

Recovery as a troublesome concept: A
phenomenographic study of mental
health nursing students' learning
experiences

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Abstract

The notion of recovery is central to mental health nursing practice, yet little is known about the ways in which nursing students understand it. This study explores the variation in how recovery is experienced by nursing students and the troublesome nature of their learning journeys as they engage with the concept. Contemporary understanding of recovery has moved beyond the idea of 'cure' and is concerned with the person building a meaningful and satisfying life. This challenges the traditional thinking and practices of mental health professionals. There is evidence to suggest that in some areas nurses still rely on out-dated authoritative models of care; however, there is little literature exploring how the concept is understood by nursing students. As today's student nurses represent the future nursing workforce, it is important that their educational experiences support the knowledge development required to embrace this contemporary practice.

Phenomenography and the threshold concept framework provide the research design. Semi-structured interviews were carried out with 13 pre-registration students at one UK University. Following phenomenographic analysis four qualitatively distinct categories of description, or ways of understanding recovery, were identified; Recovery as Clinical Improvement, Recovery as Making Progress, Recovery as Managing to Live Well, and Recovery as Learning to Live Differently. The threshold concept framework was utilised in considering the variation in how students' progress (or otherwise) in their understanding of recovery in considering the obstacles to learning that students encounter. Four categories were identified; Troublesome Knowledge, Troublesome Learning Environments, Troublesome Practice, and Troublesome Relationships.

Understanding the dimensions of variation in student understanding and the obstacles to learning they might face provides important insights for future teaching. Findings here identify recovery as posing particular challenges for students requiring educators to consider a range of strategies to support transformational learning.

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Abbreviations

APA	American Psychological Association
FACE	Functional Analysis of Care Environments
NMC	Nursing Midwifery Council
ROP	Recovery Orientated Practice
PCI	PsyCap Intervention
PsyCap	Psychological Capital
SAMHSA	Substance Abuse and Mental Health Services Administration
SCMH	Sainsbury Centre for Mental Health
SOC	Sense of Coherence
TC	Threshold Concept
TCF	Threshold Concept Framework
WRAP	Wellness Recovery Action Planning
ZPD	Zone of Proximal Development

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Declaration and Statement of Copyright

This thesis is the result of my own work. It has not been previously submitted for any other award at this, or any other university.

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Dedication

This thesis is dedicated to my parents, Dick and Doreen Dodds, who sadly were unable to see the work completed. I hope you would have been very proud.

Chapter 1: Introduction and Background

1.1 Introduction

This study examines student nurse experiences of the concept of recovery in relation to mental health nursing. It explores the variation in how recovery is understood by students and the difficulties they encounter in learning about the nature of recovery and recovery orientated practice (ROP). The study was undertaken as educational research; however, it is concerned with pre-registration mental health nursing students specifically and as such has a particular disciplinary focus. Predominantly educational theory is drawn upon to guide the study, although nursing literature and perspectives are also used to illuminate the findings and support the discussion. This chapter provides an overview of the key features related to the study in order to provide background and context. It then concludes with an outline of the chapters to follow.

1.2 Pre-registration Nurse Education within the UK - An Overview

Nursing within the UK has not traditionally been a university taught discipline and has undergone significant changes to its curriculum. The transformation of nurse education has been rapid over the last three decades. Traditional nurse education was based on an apprenticeship model with pre-registration training delivered in nursing schools and departments all part of, or aligned to, one hospital site. The focus was on achievement of clinical skill and knowledge, evaluated through state written examinations and clinical examinations undertaken in practice. This model came under increasing criticism, with concerns centred on the failing ability of nurses to advance their professional status, the lack of underpinning knowledge and poor understanding of clinical skills (Gerrish, 2000). A major review saw the Project 2000 (United Kingdom Central Council, 1986) curriculum introduced with a shifting emphasis from training to education, with pre-registration nursing programmes moved to higher education establishments. With an emphasis on problem solving and critical

thinking, the curriculum aimed to produce knowledgeable reflective nurses who could adapt to changing healthcare environments (Farrand, McMullan, Jowett, & Humphries, 2006). Nurses were encouraged to be challenging and dynamic with the aim of advancing the knowledge base of nursing. Evaluation was concerned with how students had developed as independent thinkers and knowledgeable research based practitioners.

However, the focus on educational development with Project 2000 was heavily criticised with concerns raised by both managers of services and the students themselves regarding their lack of clinical skills at the point of registration (Evans, 2001; O'Connor et al., 2001). It appeared that as a consequence of increased focus on academic theory, students lacked practical ability and confidence to carry out clinical skills at the point of registration and levels of clinical competence were well below expectations (Carlisle, Luker, Davies, & Stilwell, 1999). In response to these concerns, an outcome based curriculum with a competency based framework was introduced. The Nursing Midwifery Council (NMC) set standards for pre-registration nurse education (NMC, 2010), which included standards for competence stating what nurses must achieve before being registered. Nurses specialise in a particular field from the outset of the programme. Some elements of the curriculum are shared across the four fields of adult, child, mental health and learning disability nursing, therefore some standards apply to all fields. However, some were made specific to each field and are set out in four sections including mental health nursing. These standards are achieved by undertaking an NMC approved three-year degree programme which includes learning taking place equally in the university and practice-placement settings. Nursing students are now assessed through evaluation of clinical performance as well as academic achievement with a 50-50 split of hours on the programme between theory and practice. In the UK the requirement set by the NMC is that students spend a minimum of 2,300 hours in practice. A further significant development has been the move towards an all degree profession bringing nursing into line with other

healthcare professions. From 2013 onwards all new entrants to registered nurse programmes are educated to degree level.

Nursing has been subject to criticism due to failings in practice (Francis, 2013). Whilst the focus has largely been on nursing practice, nurse education has also come under scrutiny with the publication of the 'Raising the Bar: Shape of Caring' review (Willis, 2015). Of particular relevance to nurse education within the report was the call for flexibility in pre-registration education with the introduction of Registered Nurse degree apprenticeships and the Associate Nurse role, regulated on a separate register by the NMC. These programmes are in the early stages of implementation in some approved institutions. Following the Shape of Caring review the NMC reviewed the standards for pre-registration nursing (NMC, 2018b). These standards are expected to be fully implemented by 2020 and set out what nurses need to know and be able to do at the point of registration. They also state what approved education institutions and practice placements must provide when delivering educational courses. The standards of proficiency have been designed to apply across all four fields of nursing to meet the holistic care needs of those who are at different stages of life, who may have a range of mental, physical, cognitive or behavioural health challenges. However, there is a requirement that more advanced skills are demonstrated with a greater depth of knowledge within the chosen field (NMC, 2018b).

Clinical learning environments are vital to nurse education programmes. Students experience a range of practice settings, usually in blocks of between 6-12 weeks, in order to apply the theory gained in university to the clinical setting. For mental health nurses these clinical placements usually include both in-patient and community settings providing services across the age range from child and adolescent to older people services. Placements can also include specialist services such as addictions, eating disorder and forensic facilities. They also generally

include some experience of adult nursing within the context of district nursing services or a general hospital placement. Assessment within practice is competency based, within each placement students are supervised by a qualified nurse mentor with whom they are required to work alongside for a minimum of 50% of their practice hours. The participants in this study were all enrolled on a programme following this structure within one university.

1.3 Recovery and Mental Health Practice- an Overview

Recovery has traditionally been understood as a return to a former state of health, being linked to a reduction in symptoms associated with illness or disease. This has been the case within mental health practice as well as within other fields of healthcare. This traditional view is commonly accepted within the general population and arguably continues to be a view held by many health care professionals today. It is based on a clinical approach to understanding mental illness as a disease of the brain requiring professional assessment, diagnosis and treatment with medical interventions, predominantly medication (Double, 2018). Such an understanding focuses on an outcome, an endpoint of elimination of symptoms, which signifies a return to health. Within the field of mental health, the traditional view has been that those diagnosed with a severe mental illness are unlikely to recover because of the chronicity of the problem.

Over recent years such a clinical understanding of recovery has been challenged. Particularly by those experiencing mental distress who expressed dissatisfaction with this perception of recovery and the approach towards treatment and care adopted by professional services. As individuals sought to redefine their circumstances and gain personal understanding, a new understanding of recovery has emerged based on the right of the individual to define their own circumstances and take control over their own lives. This approach is sometimes referred to as personal recovery as opposed to the more traditional understanding of clinical recovery.

The concept of personal recovery may be difficult to define as at its heart, is the idea of a person's own unique journey and the subjective experience of the person. It is described as a process of making sense of what has happened, living with and growing beyond the limits of mental health problems in constructing a positive personal identity (Anthony, 1993; Deegan, 1993). Hence recovery is underpinned by a set of values recognising the person's right to build a meaningful life for themselves, not one predetermined by health or social care professionals.

Such an approach has had significant implications for professionals within the field of mental health as practice has needed to respond to a changed understanding and expectations of service users. Such change has involved cultural and structural transformation, as traditional paternalistic and hierarchical services have been challenged to provide more person-centred care, with partnership working between professionals and service users, and more collaborative relationships with other professionals and agencies (Chester et al., 2016; Jacob, Munro, Taylor, & Griffiths, 2017). However, to date the evidence suggests the concept of recovery is not clearly defined or understood by professional staff and that transformation of services has been slow (Chester et al., 2016; Clearly et al., 2016; Cusack et al., 2017; Kartolova-O'Doherty, Stevenson & Higgins, 2014; Le Boutillier et al., 2015; Waldemar, Arnfred, Petersen, & Korsbek, 2016).

1.4 The Research Problem and Aims of the Study

The Chief Nursing Officer for England (Department of Health, 2006) advised that the key principles and values of the personal recovery approach should inform all areas of mental health nursing and there is now a raft of government policy to support the adoption of these principles in mental health practice (e.g. Department of Health, 2001, 2009, 2011, 2012a). In these policies the term recovery within mental health practice is seen as synonymous with personal recovery; however, as identified above, the literature suggests that in some places

nurses have struggled to adopt new approaches or adapt to a changed understanding of recovery, still relying on out-dated authoritative models of care.

Initially the stimulus for this study was my own anecdotal evidence that reflects this position in that student nurses appeared to hold differing understandings of recovery. Whilst they voiced their support of the personal recovery agenda, they appeared to hold traditional views about practice and the nature of mental health problems that conflicted with the principles of personal recovery. It appeared that students found the concept complex and challenging, often not recognising the inconsistencies or misunderstandings they relayed in discussing practice. As today's student nurses represent the future nursing workforce it is important that they embrace contemporary practice to address the health needs of the population. It is of concern therefore that a concept central to such contemporary practice holds difficulties for nurses as a professional group. This warrants it worthy of further investigation.

There is now a wealth of literature on the concept of recovery. Although more limited, attention has turned to staff perceptions and their attitudes towards recovery and its associated practice. However, the perceptions of student nurses in particular, appears to be a neglected area within this literature. There is some limited evidence of educational approaches aimed at improving student nurse understanding, although the nature of the student learning journey and what difficulties they face has received little attention. This gap in the literature, along with my personal experience of discussions with students became the focus of this study. The study aims to explore student understanding of recovery in mental health nursing and to consider what it is that students may find challenging in relation to learning about the concept. The specific research questions therefore seek to address these issues in asking:

- What is the variation in mental health nursing students' understanding of recovery?

- What is troublesome for mental health nursing students in their learning experiences of recovery?

In addressing these questions insights can be gained into how recovery is currently understood by those soon to be registered nurses and therefore directly accountable for nursing practice, and the nature of the problems these students encounter when trying to grasp the concept. This then can potentially lead to the identification of more effective teaching and learning strategies to address these issues.

1.5 Study Design- an Overview

In addressing these questions the study has adopted a methodology of interpretive enquiry utilising theoretical frameworks provided by threshold concept theory and phenomenography. Originating in the field of education, phenomenography has emerged as a qualitative research approach with increasing evidence of its use in nursing. Phenomenography is concerned with the variation in how particular phenomena are experienced (Marton & Booth, 1997). It aims to map the qualitatively different ways the various aspects of phenomena are understood by people in the world around them (Marton, 1988). Through an iterative process of analysis it enables identification of the different understandings a group of individuals may hold about the same phenomenon, in this case recovery. Whilst these differences may be distinct, phenomenography asserts that they can be understood in a limited number of ways (Marton & Pang, 2008). These differing but related understandings are described in a set of related categories of description, which together make up the outcome space. Each of the categories of description describes the distinctively different ways of experiencing a phenomenon, whilst the outcome space demonstrates the logical relationships between them (Cousin, 2008).

Since their introduction in 2003 threshold concepts have been explored across academic disciplines as a way of examining and understanding ways of improving student learning. A

threshold concept (TC) is described as a portal, which opens up previously inaccessible ways of thinking about certain phenomena. It represents a transformed way of understanding the concept, that without this understanding the learner cannot make progress (Meyer & Land, 2006). TCs therefore are viewed as central to the mastery of the subject (Land, Meyer, & Smith, 2008). TCs are differentiated from core concepts in a subject in that they have distinct characteristics. Meyer and Land (2006) identified these characteristics as being transformative, irreversible, integrative, bounded, and troublesome; it is these characteristics that provide an analytical framework for exploration of the threshold concepts in the disciplines.

The non-negotiable characteristic of a TC is its transformative capacity (Land, 2013). The metaphor of liminality, or the liminal space, is used within the threshold concept framework (TCF) to understand the transformational process students undergo in the process of learning. Liminality within the TCF is a transformative state in the process of learning where the learner transitions from one state of knowing to another, where previous prevailing views are relinquished and a state of flux occurs prior to crossing the threshold. Students manage this liminal space in differing ways and with differing degrees of success (Meyer & Land, 2006). The notion of liminality is used within this study to give greater understanding to the position of students in their learning journeys as they experience recovery, as identified within the outcome space. The troublesome characteristic of the TCF is then used to explore the challenges students face in relation to recovery, identifying obstacles to learning.

1.6 Other Points of Information

1.6.1 Ethical approval

The programme of study for this thesis began at one university with ethical approval for the pilot study granted by this institution in December 2014. The programme of study then moved

to Durham University and ethical approval for the main study was sought and granted by this institution's School of Education Ethics Committee in December 2015.

It was not anticipated that participants would experience any discomfort; however, all participants were reassured of their right for non-participation or withdrawal at the beginning of the interview process. As the researcher I was known to the students as a mental health lecturer, therefore the risk that students would feel obliged to participate was acknowledged. This risk was addressed by careful written and oral explanation that decisions of participation/non participation would have no bearing on the students' programme of study, in particular any assessed work. There was also a risk that participants would feel under scrutiny as the focus of the study (recovery) is a central feature of mental health nursing and I have taught aspects of it on the programme. It was therefore stressed to participants that the focus was on their experiences, and that no right or wrong answers were being sought.

1.6.2 Academic writing style

Opinions and practice differ amongst researchers in relation to academic writing style. Traditionally a third person approach has been accepted as an indication of objectivity, although this is no longer universally supported (Cragin Shelton, 2015). The American Psychological Association (APA) style is commonly used within social sciences (as within this study) and here the use of the first person is encouraged to discuss the steps taken in the research process. Such a style directly positions the researcher within the report (Savin- Baden & Howell Major, 2013). However, as Savin- Baden and Howell Major also pointed out, the use of the third person may be appropriate in providing information necessary to the complete story of the research, therefore researchers may switch between the two. Such an approach is adopted within this study. First person style is adopted to describe the research process, in providing a reflexive account of the research experience and in other sections were

appropriate. Elsewhere a third person style is adopted in conveying information and discussing the research findings.

1.6.3 A note about language

All participants within the study are anonymised. In reporting the findings of the study, pseudonyms rather than numbers or codes are used in order to highlight the participant voice. Throughout the study the terms participants, students and student nurses are used. Student or student nurse is how individuals within the group often referred to themselves, particularly when discussing aspects of learning and practice. However, the use of the term participant reflects the different role adopted within the research process. The terms are therefore used inter-changeably as appropriate.

The terms used to describe people who use mental health services differ. Traditionally the term patient has been used; however, the changing context of health care provision has led to terms such as consumer or service user becoming more popular. As people define their own position in relation to services in different ways, each of these terms have received endorsement by some and criticism by others. As there is no universal agreement on preferred terminology, the terms are used interchangeably to reflect the diversity of opinion and readers are asked to respect such diversity.

1.7 An Overview of the Thesis

This thesis is presented in six chapters, with this chapter providing the relevant introductory information necessary for the background and context of the study. Chapter two explores the concept of recovery, reviewing the relevant literature using a range of information from both nursing and other disciplinary backgrounds, and also the personal narratives of those who have first-hand experience. Clinical and personal recovery is considered within a historical

context of mental health care. The characteristics of personal recovery are explored through the themes of hope, wellness, the recovery journey, the relationship with self and the relationship with others. The chapter goes on to consider recovery orientated practice (ROP) and the attitudes and perceptions of staff towards recovery. The barriers inhibiting implementation of ROP are also considered. The chapter finally considers recovery in relation to nurse education, exploring the limited literature currently available.

Chapter three frames the research and is divided into three parts; part one explores the main theoretical framework used within the study, that of the threshold concept framework (TCF); part two provides an in-depth discussion of phenomenography as the chosen research approach; part three explains the stages of the research and the analytical process undertaken. Whilst phenomenography and the TCF are discussed within separate parts, how theoretically they relate to each other is explored.

Chapter four and five present and discuss the findings of the study; firstly in relation to student understanding of recovery, with four categories of description identified that make up the outcome space; secondly in relation to the nature of student learning regarding recovery, with four different troublesome categories presented.

In the final chapter conclusions are drawn with the key findings of the research summarised. The quality of the study is considered in relation to the contribution of theory, reflexivity, the knowledge contribution of the study and its limitations. Recommendations for further research and teaching practice are made.

