of a peer group, is one of the most important aspects of their life. Taylor et al. (2008) found that young people felt life was best when they could be with their friends engaging in the same activities as them. However for young people with a chronic illness, this can be complicated by long term hospitalisation. During long periods of hospitalisation young people feel isolated from their friends and can experience difficulties in

making new friends because of differences in appearance (Atkin & Ahmad 2001; Ewan et al. 2004; Rhee et al. 2007). As previously discussed, young people with a chronic illness face the same developmental challenges as their healthy peers. Long term hospitalisation, changes in body image and health status can have a profound impact on adolescent development (Viner & Keane 1998; Thomas & Gaslin 2001). Getting on with their lives and being 'normal' is the next most important aspect of living with a chronic illness for young people (Atkin & Ahmad 2001; Kim & Kang 2003; Hokkanen et al. 2004; McEwan et al. 2004; Huus & Enskar 200 Cited in Taylor et al. 2008). One of the distressing aspects of hospitalisation for the young patients is that of boredom and spending long periods of time alone to think about their illness and situation. As one of the young patients aptly states *"if you think too much about getting better... think about I have to do this... think too much about the work of getting better...then that has a detrimental effect on you getting better"*. For young people it is important that they do not dwell on their illness as this helps them to get on with their life (Taylor et al. 2008). For this reason young people dislike talking about their treatment as they see this as a sign of being different and sets them apart from their friends (Atkin & Ahmad 2001; Hokkanen et al. 2004; McEwan et al. 2004; Huus & Enskar 2007). An important role the young students appear to fulfill is enabling some sense of normalcy for the young patients.

Social support as defined by Cohen & Syme (1985) includes resources provided by others in a wide variety of social networks and relationships either as practical support or emotional support. This support is reported to both directly and indirectly impact on health and can act as a buffer helping to protect people from adverse

events (Berkman 2000). Berntsson et al. (2007) highlight the importance of support from friends. Young people identified friends to be very important for invoking feelings of joy and affirming them as an equal teenager, which is a role that the young students appear to have been able to fulfill.

The benefits of good social support networks are numerous and include fewer health complaints (Geckove et al. 2003), lower levels of depression (Dumont et al. 1999), higher positive health practices (Yarcheski et al. 2003), higher optimism (Ayers 2003), higher self-esteem (Dumont et al. 1999; Yarcheski et al. 2001), fewer behaviour problems (Gaines 1997), and better adjustment to illness (Yarcheski et al. 1999). Peer support and involvement is also necessary to help young people with life threatening illnesses to develop a sense of identity and autonomy (Decker 2007). In light of the fact that evidence from the literature suggests that young people with a chronic illness are more likely to internalise their problems, (Garstein et al., 1999; Thomson et al., 2003; Alwash et al. 2000; Oguz 2002; DiNapoli & Murphy 2002) the students, by providing relief or a time when the patients can temporarily forget about their problems, can be advantageous.

In demonstrating a caring approach to their work the young students are engaging in valuable therapeutic relationships that they may be unaware of. One of the young patients felt passionately that *“the younger students are very capable of taking the kids mind of things... when you are really sick ...understand being ill with all the machines going off... when the younger nurse can still have a positive effect on that one, that is important I think”*. Caring, according to Benner & Wrubel (1989) means those persons, events, projects and things matter to people. Caring is

therefore essential if the person is to live in a differentiated world where some things are really important whilst other things do not really matter or are not important at all. Caring is ontological and it sets up what matters but this can be stressful rendering the carer vulnerable to feelings of loss and pain, but it can also be the catalyst for making things that matter work and this can result in a sense of joy and fulfillment for the student nurses (Benner & Wrubel 2001). This ontological form of care is what constitutes the person in their 'lifeworlds' and must be related to the person's ontological structures of concerns that shape their being-in-the-world (Spichiger et al. 2005). In order for the care giving to be supportive and therapeutic the carer must be tuned in to the person's ontological concerns and be able to assist in repairing the particular ontological damage that may have occurred in their 'lifeworld'. A chronic life threatening illness can seriously disrupt a young person's usual 'lifeworld' which places the student nurses in an ideal position to help them because recovery is not only about bodily cures but also about reintegrating them back into their known 'lifeworld' (Spichiger et al. 2005). The students will have a much better understanding of what constitutes 'lifeworld' for the young patients and by interacting with them on the same level as friends and mates will allow the young patients to be themselves for those moments in time. As one young patient commented, *"like the younger students are going through the teenage stuff themselves and they kind of know what I am going through, what they have been through if you know what I mean"*.

SUMMARY:

The young patients clearly appreciate the time the young students can spend with them and have identified the benefits that these caring interactions can bring. The nature of the interactions between the young patients and the young students allows the young patients to be themselves for those moments in time, which helps alleviate their boredom but more importantly to forget about the business of getting better. The therapeutic benefits of these fairly unique 'caring' interactions are not explicitly recognised by either party which is a very important implication for clinical practice that will be discussed later.

Question 5: What are the commonalities and differences in these caring experiences between the two groups of participants?

From the narratives it can be seen that there are several areas of commonality in the ontological caring experiences of the younger student nurses and the young patients. The strongest theme throughout this analysis is that of messy boundaries and this appears to have had a profound impact on the younger student nurses and the young patients from both a positive and negative perspective. Age and stage of development has been the catalyst of all the emergent themes and this is recognised by both groups of participants as being central to how the ontological caring relationships are perceived and described.

The mutuality of the notion that the patients and the younger students see themselves more as friends and mates rather than as a patient / nurse or professional, has

highlighted issues of ambiguity in the relationship and ambivalence in the students nurses' professional identity.

Clearly the students' acknowledgement of their feelings of inadequacy are heightened when caring for this particular client group and are reinforced by the reactions of the young patients and their parents in caring situations, when indeed the young patients and their parents implicitly or explicitly give signals to the young students that they do not appear to know very much and lack experience.

There is acknowledgement by the student nurses that they do not feel adequately prepared at this time in their education to deal with the emotional labour of caring for young patients of a similar age to them, and this is mirrored in the narrative of the young patients.

An interesting finding is how both groups of participants have an expectation that the young patients will be teachers, educating the younger students about of their illness. The young students have an expectation that they are entitled to learn from the young patients about their particular condition and that the patients would be in agreement with this. However, it is also clear from the narrative that this is not always how the young patients themselves view the situation.

From the younger student nurses' and the young patients' perspective the opportunity that is readily afforded to the students to engage in friendly, peer related interactions with the young patients is positively evaluated. This is portrayed by both groups as an outcome of similarity in age which is highly beneficial in respect of the young patients' emotional wellbeing. The benefits of these interactions are recognised by both groups particularly in relation to relieving their (the patients)

boredom and providing them with times of normalcy and relief from the burden of their illness. The commentary within the narratives highlights the therapeutic benefits that the similarities in age and stage of identity development bring to these ontological caring experiences of both groups of participants. Conversely, both groups of participants also recognise that older student nurses are more readily accepted by patients and their parents as real nurses or professionals and that due to their age are likely to be more experienced, knowledgeable and trustworthy. The downside of age for older students is that both groups of participants feel they do not spend as much time with the young patients, do not relate well to the young patients, do not understand them and cannot communicate with them in a non-judgemental manner.

Question 6. How can an in depth understanding of the lived experience of all participants during these caring experiences inform children's nursing practice?

It has emerged from the analysis of this data that there are implications for clinical practice and nurse education which need to be acknowledged.

IMPLICATIONS FOR NURSING PRACTICE

Healthcare providers need to be alerted to the benefits of healthy peer relationships for adolescent patients during hospital admissions, particularly in relation to their mental health, and provide support for the younger students to engage with this role when appropriate.