Chapter 2: Recovery

2.1 Introduction

The term recovery is familiar to most of the general population and has been widely used in healthcare for many years. Traditionally it has been used to indicate a return to a former state of health with a loss of the symptoms associated with illness or disease. Within the field of mental health more recently, the term has also become associated with the individualised and subjective experiences of the person as they regain control over their lives and the defining of their own circumstances. This redefined understanding, often referred to as personal recovery as opposed to the more traditional understanding of clinical recovery, is now widely accepted within UK mental health policy; however, the re-defining of a familiar term has led to confusion over meaning (Repper & Perkins, 2017). This chapter will address the different understandings of recovery and how it has come to be understood by those with lived experience of mental distress. What this redefining means to mental health professionals is also considered in relation to recovery orientated practice (ROP) and education for those working in mental health services.

There is now a large body of literature on recovery related to mental health. Although the focus of this study is on student mental health nurses, as a concept of multi- disciplinary interest the literature spans a range of professional backgrounds; this diversity is drawn upon within this chapter. It includes systematic reviews, literature reviews, original empirical research reports and theoretical papers. There also exists a raft of government policy and recommendations for practice in relation to recovery, predominantly in publications from the Department of Health, this is included where appropriate. Central to the literature on recovery are the personal narratives of those who have experienced mental distress and embarked on their own recovery journeys. Such narratives are drawn upon throughout this chapter to

consider the lived experience of recovery. The rationale for this is considered further in section 2.3 in discussing personal recovery.

The concept of personal recovery is now widely accepted in the policy and practice of several western countries notably Australia, United States and New Zealand, therefore the associated literature has an international perspective. It was first introduced into UK policy in the 1990s within documents such as 'The National Service Framework for Mental Health' (Department of Health, 1999) and the NHS Plan (Department of Health, 2000). It is endorsed by the Chief Nursing Officer for England who advised that the principles of recovery should inform all aspects of mental health nursing (Department of Health, 2006), and by the Royal College of Psychiatrists (2009) who recognised it as a key concept to contemporary psychiatric practice. Arguably the most influential report has been 'Making Recovery a Reality' (Shepherd, Boardman, & Slade, 2008) produced by the Sainsbury Centre for Mental Health (SCMH). This report not only defined recovery but set out how recovery orientated services could be developed. It identified the need for different working relationships between professional mental health staff and those using mental health services, the key skills required by professionals and how services could begin a process of transformation to respond to changing expectations of service users.

Recovery remains a concept not easily defined with ongoing debate within the literature, where different understandings have emerged. These different understandings of recovery depend upon the perspective and goals of those using it and the context in which it is used (Bellack, 2006). However, it can be broadly identified within two distinct understandings, those of clinical (or medical) recovery and personal recovery. It should be acknowledged that different classifications do exist. Bellack (2006) referred to scientific and consumer- orientated definitions of recovery within the literature, which broadly relate to clinical and personal

understandings of recovery. He emphasised that whilst scientific (or clinical) definitions relate to an outcome or endpoint that a person eventually achieves and sustains, consumer-orientated (or personal recovery) understandings are more concerned with the process of recovery that occurs over time. The classification of recovery as having scientific or consumer orientated definitions is restrictive and leads to the assumption that professionally trained staff will have a scientific understanding, whilst service users will have a consumer orientated one. However, the literature suggests a more mixed view across professional groups and service users (Katsakou et al., 2012; Mancini, 2007; Piat et al., 2009).

Watts (2012) broke down clinical and personal recovery further to identify a rehabilitation model of recovery where the person is considered to have a permanent 'mental illness' that although cannot be cured, with rehabilitation a person is enabled to return to a level of functioning they achieved prior to illness. In assuming the presence and permanency of mental illness this model can be seen to be based on pathology and within this study is incorporated into the clinical approach to recovery. In considering contemporary understandings of recovery Watts (2012) also referred to an empowerment model as one in which people are empowered to take personal control of their own lives, as well as psychological model where a person establishes a meaningful life and positive sense of self. Whilst both these approaches are of relevance to contemporary understanding of recovery, within the broader literature they are more generally incorporated as elements of personal recovery and are included as such with this chapter.

In an analysis of the literature regarding definitions and elements of recovery, Onken et al. (2007) proposed a systemic framework which regards recovery as a multi-dimensional concept, emphasising both the individual context of the person (first order change) and the role of the wider community (second order change). Considering first and second order change

allows for the interaction of individual and community to be considered, whereby change in one part of the same system, will impact on change in other parts of the system. Consideration of the individual and the context within which they exist allowed Onken et al. (2007) to move away from the clinical versus personal understandings of recovery (or outcome and process orientations), to consider the personal responsibilities of the individual alongside the role of the community to provide opportunities for growth, particular in relation to the barriers and stigma that oppress recovery. This view is consistent with a social model of understanding disability (Oliver, 2004). Within personal recovery the nature of social relationships is considered of importance and therefore social inclusion and the nature of relationships is included within this definition.

For the remainder of this thesis the term recovery and personal recovery are synonymous.

Where different understandings of recovery are discussed, for example clinical recovery, this is specifically named as such.

2.2 Clinical Recovery

A clinical understanding of recovery emanates from psychiatry as a branch of medicine.

Psychiatry in Europe was established as a medical speciality in the early 19th century, although its principles can be recognised across differing civilisations throughout history (Wright, 2010).

Psychiatric care has been influenced by religious, political, social and scientific interests, with new treatments often being heralded as scientific breakthroughs. However, such claims were often exaggerated with the negative consequences minimised (Lakeman, 2013; Watts, 2014).

Treatments have ranged from restraint and isolation, to suspending patients from the ceilings and prolonged immersion in cold baths, often in brutal regimes. As Wright (2010) observed “the treatment of mental illness through the centuries has ranged from the clearly barbaric to the insane itself” (p.435). Coinciding with the emergence of psychiatry as a branch of medicine

in the 1800s was the widespread introduction of asylums to house the mentally ill. Care within these institutions tended to reflect public attitudes on how the mentally ill should be managed at that time and was largely custodial in nature, although as societal attitudes changed this has been reflected in changing care standards and practices (Clarke & Ruthan, 2017). Medicalised approaches to care were validated by a range of government legislation (e.g. 1845 Lunacy Act) and as medicine was making significant advances, the treatment of the mentally ill largely depended on medical and surgical experimentation (Porter, 2002). Procedures such as teeth and tonsil extraction (in the belief it cured bacterial infection of the brain), lobotomy and insulin coma therapy were reported as revolutionary treatments, although all were later disproved. Although the history of psychiatry may be viewed as the implementation of new treatments becoming more humane and replacing less effective ones, it can be argued that much of what has actually been speculation and conjecture about mental disorder and its treatment, has been presented as facts (Lakeman, 2013). By the late 1950s the introduction of the phenothiazines (a new group of medications for the treatment of psychosis) was widely believed to be a new revolution of psychiatric treatment as the search for a cure for mental illness continued. This medication did improve the lives of some institutionalised patients although the debilitating side effects of long term use of such drugs was not then known. As Clarke and Ruthan (2017) also pointed out “the mythical phenothiazine revolution” (p.44) detracted from nursing education as more humanistic approaches to care on their part were played down. The pharmacological treatment of mental illness is based on the premise that medications can restore chemical imbalances in the brain making recovery possible. Pharmacological interventions continue to be the dominant treatment approaches within mental health services today (Healthcare Commission, 2007).

An orthodox clinical or medical approach to mental illness is the assessment, diagnosis and treatment of diseases of the brain (Double, 2018). A clinical model of recovery is understood

as an elimination of disease and a reduction of symptoms (Bellack, 2006). There is a focus on an end point, an outcome, where the person achieves a state of being recovered and returns to their premorbid state. Historically people with mental illness were not expected to recover as traditional views of treatment tended to focus on chronicity of the psychiatric condition. However, the 1980s saw evidence emerging that suggested people diagnosed with long term conditions such as schizophrenia could experience a range of different outcomes and that chronicity of condition was not inevitable. In an often quoted 30 year follow up study by Harding, Brooks, Ashikaga, Strauss, and Breier (1987) recovery rates of up to two thirds of people with long term conditions were found. Warner (2004) identified a range of 85 international studies which demonstrated recovery rates amongst those with a diagnosis of schizophrenia ranging from 20-45%. In analysing these studies Warner referred to 'complete recovery' and 'social recovery', the former referring to loss of symptoms and return to pre-illness functioning, the latter referring to still experiencing symptoms but maintaining a level of social functioning such as work and independent living. Whilst using the label of 'social recovery' these studies were grounded in the notion of illness with a focus on the presence or absence of symptoms as outcome measures and therefore firmly sit within a clinical approach to recovery. Whilst Warner (2004) identified recovery as possible from a diagnosable condition such as schizophrenia, much of psychiatry maintains a view of chronicity that when symptoms are no longer present the person is 'in remission' rather than 'not ill' and there is often an expectation of relapse (Slade & Longden, 2015).

Clinical definitions of recovery have evolved from the scientific research context, where the goals have been to identify "clinically meaningful and psychometrically reliable outcome measures" (Silverstein & Bellack, 2008, p.1109); however, operational definitions of clinical recovery have remained problematic and vary in their detail. Some definitions have required the absence of symptoms (e.g. Harrow, Grossman, Jobe, & Berbener, 2005; Torgalsboen &

Rund, 2002), whilst Lieberman, Kopewicz, Ventura and Gutkind (2002) took the presence of mild to moderate symptoms as measured on the Brief Psychiatric Rating Scale (BPRS) to be acceptable. These studies also adopted differing time frames for the period of 'good' functioning with a one year, five year, and two year period respectively suggested. Notably, none of the above studies' operational definitions included reference to the person's subjective experience of functioning as this was determined by the researchers using standardised rating scales. Consequently the person may be defined as clinically recovered but subjectively experiencing difficulties in functioning. As Double (2018) recognised, psychiatry as a branch of medicine values objective evidence of illness and recovery over subjective experiences.

Clinical recovery assumes professional intervention is necessary for a person to return to a state of health from a state of illness (Slade & Longden, 2015). However, evidence suggests many individuals experience what may be described as psychiatric symptoms yet do not enter psychiatric services. For example epidemiological research has indicated that approximately 4% of the western population hear voices (meeting the psychiatric criteria for auditory hallucinations, a symptom of several psychiatric disorders), yet only one third of these individuals require treatment from mental health services (Johns & van Os, 2001; Tien, 1991; van Os et al., 2001). Such individuals may not require professional services for a number of reasons including personal choice, a lack of distress from their experiences, the presence of a strong support network, or because they identify their experiences within a non-medical framework (Slade & Longden, 2015). Despite this, a clinical understanding of recovery has become closely associated with compliance to physical treatments, predominantly medication regimes (Watts, 2014).

Many service users have expressed their dissatisfaction with this clinical approach to mental distress and recovery, where their experiences are viewed as a sign of pathology. There are a number of published first-hand accounts of the disempowerment and hopelessness that treatment within such an approach can cause (e.g. Cordle, Fradgley, Carson, Holloway, & Richards, 2011; Romme, Escher, Dillon, Corstens, & Morris, 2009). Holloway (2008) has argued that psychiatry does have an established history of using a bio-psychosocial model of healthcare for over thirty years which recognises the complex interplay between biological, psychological and social factors. It is acknowledged that some medical professionals do operate in such a more inclusive way, nonetheless a dominant medical ideology has prevailed within mental health care, one which has arguably also been passively accepted by the nursing profession (Adams, 2010).

2.3 Personal Recovery

Alternative understandings to clinical recovery began to emerge as service users and some professionals sought to change what was viewed as an unresponsive and paternalistic care system (Bellack, 2006). Challenges to the notion of incurable illness and containment have existed since the beginning of modern health care provision. The idea of 'moral treatment' was established in 1796 with the opening of the York Retreat (Digby, 1985). Based on benevolence and a belief that individuals could regain social control, residents were encouraged to take part in structured activity and the beginnings of psychological approaches to treatment were established. This was in direct contrast to the often brutal practices of the time (Ramon, Healy, & Renouf, 2007; Shepherd, Boardman, & Slade, 2008). The concept of the 'therapeutic community' developed through the 1950s and '60s and was based on the idea that individuals can and should actively participate in their own and each other's care, taking shared responsibility for the day to day running of the community (Clarke, 1974). With an emphasis on group based psychological therapy these communities saw a shift away from medication

dominated treatment. Although the influence of such ventures was limited on mainstream psychiatric care, they did pave the way for the development of more caring treatment and the idea that people within care were deserving of positive regard and empathy (Clarke & Ruthan, 2017).

By the 1980s social psychiatry, with its focus on the interpersonal context of mental disorder and mental wellbeing, was gaining some prominence, particularly in the relation to explanations of voice hearing experiences. Dutch psychiatrist Marius Romme and researcher Sandra Escher identified voice hearing as more prevalent in the general population than generally believed and argued that it occurred as a reaction to personal life stress. They identified casual relationships between voice hearing and personal trauma (Romme and Escher, 1989, 1993, 2006). Rather than viewing voice hearing as a symptom of a pathological disorder, it was considered as a 'normal' human reaction with personal meaning to the person. As well as opening up further possibilities for non- physical treatments, the work of Romme and Escher was instrumental in the 'hearing voices movement' with networks set up across several countries, as those experiencing voice hearing sought ways to support each other. The first UK Hearing Voices Group was established in 1988.

The 1980s and '90s also saw the establishment of several other service user led action groups both nationally and internationally (e.g. the National Self Harm Network, the UK Advocacy Network, and the European Network for Users and Survivors of Psychiatry). Protests against the mental health system have occurred since the establishment of the asylums with a recognisable service user movement in mental health in the UK established in the 1970s (Double, 2018). The numbers of such groups have developed significantly and by 2005 numbered in excess of 500 in the UK (Campbell, 2005). Such growth has allowed for service users to "penetrate areas of the mental health system where their presence, let alone their

positive contribution, would have been inconceivable twenty years ago” (Campbell, 2005, p.74). The rise of the service user movement saw the traditional views of psychiatric illness and treatment being strongly challenged. Dissatisfaction was expressed towards provision of mental health care with a view that providers failed to offer service user choice, failed to offer optimism or hope and failed to involve those using services in their care and treatment (Shepherd et al., 2008; Bellack, 2006). From the personal narratives of those having experienced mental distress and the ‘care’ offered in mental health services, came an understanding that despite the challenges of mental health problems, people were able to live satisfying and meaningful lives (Gilburt, Slade, Bird, Oduola, & Craig, 2013; Repper & Perkins, 2009) with or without the presence of what would be diagnosed as symptoms of psychiatric illness. Non medicalised definitions of recovery emerged. Deegan (1988) referred to the lived experience of people as they overcame challenges caused by their disability, whereby a new sense of self and purpose could be achieved. However, it is Anthony (1993) who offered the most commonly quoted definition:

Recovery is a deeply personal unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. (p.15)

The meaning of recovery differs from person to person and Anthony’s description was one of the first to attempt to capture this in a way of avoiding a universal definition. Whilst capturing the personal nature of recovery, the definition does not capture its contextual nature within a social and political setting, nor does it highlight the stigma, prejudices and exclusions that hinder a person’s personal journey (Repper & Perkins, 2017). Davidson & Roe (2007) offered a more developed definition capturing the rights of the person:

The concept of recovery refers primarily to a person...reclaiming his or her right to a safe, dignified and personally meaningful and gratifying life in the community... It emphasises self- determination and such normal life pursuits as education, employment, sexuality, friendship, spirituality and voluntary membership in faith and other kinds of communities beyond the limits of both disorder and the mental health system and consistent with the person's own values, preferences and goals. (p.464)

Some authors have objected to the language of mental illness or disorder being included in any definition of recovery as this is seen to tie recovery to biomedical undertones (Coleman, 2004). From this position the need to be known as a person rather than a diagnosis, with the ability to speak for oneself instead of being devalued by others doing this on behalf of the person, is considered more important than professional discourse of diagnosis, illness and treatment (Meagher, 2004). However, Lehman (2000) has cautioned against recovery being used as a rhetoric for those adopting an anti- psychiatry stance. As Pilgrim (2008) identified, some accept the notion of mental disorder and include any related treatment as part of their personal recovery, others understand their experiences from a non-biomedical stance and oppose any defining of themselves and their situations through a biomedical lens. In this sense recovery transcends any models or theories of disability, health and illness. This point encapsulates the uniquely personal process of recovery. It is for this reason Deegan (1989) argued strongly against trying to standardise recovery suggesting that to reduce it to a systemised set of principles would be wrong. Repper and Perkins (2003) have also argued for rejection of universal definitions instead emphasising the individually subjective nature of recovery. Equally Roberts (2011) warned against considering recovery as a 'single story' being concerned that this puts it at risk of failure or constraint, instead suggesting recovery should be viewed as an "approach, orientation....philosophy, ambition and achievement, but not a model"(p.47). However, Roe, Rudnick and Gill (2007) have warned that "if recovery can be

taken to mean anything, then it comes to mean nothing at all" (p.173), the concern being that without a shared focus recovery becomes a meaningless concept with little credibility. It is then difficult to operationalise that which is not clearly defined and there is evidence to suggest inconsistency in how recovery principles are being translated in practice (Davidson, O'Connell, Tondora, Staeheli, & Evans 2005; Ramon et. al, 2007). Others have also argued that to advance the research agenda a shared understanding of recovery is required. Silverstein and Bellack (2008) and Leamy, Bird, Le Boutillier, Williams and Slade (2011) argued that there needs to be a consensus on how it is being understood, otherwise the implications of recovery orientated practice on services will remain unclear. Kartalova-O'Doherty, Stevenson and Higgins (2012) recognised that to 'fix' a single definition maybe impossible because of the underlying principle of individuality. However, they recommend research aimed at conceptualising recovery experiences to form a coherent theory that will provide guidelines and inform practitioners. Frese, Knight and Saks (2001) expressed concern that any drive towards empirical and experimental evidence based research in relation to defining and measuring recovery was the polar opposite of the recovery movements focus on the subjectivity of experience. It should be noted that the calls for conceptual clarity stem largely from those holding professional positions within services or academia, rather than being driven by those experiencing recovery or mental distress. Whilst these efforts to advance the research agenda may be to improve practice and the experience of those using services, Pilgrim (2008) has highlighted that such efforts can be viewed as professional recolonisation of recovery.

Anthony's (1993) seminal paper was amongst the first to explore recovery from a personal orientation. The assumptions made in relation to recovery were developed from first-hand accounts and from Anthony's own experiences of the recovery process, as at that time there had been no research into the concept (Anthony, 1993). These assumptions have been

developed and expanded by others with an increasing body of literature exploring and describing the concept, with some attempting to conceptualise a theory of recovery. Recovery has emerged as a complex and multi-dimensional concept and there are various terms used to describe these dimensions. Whilst some refer to recovery themes (Bonnie & Stickley, 2008; Kidd, Kenny, & McKinstry, 2015), others refer to elements (Onken et al., 2007), domains (Resnick et al., 2005), components (Andreason, Oades, & Caputi, 2003), categories (Leamy et al., 2011), or principles (Repper & Perkins, 2009). These descriptions also differ in how the themes, elements etc. are organised. For example, Leamy et al. (2011) identified three superordinate categories: characteristics of the recovery journey, the recovery processes, and descriptions of recovery stages. Whilst Andresen et al. (2003) identified four key processes of recovery: finding hope, self-identity, having meaning in life, and taking personal responsibility. This has led to what Winship (2014) identified as a multiplicity, rather than a shared understanding of what recovery means. Such meanings are considered in the now considerable array of recovery literature.

From the literature reviewed it is clear that qualitative research approaches are the dominant forms of enquiry in relation to recovery. From the 97 papers that met the criteria and quality checks within the systematic review and narrative synthesis by Leamy et al. (2011), only two were of a quantitative design. The literature included in the review consisted of book chapters, narrative literature, consultation documents and other grey literature. Similarly a review of peer reviewed published literature by Jacob, Munro, Taylor and Griffiths, (2017) included 26 publications including a delphi study, two mixed method studies and three quantitative studies. The remaining 20 studies were all adopted qualitative methodology. Bonny and Stickley (2008) conducted a review of British literature in relation to recovery, with 170 papers reviewed including a range of theoretical papers, empirical research, literature reviews and first-hand accounts. They suggested that the literature on recovery could be grouped into

three broad categories of author, service users, health care providers and policy makers, although their expectation that the findings would directly relate to agenda of these specific groups was not borne out. This division of authors may not be helpful as the delineation of the groups is problematic. Some authors may occupy the role of service users, health care providers and policy makers simultaneously therefore identifying their appropriate grouping is difficult. Bonnie and Stickley (2008) chose to exclude papers related to recovery in addictions or early intervention psychosis, choosing to concentrate on papers related to severe mental health problems only. Although no reason for this exclusion is given, it does suggest an assumption that recovery in these areas may hold a different meaning. However, the American Substance Abuse and Mental Health Services Administration (SAMHSA) (2005) held a National Consensus Conference to develop a definition and key principles of recovery. From this, 10 characteristics of recovery emerged that can be seen to match the themes and categories discussed in the wider literature suggesting consistency of understanding. Stickley and Wright (2011) chose to follow up on the Bonny and Stickley review, citing the significant increase in recovery related literature as giving rise to the need for a further review. This was a small review with only 23 papers meeting the inclusion criteria. The authors chose to exclude personal narratives and policy documents, only including theoretical papers, literature reviews and empirical research. This arguably places it in a stronger position to critically analyse the theoretical development of recovery as Bellack (2006) has expressed concern that narrative type evidence is collected more by consensus than by being empirically determined, as such it lacks power in guiding research or service provision. Whilst powerful in portraying individualised recovery journeys, their importance can be minimised within the wider research agenda and there has been increasing calls for more research on recovery (Ramon et al., 2007).

However, personal narratives from those having experienced mental distress are central to the body of literature on recovery. Deegan's (1996) powerful account of her own experience 'Recovery as a Journey of the Heart' is widely accepted as a key piece of recovery literature and many collections of personal stories now exist (e.g. Barker, Campbell, & Davidson, 1999; Carlton, 2013; Cordle et al., 2011). Such narratives demonstrate that recovery can and does happen in a unique way, with the sharing of these stories shown to inspire hope of recovery in others. Additionally many of the factors found in such individual stories when themed through analysis, have formed the basis of the international recovery movement (Roberts, 2011). The importance of such narratives is therefore recognised and valued with their contributions to understanding recovery included within this chapter.

Whilst opinions about recovery are wide ranging, core characteristics can be identified that indicate how recovery is experienced and what is important to the person to support their recovery. From the literature reviewed these characteristics have been grouped into common themes and are discussed in detail under the headings: hope, wellness, the recovery journey, relationships with self, and relationships with others. This is not an attempt to offer a framework for understanding recovery, nor do these themes stand as discreet entities as the dimensions of recovery are necessarily interwoven. Rather the themes are used here as a practical way of grouping and presenting the relevant information for this chapter.

2.3.1 Hope

Stickley and Wright (2011) recognised that hope is relevant across the wider discourse of mental health practice, although it holds particular significance to the concept of recovery, being the most widely cited characteristic in the recovery literature. In a review of 50 articles on recovery, Andresen, et al. (2003) found that it was referred to in 19 of the 28 consumer narratives, in 9 out of the 10 consumer articles and in all eight qualitative studies. Similarly for

Leamy et al. (2011) hope and optimism was identified as a characteristic of the recovery process in 79% of the studies reviewed. Hope is viewed as central to the recovery process as it provides the message that people can and do overcome obstacles or disability, therefore providing belief in a personal recovery (Onken et al., 2007; Piat et al., 2017; SAMSHA, 2005). The significance of hope is captured by Deegan (as cited in Repper & Perkins, 2009) when she states:

for those of us who have been diagnosed with mental illness and who have lived in sometimes desolate wastelands of mental health programmes, hope is not just a nice sounding euphemism, it is a matter of life and death. (p.91)

Hinds (1984) defined hope as “the degree to which a personal tomorrow exists” (p.360). It is therefore linked to a personal future with the expectation of better things. Although these ‘better things’ will vary from person to person they may include a reduction of symptoms, better surroundings, emotional support or career related aspirations. They indicate optimism for an improved life situation and provide the motivation for the person to take steps towards improving their situation (Onken et al., 2007). Its significance has led to it being described as the first step in the recovery process, that which initiates a recovery journey (Andreason et al., 2003; Leamy et al., 2011) and as the key contributory factor in maintaining this journey (Schrank, Stanghellini, & Slade, 2008; Spandler & Stickley, 2011).

The importance of hope is not limited to the individual, but extends to those within the person’s social networks and communities and can be triggered by a significant other or role model (Andresen et al., 2003). Peer support and the sharing of recovery stories demonstrating that recovery is possible are described as particularly hope inspiring (Cordle, 2011; Romme et al., 2009). Others have highlighted the role of those working in mental health services in relation to hope (e.g. Bonnie & Stickley, 2008; Onken et al., 2007; Stickley & Wright, 2011; Spandler & Stickley, 2011). Bassett and Repper (2005) highlighted the capability of mental

health workers to inspire hope in others, not only the person but their family members, friends and employers, this then they argued facilitates recovery and increases hope in others' potential. However, the negative impact of care environments that are non- conducive to hope, where chronicity and limited prospects are expected, has also been recognised (Anthony, 1993; Ramon et al., 2007; Repper & Perkins, 2009; Stickley & Wright, 2011). May (2001) refers to a 'learned hopelessness' as a result of experiencing such services. This is reiterated by Mead and Copeland (2002) who stated "too many people have internalised the messages that there is no hope, that they are simply victims to their illness, and that the only relationships they can hope for are one- way and infantilising" (p.2). Here there is a role for others in inspiring hope and as Spandler and Stickley (2008) pointed out, the role of mental health workers may be to carry hope for service users when they are not able to do this for themselves.

2.3.2 Wellness

Mental health systems have historically emphasised illness with a focus on symptoms and problems that the person experiences. Recovery represents a move away from illness orientated thinking to embracing health and wellness, with consideration of the person's strengths. This has involved a conceptual change about the nature of mental health problems, whereby individuals view themselves as more than a diagnosis or a disease, but as a whole person facing challenges. Feelings of wellness are linked to hope in that hope can counteract helplessness and pessimism, it has been described as the power that provides a person with a feeling of wellbeing (Coskun & Altun, 2018). Wellness does not suggest that all functioning has been restored and that the person has returned to a former state of health, nor does it mean all suffering is diminished, rather the idea of suffering is transformed into significant life experiences (Davidson et al., 2005; Onken et al., 2007). This approach recognises mental distress as holding meaning and value, with opportunities for personal growth and

development. Mental distress is viewed as part of shared human experiences. In this sense those with debilitating and progressive conditions such as dementia can also experience purposeful and fulfilling lives, as the focus is on optimal well-being rather than an absence of ill-health (Adams, 2010).

Such an understanding has parallels with the notion of salutogenesis. Salutogenesis, developed by medical sociologist Antonovsky, stated the importance of focusing on an individual's strengths and abilities towards health over the classical focus on ill-health, risks and disease. It is described as a way of being, a life orientation focusing on problem solving (Lindström & Eriksson, 2005). Antonovsky (1987) referred to people's understanding of their situation and ability to respond to it as having a sense of coherence (SOC). This SOC has three elements, comprehensibility, manageability and meaningfulness. Comprehensibility is the extent to which an individual perceives the stimuli derived from both the internal and external environments as making sense. It is their ability to assess and understand their situation and can be seen as the cognitive component of SOC. Manageability refers to the extent to which an individual considers resources are available to them and the utility of these resources in meeting the demands placed upon them. These resources may emanate from the person or from the wider society and maybe genetic, constitutional or psycho-social in nature. What is crucial is the person's ability to use what is available effectively to manage, change or adapt to their situation. This is viewed as the behavioural component of SOC. Meaningfulness refers to the extent to which a person finds meaning in their circumstances and how these circumstances are made sense of. It involves the degree to which problems or demands are seen as worth investing in, whether they are considered challenges to overcome rather than burdens to carry. This can be seen as the motivational component of SOC. With salutogenesis the person is viewed as an active system interacting with the environment, as with recovery the story of the person takes priority over diagnosis (Ford, 2016).

Onken et al. (2007) suggested that such a reconceptualisation in relation to recovery requires a re-authoring of the person's personal narrative which incorporates the four elements of coping, healing, wellness and thriving. Each of these are viewed as providing a staging ground for the next element, although some oscillation may occur between the elements. The use of coping skills is considered essential as a method to provide the individual with a way of re-framing life experiences and as a set of techniques to enable steps towards wellness. However, Deegan (1996) demonstrated how individuals choosing not to embark on a recovery journey also use coping skills:

Giving up was not the problem. It was a solution because it protected me from wanting anything. If I didn't want anything then it couldn't be taken away. If I didn't try, then I wouldn't have to undergo another failure. (p.95)

Deegan (1996) therefore argued that the strategy of 'giving up' must be honoured as a rational approach to protecting oneself. The development of alternative coping skills will be dependent on when the time is right for the person but are helped by opportunities for choice, accurate information that enables more personal control, peer support and self- help, and enabling the person to have a voice. Meade and Copeland (2000) also identified that any change can be difficult and some may appear resistant or apathetic towards new options or perspectives. Learned helplessness, severity of distress, personality type, accessibility of information, perceived benefits of maintaining the status quo and the quality of support are cited as examples of issues which will affect a person's motivation towards changing their circumstances. The use of coping skills leads to healing which involves a process of adjustment and forwards movement beyond the trauma of mental distress. This may involve finding an alternative way of living with mental health problems through coping strategies, but also overcoming issues related to stigma, discrimination and exclusion. Such issues can often have a significant impact on those facing mental health challenges (Repper & Perkins, 2017). Beyond healing, Onken et al. (2007) considered wellness as the active adoption of coping strategies

and engagement in the healing process that enables the person to navigate the challenges and stressors in life. It incorporates the person's willingness to take control over their own lives, echoing the ideas of salutogenesis. Finally thriving is considered a process whereby an individual comes through their traumatic life experiences, having rebuilt their lives in a way that leads them to have a more enriched quality of life than before, as Onken et al. (2007) suggested "recovery is an expression of one's ability not only to survive but to thrive in the midst of extremely difficult circumstances "(p.15).

2.3.3 The recovery journey

Recovery has been referred to as a process and as having different stages. However, much of the literature, particularly that written by people with experience of recovery refers to the journey undertaken. The overall direction of the recovery journey is forward although it has been identified as a non-linear process. Anthony (1993) and Deegan (1996) both identified that the journey involves progress and setbacks and this can be a struggle for those on that journey, as Anthony (1993) stated "recovery involves growths and setbacks, periods of rapid change and little change. While the overall trend maybe upward, the moment to moment experiences does not feel so directional" (p.19).

Relapse within a clinical recovery paradigm may be considered as a deterioration in health, with a return of illness because of a medical condition. However, within a personal recovery paradigm relapse is seen as part of the recovery journey which can be turbulent as Deegan (1988) described, "at times our course is erratic and we falter, slide back, re- group and start again" (p.15). Such periods are viewed as challenges of life with opportunities for learning and developing resilience, therefore providing opportunities for growth. Whilst clinical recovery may have expectations of progress in response to particular treatments identified, the personal recovery journey holds a very different understanding. The personal recovery journey

is uncharted and unpredictable (Sheehan, 2002) and for many is summed up by Deegan's (1996) description of a journey of the heart. Such a description suggests this journey can be understood through spirituality or personal philosophy rather than treatment pathways, in that it involves what is important to the person in terms of their experiences, values and sense of identity as opposed to what is felt important by professionals.

Kartolova- O'Doherty et al. (2012) sought the views of those having experienced mental health problems and their experiences of recovery. Using a grounded theory approach recovery was identified as 'striving to reconnect with life'. One of the three core categories related to this was 'reconnecting to time' where participants identified the journey as 'futurising and moving on'. This involved the recognition of positive change and planning new experiences. Also linked to this was a need for acceptance of past life events and making positive connections from the past with the present and future. Echoing the experiences of both Shepherd (1993) and Deegan (1996) discussed above, participants of the study also recognised 'reconnecting' as a fluctuating process with both good and bad days encountered. Personal coping strategies were identified as useful in dealing with bad days, but also the recognition that such days are to be expected as part of the ups and downs of life. These findings are similar to an Australian action research study (Kidd et al., 2015) where a global theme of recovery as a 'quest for life' was identified. The 'passage of time' was identified as one central organising theme to this quest. Here the recovery journey was viewed as a process of rebuilding, with the recognition that this was painstaking and only happened over time. The study also highlighted that this ongoing effort to rebuild was perceived as often unrecognised by others.

These studies echo the findings of an earlier systematic review and narrative analysis (Leamy et al., 2011) where all 87 studies included identified the recovery journey as having certain

characteristics. The most common characteristic, recovery as an active process was identified in 44 of the studies, with the unique and individual nature of the process identified in 29. Twenty-one studies identified the non-linear journey with the remaining 10 characteristics reflecting the multi-dimensional nature of recovery discussed within this chapter. The review also highlighted 15 studies that identified recovery as having stages. Leamy et al. (2011) mapped these descriptions onto the Transtheoretical Model of Change (Prochaska & DiClemente, 1984). This model suggested six stages of change represented in a cyclical rather than linear fashion. Firstly pre-contemplation, where there is a lack of readiness for change; contemplation, where change is considered; preparation, towards making identified change; action, where new behaviours are initiated; and maintenance where new behaviours are sustained. The final stage of the model, relapse, where old behaviours may re-emerge was not included in the mapping process. Although not discussed in any detail by the authors, this mapping exercise again demonstrates some differences in defining recovery. The models included have differing number of components to them, not all map onto each stage of the transtheoretical model, with the language used to describe the stages markedly different in places. Comparing the stages mapped onto the maintenance and growth component of the transtheoretical model it can be seen that variation occurs in language use from 'full recovery', to 'efforts towards community integration' and improving quality of life'. Whilst the full meaning of these constructs is not discussed by the authors, it would be difficult to view these as meaning the same thing. However, what is significant is the reference to change, this emerges as an essential part of action on behalf of the person.

Included in this review was the study by Andresen et al. (2003) which is widely cited in the literature as providing a model of the stages of recovery. Andresen et al. (2003) reviewed a collection of first-hand accounts and papers based on service user accounts. They identified four key processes of recovery; finding hope, self-identity, having meaning in life, and taking

personal responsibility. In a second aspect to this review, they then developed a five stage conceptual model. The authors were able to identify five studies which referred to stages in the recovery stages. Although there was no clear consensus regarding delineation, a pattern was identified and developed into a five stage model consisting of moratorium (characterised by denial and hopelessness), awareness, preparation, rebuilding and growth. These stages can be seen to be in line with the transtheoretical model used by Leamy et al. (2011) to frame the stages in their study. Within this model growth, the final stage, is viewed as the outcome of the recovery process, this then suggests the presence of constructs that can measure recovery. This idea of an end outcome is in contrast to the majority of service user led research which sees the journey as an ongoing process, a continuous journey rather than a final destination. Ford (2016) suggested studies highlighting stages of the journey have contributed to the drive towards understanding recovery, although recognises a certain lack of clarity within these. However, some consideration should be given to the purpose of such models. Leamy et al. (2011) identified their model as a resource to inform future research and clinical practice, whilst Andresen et al. (2003) suggested their model provided a basis for moving recovery research from qualitative to quantitative methodologies. Such statements appear to be more concerned with professionally focused goals rather than those of service users and may be of concern to those who fear the recolonising of recovery by those holding professional status.