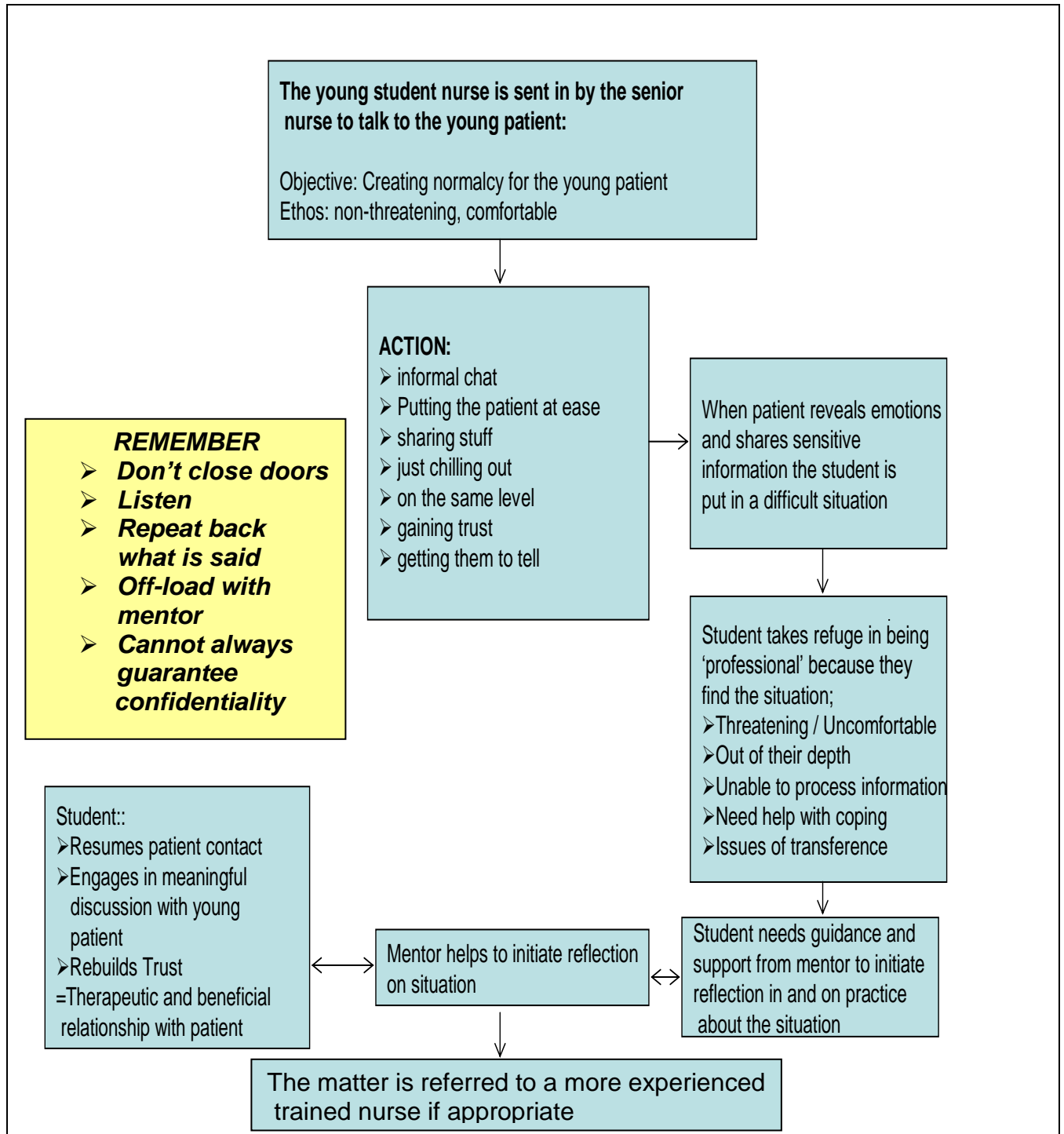
The detrimental impact for young people of spending long periods of time in hospital, being bored and dwelling on their illness, needs to be highlighted and

mentors need to be made aware of the benefits that can be gained by supporting the young student nurses, who are ideally placed, to engage in caring, therapeutic interactions. Because these caring interactions are quite unique and may only be relevant in those particular moments in time for both participants, it is important that these opportunities for therapeutic engagements are not lost. It is, however, evident within the data that the students find it emotionally difficult and even painful, to engage in interactions and communications about sensitive and life threatening matters. A framework for processing sensitive information which the patients may share with the young students is proposed. This framework has been designed as a step by step process that the students and mentors can follow to maximise the therapeutic value of these caring interactions and should be introduced into practice areas to provide a strategy for mentors and students to work with. (See figure 1 p167)

The young students need time to reflect on emotionally challenging situations and should be afforded the time for this in practice along with the support of their mentors.

It is important that mentors, when supervising students, ensure that students do not expect young patients to act as teachers when it might not be appropriate for them to do so. Mentors are in a position to raise awareness for students in respect of ascertaining whether or not the young patients might be emotionally distressed by undertaking the role of teacher.

Figure 1:
Framework for enabling young students to process sensitive information revealed by young patients



IMPLICATIONS FOR CHILD NURSE EDUCATION

The ambivalence in their professional identity created by “messy boundaries” could have a detrimental effect on the students’ self esteem and cause disillusionment with the profession, thus increasing the risk of attrition from the programme. It is important that students on the children’s nursing programme feel valued and supported in order to redress the issue of attrition thus preventing negative feelings of self worth and failure.

Belonging to a peer group with social support is important for young students in respect of their self esteem. The student nurses need opportunities to share their experiences with each other, to learn from each other’s experiences as well as get support from each other when they need this. Support groups, particularly in the first year on the pre-registrations children’s nursing programme, could be an ideal forum for students to engage with their peers and share difficult experiences. From a psychodynamic perspective, with the support of personal tutors or significant other education staff to facilitate these support groups, the students could debrief and reflect on difficult practice situations, thus reducing their emotional distress (Allan 2011).

From the point of recruitment it is essential that the coping abilities of individual candidates be assessed in relation to some of the emotional challenges they may be exposed to. It is also important that those providing pastoral support to students are made aware of the different approaches to coping that students may adopt. The pre-registration children’s nursing curriculum should be reviewed to incorporate

modules of learning designed to enhance effective coping skills of the student nurses.

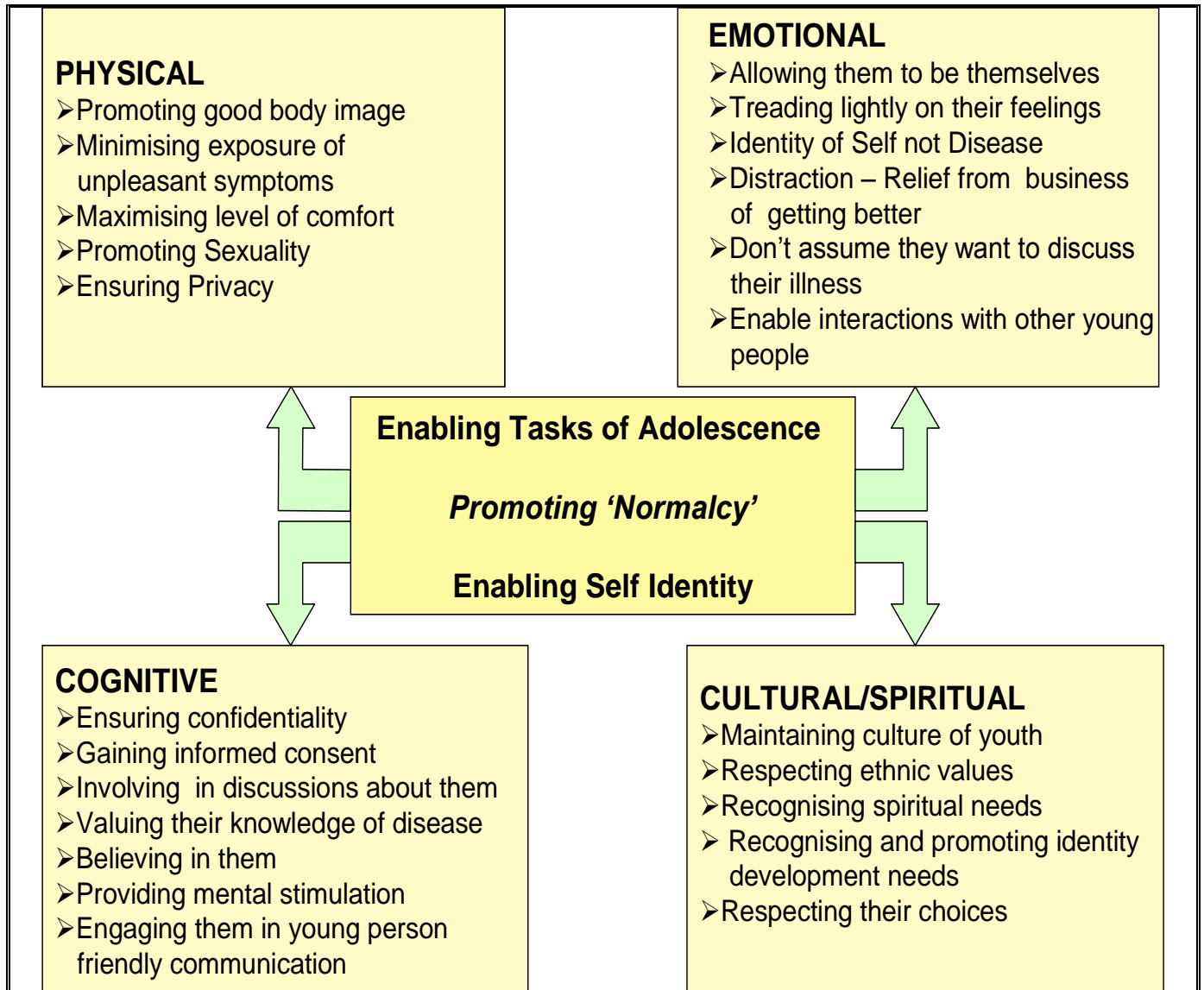
As part of the pre-registration children's nursing programme review, it is essential that the profile of adolescent health care be raised in line with national and local policies. The thread of adolescent healthcare needs to be much more visible within the programme structure and there needs to be more adolescent healthcare specific courses.