2.3.4 Relationship with self

Historically those diagnosed with mental illness were often not expected to recover, it was considered a lifelong disabling condition with lifelong treatment (Department of Health, 2001; Pilgrim, 2008). Such views and the associated care environments can erode personal identity. A diagnosis is often associated with loss which can be experienced as a bereavement. Such losses include sense of self, meaning and purpose, a sense of control and hope (Deegan, 1988;

Repper & Perkins, 2012). Theologian and hospital chaplain Hauerwas (as cited in Roberts, 2011) noted the need to restore the human subject at the centre of care and argued:

we must deepen our case history to a narrative or tale, only then do we have a who, as well as a what, patient- a person, in relation to a disease....it is only within a life story that illness has a meaningful place. (p.44)

The role of patient is only one (potentially small) descriptor of an individual and cannot capture the wholeness of the person. Telling the personal story and having it heard, is considered fundamental to recovery in the process of building (or re- building) a positive self-image. Andersen et al.'s (2003) review of the literature identified the importance of the sense of self in 42 out of 46 articles reviewed. Often this fostering of personal identity involves a re-authoring of the personal narrative (Onken et al., 2007), with a re-defined understanding of self emerging. Drawing on their own experiences Mead and Copeland (2000) recognised how this can be a difficult step to take in the recovery journey as it involves significant change that maybe perceived as beyond the person, "people have gotten used to their identities and roles as ill, victims, fragile, dependant and even unhappy. Long ago we learned to accept our illnesses, give over control to others and to tolerate the way of life" (p.4). However, they argued that the individual must take personal control in the process of rebuilding a positive self-image, echoing the dominant characteristic of the recovery journey identified in Leamy et al.'s (2011) review of the journey as an active process. Similarly the participants in Kartolova-O'Doherty et al.'s (2012) study identified realising the need for change and making the decision to act had to come from within themselves, although as previously identified within this chapter hope for change can be inspired by others. Recognising and accepting oneself as worthy and capable of change was identified as the catalyst for the person to 'reconnect with self'. The capability to change and overcome 'stuckness' has also been identified in an Argentinian study particularly related to those receiving day hospital care (Agrest et al., 2018). In this study participants identified regaining a sense of self efficacy as important in redefining

their personal identity in a more positive way. Experiencing serious mental health problems presents profound challenges to a person's self-concept (Bonnie & Stickley, 2008). The process of overcoming these challenges has also been described as a 'reinvention of self' (Whitehead, 2003), 'developing a new sense of self' (Burnett, 2005), and a 'transformation of self', from an illness identity to an identity marked by meaning and well-being (Jacob et al., 2017). The role illness plays as a part of personal identity varies from person to person. It may be considered as part of the self, or as separate from the self and something to be lived with (Andresen et al., 2003). Where the personal recovery literature does provide consensus is with the view of self as more than simply an illness or diagnosis. For the participants of Kidd et al.'s (2015) study it was important that this personal understanding of experiences was accepted by others. Clinical diagnosis and treatment were felt to overshadow and devalue the person's own understanding. This was experienced as a barrier to recovery.

Treatment and care within mental health systems has historically fostered dependency. A paternalistic attitude inhibited any attempts at independence due to a fear of an exacerbation of symptoms (Barker, 2000; Mancini, Hardiman & Lawson, 2005; Mead & Cope 2002). However, as Anthony (1993) asserted "professionals do not hold the key to recovery; consumers do" (p.18). The concept of recovery identifies individuals as having the potential to use available internal and external resources, taking control and responsibility for recovery is a personal task the individual needs to accept for themselves. Such responsibility is considered to include making life choices, self-management of wellness, being accountable for own actions and taking informed risks (Andresen et al., 2003; Kartolova- O'Doherty et al., 2012; Mancini et al.,2005; Mead & Copeland, 2002; Piat, Seida, & Sabetti, 2017; Repper & Perkins, 2012). With the principle of self- determination, an individual directs their own steps in choosing options and designing their own life, one that is meaningful to them.

Meaningful activity is central to having a sense of purpose, optimism and hopefulness; it can enable individuals to reconstruct a valued sense of self. Such activity may include leisure pursuits, employment, education, forming new relationships and treatment options. (Stickley & Wright, 2011; Mancini et al., 2005; Agrest et al., 2018). The ability to engage in meaningful activity is considered an important aspect of recovery including the ability to take risks. Risk is considered a potential catalyst for change (Rethink, 2005). Those having experienced recovery associate risk taking with overcoming the perceptions of others that they are fragile or low functioning (Mancini et al., 2005; Mead & Copeland, 2002). Some also identify failure in such activities as important because it results in personal growth, as identified in Mancini et al.'s (2005) study of those having experienced recovery: "...taking risks and not succeeding is not the end of the world because you learn something from it... So you make a mistake but it's your mistake and you own it, and that's a great thing" (p.53).

Whilst choices associated with meaningful activity will depend upon a person's values and preferences, they will also depend on their capacity to develop and act upon these choices (Onken et al., 2007), although capacity should be assumed unless there is evidence to the contrary. Adams (2010) considered the applicability of recovery to those with dementia. Whilst recognising that cognitive impairment can impact on a person's ability to self- manage, he argued that many people are able to exercise some control, make decisions and express their views. Although this may require increasing levels of encouragement and support from others, contemporary approaches in dementia care have identified the need for increased involvement of people with dementia in care provision (Adams, 2008, 2010), hence promoting the maintenance of a sense of self and personal identity.

2.3.5 Relationships with others

Whilst the recovery journey is personal and individualised, it is not one that is taken alone.

Recovery is a social process whereby a person connects with others in supportive relationships (Kartolova- O'Doherty et al., 2012; Kidd et al., 2015; Leamy et al., 2011; Onken et al., 2007; Repper & Perkins, 2017). The importance of relationships with others is summed up by Anthony (1993) when he stated "seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to 'be there' in times of need" (p.18). Such valued helpers are often identified as family and friends. In Mancini et al.'s (2005) study such relationships were described as the 'cornerstone' to recovery, providing ongoing support and belief in the person's ability to recovery. Similar findings are reported by Piat et al. (2017) where family members are described as a source of material and emotional support, for example by taking the person on shopping trips.

The value of peer support is also highlighted throughout recovery literature. Peer support may be understood as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations" (Repper, 2013, p.1). The support of those who have 'walked a similar path' has been described as the most significant in helping to find meaning in what has happened, helping to rebuild and helping to find hope that recovery is possible (Repper & Perkins, 2012; Cordle, 2011; Agrest et al., 2018). This may be through personal relationships, or from hearing and sharing the stories of others through published work. The process of sharing personal narratives supports the process of healing as stories are developed and re- developed. Individuals connect with others through stories, seeing possibilities for their own futures through what others have achieved (Repper & Perkins, 2012; Roberts, 2011). The value of such stories may lie in the changing language, a move away from the dominance of the clinical story and its associated terminology, to a personal one made up of relationships, fears, hopes and circumstances. Such narrative

transformation allows the person to move away from being a victim of illness and associated treatment, to being a victor of experiences, encouraging the person to find paths to recovery (Coleman, 2000).

Services are increasingly employing peer support workers, individuals who have experienced mental health difficulties themselves and are trained to use their experience to support others (Repper & Perkins, 2017). Abraham and Perez (2018) provided an account of one of the authors' own recovery journey and the work they now undertake as a peer support worker:

I recognise my overall role...is to help those who are seeking recovery. I do this by walking the bridge with peers and members who are travelling from hopeless to hopeful. I want to be the role model they can follow. My goal is....to provide them with tools they need to seek recovery on their own. (p.10)

The role of peer support in mental health has been recognised in policy documents within the UK with the Department of Health (2011, 2012a) encouraging a range of peer support services to promote self-management and wellbeing. Implementing such services is not without challenges (Repper, 2013) although benefits to both those being supported and the support worker themselves have been reported. Salzer and Shear (2002) found peer support workers themselves felt more empowered in their personal recovery journeys through the work undertaken. Greater confidence, a more positive sense of identity and less stigmatisation have also been reported (Bracke, Christiaens, & Verhaeghe, 2008; Ratzlaff, McDiarmid, Marty, & Rapp, 2006). Davidson, Bellamy, Guy and Miller (2012) reviewed the literature related to peer support within mental health services. Three categories of literature were determined relating to feasibility studies into peer support roles, comparison studies of peer and non- peer staff functioning in conventional roles, and evaluation of peer support worker new functions in new roles; although little attention is given to the nature or robustness of these studies. However, overall findings do suggest such support creates more responsive and inclusive

services where issues such as housing, employment and relationships are addressed as well as treatment issues. Feelings of personal control, self-agency and reduced stigmatisation were also reported within the review. Whilst the findings suggest service user experiences are enhanced, the authors do caution that organisations must prepare adequately with appropriate selection, training and supervision being made available.

The helping relationship between individuals and professional support staff is also considered important. Whilst it is recognised that recovery is not dependent upon professional help (Anthony 1993; Mead & Copeland, 2002; Repper & Perkins, 2017) studies suggest positive relationships based on mutual respect are influential in supporting recovery (Piat et al., 2015; Agrest et al., 2018). This requires a shift away from traditional paternalistic practices associated with mental health care. Repper and Perkins (2017) identified these relationships as being between two experts, “one an expert through professional training and experience, and the other...through personal experience” (p.35). This issue is discussed further in considering ROP and partnership working in section 2.5.

Barriers to recovery have been identified, where stigma, discrimination and prejudices are often experienced by those with mental health problems (Kidd et al., 2014; Frese et al., 2009; Boardman et al., 2010). Such barriers lead to social exclusion which undermines any efforts by individuals in relation to employment, education and social engagement in their local communities (Boardman & Friedli, 2012). Drawing on their own experiences both Anthony (1993) and May (2000) stressed how overcoming such social exclusion brought about by being labelled ‘mentally ill’ can be more challenging than the actual condition. Such barriers continue to be experienced by those with mental health problems as described by Piat et al. (2017): “since Fred has been refused service at a hair salon, he cuts his own hair” (p.274). A strong theme of the recovery literature is having the opportunity to engage in mainstream

community activities, be these leisure, social or employment related. Such opportunities create a sense of being integrated into the community and are considered to be less stigmatising than communities or schemes specifically set up for those with mental health problems (Bonnie & Stickley, 2008; Essen & Cahill, 2008; Piat et al., 2017; Repper and Perkins, 2012). Appropriately challenging and meaningful activity has been identified as contributing to a positive sense of wellbeing (Boyce et al., 2008; Nithsdale, Davies & Croucher, 2008). Where such obstacles to inclusion exist opportunities for social engagement are reduced. Essen and Cahill (2018) identified that coping with the practical and social aspects of activity such as employment can be problematic for some individuals for a number of reasons including stigma, family or cultural issues, and individual adaptation to diagnosis. However, having the opportunity to contribute to communities is a right for all citizens. Citizenship is considered crucial to the recovery process where individuals have the right to control their own lives and decisions but also have a sense of belonging within communities, where reciprocal support is available (Boardman & Friedli, 2012). In this sense recovery is not just a personal responsibility but a collective one. Being socially inclusive aids the recovery journey for the person and also benefits the community.

2.4 Clinical and Personal Recovery Approaches

The concepts discussed in this chapter highlight the differing understandings of clinical and personal recovery. Whilst now central to mental health policy recovery continues to attract controversy. Rose (2014) suggested the 'vagueness' of the concept has led to general acceptance without consideration of the underlying politics. Confusion around meaning and articulation of the concept has led others to suggest its subjective and individualised nature is problematic (Repper & Perkins, 2017). However, as Deegan (1988) pointed out:

Perhaps it is because the recovery process cannot be completely described with traditional scientific, psychiatric or psychological language... [that it is considered

elusive and argues that] those of us who have been disabled know that recovery is real because we have lived it. (p.12)

Whilst personal recovery offers an alternative view to that of clinical recovery, some have viewed it as a challenge with concern expressed that contemporary understandings of recovery have led to an attack on the discipline of psychiatry with criticisms of its reductionist and biological approach (Craddock et al., 2008). A detachment from the recovery approach has been recognised within the medical profession with some suggesting it offers false hope to those with chronic conditions (Mountain & Shah, 2008). Oyeboode (2004) viewed talk of recovery for people with chronic long term conditions as an unacceptable distortion of language, whilst Craddock et al. (2008) went so far as to suggest to avoid medicalisation may even be life- threatening as the impact of chronic conditions on patients are underplayed. However, such arguments may be viewed as defensive attempts to maintain the position of a dominant discourse that provides a position of authority to some over others, with many mental health professionals recognising the need for a change of thinking and practice within mental health services. Although both psychiatrists, Mountain and Shah (2008) recognised that those with lived experience identify that the recovery approach works and therefore warrants recognition. They suggested the medical model should embrace some necessary change in order for the two approaches to complement, rather than compete with each other. This is a view shared by the Royal College of Psychiatrists (2009) who clearly identified both clinical and personal recovery as key concepts for contemporary psychiatric practice. Therefore these principles of recovery should be incorporated into recovery orientated practice.

2.5 Recovery Orientated Practice (ROP)

Recovery principles have been largely articulated by individuals describing their lived experiences of mental distress and their endeavours to build meaningful lives in the face of adversity. Whilst the recovery journey may be an individual one, the significance of meaningful

relationships in supporting this journey has been highlighted within the recovery literature. For relationships between the person and mental health professionals to be meaningful to the recovery journey, a change to traditional ways of working is required, along with a change in organisational culture and structure (Royal College of Psychiatrists, 2009). In the UK a series of events organised by the Sainsbury Centre for Mental Health (SCMH) reviewed the available literature pertaining to practice and key organisational challenges for transformation of services were identified (SCMH, 2010). These involved redefining service user involvement so that services could be user led with co-produced education and training programmes; increasing opportunities for individuals to build lives beyond illness with increased personalisation and choice within services; and organisational commitment and support for staff at all levels to transform the workforce and foster recovery orientated relationships and interactions. It is within these relationships that ROP takes place.

Mental health professionals do not do recovery, nor can they make someone recover. The traditional role of 'fixer' or 'expert' needs to be reconsidered as supporter and resource in aiding the person's recovery journey (Repper & Perkins, 2012, 2017). This change is summed up by Chester et al. (2016) who stated that "recovery orientated professionals must be mirrors of hope, choice, dignity, respect, and social support, facilitators of meaningful activity and sounding boards for finding meaning and purpose in life" (p.271). Whilst this description identifies what mental health professionals need to be, identification of what they actually need to do is also required (Chester et al., 2016). Whilst there is a wealth of literature on what recovery means, the literature pertaining to ROP is more limited, although it is an area receiving more attention in professional literature. Chester et al. (2016) undertook a systematic review to identify what the work of ROP involved. Purposefully only including qualitative studies to uncover the meaning of ROP rather than measuring its effectiveness, 21 international studies were included with overarching themes being developed. In a review of

peer-reviewed published literature on recovery Jacob et al. (2017) gathered views from service users, providers and carers on what aided recovery. Twenty-six contemporary studies of both qualitative and quantitative methodologies were included and identified roles for mental health workers different to those of traditional practice. From these reviews three themes can be identified as to what mental health professionals need to embrace to practise in a recovery orientated way. These are adopting a person-centred approach, partnership working and collaborative partnerships with other professionals and agencies.

Rather than focusing on symptoms of illness ROP is underpinned by the philosophy of person-centredness where the needs of the whole person are addressed (Chester et al., 2016; Jacob et al., 2017). This requires a shift away from diagnostic labelling to valuing the individual as a person with experiences and expertise in their own lives. The wishes, hopes, fears and beliefs of the person need to be understood and this understanding becomes central to mental health practice (Thornton, Crepaz-Keay, Birch, & Verhaegh, 2017). Any diagnosis carries a degree of stigma with some singled out more than others, often because of a perceived association with violent behaviours (Crisp, 2004). However, stigma and discrimination from within mental health services is most concerning with studies identifying the judgemental and stigmatising nature of the language and actions of some mental health professionals (Linden & Kavanagh, 2012; Westwood & Barker, 2010). Moving beyond the diagnostic label with a focus on person-centred care can help alleviate such stigma as power is diffused and egalitarian relationships are established (Chester et al., 2016). A shift of focus to embrace person-centred care also allows for a range of interventions, both medical and non-medical to be considered.

Crucial to ROP is a partnership way of working between professional and the individual (Chester et al., 2016; Jacob et al., 2017). This involves mutual trust and respect, with a strengths based focus directing relationships with shared decision making in relation to treatment options, risk assessment and the development of care plans (Davidson et al., 2009;

Repper & Perkins, 2017). This 'side-by-side' relationship (Jacob et al., 2017) requires health professionals to let go of traditional hierarchical arrangements, instead developing an understanding of the person's meaning of recovery to walk alongside them on their recovery journey. Such partnerships often involve supporting individuals with their personally developed self-management plans which requires an acknowledgment of the expertise of the person in their own care, recognising and working with their strengths rather than deficits (Chester et al., 2016; Repper & Perkins, 2012). Humanistic inter-personal principles are considered central to the relationship, including compassionate listening, offering encouragement, fostering hope and discussing future plans (Chester et al., 2016). Borg and Kristiansen (2004), in exploring the nature of helping relationships in recovery, identified how from a service user perspective the importance of 'being seen' within relationships was also crucial. Examples were given of professionals asking about a relative, telling stories about their own dog and giving a small gift. Such acts were considered to have a profound positive value to the person. In describing her own experiences of such a relationship Korsbek (2016) suggested the term 'co-recovery' should be used as the engagement of both parties is required in a changing relationship where the professional learns how to adapt to the needs of the individual, with the individual supported in a hopeful and mutual way. Responsibility for recovery remains with the individual, although within such mutual relationships the professional can advise, suggest, guide and encourage those on a recovery path without imposing professional views on the nature of the recovery process (Davila & Secor, 2016). Such a coaching role can be seen to aid partnership working.