The content in relation to adolescent healthcare within the curriculum needs to be structured in a way that will increase the students' understanding of the psychological impact of a chronic life-threatening illness on a young person. The emotional distress that can be caused to the young patients, particularly when they are feeling unsafe and vulnerable also needs to be emphasised. It is also important that when teaching clinical skills in relation to meeting the hygiene needs of young people, emphasis is placed on the need for sensitivity relating to the emotional and psychological discomfort that can be caused during these procedures. In recognising the importance of providing a sense of normalcy for the young patients, whilst in hospital, a framework for care, which draws on the findings of this research, is proposed (see figure 2 p171). The central aim of this framework is to encourage a sense of normalcy for the young patients which will enable them to fulfil the tasks of adolescence in order for them to continue on their journey of self identity. The physical, emotional, cognitive, cultural/spiritual needs of the young patients in relation to their hospital care are extracted from the findings of this research which represent the voices of the young patients. This framework can be introduced into

the nurse education curriculum to provide guidance on enhancing the nursing practice of caring for young people by promoting a sense of normalcy for them.

Reflection in and on practice is an important pre-existing feature of nurse education today. It is important that student nurses, particularly younger student nurses, are supported and encouraged to use reflection in and on practice. It is equally important that the use of reflective practice is re-enforced with those practitioners supporting and mentoring students through the vehicle of mentor update sessions.

**Figure 2:
Framework of Care for young People – Promoting ‘Normalcy’**



Foot note

- Being quiet doesn't equate to being OK
- Listen to Young People
- Continuity of Care very important to young people
- Enable progression in respect of tasks of adolescence
- Read the notes avoid them having to keep telling their story

CHAPTER SIX

FINAL CONCLUSIONS & RECOMMENDATIONS FOR FURTHER RESEARCH

Issues of concern to the young students during these ontological caring experiences

Clearly there are issues of concern faced by younger student nurses when they are engaged in ontological caring experiences with young patients whom they perceive to be of a similar age to themselves. What has emerged from the data is the issue of messy boundaries underlying both the positive and negative aspects of these lived experiences for both groups of participants. The student nurses appear to have found it very difficult to build appropriate professional relationships when they are drawn into trusting, caring and friendly relationships with the patients. Compounding all of this is the fact that both groups of participants are at a similar stage in relation to their identity development which has clearly enabled the students and the patients to relate well to each other and perform on the same level. Confusion has arisen because in order to gain the patients' trust the students have to some extent had to abandon their professional role and adopt more of a friendship role, clearly blurring boundaries. This has caused distress for some of the students because their main aspiration is to develop a professional nurse identity in order to fulfil the requirements and demands of the nurse education programme. Because the students have instinctively related well to the young patients, this has to some extent necessitated them adopting rather a unique role, that of nurse and carer but also that of friend or mate. Because of their developmental stage, they are engaged in the same developmental tasks as the patients

and are well placed to more fully appreciate their development needs, especially when engaging with patients who have very serious and life threatening illnesses. This has lead to the student nurses being placed in confusing situations with messy boundaries. They have felt that the only way to meet the needs of the young patients, was to abandon their professional role and this has brought about broader issues for them with the parents and the patients not viewing them as health care professionals, at the very time when they are aspiring to obtain this status.

One of the more serious concerns is that when the student nurses are engaging in these ontological caring relationships with the young patients they are encountering stressful emotional difficulties in relation to issues of death, dying, and other difficult personal situations. Lack of knowledge and skills, due to their stage in the education programme, has resulted in the student nurses being drawn into emotional disclosures and exchanges which they have felt inadequately prepared to deal with. The irony of this is that the level of confidence being shared with the younger students, by the patients, is unlikely to be so freely shared with older students or even trained nurses due to the very nature of adolescence. It is well described and documented within the literature that young patients are much more likely to engage in these interactions with young people of a similar age and by whom they do not feel so threatened or judged.

What needs to be seriously considered by nurse educationalists is the cost of caring for the younger student nurses when engaging with the young patients. As part of their child nurse education, students should be provided with appropriate education and support from mentors and other professionals to enable them to develop better coping

strategies and help them to better manage stressful situations they may find themselves in.

Another issue of concern for the student nurses is their recognition that parents, by their reactions to them, demonstrate feelings of lack of confidence in their ability to care for their adolescent children. They suspect that assumptions are being made about their lack of knowledge and skills based upon their age rather than their individual abilities. To a lesser degree there are also issues of concern for some of the students in respect of gender based clinical tasks, particularly in relation to meeting the hygiene and toilet needs of opposite gender patients. Of course, it is recognised that this issue is not peculiar to children's nursing but is mirrored in other branches of nursing throughout the literature.

The fact that there are very few specialist courses available to nurses which enables them to fully meet the needs of adolescents and young people is testament to the fact that adolescent health care is still not the highest of priorities within the healthcare system. There is a wealth of literature now advocating the specific needs of adolescents and young people and highlighting the fact this client group are a unique and individual group with unique and individual needs.

Benefits the young students feel their age brings to these ontological caring experiences?

Having discussed the issues of concern brought about by engaging in these ontological experiences, it is important to balance this with the positive outcomes that have been articulated by the young students in relation to the messy boundaries. The commonalities of their lived experience brought about specifically by their similar

ages and stage of identity development has made it easy for the student nurses to relate to young patients. From the data it has emerged that the students feel proud and pleased that the young patients find it easy to talk to them, whether this be in a light-hearted way or in a more serious, deeply emotional way. The students clearly recognise their ability to be able to make a breakthrough with the younger patients and get them to talk and share their concerns and worries with them. This aspect of the relationship is recognised as one of the major benefits of being a younger student and they are able to clearly articulate that this kind of relationship would not be so likely with the older student nurses or older trained nurses: *“I think teenagers when they open up to you...you sort of you feel quite happy...you feel like you have achieved something by them talking to you...when someone can be quite closed not say anything you think they are talking to you... a breakthrough almost, they are talking to me... brilliant”*.

This could enable some of the student nurses to experience feelings of pride and achievement and a boost to their self esteem and to their personal growth and development.

What has also emerged from the data is that the student nurses recognise that they are playing an important role in helping to alleviate the boredom experienced by the young patients during long hospital admissions. This they feel enables them to make a positive contribution to their care brought about by the uniqueness of their ability to relate well to the patients and fulfil a role which would not so easily be filled by the older student nurses or older trained nurses. What is not so clear is that the student nurses actually appreciate the therapeutic value of these interactions and how they could capitalise on this uniqueness to the further benefit of the young patients.

Caring and emotional connections with the young patients have been discussed, particularly in relation to emotional labour and emotional intelligence. It has been highlighted within the literature that student nurses begin to lose their idealism about caring after about one year into their education programme and that younger nursing students view caring in more psychosocial terms, whereas older student nurses incorporate more professional and technical aspects into their perception of caring. The student nurses in this study appear to be in a unique position, due to their age and similar stage of development to the young patients, to engage in real caring interactions. Caring, for the young patients, relates to the range of connectedness and concerns that the younger students can experience in their “lifeworlds”. By understanding what is likely to constitute “lifeworld” for the young patients, because they are experiencing a similar “lifeworld” to them, they are able to engage in ontic care giving in a nurturing and supportive way because they are attuned to the young patient’s ontological concerns that shape their being-in-the-world. Illness can seriously disrupt the young patient’s taken for granted “lifeworld” and the younger students are ideally placed to help re-integrate the young patients back into their “lifeworlds”. In order for this unique opportunity not to be missed, it is crucial that younger student nurses are supported from the very beginning of their nurse education, and made aware of the unique role they can play when caring for young people.

Identification of issues of concern to the young patients during these ontological caring experiences

Whilst the young patients have mostly enjoyed the company of the younger student nurses, there are some worries and concerns that have emerged from the data. The young patients are happy to treat the younger students as friends and mates but there is strength of feeling within the data that the young patients do not consider the younger students to have the same level of knowledge and skills as the older students. Several of the young patients freely express concerns about the younger students' lack of knowledge and understanding in respect of their own treatments and management of care. They are clearly equating young age with lack of knowledge and skills, and older age bringing with it more knowledge and skills, despite the fact that both groups of students may be at the same stage of their nurse education. An issue of concern that has also been expressed by the young patients is that of having a responsibility to teach the students. For some of the young patients this is a huge issue of concern because having to repeatedly explain to others about their illness and treatments does not allow them to forget about their condition or experience a sense of normalcy whilst in hospital.

Another issue of concern for the young patients is that they lack confidence in the younger student nurses' ability and therefore have not felt safe when they have been undertaking procedures on them. Because the young patients are so conversant with their own treatments and care management they resent the fact that sometimes the younger students may clumsily challenge their knowledge base and question their ability to care for themselves.

In relation to the young patients' emotional security, it has emerged from the data that the younger students appear to lack understanding of their personal feelings and that some of their cues have been misread. Also, due to the lack of skills and experience, at times the younger students have unintentionally trodden heavily on their feelings. Similarly, the young patients, whilst readily engaging in friendly relationships with the student nurses, render themselves to be vulnerable when they are sharing deep emotional concerns about their illness or treatments and with the students when it is very likely that the younger students are not adequately prepared emotionally and clinically to deal with these interactions in a therapeutic way.

What has also emerged from the data is the fact that the young patients trust the older students more and attribute more knowledge, skills and experience to the older students even when they are at the same stage of their education programme.

Benefits that the young patients feel younger students bring to these ontological caring experiences

The overarching theme of messy boundaries appears to have been influential during the ontological caring experiences of both student nurse and patient. What has emerged from the data is the importance the young patients place on having the opportunity to be themselves, chill out and spend some time just being a young person. Having to balance the dual identity of being the sick young person with being an emergent adult, appears to have been buffered and aided by the fact that the young patients have been able to engage in friendly, non professional relationships with the younger student nurses and interact with them on the same level. Sharing ideas and

experiences which are appreciated and understood by both parties has brought about an element of normalcy which has been acknowledged and appreciated by the young patients. From the data it has emerged that there have been many occasions when these encounters have enabled free and easy interactions providing relief from the boredom of hospital admissions and respite from the label of their illness or condition, allowing them to be themselves and behave in a way that is comfortable and non-threatening for them. The young patients have felt that they could speak freely to the younger students and engage in conversations which they felt would not be subjected to judgmental views. From the data it has also emerged that one of the important things about being in hospital is meeting someone who can put a smile on their face and this is a quality and attribute that they feel is much more likely to be recognised in the younger students. In relation to their care and management, the young patients have placed a very high value on this skill. By engaging with and opening up to the student nurses it would appear that the young patients are trying to maintain some kind of normalcy in their lives and just be young people with all the needs and aspirations of any young person from a social and psychological perspective but at the same time being burdened with their illness. What is evident in the data is the fact that young people with life threatening illnesses spend a lot of time in hospital and this has resulted in many hours, days, weeks and months of lying around with nothing else to think about other than their illness or the business of getting better. The importance of social support and relief from the burden of the illness in preventing secondary mental health issues for these patients has been identified within the literature. In the busy hospital environment, assumptions can so easily be made that, because these young

patients do not make a fuss, they are coping well and that their needs are being met. One of the major advantages of the interactions they are able to have with the younger students is that of bringing an element of normalcy to their lives with time out from being ill and opportunities for them to engage in the normal tasks of adolescence and progress with their own identity development. With limited access to their friends and family the younger student nurses are able to fill the gaps and provide them with friendship and company during their hospital admission.

The following are considered in terms of future research:

1. An in depth study exploring the real cost to young patients when they are left alone for long periods of time to think about the business of getting better.
2. An investigation to determine the real costs and benefit for patients and the clinical staff in relation to young patients being teachers of their condition.
3. A longitudinal study of the benefits of early assessment of coping and the impact of early interventions to enhance coping strategies in relation to student retention.
4. A longitudinal study of the impact of implementing the framework for working through the stages involved in processing disclosed sensitive information with the student nurses.
5. An investigation to determine other factors influencing the attrition of children's nursing students

LIMITATIONS OF THE STUDY

Undertaking a study of this kind brought with it many challenges for the researcher particularly in relation to gaining ethical approval to interview young patients. This delayed progress with the thesis for over a year. The researcher's experience of working with young people in clinical practice and in education for many years provided a solid background and understanding of the importance of protecting the wellbeing of all the participants at a challenging developmental stage in their lives.

Every precaution has been taken to ensure the wellbeing of the participants during this study, and in so doing, may have resulted in some slight limitations of the research which need to be taken into consideration. Hermeneutic phenomenological research methodology requires the researcher to allow the participants to tell their story in their own words. The data needs to be collected and analysed in line with this methodology. Whilst the young students were happy to tell their stories freely, requiring little in the way of prompting during the interviews, the young patients were shyer at times, resulting in the need to plan for more time for these interviews as it was important to allow for occasional silences until they were ready to continue telling their stories.

Although not intentionally planned for, all of the young patients who came forward to take part in the research had long term health problems. To ensure that they were physically well enough to be interviewed, there was a criterion that no young patient who had been admitted to hospital within the previous three months, would be able to participate. There are implications when using young people with long term health problems in a study that need to be acknowledged. All of the young patients had

experienced multiple, and at times, long hospital admissions. This may have influenced their experience of the caring interactions being investigated, particularly in respect of their knowledge and understanding of their disorder. They may also have gained more insight into the caring interactions, and their expectations may have been different, due to the length of stay in hospital that they had endured. The researcher also heard in some of their voices a reluctance to say anything detrimental about the nurses. This may have been due to a perceived loyalty or high regard towards the nurses because of these previous extensive admissions, and possibly due to an anticipation of further admissions.

It is also acknowledged that within this thesis comparisons have not been made between cultures of the participants which might be worthy of another study although on analysing the data there did not appear to be any obvious differences that could be addressed within the scope of this work.

The age difference between the student nurses is sixteen months but for the young patients it is four years and seven months. The effect this may have had on responses has not been analysed within the scope of this thesis and may have enhanced the analysis. Initial evaluation of the data did not highlight significant differences other than, perhaps, the ability to articulate their experiences, particularly the older patients.

Because all the patients were recruited from one hospital trust and all the students were recruited from one nurse education institution, it is acknowledged that the insights gained from these experiences are relevant locally. Because of the small number of participants that were interviewed, which is in line with the methodology of phenomenology, the capacity for wider representation is limited. It is however,

anticipated that through the publication of the results of this study, the voices of the participants will echo for readers in a wider audience, similarities in their field of work, in a manner which will encourage them to rethink their practices and effect change.

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APPENDIX ONE: - information letters

Version 2: 9th July 2008 (Ref 08/H0809/33)

Information Sheet for Young Patients

Hi,

"Title of Study: An investigation into what it is like for young patients aged between 13 years and 16 years when they are cared for in hospital by younger student nurses who appear to be of a similar age to them."

I am asking if you would agree to take part in my research project to find out what it was like for you when you were cared for by younger student nurses who you feel might be of a similar age to yourself.

Before you decide if you want to join in it's important to understand why the research is being done and what it will involve for you. So please read this leaflet carefully. Talk about it with your family, friends, doctor or nurse if you want to.

Thank you for reading this.'

Why am I doing this research?

I am interested to find out what it is like for you when you are being cared for by a younger student nurse and to discover what you feel are the benefits of disadvantages for you in this situation.

Why have I been asked to take part?

I chosen to ask you to take part because you are of the right age for my research, that is between the ages of 13 years and 16 years and have been in hospital more than once. I am hoping to be able to involve about six young patients who have been in hospital more than once in the hope that you may have been cared for by younger student nurses during one of your stays in hospital. This is the first time that I have done research like this and I am asking you because I think it is very important to be able to listen to your views.

Do I have to take part?

You do not have to take part; it is entirely up to you to decide whether or not to take part. If you do decide to take part you will be given this information letter to keep and be asked to sign a consent form. If you decide to take part you are still free to drop out at any time and without giving a reason. A decision to drop out at any time, or a decision not to take part, will not affect in any way how you are cared for at Lewisham Hospital.

What will happen to me if I take part?

If you do decide to take part in this study you will be asked to do just one interview with me and talk to me for about half an hour. This interview could be arranged at a time and place to suit your own convenience (probably during a normal clinic visit) and you could invite a friend or relative to join you if you wish. Of course, at this interview, you will not be asked to talk about anything that you do not feel happy so to do. I would need to tape record this interview in order not to miss anything you say. Once I have completed the interviews I will write down what is said from the tape and then work with this information for my research.

What will I be asked to do?

What I would like you to do is spend about half an hour with me to allow me to interview you and ask you a few questions.

What are the possible benefits of taking part?

I cannot promise that the study will benefit you immediately, but any information you share with me could be used to help improve the training of younger student nurses and hopefully make sure young patients like yourselves get the best possible nursing care when they are in hospital, especially when being cared for by younger nursing students.

Contact Details

My contact details are: Jean Shepherd, University of Greenwich, Room S120, Mary Seacole Building, Southwood Site, Avery Hill Campus, Eltham, London SE9 2UG.

Tele: 0208 331 8078

Email. j.m.shepherd@gre.ac.uk

Thank you for reading so far - if you are still interested, please go to Part 2:

Part 2 - more detail - information you need to know if you still want to take part.

What happens when the research project stops?

If for any reason the research project were to stop, I would let you know immediately.

What if there is a problem or something goes wrong?

It is not expected that anything will go wrong, but if you are unhappy about how the interview is carried out you should contact Lynn Hyams who is the Patient Advice and Liaison Service manager at Lewisham Hospital. She will be happy to speak to you confidentially about any concerns you may have. Her phone number is 0208 333 3000 (ext. 6363).

Will anyone else know I'm doing this?

Yes my supervisor would need to know. If you do agree to take part, the interviews and any information gained from the interviews will be treated with the strictest of confidence and no person will be named, you will all be given a code. All interview tapes will be securely kept and will be made available only to myself and my supervisor. Any information from the research will be shared with you if you wish.

Who is organising and funding the research?

The University I work for, The University of Greenwich are funding me to undertake this research. Whilst I am not able to pay you to take part in my research, I could pay any travel expenses you may incur.

Who has reviewed the study?

Before any research goes ahead it has to be checked by an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by the South East Research Ethics Committee.

About Consent

You will be asked to sign a consent form if you do decide to take part in my research. I will also need to get the consent of your parents/guardians if you are under 16 years of age. If your parents/guardians give their consent but you do not wish to take part then I would respect your wishes and not ask you to take part.

Thank you for reading this - please ask any questions if you need to.

Best wishes,

Jean Shepherd

Date...