The Department of Health (2009) suggested that to assist recovery organisations should provide tools and measures that promote service user involvement in their care. The need to objectively measure recovery has also been reinforced by the Department of Health (2012b) with their 'payment by results' initiative. A range of recovery measures have been developed,

for example the Mental Health Recovery Star (Association of Mental Health Providers, 2012). Gordon (2013) warned that in an outcome driven health service their use may impact on what services are made available, but reported that such measures have not been enthusiastically adopted within services. Baker, Sanderson and Challen, (2014) argued that tools such as the recovery star are necessary for people to be involved in setting their own goals and agreeing care. However, as Henderson and Jackson (2017) pointed out, using a numerical score may be at the detriment of understanding what recovery actually means to the person. A reluctance by mental health professionals and those that use services to adopt such measures may indicate the failure of such tools to capture the personal and subjective experience of recovery. Where they are used in services, their use may reflect the needs of the organisation rather than the individual to measure and score recovery.

Collaborative Partnerships within ROP are crucial as professionals need to reconsider treatment in light of the needs of the person. Such interventions require a move away from an illness perspective in medically orientated environments to providing practical and multi-level support. This requires a cohesive and collaborative approach from health professionals working within a multi-disciplinary team context (Chester et al., 2016; Jacob et al., 2017). Traditionally collaborative working may have been viewed as being between health and social care professionals; however, with a focus on social inclusion ROP requires a broader view as a number of community agencies may be significant (for example housing departments or community support groups). ROP therefore requires a significant shift in how multi-professional or multi-agency resources are utilised. Traditionally clinical approaches to enabling a person to access social opportunities have depended upon promoting inclusion by 'fixing' the person so they fit into society. A broader social disability approach requires health care professionals to address the barriers that give rise to social exclusion, utilising and

supporting community resources (Cusack, Killoury, & Nugent, 2017; Repper & Perkins, 2012, 2017).

2.6 Staff Attitudes and Perceptions of Recovery

Staff perspectives on recovery have not been widely considered until more recently (Le Boutillier et al. 2015) and no literature was found particularly pertaining to student nurse attitudes or perceptions. Yet without an understanding of the concept of recovery mental health professionals will have difficulty in implementing ROP (Aston & Coffey, 2012). Chester et al. (2016) found “a palpable enthusiasm for ROP” (p.280) and in a literature review of ROP in in-patient settings Waldemar, Arnfred, Petersen and Korsbek (2016) report similar findings. Their review of eight international studies incorporating mostly qualitative methodologies concluded that there was clear evidence of staff attempting to incorporate recovery principles into their practice. However, despite this reported staff interest in ROP there is clear evidence of conceptual ambiguity, role uncertainty and different opinions on what constitutes ROP. Waldemar et al. (2016) found the definition of recovery to be considered vague and understood by different staff in different ways. Staff were reported to have difficulty articulating what recovery was or how this impacted on their practice. This is echoed in the findings of Le Boutillier et al. (2015) who conducted a systematic review of staff understanding of ROP across all professional groups. From an inclusion of 22 qualitative and mixed methods papers, nine reported conceptual uncertainty in relation to recovery leading to uncertainty of staff role.

In line with the two dominant ways of understanding recovery previously discussed in this chapter, contemporary reviews suggest professional mental health staff continue to hold different understandings of clinical and personal recovery (Chester et al., 2016; Le Boutillier et al., 2015; Waldemar et al., 2016). Within the Le Boutillier et al. (2015) review, clinical recovery

was identified as the strongest staff understanding mapping against 23% of participants with no differences noted between professional groups. Also identified is the idea of service led recovery (Le Boutillier et al., 2015), in which recovery is driven by the organisation. Here practice is shaped by financial targets and administrative goals, with recovery measured by service through put and discharge rates. Staff perceptions and attitudes are dependent on these particular understandings and differ accordingly. The lack of theoretical basis for personal recovery is cited as being problematic (Le Boutillier et al., 2015) with some studies reporting staff to consider stabilising illness, providing medication and psycho-education as a priority (Waldemar et al., 2016). Misconceptions of indicators of recovery as returning to 'normal' level of functioning or pre- illness state compromise ROP, along with a fear that individuals place too much hope on recovery, that risks are increased by ROP and that it does not work (Chester et al., 2016). Some studies found ROP not to be a new concept with staff suggesting recovery had become a 'buzz word' in mental health discourse, an organisational initiative and a re-invention of what already exists in practice (Le Boutillier et al., 2015). Where ROP was evident studies report staff embracing key principles of recovery. Here addressing social factors such as relationships, providing practical support and supporting hope were identified as relevant to professional practice (Le Boutillier et al., 2015). Combating stigma, working with complex issues through partnership relationships have also been identified as deemed relevant to nursing practice (Chester et al. 2016). As has collaborative planning, maintaining a positive attitude and promoting hope and self-determination (Waldemar et al., 2016).

Staff perspectives are crucial to the adoption of ROP and a lack of shared understanding of what recovery means in practice impacts on attempts at implementation (Le Boutillier et al., 2015). Few studies have considered whether ROP is actually taking place as the focus has been on staff attitudes and perspectives. However, Waldemar et al., (2016) concluded that from the

studies within their review, it is evident that although some staff report aspects of ROP such as instilling hope and working in partnership, when practice was examined a focus on problems, deficit and clinically orientated treatment packages was apparent. Stuber, Rocha, Christian and Johnson (2014) assessed the recovery orientated competency of 813 mental health professionals working with those with severe and enduring mental health problems. Their findings, based on the use of a self-assessed competency scale, identified the overall score as less than two thirds the total possible score, with the lowest competencies pertaining to areas of practice such as helping individuals identify stressors and identification of personal goals. Stuber et al.'s overall results should be viewed in the light of the nature of self-reported measurements, whilst participants may be reporting a preference for recovery orientated practice, such a scale is not a direct measure of actual clinical interventions.

This confusion on what constitutes ROP and whether it is actually operationalised is seen in Cusack et al.'s (2017) exploratory study of mental health nurses professional roles, where 45% of the sample surveyed (n= 1,017) reported that their service had not implemented ROP, or were unsure whether it had or not. This large scale study which explored nursing perceptions of ROP identified the continued emphasis on medical models of care as being a major factor inhibiting the development of the nurses' role in ROP, suggesting a status quo of traditional practice.

Health professionals hold different understandings of recovery with preferences in treatment methods which impacts on the implementation of ROP and creates tensions within mental healthcare. Some staff can be hard to engage as they have difficulties understanding the benefits of ROP, some feel dubious in how it differs from existing interventions and some fear failure on behalf of the service user. Such doubts lead to reversal to traditional methods of working (Chester et al., 2016). However, if ROP is to be effective mental health professionals

must manage the multiple tensions within service delivery and clinical care environments (Chester et al., 2016; Jacob et al., 2017). Jacob et al. (2017) referred to the need for 'rapprochement' between the medical and psycho-social perspectives on recovery; however, it is also clear that staff perceptions and attitude towards recovery should be addressed to counteract the doubts and ambivalence towards ROP. The literature to date suggests there is a disparity between the aspirations and achievement of implementation of ROP (Chester et al., 2016), with the rhetoric of recovery being applied without clear understanding of what this means in practice (Le Boutillier et al., 2015). Within some in-patient settings there appears to be a general lack of recovery ideology with some staff concluding ROP does not apply to this practice context, hence recovery appears to be more rhetorical than an integrated model of practice (Waldemar et al., 2016). There are clear concerns in relation to staff understanding of recovery and attitudes towards ROP. Where attempts to embrace recovery exist, its implementation is considered difficult with barriers to implementation evident (Chester et al., 2016; Waldemar et al., 2016).

2.7 Barriers to Implementation of ROP

The majority of the eight studies in Waldemar et al.'s (2016) review highlighted constraints to practicing ROP in relation to resources. For in-patient staff crowded wards, increased acuity, rapid turnover and insufficient beds were all issues which consumed staff time and compelled them to become problem focused, which undermined staff attempts at ROP. Jacob et al. (2016) also identified staff shortages, poor staff skill and poorly equipped facilities, particularly in in-patient units.

Organisational policy and the goals of the organisation have been identified as influencing the delivery of ROP. Where this is focused on service led recovery rather than personal recovery, ROP is limited (Le Boutillier et al., 2015). A commitment to the principles of recovery and ROP

should be embedded at all levels of organisations (Gaffey et al., 2016) and there have been calls for organisations to review their policies and guidelines to reflect this (Cusack et al., 2017). However, concerns have also been expressed regarding the potential misuse of recovery to meet service demands rather than those of the individual (Le Boutillier et al., 2015) and inappropriately shift the burden of responsibility onto service users (Aston & Coffey, 2012).

Realisation of ROP has been slow with one of the most significant barriers to change being the culture of healthcare organisations (Clearly, Lees, Escott, & Molloy, 2016). There are clear indications that the culture and structure of organisations must support recovery for ROP to become a reality (Cusack et al., 2017; Jacob et al., 2016). However, evidence to date suggests that in many areas there remains a dominance of bio-medically orientated cultures and practices (Chester et al., 2016; Cusack et al., 2017; Le Boutillier et al., 2015; Waldemar et al., 2016). Fundamental transformation is required for the necessary paradigm shift to occur (Repper & Perkins, 2012; Slade, 2009). Arguably the greatest culture change required relates to risk management practices. The Department of Health (2007b) in providing guidance on best practice in managing risk emphasised the notion of positive risk taking, an important principle of ROP whereby individuals are encouraged to take risks which enable them to progress with their recovery journeys (Holley & Pearsey, 2017). A positive risk taking approach recognises the inherent and chronic risk associated with loss of personal agency and self-determination. However, there is significant evidence to suggest organisations are reluctant to support such practice with a risk adverse culture dominating mental health services (Clifford, 2011; Gaffey & Evans, 2016). ROP cannot be realised in services that operate within such risk adverse cultures, less defensive practices must be embraced where risks are shared with the individual and mental health professionals feel able to support positive risk taking in the person's recovery journey (Henderson & Jackson, 2017).

Fundamental changes are required within mental health practice, in the behaviour and attitudes of mental professionals to realise ROP and support individual recovery journeys. Yet the literature to date suggests much of this change is still required. As discussed within this chapter there would appear to be a significant difference between the rhetoric of recovery in practice and the realities of care provision. Bonnie and Stickley (2008) suggested that ROP is unlikely to ever be embraced by statutory services with the current focus on risk; however, service providers have a duty to provide recovery orientated care (Ramon et al., 2007). The importance of recovery is now well established through personal narratives, research and central policy, although how ROP can be implemented is currently poorly defined and articulated (Machin & Watson, 2018). The next challenge for mental health services therefore is to provide the services that support the principles of recovery.

2.8 Recovery and Nurse Education

A perception amongst staff of the need for more training and education encompassing all professional groups to support a recovery orientated approach has been highlighted (Cusack et al., 2017). Linked to this is the recovery orientated competency of staff. In investigating such competency Stuber et al. (2014) identified in-depth training on recovery received within the prior year was positively associated with staff skills associated with ROP, although it is acknowledged by the authors that those staff who enrol on training may be those with the greater competency in the first place. Staff with greater experience were found to have a greater level of competence, with the idea that such staff would have difficulty adjusting to a new way of working not borne out. Gilburt et al. (2013) evaluated the effectiveness of a specifically designed five day recovery training programme for multi-disciplinary community and rehabilitation based teams. Whilst findings indicate training increased awareness of recovery principles with care plan content demonstrating greater recovery orientation, this was not followed through into subsequent action in delivering interventions. Gaffey, Evans and

Walsh (2016) assessed current knowledge of, and attitudes towards, recovery in an Irish study to compare findings to a similar previous Irish study (Cleary & Dowling, 2009) with nurses making up 77% of the sample population. Significantly more staff had received training about recovery and higher scores were noted in relation to knowledge and attitudes, although these were not significantly different to those in the previous study. These findings suggest initial positive results from staff training may not be sustained over time, with a need for ongoing training to embed knowledge and understanding.

Of particular relevance to mental health nursing in the UK is the 'Ten Essential Shared Capabilities for Mental Health Practice' (Department of Health, 2004), which provides guidance on best practice in mental health education and training across all mental health workers. This framework has a clear recovery focus in its stated competencies, being developed by a range of stakeholders including service users and carers. Whilst some professional groups, for example occupational therapists and psychologists, have identified the usefulness of the framework, there has been little critical appraisal within nursing literature. The competencies are reflected within the 'Standards of Competence for Registered Nurses' (NMC, 2010), particularly in the section of relevance to mental health nursing (Stickley et al., 2016). However, these standards are soon to be superseded by the Standards for Proficiency for Registered Nurses (NMC, 2018b) where no explicit reference to recovery is made, although the principles of person-centred care, collaboration and partnership working are referred to.

Few studies have specifically addressed recovery education for pre-registration nurses although Gaffey et al. (2016) found that the recovery principles espoused in nurse education have failed to translate into practice, with a gap between perceived ability and what is taught academically. This view is supported by Stacey et al. (2015) who argued from their personal observations that often students only understand recovery at an academic level and with only

mimicry of the principles seen in practice. Contemporary literature suggests the involvement of those with lived experience of recovery is most useful in recovery education (Lesser & Paleo 2016; Maher, Bell, Rivers-Downing, & Jenkins, 2017; McCutcheon & Gormley, 2014). Service user involvement in nurse education generally is now widely accepted as good practice although its implementation remains patchy within the UK (Happell et al., 2014). Byrne, Happell, Weich and Moxham (2013) suggested that any attempts to teach recovery without such participation could be construed as misappropriation by nurse educators, yet there is limited literature to describe its implementation or demonstrating its value within pre-registration mental health nursing programmes. Byrne et al.'s (2013) Australian study explored student perceptions of being taught by an academic with lived experience of using mental health services. Their findings are described as wholly positive with students demonstrating enhanced self-awareness and greater person-centeredness. Maher et al. (2017) described the value of a service user led teaching and learning session about recovery using written accounts of participants. Students reported feeling an increased motivation towards learning about recovery; a greater understanding of the stigma individuals with mental health problems face; developed commitment towards the service user perspective; and developed sensitive and supportive communication skills. Similar positive student experiences are reported by Lesser and Paleo (2016) who provide training in recovery orientated relationships for nursing students in the USA, with one student commenting "I was introduced to a different way of learning in which the information that would normally be taught and read was, instead, heard and seen. It was reality, it brought everything into perspective for me" (p.436). The authenticity of the experiences of service users and the experiential nature of such sessions can assist students to integrate the values and skills associated with ROP. The findings of the above studies may be transferable to the UK, although they do need to be considered in relation to the differing structure and curricula content of pre-registration nursing programmes across the USA and Australia. Here there is no specific mental health field

programme, unlike the UK, therefore the students involved may not have a specific interest in the field of mental health, or an intention to work in this speciality once qualified.

In a theoretical paper exploring recovery as a threshold concept (TC), Stacey and Stickley (2012) suggested a range of approaches to overcome the barriers to understanding recovery in pre-registration mental health nursing programmes, although these suggestions are not supported with empirical evidence. Recovery narratives are promoted as enabling students to emotionally understand the nature of mental health problems, a view supported by Stickley et al. (2016) who recognised that this approach is widely used in service user and peer support training. Problem based learning with the use of clinical scenarios is also suggested as a pedagogical approach to provide a space for students to examine complex issues, draw upon their experiences in practice, and consolidate learning by revisiting areas or applying them to different contexts. Group supervision is proposed as a forum for students to analyse practice experiences, increase self-awareness by considering how their own values may influence their responses, and gain feedback and alternative perspectives from peers and facilitators. Such approaches are argued to facilitate transformative learning.

In a UK study Stacey et al. (2015) evaluated the effectiveness of an enquiry-based learning programme which was co-facilitated by individuals with lived experience of mental health problems, utilising their experiences to 'trigger learning'. Evaluations demonstrated that students perceived transformational learning had taken place with assimilation of new understandings and values. In addition there was consideration of how these new understandings and values could be transferred to areas of practice, with recognition of the individuality of mental distress. Of concern within the study was the recognition that some students, most commonly those from the mental health field, employed distancing techniques to avoid engagement with the personal accounts given. The authors suggest this may be a

protective strategy to maintain the power imbalance within the nurse-patient relationship and reflects a view that negative stereotypes remain within mental health practice. However, it is also acknowledged that some students found the encounter emotionally challenging, disengagement may therefore be associated with the affective dimension of learning.

Although not specific to mental health nursing, two Australian papers have considered strategies to integrate other concepts, described by the authors as TCs, into nursing curricula. Although descriptive rather than evaluative, McAllister, Laster, Stone and Levett- Jones (2015) promoted the use of published narratives with guided engagement to help students examine assumptions and values related to caring experiences, which they argued can lead to transformative learning. Using examples of texts the authors described how such an approach can assist students to examine their emotional aspects of caring and challenge stigma and stereotypical thinking. A further paper (Levett- Jones, Bowen, & Morris, 2015) promoted the use of digital stories with virtual communities to achieve transformative learning about the concepts of social justice, person centred care and patients safety, which the authors considered to be TCs. Again no formal evaluations of the effect of this approach is reported, although the authors did provide anecdotal evidence from students and routine course evaluations demonstrating an overall positive response from students.

In relation to practice experience, an Australian study by Perlman et al. (2017) evaluated the experiences of 23 pre-registration nursing students of 'recovery camp', a five day innovative recreation camp involving staff, service users and students all participating in the activities. Data from individual student interviews and student reflections demonstrated increased understanding of stigma, individuality, supportive interventions and the expert experiences of service users. Whilst positive results were gained, clinical placements such as 'recovery camp' are currently scarce with the majority of UK students attending traditional community or in-

patient clinical environments. Here such innovative practice is likely to be less evident, with the barriers to implementation of ROP previously discussed likely to exist.

The literature discussed in this section suggests immersive engagement with people who have lived experience of mental distress, whether through clinical placements such as 'recovery camp', or user led teaching and learning sessions can facilitate enhanced learning. However, this literature to date remains limited and its full potential as learning tool in relation to recovery and ROP requires further evaluation.