Hi,

Title of Study: "The lived experience of younger student nurses, especially when they are required to care for young patients of a similar age to themselves"

I am a senior lecturer in children's nursing at the University of Greenwich. Currently, as part of my Education Doctorate I am undertaking the above research study which is being sponsored by the University of Greenwich and which it is anticipated will take me two to three years to complete.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

In undertaking this research it is hoped that it will contribute to improved knowledge and understanding of what it is like to be a younger children's nursing student especially when required to care for young patients who may be of a similar age to themselves. The aim of the research is to explore if there are any strategies which could be employed to improve the overall experience of younger students. Equally importantly I want to explore the experience of young people as patients when they were cared for by younger student nurses.

Why have I been chosen?

You have been chosen because you meet the age requirement for my research being aged between 17.5 years and 20 years when you commenced on the children's nursing programme. I am hoping to involve about 8-10 children's nursing students in my study.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be given this information letter to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your position on the programme or have any detrimental effect of your future career.

What will happen to me if I take part?

Your involvement would be one interview that would take approximately forty-five minutes and this interview could be arranged at a time and venue of your own convenience. Of course, at this interview, you will not be asked to discuss anything that you do not feel comfortable with. In order to capture all the discussions at the interview, it will be necessary to tape record the interviews.

Expenses and payments

It is not anticipated that you will incur any expenses.

What do I have to do?

I am asking you to participate in one individual interview which should last no more than 45 minutes.

What are the possible benefits of taking part?

Whilst I cannot guarantee that you will experience any immediate benefit from participating in this research, it is anticipated that any

information gained will be used to guide and inform future training programmes for children's nursing students with an intended outcome of improving the overall experience of younger student nurses.

What happens when the research study stops?

If for any reason I could not continue with this research I would let you know immediately.

What if there is a problem?

It is not anticipated that you will encounter any problems when participating in this research, but if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal University of Greenwich complaints mechanisms should be available to you.

Will my taking part in the study be kept confidential?

'Yes. All the information about your participation in this study will be kept confidential. The details are included in Part 2.

Contact Details

My contact details are: Jean Shepherd, University of Greenwich, Room S120, Mary Seacole Building, Southwood Site, Avery Hill Campus, Eltham, London SE9 2UG.

Tele: 0208 331 8078

Email. j.m.shepherd@gre.ac.uk

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Will my taking part in this study be kept confidential?

The interviews and any information gained from the interviews will be treated with the strictest of confidentiality and no person will be identified by name, all participants will be given a code. All interview tapes will be securely kept and will be made available only to the researcher and supervisor. Any findings from the research will be shared with the participants where desired.

Who is organising and funding the research?

The University of Greenwich is funding me to undertake this research. Whilst I am not able to pay you to take part in my research, I could pay any travel expenses you may incur.

Who has reviewed the study?

Before any research goes ahead it has to be checked by an Ethics Committee. They make sure that the research is OK to do. My project has been checked by the South East Research Ethics Committee.

The Consent Form

Enclosed is a copy of a consent form which I will need you to complete if you would like to participate.

I very much look forward to hearing from you again.

Best wishes,

Jean Shepherd
Senior Lecturer

Version 2: 9th July 2008 (Ref 08/H0809/33)

Information Sheet for Parents/Guardians of Young Patients

Hi,

"Title of Study: An investigation into what it is like for young patients aged between 13 years and 16 years when they are cared for in hospital by younger student nurses who appear to be of a similar age to them."

I am asking if you would agree to your son/daughter/youth taking part in my research project to find out what it was like for young patients when they were cared for by younger student nurses of a similar age to themselves.

Before you decide if you want your son/daughter/youth to take part in my study it is important to understand why the research is being done and what it will involve for them.

Thank you for reading this.'

Why am I doing this research?

I am interested to find out what it is like for young people when you are being cared for by a younger student nurses and to discover what they feel are the benefits or disadvantages for them in this situation.

Why have they been asked to take part?

I chosen to ask your son/daughter/youth to take part because they are of the right age for my research, that is between the ages of 13 years and 16 years and have been in hospital more than once. I am hoping to be able to involve about six young patients who have been in hospital more than once in the hope that they may have been cared for by younger student nurses during one of their stays in hospital. This is the first time that I have done research like this and I am asking them because I think it is very important to be able to listen to their views.

Do they have to take part?

They do not have to take part; it is entirely up to you and them to decide whether or not to take part. If you do decide to allow your son/daughter/youth to take part you will be given this information letter to keep and be asked to sign a consent form. If you decide to give your consent to them taking part they are still free to drop out at any time and without giving a reason. A decision to drop out at any time, or a decision not to take part, will not affect in any way how they are cared for at Lewisham Hospital.

What will happen if they do take part?

If you do decide to give your consent to them taking part in this study they will be asked to do just one interview with me and talk to me for about half an hour. This interview could be arranged at a time and place to suit their own convenience (probably during a normal clinic visit) and they could invite a friend or relative to join them if they wish. Of course, at this interview, they will not be asked to talk about anything that they do not feel happy so to do. I would need to tape record this interview in order not to miss anything they say. Once I have completed the interviews I will write down what is said from the tape and then work with this information for my research.

What will they be asked to do?

What I would like them to do is spend about half an hour with me to allow me to interview them and ask a few questions.

What are the possible benefits of them taking part?

I cannot promise that the study will benefit them immediately, but any information they share with me could be used to help improve the training of younger student nurses and hopefully make sure young patients like your son/daughter/youth get the best possible nursing care

when they are in hospital, especially when being cared for by younger nursing students.

Contact Details

My contact details are: Jean Shepherd, University of Greenwich, Room S120, Mary Seacole Building, Southwood Site, Avery Hill Campus, Eltham, London SE9 2UG.

Tele: 0208 331 8078

Email. j.m.shepherd@gre.ac.uk

Thank you for reading so far - if you are still interested, please go to Part 2:

Part 2 - more detail - information you need to know if you consent to them taking part.

What happens when the research project stops?

If for any reason the research project were to stop, I would let them know immediately.

What if there is a problem or something goes wrong?

It is not expected that anything will go wrong, but if they are unhappy about how the interview is carried out they should contact Lynn Hyams who is the Patient Advice and Liaison Service manager at Lewisham Hospital. She will be happy to speak to them confidentially about any concerns they may have. Her phone number is 0208 333 3000 (ext. 6363).

Will anyone else know I'm doing this?

Yes my supervisor would need to know. If you do agree to your son/daughter/youth taking part, the interviews and any information gained from the interviews will be treated with the strictest of confidence and no person will be named, they will all be given a code. All interview tapes will be securely kept and will be made available only to myself and my supervisor. Any information from the research will be shared with the young people if they wish.

Who is organising and funding the research?

The University I work for, The University of Greenwich are funding me to undertake this research. Whilst I am not able to pay participants to take part in my research, I could pay any travel expenses they may incur.

Who has reviewed the study?

Before any research goes ahead it has to be checked by an Ethics Committee. They make sure that the research is OK to do. My project has been checked by the South East Research Ethics Committee.

About Consent

You will be asked to sign a consent form if you do decide to allow your son/daughter/youth to take part in my research. I will also need to get the consent of your son/daughter/youth. If you do give your consent but your son/daughter/youth does not wish to participate then I would respect their wishes and not ask them to take part.

Thank you for reading this - please ask any questions if you need to.

Best wishes,

Jean Shepherd

APPENDIX TWO: consent/assent forms

Consent Form

Title of Project: The Lived Experience of Younger Children’s Nursing Students, Especially when they are required to care for young people of a similar age to themselves.

Name of Researcher: Jean Shepherd

Participant Identification Number for this project

Please initial box to indicate agreement

1.	I confirm that I have read and understand the information letter dated for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw any time, without giving any reason.	
3.	Data collected during the study will analysed by myself, the Researcher who will take all reasonable steps to protect your privacy.	
4.	In understand that the interview will be tape recorded and I am in agreement with this.	
5.	I agree to my GP being informed of my participation in the study if deemed necessary.	
6.	I agree to take part in the above study.	
7.	Would you like to be sent details of the results of the study	

Name of Participant _____

Date _____

Signature _____

Age of Participant _____

Investigator _____

Date _____

Signature _____

THANK YOU!

(Ref 08/H0809/33)

Version 1: 30th April 2008

ASSENT FORM FOR CHILDREN (to be completed by the child and their parent/guardian)

Title of Project: The Lived Experience of Younger Children's Nursing Students, Especially when they are required to care for young people of a similar age to themselves.

Name of Researcher: Jean Shepherd

Participant Identification Number for this project:

Young person to circle all they agree with please

1.	Have you read (or had read to you) about this project?	Yes/No
2.	Has somebody else explained this project to you?	Yes/No
3.	DO you understand what this project is about?	Yes/No
4.	Have you asked all the questions you want? Yes/No	Yes/No
5.	Have you had your questions answered in a way you understand? Yes/No	Yes/No
6.	Do you understand it's OK to stop taking part at any time? Yes/No	Yes/No
7.	Are you happy to take part? Yes/N	Yes/No

If any answers are 'no' or you **don't** want to take part, **don't** sign your name! If you do want to take part, please write your name and today's date

Your name _____ Date _____

Your parent or guardian must write their name here too if they are happy for you to do the project

Print Name _____ Sign _____

Date _____

The Researcher who explained this project to you needs to sign too:

Print Name _____ Sign _____

Date _____

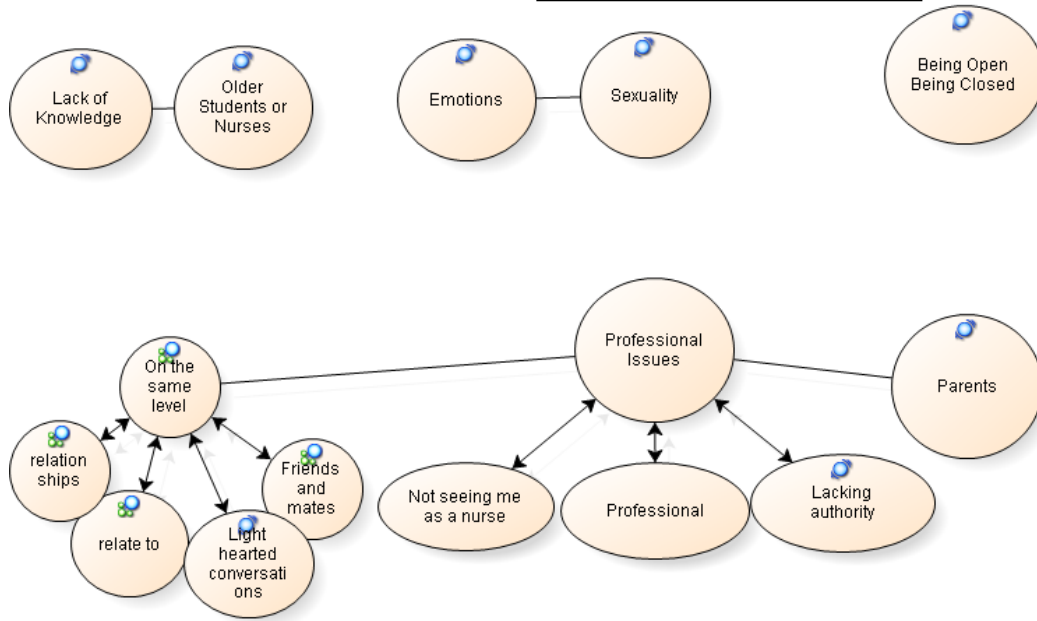
THANK YOU!

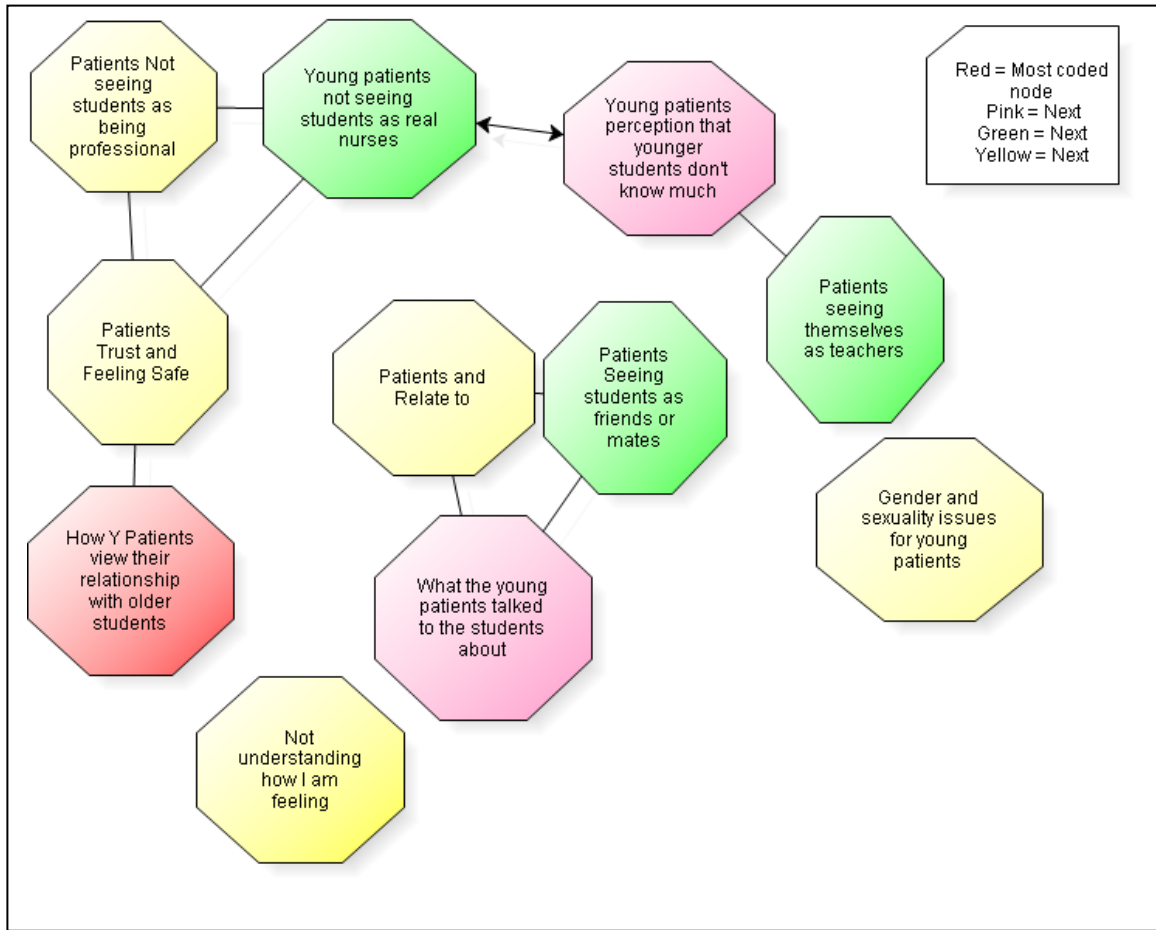
Version 1: 30th April 2008 (Ref 08/H0809/33)