2.9 Conclusion

This chapter has identified the differing understandings of clinical and personal recovery in relation to mental health. The traditional view of clinical recovery, based on a bio-medical understanding of illness, views recovery as a return to a former state of health. However, from the personal narratives of those who have experienced mental distress, alternative non-medicalised understandings have emerged based on the subjective experiences of the person as they overcome their difficulties and gain a positive sense of personal identity. Such understandings vary between individuals but personal recovery can be seen as a multi-dimensional concept with the principles of hope, wellness, recovery as a journey, the relationship with self, and the relationship with others having particular significance. The wealth of literature in relation to recovery includes personal narratives, theoretical papers, empirical research and policy documents. This focuses more on the personal meaning of recovery and is more limited in relation to professional staff attitudes and understandings, particularly those of student nurses.

Whilst the discourse of clinical recovery has dominated practice, healthcare policy now fully endorses the principles and associated practices of personal recovery. Mountain and Shah

(2008) have suggested that these two understandings do not need to be mutually exclusive; however, a significant shift is required in terms of working practices and workplace cultures for recovery orientated services to be realised. Service provision requires transformation to support person centred approaches, partnership working between mental health professionals and those who use services, as well as collaborative multi- agency partnerships. To date this transformation has been slow with the evidence discussed in this chapter suggesting uncertainty over definitions of recovery, poorly defined roles for staff, and barriers to ROP affecting the day to day practices of staff. The literature does suggest that mental health professionals generally hold a positive view of recovery. However, the inconsistencies between the promotion of recovery through policy documents and the espoused views of staff, and the realities of practice, highlight a significant issue of concern. Future practice, the pace of change and how ROP is embraced will be influenced by the next generation of registered nurses. Student nurses as future registrants have received little consideration in relation to their understanding of recovery and none of the literature explored in this chapter specifically identifies student nurses as participants of those studies which have explored attitudes and perceptions.

Stevens (1999, p.3) called for “conscientious, explicit and judicious use of current best evidence in making decisions about the education of professional nurses”. However, despite increased attention to nurse education over recent years there is a lack of clarity regarding how evidence is being used, with calls for greater research in nursing education (Patterson & Klein, 2012). This can be considered of particular importance where there exists gaps in the literature. This study addresses such a gap in that to date there has been little attention given to the nature of the student learning journey in relation to recovery, or how students experience recovery and the challenges that the understanding of personal recovery may pose. Nurse educators should be mindful of the practice of nursing and the practice of

education (Patterson & Klein, 2012). Exploration of these issues can provide insights into the understandings of recovery that students use to guide and underpin their practice. Such information can then better prepare educators in addressing approaches to teaching and learning a concept central to contemporary mental health nursing. This work aims to provide such insights by addressing the research questions highlighted in section 1.4. The following chapter discusses the main theoretical approach informing the study, the threshold concept framework and phenomenography as the chosen research approach.

Chapter 3: Designing the Research

Part 1: Theoretical Framework

3.1.1 Introduction

Theory is considered a key issue in educational and social science yet much of the published papers in higher education research have demonstrated limited engagement with theoretical perspectives (Tight, 2004). However, as the field matures there has been increasing recognition of the importance of theoretical perspectives and their potential positive impact on practice improvement (Tight, 2014). One difficulty with engagement may be the lack of clarity in the language used and the multiple meanings of theory as used within the literature. Whilst having the potential to cause confusion, Tight (2014) suggested the multitude of terms used, for example framework and model, are broadly comparable in meaning and that some looseness of language must be accepted. Thomas (2009) also highlighted the variability of meaning with the term theory describing different uses within the social sciences. 'Grand theory' he described as broad overarching theories relating to worldviews, Marxism is provided as an example. Scientific theory, Thomas stated, relates to formally expressed ideas that can be used to predict and explain, suggested as of limited value within social sciences. Theory can be used as a term to describe a developing body of knowledge in a particular field such as 'learning theory' or related to a particular set of ideas (ibid) such as threshold concept theory. Theory is also proposed by Thomas as a term to describe reflective practice, personal and practical theorising to further professional development. Finally he suggested that theory can refer to an explanatory model where a range of specific findings are brought together into propositions that explain the findings. Thomas also highlighted that theory can be considered a product, the aim of research endeavours to enable further explanations and predictions, or as a tool, used to help explain the object of the research.

In this study theory is used as a tool to guide the collection, analysis and interpretation of the data. It provides a framework for meaningful connections to be made to the work of others and gives explanatory power to the findings of the study. The main theory utilised is the threshold concept framework (TCF), which, along with phenomenography informed the study design.

3.1.2 Defining the Threshold Concept Framework (TCF)

The threshold concept framework (TCF) emerged from the 'Enhancing Teaching- Learning Environments in Undergraduate Courses' project involving several UK universities and was proposed as an approach to understand student variation in learning within disciplines (Meyer & Land, 2006). The TCF suggests that within any discipline there are certain conceptual gateways or portals that once traversed, lead to new ways of understanding (Meyer & Land, 2005; Meyer, Land, & Baillie, 2010; Quinlan et al., 2013). The term threshold concept (TC) was adopted by Meyer and Land (2003) as a way of describing and understanding how student learning develops and is defined as:

akin to a portal, opening up a new and previously inaccessible way of thinking about something. It represents a transformed way of understanding, or interpreting, or viewing something without which the learner cannot progress. (p.3)

Once the portal is traversed the student holds a changed conceptual understanding with an accompanying shift in subjectivity. This transformation can be sudden or protracted over time, with the learning journeys taking different courses; such journeys often present as troublesome to the student.

Meyer and Land (2003) identified five defining characteristics of a TC as transformative, irreversible, integrative, bounded and troublesome. Further work identified the discursive nature of TCs and their reconstitutive characteristics (Land, Meyer, & Smith, 2008).

TCs are transformative in that once the threshold is crossed, the learner experiences a significant shift in their perception of the subject and there is a transition from one state of knowing to another. This shift of understanding can bring with it an ontological shift in transformation of identity as the learner's new understandings become "part of what he [*sic*] knows, who he is and how he feels" (Cousin 2006a, p.135). Transformation therefore also includes an affective dimension. Walker (2013) suggested that the idea of transformation is so powerful within the TCF that it can be viewed as a superordinate category under which the other characteristics can be grouped. Indeed in later work Land, Meyer and Flanagan (2016) confirmed transformation as the non- negotiable characteristic of a TC.

A characteristic of the transformation occurring with the acquisition of a TC is that it is likely to be irreversible. Whilst further transformation may take place, it is unlikely to be in the reverse direction. This idea of irreversibility points to the difficulty discipline experts may experience in attempting to look back across thresholds. From their own transformed perspective they may struggle to understand the difficulties faced by students yet to cross the threshold, still holding an untransformed view (Meyer & Land, 2006; Walker, 2013).

TCs are integrative in the way that they help learners identify the relationships between multiple concepts within a discipline that may previously have been hidden. A TC enables the disparate aspects of learning within that discipline to come together as the learner makes connections, often with other TCs (Meyer & Land, 2006; Davies & Mangan, 2007).

TCs tend to be bounded in that they “serve as boundary markers for the conceptual spaces that constitute disciplinary terrain” (Land, Meyer, & Smith, 2008, p.x). As TCs are discipline specific, meaning is related to the thinking and reasoning associated with that particular discipline, this provides learners with an understanding different to that of a lay perspective. However, as Cousin (2008b) points out, a TC should be regarded as provisional in the sense that they are not ‘fixed truths’ about a subject. Where competing paradigms exist within a discipline, as discussed within chapter two in relation to recovery, there may be a divergence of views regarding what constitutes a TC.

Land, Meyer and Smith (2008) stated that the learning journey begins when students are faced with troublesome knowledge. Troublesomeness is of major pedagogical importance as progression cannot be achieved without overcoming it. TCs can be problematic for students in that they constitute knowledge that is challenging or difficult to come to terms with, although Land (2011) highlighted that knowledge often needs to cause difficulty to provoke students to leave their prevailing views behind and move on to seeing the concept in a new way. The characteristic of troublesome knowledge and its potential to pose significant challenges to students led Perkins (2007) to identify the TCF as a theory of difficulty as it is concerned with obstacles of content: “it foregrounds what parts or aspects of content persistently prove troublesome for learners and why” (p.33). Perkins (1999) first presented the notion of troublesome knowledge and identified the five different categories of ritual, inert, conceptually difficult, foreign and tacit. Perkins (1999) went on to suggest there may be other troublesome factors relating to the complexity of knowledge. Meyer and Land (2003, 2006) identified troublesome language as a further category.

Ritual knowledge refers to that which has a routine way of giving answers to questions. Perkins (2006) argued that it feels “like part of a social or an individual ritual: how we answer when

asked such and such, the routine that we execute to get a particular result” (p.37). Perkins (2006) suggested lists of names and dates would fall into this category; whilst Meyer and Land (2003) identified that the use of graphs in economics can also highlight this form of knowledge, where students can diagrammatically explain a model, but have little understanding of the complexity it represents.

Inert knowledge is that which “sits in the minds attic, dusted off only when specifically called for” (Perkins, 2006, p.37), there is little connection made between ideas or knowledge gained and the real world it can apply to. Perkins offered the examples of passive vocabulary where words are understood but rarely used, and mathematical techniques where there is a failure to connect them to everyday application.

Whilst Perkins (1999) suggested conceptually difficult knowledge is particularly encountered in mathematics and science, his acknowledgement that it occurs across all curricula is apposite, where misimpressions, mistaken expectations and complexity of views make grasping concepts difficult. Health and health care are topics of relevance to everyday experience, such lay knowledge gained through personal experience or media portrayals etc. may result in different understandings from those within the discipline, which may inhibit further learning. Furthermore mental health nursing is a field with differing conceptual frameworks and models of practice which may be encountered as challenging in their complexity.

Foreign or alien knowledge is that which comes from a differing perspective to our own, maybe counter-intuitive and may not even be recognised as foreign (Perkins, 1999). Shanahan and Meyer (2006) identified alien knowledge in their study of economics students where one respondent, in taking an ‘outsider’ position, spoke of what ‘economist’s would do’ rather than that which they may do or think themselves in economic terms. Cheek (2010) identified that

for geology students the notion of deep time is troublesome because of issues of scale, whereby the process involves such slow rate of movement imperceptible to the human eye that it is out with the student experience. The idea that one day the mountains we see today will one day be gone is alien and counter-intuitive.

The term tacit knowledge was conceived by Polanyi in the 1950s where he used it in consideration of the nature of scientific knowledge. Polanyi (1967) suggested that tacit knowledge was personal knowledge, implicitly known but that which could not be articulated. Tacit knowledge is part of non- formal learning and since Polanyi's original work has acquired a range of meanings (Eraut 2000). Evans and Donnelly (2006) argued that "tacit knowledge is a generally unarticulated, pre- conscious form of knowledge that forms a basis for human judgement and decision making" (p.152). In nursing literature tacit knowledge is often referred to as intuition (although other authors have separated the two) and has been explained as "patterns that are developed to the point where they are automatically brought to mind" (Evans & Donnelly, 2006, p.152). In nursing practice knowing when and how to use a particular skill can be viewed as intuitive or tacit knowledge.

Further consideration of TC characteristics led Meyer and Land (2005) to also emphasise the discursive nature of TCs in that new ways of understanding are associated with new forms of expression that often characterise the ways of thinking within the discipline, this may involve natural, formal or symbolic language. Whilst this discursive aspect might be motivating for some in generating new insights, it can also present as an epistemological obstacle which impedes further development. This discursive nature of TCs also gives rise to a reconstitution of the learner's subjectivity. The learner's identity, thinking and use of language are inter-related, with transformation of identity accompanying transformation of thinking and adoption of a disciplinary discourse.

Davies and Mangan (2007) described the defining characteristics of transformative, integrative and irreversible as interwoven, suggesting that if a concept is integrative and changes a learner's perception of their prior understanding, then it must necessarily be transformative. Similarly if a concept is integrative and holds together a learner's thinking on a range of ideas then it is more likely to be irreversible, as to abandon these ideas would disrupt the learner's whole way of thinking. The conceptual gateway is often the point that students experience difficulties as they are required to 'let go' of prior ways of knowing which may be familiar or customary and face knowledge potentially alien or counter intuitive (Perkins, 1999). This space of conceptual change is referred to as the liminal space (Meyer & Land, 2005).

3.1.3 Liminality and the Liminal Space

The non-negotiable characteristic of a TC is its transformative capacity (Land, 2013). The metaphor of liminality, or the liminal space, is used within the TCF to understand the transformational process students undergo in the process of learning. The term liminality originates from the Latin 'limen' meaning boundary or threshold. Its use within TCF is adapted from the work of van Gennep (1960) and Turner (1969) in the field of anthropology who sought to explain the transitional journey of an individual (or groups of individuals) at significant life stages (Meyer & Land, 2005). Within this work 'rites of passage' (or transitional rituals) are identified within a range of cultures which are marked by formalities, ceremonies, or symbols of the culture. Rituals are described as having three phases: a separation phase in which the individual leaves the former state; a liminal phase of transition or limbo; and an incorporation phase in which the individual is reintegrated into the society with new roles and status (Barton, 2007). Turner (1969) adopted the term liminality to explain this period and place within which the rites of passage took place. Liminality is described by Trubshaw (1995, para.9) as "a betwixt and between" where ambiguity and uncertainty exist in relation to the

social position of the individual as there is a letting go of old ways and preparation for new. As Turner (1969) suggested, “anything might, even should, happen” (p.465).

Based on the above, liminality within the TCF is a transformative state in the process of learning with transition from one state of knowing to another, where previous prevailing views are relinquished as there is a reformulation of meaning for the learner (Schwartzman, 2010). A state of flux and uncertainty occurs as the learner recognises shortcomings in their understanding of the phenomenon, relinquishes prior views and accepts emergent understandings prior to crossing the threshold (Cousin, 2006; Land, 2013). There are both conceptual and ontological shifts associated with this transformation process as learners experience transformed understanding of the phenomenon, and transformed understanding of self (Land, Rattray, & Vivian, 2014; Rattray, 2016).

Meyer and Land (2005) characterised this transformative state as often being unsettling with learners experiencing a sense of loss and uncertainty as previous assumptions are relinquished. It has been described as intimidating, scary and frightening (Felton, 2016; Syed Mohamed, Land, & Rattray, 2016). However, others have recognised the potential of the liminal space as its fluid state provides a creative space for exploration (Land et al., 2014). Regardless of the emotional experience, the transition to understanding is viewed as potentially troublesome (Meyer, Land, & Davies 2008). Students manage this liminal space in differing ways and with differing degrees of success. Transformation may be sudden or protracted over significant periods of time and may involve oscillation between states as learners are faced with conceptual and identity shifts. For a number of epistemological and ontological reasons some may become stuck in the liminal space unable to progress. Here learners may resort to forms of mimicry. This mimicry may be compensatory in that the student seeks comfort from what is known, temporarily regressing to a prior state as part of

oscillation, or it may be conscious mimicry in that the student is aware that the concept is currently beyond their grasp and uses a pretence of knowing (Meyer & Land, 2006). Meyer and Shanahan (2003) also identified functional naivety as a form of mimicry in that the student 'does enough' to get through exams through ritualised learning but never actually achieves a level of mastery. Such mimicry strikes a chord with the surface and deep approaches to learning identified by Marton and Säljö (1976) and discussed in section 3.1.4, although as Meyer and Land (2005) pointed out, mimicry involves attempts at understanding rather than just an intention to reproduce information.

Identified within the student journey towards threshold crossing are four modes of liminality which can be represented as having relational characteristics: the pre-liminal, liminal, post-liminal and subliminal. The pre-liminal mode refers to how the threshold comes into view and how it is approached or withdrawn from, depending upon the individual learner. Here the encounter with new and troublesome knowledge instigates uncertainty in relation to prior knowledge, rendering it fluid. The liminal mode refers to how the portal is made sense of by the learner, how it is negotiated and passed through or otherwise. Here integration of new knowledge occurs with prior understandings relinquished or reconfigured. An ontological and epistemic shift occurs along with this reconfiguration and is seen as the reconstitutive feature of the threshold concept. The post liminal mode refers to the state of having crossed the threshold and exited the portal into a new conceptual space with irreversible transformation of learning and learner as a consequence of the new understanding. This is the consequential feature of the threshold concept. The subliminal mode can be understood as the 'underlying game' running throughout the liminal journey and characterises how tacit knowledge and practices come to be recognised and understood by the learner (Land et al., 2008, Meyer et al., 2008).

3.1.4 Theoretical Perspectives of the TCF

The TCF is described as a set of transferable ideas that can be applied across a range of disciplines (Land et al., 2008). Theoretically the framework draws on a number of different perspectives leading Land et al. (2008) to refer to it as “a conceptual sangria” (px11), which does not fit one particular label. Broadly speaking the framework can be seen to take a social constructivist position in that learners are viewed as constructing knowledge within a social context. Social constructivism upholds that individuals mentally construct understanding through cognitive processes. However, these processes are derived from the social relationships that they are preceded by. Therefore whilst constructivism considers the individualised cognitive construction, social constructivism recognises the influence of social interaction, culture and discourse in meaning-making (Young & Collin, 2004; Aubrey & Riley, 2016).

Walker (2013) proposed that a TC can be considered as a product, developed in the mind of the learner, and a process, a transformative journey having distinct phases. The product view of TCs incorporates cognitive ideas with the TCF being aligned with conceptual change models. In exploring this Davies and Mangan (2007, 2008) made a distinction between basic concepts and TCs. Basic concepts are those in which understanding from every day experience is transformed as ideas from the discipline are combined with personal experience. Students bring non-specific knowledge with them; however, through exposure to disciplinary interpretation students can relate this knowledge to the particular disciplinary ideas. A TC differs in that more profound conceptual change occurs as students develop ways of thinking and practising within the discipline. There is integration of disciplinary ideas, sometimes other TCs or lower levels concepts, for a unified view to be developed. Transformation occurs as theoretical perspectives are acquired. Students may undergo transformation in how they are

able to use this transformed understanding to construct disciplinary narratives. In this sense TCs are central to the mastery of the subject (Land et al., 2008).

TCs have also been associated with different forms of knowledge. Perkins (2008) differentiated between possessive, performative and proactive knowledge. Possessive knowledge refers to information which is retained in working memory for use within a given situation or context, for example telephone numbers or the opening hours of a restaurant. Performative knowledge relates to what is done with the knowledge held. This goes beyond possession, in that how well something is understood, depends on whether a person can use this knowledge in performance. Proactive knowledge goes beyond understanding in that not only is knowledge possessed and applied, it is proactively deployed in connection making and further knowledge generation. TCs, Perkins (2008) argued, are associated with such proactive knowledge.

Crossing the threshold demonstrates an epistemic shift in how the discipline is understood along with “serious energetic engagement with knowledge and alertness to where it applies” (p.13). Proactive knowledge applies to what is done with the understanding within, but also outside of formal study. It is this proactive knowledge that is needed to apply theoretical perspective of nursing to its actual practice within clinical contexts.

Comparisons with the TCF can also be drawn with the distinction made between deep and surface approaches to learning in the phenomenographic tradition (Marton & Säljö, 1976). Whilst a surface approach reflects an intention to reproduce facts through memorisation, a deep approach aims for understanding through a critical consideration of the concepts. Whilst the surface approach can be aligned with possessive knowledge, the deep approach relates to proactive acquisition of knowledge. However, approaches to learning themselves do not involve a threshold, although adopting a deep approach may enable the student to view the

concept differently with understanding of the concept and its inter-relatedness to others within the discipline, thereby crossing the threshold.

The process view of TCF is related to the transformative nature of knowledge as students undertake a learning journey (Walker, 2013) and is reflected in the original Meyer and Land (2003) definition. The key characteristics of a TC are embedded within the learning journey that students make, during which they will enter a liminal space of uncertainty as new ways of knowing come into view and old ones have to be relinquished. This notion of liminality is central to the process view of TCF. Parallels can be drawn here with Säljö's conceptions of learning model (Säljö 1979, cited in Entwistle, 2008) who identified developmental progression as having distinguishable categories as the learner moves from acquiring knowledge and memorising what has been learnt, to applying the use of the knowledge. Here the learner reaches a threshold as learning becomes equated with understanding. Learners attribute personal meaning, ideas are understood related to previous knowledge and experience, with transformation of understanding and possibly personal identity taking place. This developmental model has similarities with the TCF in describing transformations of thinking as thresholds are crossed. However, these transformations are not discipline specific thresholds and students will not necessarily have conscious recognition of enhanced understanding. Within the TCF the process of learning is contents based, TCs are the direct focus of learning and therefore learning is directly experienced by the student (Entwistle, 2008).

Cousin (2008a) has recognised similarities between the notion of a liminal space in the TCF and the Zone of Proximal Development (ZPD) advocated by Vygotsky. The ZPD refers to the space between the learner's actual knowing and their potential knowing. Through scaffolded support learners can cross this zone gaining access to new spheres of knowledge. As with the liminal journey, moving through the ZPD involves the uncertainty of transitional states until mastery is

reached. This movement is not necessarily linear, involving recursive movements in a similar way to the oscillation described within the liminal space of the TCF. However, the ZPD does not directly address issues related to transformation of identity as identified within the TCF (Cousin, 2008a). The TCF draws on social learning theory and affinities can be drawn with Wenger's (1998) work on communities of practice (Land et al., 2008), which in turn draws on the notion of ZPD. Based on situational learning theory, a community of practice is formed when groups of people "who share a concern, a set of problems, or a passion about a topic deepen their knowledge and expertise in this areas by interacting on an ongoing basis" (Wenger, McDermott, & Snyder, 2002, p.4). A community of practice is more than an informal network. Wenger (1998) suggested communities of practice come together because they are about something, they continue to exist as members engage in a collective process of learning, producing shared practice. Wenger et al. (2002) identified that although communities of practice may take a variety of forms, they do all share a basic structure with the three defining characteristics of domain, community and practice. Domain creates a shared identity and common ground that the community of practice focuses on, legitimising the value and purpose to members. Community creates the social structure in which learning takes place through interactions and relationships amongst members. Practice is the shared repertoires of members including documents, experiences, information and ideas. The specific knowledge shared, developed and maintained by the community is done so through these repertoires (Wenger et al., 2002). These characteristics link understanding with identity, both individually and as a community member. Through participation in a community of practice identity is developed and members engage in authentic tasks through formal and informal learning interactions between novices and experts. Lave and Wenger (1991) referred to 'legitimate peripheral learning' in which newcomers actively participate in simple tasks, working alongside experts. As learning develops newcomers move towards full participation, reminiscent of progression through the liminal space within the TCF. However, the social and situated aspect

of learning is emphasised more strongly here as the communities of practice framework emphasises the informal nature of learning that takes place within working communities, rather than through delivery of formal curricula: “the learning that is most personally transformative turns out to be the learning that involves membership in these communities of practice” (Wenger, 2009, p.212). Although the TCF recognises a social dimension to learning, the liminal space within TCF places greater emphasis on the journey of students as individuals (Savin-Baden, 2008).

The transformational nature of the learning journey within the TCF can be likened to the transformational learning theory of Mezirow (Meyer et al., 2010). Transformative learning theory refers to the process whereby students undergo fundamental change in the way they view themselves and the world. Mezirow (2003) referred to a ‘disorientating dilemma’ as the trigger for this transformation. The students frame of reference is transformed “to make them more open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove more true or justified to guide action” (Mezirow, 2000, p.7-8). Transformative learning occurs when the student questions current understanding and discovers faulty assumptions. The student acts differently as new knowledge is generated based on their experience, reflection and analysis. This can be seen to correspond with the instigative features of a TC within the pre-liminal mode and the subsequent journey through the liminal space and threshold crossing. Mezirow (2009) emphasised social discourse as essential for transformative learning to take place and focuses on critical reflection as a further major element. However, the affective processes involved in transformation are less defined within his work (Meyer et al., 2010). For example Cranton and Carusetta (2004) highlighted that transformative learning occurs when students actively engage in the learning process in a climate of authenticity, collaboration and openness, therefore engaging on an affective level. Such recognition of the affective domain is more in keeping with the TCF in that changes in

cognitive understanding are accompanied by a change in subjectivity during the liminal phase (Meyer et al., 2010).

3.1.5 Critique of the TCF

Since its introduction the TCF has attracted considerable attention within the field of higher education, with the substantial body of published papers demonstrating its popularity. However, it has also been the subject of some critique, particularly in relation to the defining and identification of TCs, the clarity of the framework, the methodological approaches utilised by researchers in the field and the lack of empirical literature related to threshold acquisition.

O'Donnell (2010) suggested that theoretical definitions should be definitive rather than conditional and was critical of the way in which the characteristics of a TC have been explained. In defining the key characteristics Meyer and Land (2006) identified TCs as being 'probably' irreversible, 'potentially' troublesome and 'possibly often' bounded. It is this use of adverbials of probability that O'Donnell (2010) objected to and led him to write;

It is possible...for some threshold concepts to have all five characteristics, for some to have between one and four characteristics, *and for some to have none of the characteristics at all*. This renders the attributes impotent as definitional criteria.

(p.4)

The failure to specify what is essential for a TC has also led Rowbottom (2007) to suggest their existence cannot be empirically determined. In focusing on the identification of TCs, Barradell (2013) recognised a lack of consensus within the literature on which or how many of the defining characteristics are necessary to designate something a TC. Whilst for many troublesome was reported as the most important characteristic, transformation was also given significant attention. The integrative, irreversible and bounded characteristics were identified as rarely being given the same consideration as the other two. This openness to interpretation

was also identified by Carmichael (2012) who found that teachers and researchers needed to 'interrogate' the defining characteristics, developing their own interpretations of what they might mean. However, as Baillie, Bowden and Meyer (2013) pointed out, the notion of TCs was not developed according to a fixed set of criteria, as implicit within the framework is the idea that learners will experience TCs in different ways: "the whole point about the apparent (to some) looseness of the language used to describe the characteristics of threshold concepts is they will be experienced in varying degrees by students because of individual differences.." (p.240). Transformation and troublesome are the two easiest characteristics to identify and the two most likely to impact on learning, therefore the attention given to them is justified (Barradell, 2013). The nature of troublesome knowledge is also given significant attention in the seminal work by Meyer and Land (2003, 2005) and given that transformation is the non-negotiable characteristic of TC's (Land, Meyer, & Flanagan, 2016), the significant attention these characteristics have attracted is warranted. In addition, disciplinary differences in relation to ways of thinking and practices may mean that exactness of defining characteristics are not necessary, as TCs are disciplinary focused. For these reasons there is no rigid requirements within the framework concerning exactness of criteria to be applied.

This openness to interpretation has also raised the question of who defines a TC. Many disciplines, particularly those in the social sciences such as nursing, will have differing schools of thought. This is very apparent within mental health nursing with different health related models being utilised within the field. As demonstrated in chapter 2, the concept of recovery is itself contested. Cousin (2008a, 2008b) stressed the provisional stability of TCs which she argued are always epistemologically informed, socially contextualised and open to interpretation. What is then considered a TC will depend on particular schools of thought with potential differences in what is felt central to the discipline. Students are therefore also being inducted into a school of thought within the discipline, as well as the discipline itself. O'Donnell

(2010) voiced concern that little attention has been given to these hegemonic issues where power and control within a discipline can be held by the dominant schools of thought. It is likely he argued that they will define what constitutes the TCs with alternative or emerging schools of thought marginalised. Meyer and Land (2006) acknowledged the “colonising view of the curriculum” (p.16) as a non-trivial concern and one that merits further investigation. This is not an issue widely debated within the TC literature to date, yet the concerns expressed above appear justified. The promotion of one school of thought over another may not be a new concern; however, the status given to TCs as “jewels in the curriculum” providing students with crucial insights into the subject they are studying (Land, Cousin, Meyer, & Davies, 2005, p.57), gives significant merit to any concept bestowed the status of a TC. This does require educators to be aware of competing perspectives and be reflexive of their own position in the identification and representation of TCs.

Walker (2013) questioned whether the TCF can be identified as a theory explaining empirical observations or whether it is a concept bringing together several ideas, viewing the varying use of language e.g. theory, framework and concepts within the literature as problematic. Tight (2014) suggested that whilst not a grand theory, the TCF can be viewed as theoretical in that it has generated new ways of thinking which are transferable within the context of higher education. Early criticism (e.g. Rowbottom, 2007) also centred on the difficulty in differentiating TCs from core concepts. As with any emerging theoretical framework, ideas are tentative and open to critique and consideration by the wider academic community. Further work (e.g. Meyer et al., 2008; Land, 2011) has continued to refine the framework, notably with the emphasis placed on the non-negotiable characteristic of transformation, the discursive nature of TCs and the relational view of their features. This development of the theoretical stance has gone some way to address the criticism on the lack of distinctiveness of TCs (Baillie, Bowden, & Meyer 2013).

Walker's (2013) second concern is related to the lack of empirical literature on threshold acquisition. The call for robust empirical consideration is echoed by other authors with concerns expressed regarding methodological rigour of research projects to date. Barradell (2013) has called for greater clarity from researchers into what they are investigating and the rigour with which these investigations are undertaken, expressing concern that as an emerging framework, important questions still need answering. Quinlan et al. (2013) identified the methodological difficulties of researching TCs, particularly in relation to the most appropriate methods for the analysis and interpretation of findings. They suggested each characteristic if taken as a focal point, may require different kinds of research to answer the different questions raised. This then raises the possibility of multiple research questions and methods to match these characteristics: "to simply refer to TCs without making clear the features under examination can muddy the discourse around this complex construct" (p.597). They called for researchers to collectively compare and contrast approaches and to develop more robust methodological guidelines. Nicola-Richmond, Pepin, Taylor and Larkin (2018) highlighted that whilst continued critique of methods for identifying TCs is justified, the focus of studies has moved from TC identification to exploring the student experience of threshold crossing and identifying how this can be measured. However, their literature synthesis highlighted methodological problems continue with poor descriptions of sampling, data collection and analysis methods. Further limitations were reported such as small sample size in quantitative studies and compromised trustworthiness in qualitative studies, all introducing possible bias therefore limiting the interpretation and replicability of findings. Nicola-Richmond et al. (2018) also highlighted a lack of consensus on the most effective measurement strategy and recognised enabling students to articulate threshold crossing is difficult. They called for greater consideration of strategies to elicit deeper reflection by students, proposing a mixed methodological design as best placed to collect quantitative data and provide deeper insights

into student thinking. Given the disciplinary focus of TCs and the variation across disciplines, a range of methodological approaches may be most suitable as the exact nature of the research questions posed may vary. However, meaningful research requires the implementation of robust and transparent methods and calls for rigour in this area appear justified. Although this is not a weakness in the framework itself, poor quality research will hinder further theoretical development.

Concerns regarding the lack of involvement of students within the dialogue regarding TCs have also been expressed (e.g. Barradell, 2013; Felton, 2016). Students will experience TCs in different ways and will offer a different perspective on the experience of threshold crossing. This is important given the difficulties of those who have already crossed thresholds to then recall the troublesome nature of this experience. Calls for ways of involving teachers, students and other stakeholders in these discussions have been made, notably by Cousin (2008a, 2008b) who referred to 'transactional curriculum inquiry' as the process of investigating TCs through a shared dialogue between teachers, students and educationalists.

To date the evidence is that the TCF has demonstrated its usefulness as a way of considering issues in teaching and learning in the disciplines (Tight, 2014). The body of literature regarding the TCF is maturing; however, legitimacy requires a convincing and sustained evidence base. Therefore ongoing work adopting rigorous methodological principles is required.

3.1.6 TCF Application within Nursing and Related Disciplines

The TCF has had a significant impact upon research within higher education (Tight, 2014) with a substantial body of research across a diverse range of academic subjects. Much of the early work related to TCs focused on identification within the disciplines, with the field of economics particularly leading the way (e.g. Shanahan & Meyer, 2006; Reimann & Jackson, 2006).

Examples from other academic areas include biology (Taylor, 2006), geography (Fouberg, 2013) mathematics (Scheja & Pettersson, 2010), engineering (Male & Baillie, 2011) and literature (Abbott, 2013). Whilst Meyer and Land (2003) suggested that TCs may be more readily identifiable in disciplines where there is relative agreement on that disciplines body of knowledge, Boustedt et al. (2007) and Zander et al. (2008) both reported on identification of TCs in the relatively newer discipline of computer science where there has been rapidly developing and changing body of knowledge. Whilst Cousin (2006) in cultural studies and Wimshurst (2011) in the multi- disciplinary field of criminal justice both suggested that where the disciplinary knowledge is contested, specific TCs are still identifiable. Whilst the discipline specific nature of TCs is highlighted by many authors, Wimshurst's study suggested that there are generic TCs across different disciplines where the students are studying the same concepts, giving the examples of 'theoretical engagement' and 'rule of law'. Similarly research into doctoral studies has illustrated how although students may come from different subject areas, in relation to their doctoral studies there are common TCs that students experience difficulty in understanding but which must be mastered. Trafford (2008) identified 'using conceptual frameworks' as a non- discipline specific TC within the research process. Supporting this view Kiley and Wisker (2009) identified six potential generic doctoral level TCs: argument, theorising, framework, knowledge creation, analysis and interpretation, and research paradigm.

Despite the body of published literature utilising the TCF, there has been limited application to disciplines within health and social care, particularly nursing. To date there is no published literature using empirical data to explore the concept of recovery in mental health nursing utilising the TCF. Of most relevance to this study is a robust theoretical article by Stacey and Stickley (2012) who explored recovery as a threshold concept in mental health nurse education. Using relevant disciplinary literature the authors described how recovery can be

seen to meet the five defining characteristics of a TC as described by Meyer and Land (2003). Using their own observations the authors described transformational learning as having taken place when students are able to critique nursing practice which contradicts the values of ROP and through the use of reflective practice they connect on an emotional and behavioural level, demonstrating both a conceptual and ontological shift. The integrative nature of recovery is described as being realised when students articulate how recovery underpins all areas of their nursing practice. It is further argued that the bounded nature of recovery can be seen in the clash of perspectives, with understanding of personal recovery demonstrated when students accept its ambiguous and subjectively determined meaning. Again drawing on personal experiences, the authors suggested that the troublesome nature of recovery can be seen in students' difficulties in applying ROP. Whilst they may articulate the principles of recovery, it is argued that these are not implemented in a sustained way in practice. They go on to suggest a number of epistemological and ontological reasons for this and recommend educational forums which include recovery narratives, problem based learning, group supervision and debates as approaches to stimulate the necessary transformational learning.

While Stacey and Stickley (2012) focused on the experiences of student mental health nurses in relation to recovery as a TC, Marsland and Pollock (2010) described how the development of an accredited recovery programme provided an illustration of recovery as a TC. The authors described having no doubts of the irreversible transformational power of recovery as it is assimilated into individuals' personal narratives, with group members and facilitators experiencing a sense of solidarity and commitment to the recovery approach. Its integrative nature is described in the way different aspects such as person- centeredness, self-direction and positive risk- taking are united under recovery as a concept. In relation to the bounded nature of recovery, Marsland and Pollock (2010) warned against viewing recovery as disciplinary property, advocating that the concept should not be viewed as a model with fixed

understanding, but rather something more creative and open to questioning. This supports Baillie et al.'s (2013) position discussed earlier that TCs should not be viewed as having a fixed set of criteria. The specific concept of recovery in this context highlights discipline specific differences where strict application of all defining characteristics are not supported. Marsland and Pollock (2010) identify the troublesome nature of recovery as evident in the way some people struggle to accept recovery from mental health problems is possible, or that recovery does not mean a return to a former state of health. The paper also highlights how recovery involves examining issues of power and how this may be particularly difficult for some people to address. Although offering a convincing argument, both these papers relating to recovery are based on the thinking of the authors, therefore lack empirical data to support the claims made.