APPENDIX THREE – mind maps



FIRST MIND MAP-
STUDENTS January 2010

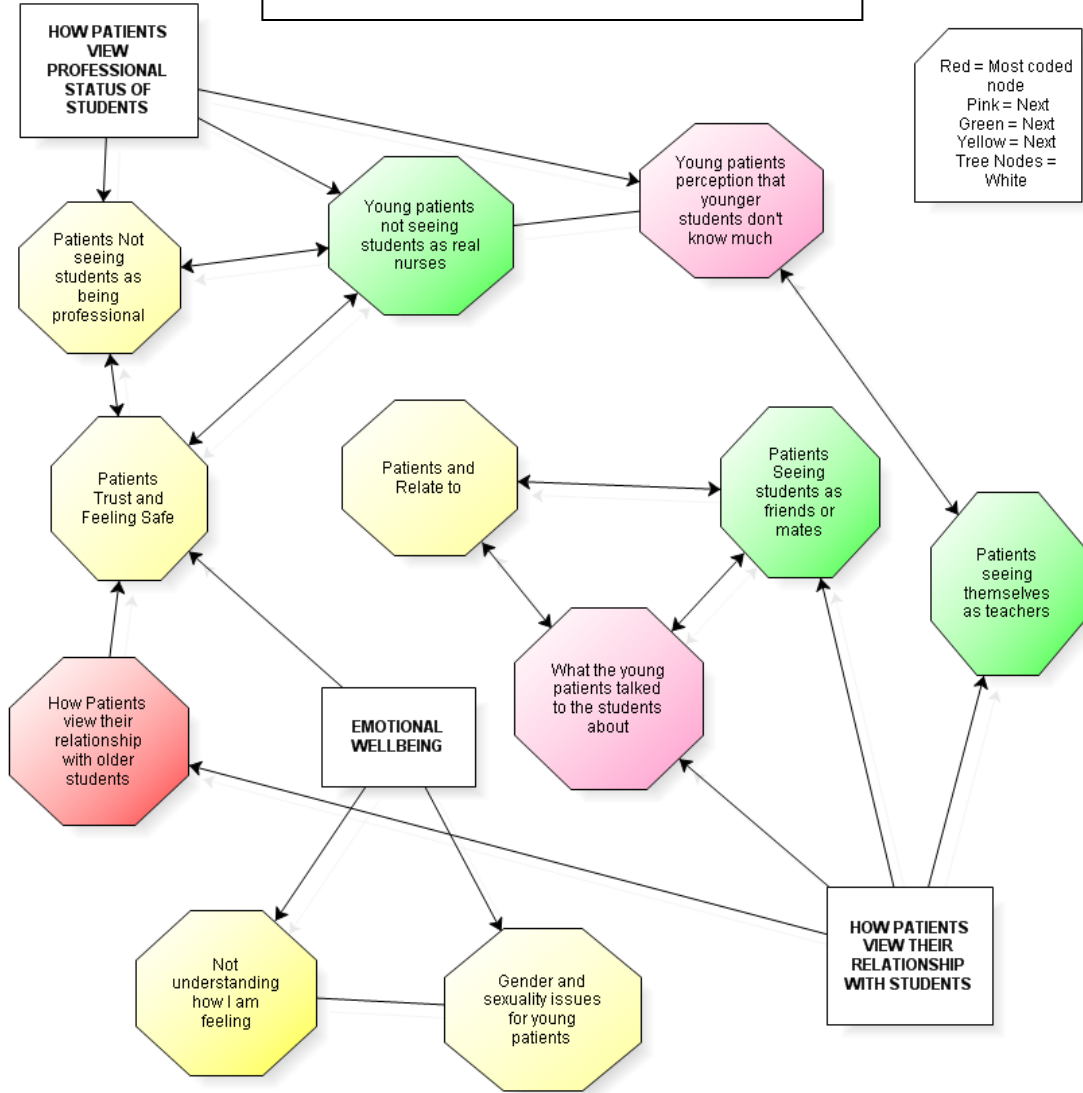




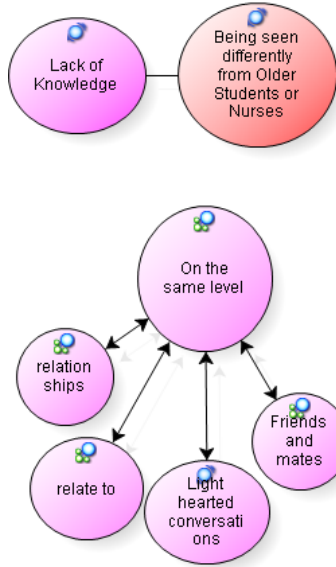
MIND MAP YOUNG PATIENTS DATA 19.2.2010

MIND MAP YOUNG PATIENTS

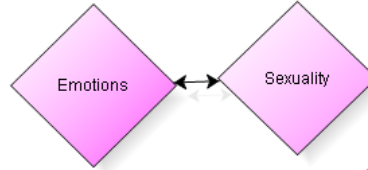
26.2.2010



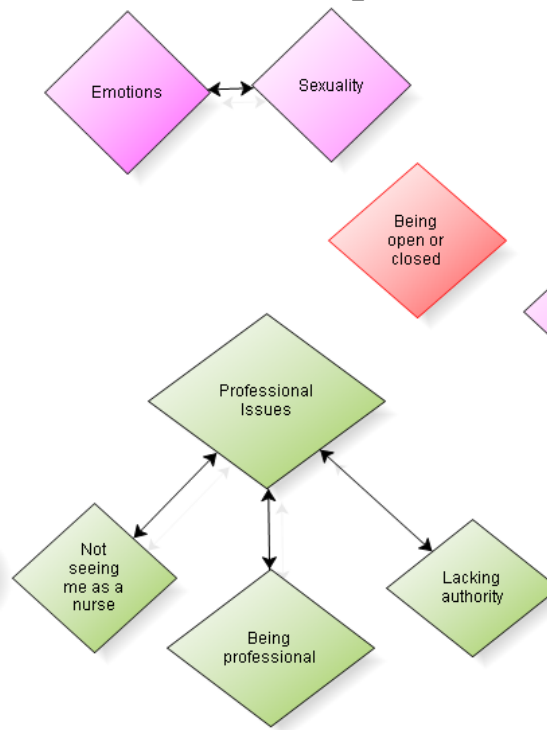
Students



Mind



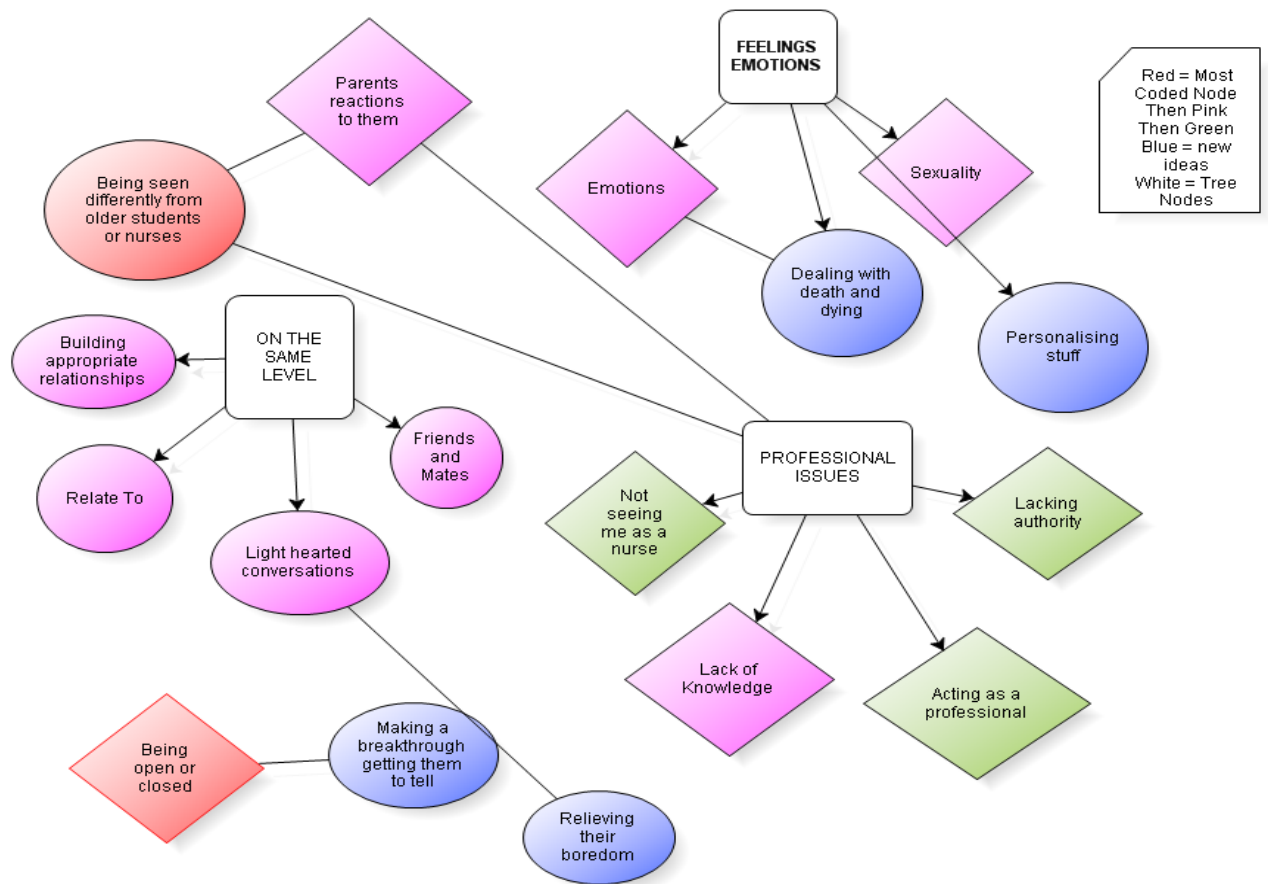
Map

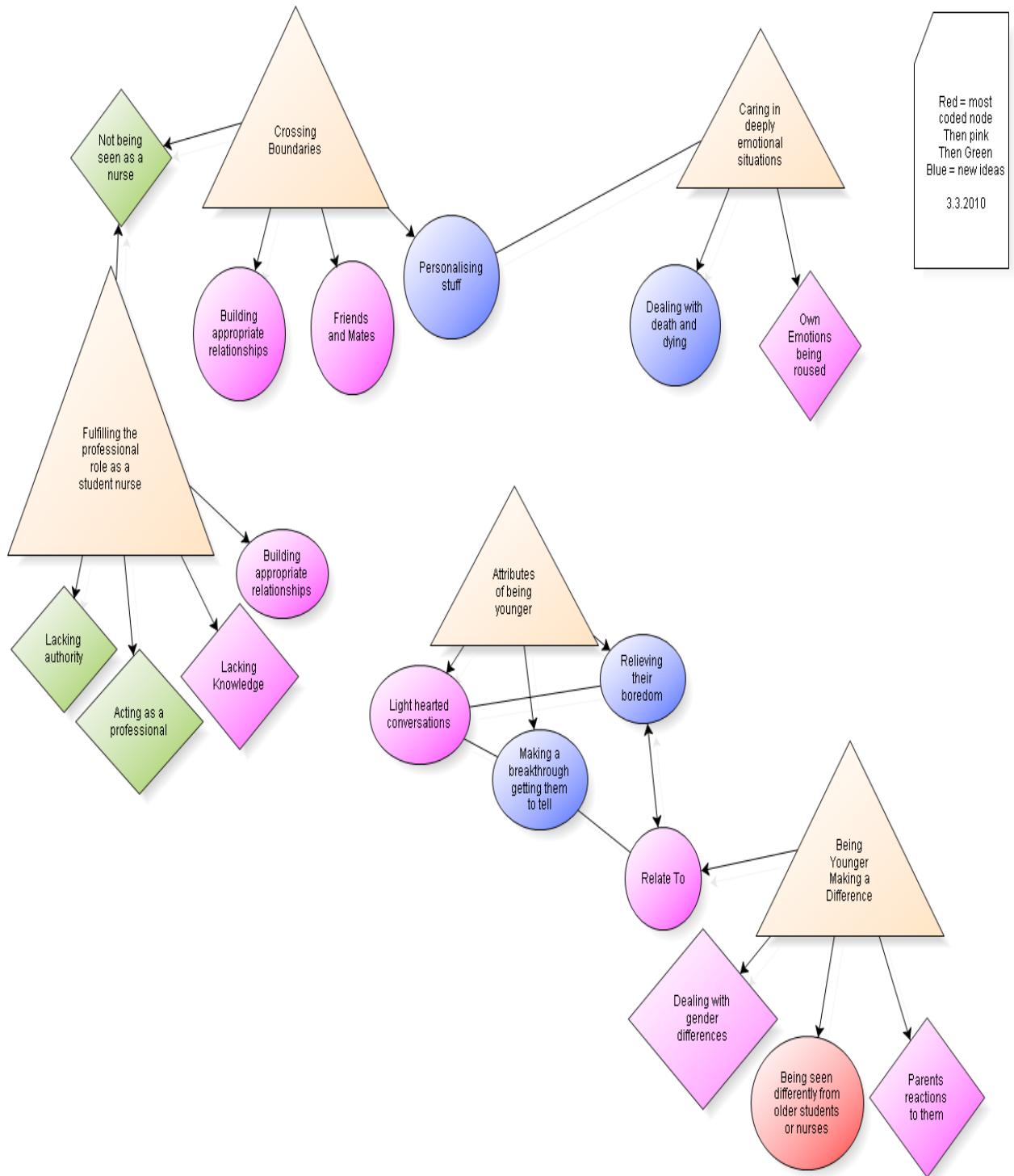


22.2.2010

Red = Most Coded Node
Then Pink
Then Green

STUDENTS' MIND MAP 26.2.2010





STUDENTS DATA MIND MAP 7TH MARCH 2010

YOUNG STUDENTS FINAL MIND MAP 22ND APRIL 2010

<p>THEME ONE MESSY BOUNDARIES Issues</p> <p>Building appropriate relationships</p> <p>Being seen as a friend or mate</p> <p>Not being seen as a professional nurse</p> <p>Benefits</p> <p>Being on the same level as the patients making it easier to talk to them</p> <p>Being able to make a break through getting them to tell</p>	<p>THEME TWO EMOTIONAL SECURITY Issues</p> <p>Death and Dying</p> <p>Difficult Situations</p> <p>Personalising Stuff</p> <p>Benefits</p> <p>Relieving the boredom o the patients/ allowing them to be normal and forget about their illness</p>	<p>THEME THREE YOUNG AGE MAKING A DIFFERENCE Issues</p> <p>Treating older students differently</p> <p>Patients and parents reactions to them</p> <p>Lack of Knowledge and experience</p> <p>Benefits</p> <p>More in common and can relate to young patients</p> <p>Easier communication, understanding language and not being seen as judgemental</p>
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YOUNG PATIENTS FINAL MIND MAP 22ND APRIL 2010

<p>THEME ONE MESSY BOUNDARIES Issues</p> <p>Not seeing younger students as professionals or nurses</p> <p>Expectations of them being teachers</p> <p>Benefits</p> <p>Younger students as friends and mates and being able to talk to them on the same level</p>	<p>THEME TWO EMOTIONAL SECURITY Issues</p> <p>Feeling safe and trusting the students</p> <p>Younger students not understanding how they might be feeling</p> <p>Benefits</p> <p>Relieving boredom, enjoying their company Letting them forget about their illness for a while</p>	<p>THEME THREE BEING YOUNGER MAKING A DIFFERENCE Issues</p> <p>Younger students not knowing very much</p> <p>Benefits</p> <p>Seeing older students differently</p>
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APPENDIX FIVE – SYNOPSIS OF GRAND THEORISTS

William James (1842-1910)

William James was an original thinker in and between the disciplines of physiology, psychology and philosophy. He is probably best known for his theory on pragmatism. His theory of pragmatism and phenomenology influenced others including Edmund Hersehl, Bertrand Russell, and John Dewey and he was famous for his view that philosophical theories are reflections of a philosopher's temperament. According to pragmatism, the truth of an idea can never be proven. James proposed we instead focus on what he called the "cash value," or usefulness, of an idea. He defined psychology as "the description and explanation of states of consciousness and published his theory of consciousness well before Breuer and Freud. James described consciousness as being simultaneously continuous and discrete. There is no individual consciousness independent of an owner. Every thought is part of a personal consciousness. Consciousness always exists in relation to some person. The same exact thought can never occur twice. Thought is continuous, within each personal consciousness. Each thought emerges from a stream of consciousness, taking part of its force, content, focus and direction from preceding thoughts. Consciousness is selective. Attention and habit are major variables in what an individual chooses and what determines the choice.

In relation to the "self" and being conscious of your own "self", James recognised that each time one awakens is the self. It has several layers: the biological, the material, the social and the spiritual as quoted by James:

"In its widest possible sense, however, a man's Self is the sum total of all that he CAN call his, not only his body and his psychic powers, but his clothes and his house, his wife and children, his ancestors and friends, his reputation and works, his lands and horses, and yacht and bank-account."

Rejecting the notion that the mind is passive and that experience simply rains upon it, James felt that before something can be experienced, it must be attended to. Experience is utter chaos without selective interest, or attention.

James-Lange Theory of Emotion

The James-Lange theory of emotion proposes that an event triggers a physiological reaction, which we then interpret. According to this theory, emotions are caused by our interpretations of these physiological reactions. Both James and the Danish physiologist Carl Lange independently proposed the theory.

George Herbert Mead (1863-1931)

George Herbert Mead was an American philosopher and social theorist. He is considered by many to be the father of the school of Symbolic Interactionism in sociology and social psychology and contributed the original theory of development of the self through communication.

Symbolic interaction theory describes the family as a unit of interacting personalities and focuses attention on the way that people interact through symbols; words, gestures, rules, and roles. The symbolic interaction perspective is based on how humans develop a complex set of symbols to give meaning to the world.

Meaning evolves from our interactions in the environment and with people and these interactions are subjectively interpreted through existing symbols. Human beings act toward things on the basis of the meaning they have but things do not have an inherent or unvarying meaning; rather their meanings differ depending on how we define and respond to them. We are not born knowing the meanings of things and we do not learn these meanings simply through individual experiences but through our interactions with others.

Understanding these symbols is important in understanding human behaviour. Interactions with larger societal processes influence the individual, and vice-versa. It is through interaction that humans develop a concept of larger social structures and also of self concept. According to Mead, self does not exist at birth but is developed through interactions with others.

Predominantly symbolic interactionism is the way we learn to interpret and give meaning to the world through our interactions with others.

Charles Horton Cooley (1864-1929).

Cooley's describes the concept of a "looking-glass self" in that one's perception of self is dependent on the thoughts of others. He suggests that one formulates an idea of one's self based upon information gathered from the reactions and the interactions with others. Cooley proposes that whatever one considers to be their "self" one has to commit to perceiving this to be their true self. Cooley suggests that individuals look to others to create the understanding of self, stating that one's definition of self includes "definite imagination of how one's self appears in a particular mind – particularly in the minds of others. This can be explained as how a person appears to other people and how we imagine others judge our appearance.

So, essentially, we as people imagine someone else's perception of us, and subsequently we are affected by the conclusions we have imagined; this is the creation of the self via a "looking-glass".

Cooley, further describes the construction of one's "looking-glass self" to occur in three definitive steps. Firstly "the imagination of our appearance to the other person. In other words, we, to the best of our abilities, put ourselves in the heads of others and try to evaluate our appearance from an external perspective. Secondly, we imagine "his judgment of that appearance. So, after we first imagine our appearance from another individual's perspective, we imagine what that individual thinks about what we imagine they have concluded. Based upon what we think of the judgments of the external individual, we experience the third step: "some sort of feeling such as pride or mortification.

Jean Piaget (1896-1980)

Piaget's Stage Theory of Cognitive Development

Swiss biologist and psychologist Jean Piaget observed his children (and their process of making sense of the world around them) and eventually developed a four-stage model of how the mind processes new information encountered. He famously referred to children as “lone scientists” and described how children build their knowledge around known “schemas”, and process new knowledge by equilibrium, assimilation and accommodation. Children construct an understanding of the world around them, and then experience discrepancies between what they already know and what they discover in their environment.

He proposed that learning reinforces the development of language. He posited that children progress through 4 stages and that they all do so in the same order (although they may progress at different rates). These four stages are:

Sensorimotor stage (Birth to 2 years old). The infant builds an understanding of himself or herself and reality (and how things work) through their sensory motor interactions with the environment. It is able to differentiate between itself and other objects. Learning takes place via assimilation (the organization of information and absorbing it into existing schema) and accommodation (when an object cannot be assimilated and the schemata have to be modified to include the object). It is during this stage of development that children begin to understand that objects and people are permanent in the world (object permanence: around 6-9 months).

Preoperational stage (ages 2 to 4). The child is not yet able to conceptualize abstractly and needs concrete physical situations. Objects are classified in simple ways, especially by important features. Children are referred to as egocentric during this stage of their development.

Concrete operations (ages 7 to 11). As physical experience accumulates, accommodation is increased. The child begins to think abstractly and conceptualize, creating logical structures that explain his or her physical experiences.

Formal operations (beginning at ages 11 to 15). Cognition reaches its final form. By this stage, the person no longer requires concrete objects to make rational judgements. He or she is capable of deductive and hypothetical reasoning. His or her ability for abstract thinking is very similar to an adult.