Martindale (2014) considered student learning in relation to research and evidence based practice in pre-registration nursing curricula and the troublesome nature of this subject. This in-depth narrative research study involved 17 participants from two UK universities. Following in-depth interviews and analysis findings illustrated how troublesomeness is related not only to knowledge, but also to the learning environments in which students are placed and intrinsic factors such as attitudes and perceptions of research. This suggests a multi-faceted aspect to professional learning where difficulties are not only linked to the concept itself, but to the cultures, practices and relationships students are exposed to as part of their learning in clinical contexts (Martindale, 2014).

The notion of troublesomeness was also a focus of Blackburn and Nestle's (2014) investigation within paediatric surgery training programmes. Following semi-structured interviews with eight trainees, thematic analysis identified five troublesome themes relating to knowledge, clinical judgement, technical skills, transition of roles and increasing responsibility, and

relationships with trainees. Although somewhat limited in terms of discussion, the authors argued such identification using the TCF provides important insights into the need for a holistic approach to curriculum development. This echoes findings from Martindale (2014) on the complex nature of troublesome aspects in professional programmes.

Smith, Blackburn and Nestel (2018) also considered the learning journeys in relation to junior cardiothoracic surgeons, with troublesomeness again being identified. In a well reported study, thematic analysis from data generated from the junior surgeons themselves, identified three TCs of uncertainty, speed of operating, and complexity of care. All TC defining characteristics were considered with troublesome, transformative and the reconstitutive nature of the concepts being most prominent. The characteristics of integrative, irreversible and bounded were reported to be less evident. Smith et al (2018) also identified one potential TC as change, although only its troublesome nature is offered as a defining characteristic. In terms of the learning journey, it was commencement of consultant practice that participants experienced as particularly challenging. However, once the liminal space had been traversed, positive professional identity and a sense of self-worth was reported, suggesting a transformed ontological state.

The troublesome nature of care in Smith et al.'s (2018) study discussed above related to the technical nature of cardiothoracic procedures, previous technical experience and confidence to carry out the procedure. A further study by Wilkinson (2018) highlighted how non- technical aspects of care were also experienced as troublesome. Wilkinson considered the troublesome nature of training for junior doctors in older people's medicine. Gathering data from a combination of interviews and questionnaires with medical educators and trainees, a number of concepts were identified as troublesome. Following a concept mapping exercise these were grouped into two themes, which the author equates to TCs; the complexity of care, related to

what is delivered; and nurturing care, related to how it is delivered. Whilst complexity of care was based on traditional medical care, nurturing care was considered to be concerned with seeing the patient as a person, providing holistic care and showing empathy. Further thematic analysis identified the tacit nature of nurturing care as being particularly troublesome, although other aspects of troublesome knowledge are not reported on. It is also unclear if other defining characteristics of a TC were considered. Wilkinson identified that the thresholds are crossed at different times in the trainees' careers, suggesting that the catalyst for transformational learning is observing someone else providing care. He therefore highlights the need for appropriate role- modelling and encouragement from senior clinicians to enable journeys through the liminal space.

Clouder (2005) also considered how student healthcare professionals experience troublesome learning with the notion of 'caring', which she put forward as a TC. This research utilised data previously gained from two different research projects. Data was drawn from interviews with 12 occupational therapy students and analysis of critical incidents posted to an online discussion forum involving 256 physiotherapy students. Focusing on the troublesome and transformational characteristics, findings suggested that as students experience caring in practice, common sense understandings are challenged by the ethical, moral and personal challenges caring presents with, hence making it troublesome. As students engage in caring discourses and achieve threshold crossing, it is argued that they undergo a transformed professional identity related to professional understanding of caring. Clouder therefore recommends a rethink on how students are prepared for practice, with attention given to the affective domain of learning. Strategies are recommended to immerse student in the realities of practice and provide opportunities for them to express uncertainties in a supportive way. Carlisle (2016) considered troublesome knowledge in relation to social work, highlighting the concepts of religion and spirituality as presenting with significant challenges. Presenting the

results of a combined narrative and grounded theory approach, Carlisle considered religion and spirituality within social work practice in Northern Ireland. The concepts were not specifically referred to as TCs, but the author focused on tacit knowledge related to the concepts as particularly troublesome. Findings suggested that whilst participants recognised the role of religion and spirituality in mental health recovery, its inclusion in social work practice was problematic, marked with ambivalence and controversy. From the narratives, the history of sectarianism within Northern Ireland was highlighted as creating contextual difficulties because of the emotion the concepts provoked, highlighting a social dimension to TCs. The author argued for legitimacy to be given to the subject, with 'safe places' for exploration of the concept enabling service users to express this aspect of their lives, should they wish to do so. The specific context of this study may limit its transferability outside of Northern Ireland; however, other areas may have specific contextual issues that also provoke troublesome knowledge. The study does highlight the troublesome nature of tacit knowledge and the impact of this on practice, demonstrating that tacit knowledge needs to be exposed to address the difficulties.

The troublesome nature of knowledge in social work was also considered by Morgan (2012) who argued that when students are faced with a social model of disability, this challenges their lay perspective of disability as personal misfortune. Learning is considered troublesome in that it requires a radical repositioning both conceptually and ontologically, where cultural processes and societal structures are deconstructed to promote more inclusive environments and practices. Whilst this argument is supported with discipline specific and educational literature, the notion of the social model of disability as a TC is not empirically supported. However, Morgan utilises the TCF to encourage social work educators to make explicit what it is students are expected to know and to identify the potential points at which they become stuck.

The use of the TCF to promote curriculum re-design has been a feature of published health related papers, notably in the field of occupational therapy. Using an action research approach Rodger and Turpin (2011) identified five concepts meeting all the defining characteristics of a TC which underpinned their curriculum re- design process. Evaluation of this found staff to be engaged with the TCF, finding it a useful approach to understanding the whole curriculum and in turn developing learning and assessment activities. Shared benefits for staff and students included the provision of a shared language, consistency of approach making learning more integrated, making explicit troublesome knowledge, and cohesive integration of concepts within the curricula (Rodger, Turpin & O'Brien, 2013). Although reported to be helpful in guiding the process of curriculum reform, none of the four cycles of the action research process included students or other stakeholders, with only those teaching on curriculum involved, hence not delivering on the notion of transactional curriculum inquiry advocated by Cousin (2008a, 2008b).

In contrast, Nicola- Richmond et al. (2016) identified 10 TCs for occupational therapy to inform curriculum design from a delphi study involving students, academics and clinicians. Notably statistically significant differences were found between academic, student and clinician responses, therefore highlighting multi-stakeholder involvement as an important factor in TC identification. A follow up study by the same authors (Nicola- Richmond, Pepin, & Larkin, 2018) sought to identify if these identified TCs were being taught within occupational therapy, and if so how. Findings from focus groups of 12 occupational therapy educators suggested that although TCs were not explicit within the curriculum, they were present in the teaching and learning philosophy. The five themes of professional identity, time, the impact of the learning environment, explicit versus implicit content and language, and the value and understanding of the TCF emerged. Practice learning was identified as pivotal in facilitating acquisition of TCs.

Participants also believed it to be unlikely that all students had crossed the threshold for all TCs at the point of programme completion, suggesting that further clinical practice experience is required after graduation to complete the process of TC acquisition, although student views on this were not determined. Given the differences in responses in the authors' 2015 study, significant differences in interpretation of this may be unrecognised.

Further consideration of a professional higher education programme with radiology students (Hudson, Engel- Hills, & Winberg, 2018) also argued for the significance of practice to threshold acquisition. In this study, transactional curriculum inquiry was adopted with nine BSc students and four educators. The authors noted the difficulty in identification of TCs as different to key concepts, with several concepts initially identified. Only one, 'the inverse-square rule' was selected for further investigation as it was determined to be difficult to define and apply. In terms of TC characteristics, the authors identified the presence of troublesome, bounded and integrative; however, transformative and irreversible were found to be not evident in learning. Given the non-negotiable status of transformation this brings into question the concept's legitimacy as a TC. However, Hudson et al. (2018) argued that it is the reciprocal relationship between concept and practice where the transformative and irreversible characteristics can be seen, as inverse -square law underpins radiology practice, "but equally it is practice that makes visible the abstract nature of the concept and which helps students to integrate and internalise the concept (thus rendering it irreversible)" (p.60). Hence making practice essential for threshold acquisition. This highlights the importance of the role of clinical educators to student education and is a point applicable to other professional programmes where elements of theory and practice integration are required.

Also recognising the importance of clinical practitioners to student education, Tanner (2011) carried out an explorative study with 24 occupational therapists based in practice. Data from

two focus groups identified three TCs facing students in practice education, client-centred practice, developing professional identity and practising in the 'real world'. However, whilst practitioners who support students in practice were engaged in a productive dialogue regarding curriculum content, students themselves were not included. It is therefore not known how the perceptions of students regarding their troublesome experiences of learning in practice compared to those of the practitioners. Nevertheless the inclusion of clinical educators provides a different perspective, potentially capturing an element of student learning not accessible to university based educators.

Clinical educators were included in Barradell and Peseta's (2018) case study regarding curriculum design. Their detailed account described how threshold concepts and 'ways of thinking and practising' were combined to support physiotherapy students in gaining a connected understanding of what knowledge is required and how this knowledge is put to use within professional practice. Adopting a nominal group technique, clinical educators developed 13 statements identifying what was considered clinically important for students to learn. These statements were further developed by the researchers using related scholarly literature to produce eight 'framing ideas', which were considered to represent a mix of TCs and 'ways of thinking and practising', involving knowledge and the elements that made knowledge work. These were then used as a basis in developing teaching activity and the learning environment. Students were asked to complete concepts maps to explore their understanding of these framing ideas. Analysis of 100 maps indicated significant student variation from sophisticated conceptual understanding and integration, to the production of descriptive processes demonstrating superficial understanding only. The authors linked the variation found to students occupying varying positions within the liminal space, although the reasons for such student variation was not empirically determined. However, the combined use of TCs and

'ways of thinking and practising' offered an approach whereby student learning associated with professional knowledge, skills and attitudes could be considered in an integrated way.

Fortune and Kennedy Jones (2014) argued that many TCs identified within studies across the discipline of occupational therapy can be viewed as cross- disciplinary concerns and therefore to not hold the characteristic of 'bounded', defining the boundaries of occupational therapy as a discipline. There may therefore be TCs applicable across disciplines related to professional practice, particularly in disciplines closely aligned such as those concerned with professional practice in healthcare. In a theoretical paper, Basic Royeen, Jensen, Chapman and Ciccone (2016) put forward interprofessionalism within healthcare education and practice as a TC, suggesting misunderstandings occur when inter-professional issues are only considered from a uni- disciplinary position. They consider issues of professional identity may be most troublesome in preventing threshold crossing in relation to inter-professional practice.

Professional identity was also considered by Nambiar- Greenwood (2010) in relation to inter-professional learning who drew upon experiences from running inter- professional student seminars. Understanding of mental health was included in the seminar work as vital to the centrality of the patient and as part of skill development within a multi- disciplinary team. However, the concept of mental health was highlighted as troublesome for some health care students. Where students were not expecting this concept to be in the curriculum, its inclusion was felt to challenge previously held assumptions in relation to their anticipated roles and the knowledge required to carry these out. These conclusions led Nambiar- Greenwood (2010) to argue that healthcare students require early and continued exposure to inter-professional learning to challenge assumptions, avoid uni-professional socialisation and provide person centred care.

The issue of professional identities was explored by Neve, Lloyd and Collett (2017), who sought to identify what TCs were involved in the concept of professionalism with undergraduate medical students. Adopting a naturalistic method of enquiry utilising audio diaries, the study focused on the student experiences of professional learning. Analysis identified seven potential TCs: professional culture, consideration of the whole person, working with uncertainty, consideration of the bigger picture, not needing to know everything, meeting differing expectations, and emotional intelligence. In terms of TC characteristics the authors report evidence of troublesome, integration and transformation; with little evidence of irreversible and no evidence of bounded. Also noted was the lack of clear edges in relation to the TCs, which the authors suggested added to their troublesome nature. The identified TCs may be considered broad concepts and the authors did note the relationship of these identified TCs to ways of thinking and practising, concluding that they were “fundamental to thinking and practising as a doctor” (p.106) and suggested further research to explore their relevance to other disciplines. It may be that the unbounded nature of these TCs supports their significance to other professional disciplines, although it cannot be assumed that they would be integrated into other disciplines in the same way. However, the findings from this study are supported by other research discussed in this section. Wilkinson’s (2018) suggested TCs of nurturing care and complexity of care included the elements of providing holistic care, identifying the bigger picture, meeting differing expectations in relation to multi-disciplinary teams and emotional intelligence, although this was also within the medical discipline. Again within the medical profession, Smith and et al. (2018) also identified dealing with uncertainty. However, the concepts of considering the whole person have also been identified in occupational therapy (Barradell & Peseta, 2018; Nicola- Richmond et al., 2018), as has understanding the bigger picture (Nicola- Richmond et al., 2018). Whilst Clouder’s (2005) study with occupational therapy and physiotherapy students identifying the TC of caring links to emotional intelligence.

How TCs may cross health and social care settings has not been empirically explored. In a theoretical paper, Foote (2013) explored critical reflection as a TC, concluding that it held a significant position within social work education and highlighted the troublesome nature of the concept which educators should focus upon. However, social work cannot lay claim to critical reflection as a TC unique to its own discipline, as others including nursing (Dearnley & Matthew, 2007) and occupational therapy (Rodger & Turpin, 2011; Barradell & Peseta, 2018) consider it a threshold concept crucial to effective knowledge and skill development. Similarly, the areas of caring (Clouder, 2005) and research learning (Martindale, 2014) already discussed can be viewed as significant across health and social care disciplines. It may be that whilst some concepts such as interprofessionalism and professional learning are broad concepts holding a shared understanding across disciplines, others may hold specific meaning not wholly applicable to other disciplines despite sharing the same labels. This is an area for further research.

Methodological limitations as discussed in section 3.1.5 are acknowledged in the discussion above. Whilst the discussion within the wider literature has generally moved on to explore student experiences rather than TC identification (Nicola- Richmond et al. 2018), several of the studies discussed within this section are concerned with identification of TCs. This may reflect the fact that until recently little research utilising the TCF has been undertaken within the area of health and social care. Whilst recognising this movement within the wider literature, robust methods for identification of TCs are still required as their existence cannot be simply assumed. Five of the papers discussed (Stacey & Stickley, 2012; Marsland & Pollock, 2010; Basic Royeen et al., 2016; Nambiar- Greenwood, 2010; Morgan, 2012) present theoretical discussions only. Whilst these offer useful perspectives, there is a lack of empirical data to support the assertions made therefore their arguments must be considered in light of this. Also, the empirical studies discussed vary in terms of the defining characteristics used in

identifying TCs and involved different groups of participants. Rodger and Turpin (2011) required all five of Meyer and Land's (2003) defining characteristics to be present for confirmation of TCs. Nicola- Richmond et al. (2016) specified transformative and integrative as necessary, whilst Tanner (2011) required transformative and one other characteristic to be present for TC identification. In other studies there were differences in terms of which characteristics were reported on when considering TCs. Wilkinson (2018) only made reference to troublesomeness, particularly identifying tacit knowledge as causing difficulty. Troublesomeness also featured in the TCs identified by Smith et al. (2018), Clouder (2005), Neve et al. (2017), and Hudson et al. (2018). It was also the particular focus of the work described by Martindale (2014), Blackburn and Nestle, (2014) and Carlisle (2016). Troublesomeness is the most frequently reported characteristic within the studies identified in this section, reflecting the wider TC literature. Hudson et al. (2018) go as far as to suggest its significance may make it an essential characteristic for defining TCs. However, considering students will engage with TCs in differing ways, it may be erroneous to suggest all will experience them as troublesome. Transformation also featured strongly, identified in the studies by Smith et al. (2018), Neve et al. (2017), Clouder (2005), Rodger and Turpin (2011), and Nicola- Richmond et al. (2016). Given it is the non- negotiable characteristic of TCs (Land et al., 2016) its inclusion is to be expected. Although identified by Nicola- Richmond et al. (2016) as an essential characteristic within their study, the integrative nature of TCs featured less strongly, present in only three further studies (Neve et al., 2017; Rodger & Turpin, 2011; Hudson et al., 2018). The irreversible and bounded nature of TCs were the least articulated characteristics. Whilst Smith et al. (2018) stated there was limited evidence for these characteristics in their study, Neve et al. (2017) founds no evidence of bounded in any of the seven TCs related to professionalism identified in their study.

Variation in participants selected to take part in the study is also evident across studies. Only one study (Nicola- Richmond et al., 2016) involved students, educators and clinicians, thereby including the student experience and that of both practice and university based educators. Rodgers and Turpin (2011) only involved university based educators in developing TCs for occupational therapy curriculum, whilst only clinical educators were included in the studies by Tanner (2011) and Barradell and Peseta (2018). Students/ trainees and university based educators were involved as participants in three studies, those by Wilkinson (2018), Hudson et al. (2018) and Neve et al. (2017). Whilst student/ trainee only participants were selected in five of the studies; Martindale (2014), Blackburn and Nestle (2014), Smith et al. (2018), Clouder (2005), and Carlisle (2016). The selection of participants may depend on the aims of the study. Where there is an identified focus on the student experience, then their inclusion as a single group of participants appears justified. In terms of TC identification and curriculum design, calls have been made for a more inclusive approach adopting transaction curriculum inquiry to instigate a shared dialogue between the major stakeholders (Cousin 2008a, 2008b). As a minimum, it can be argued that this should include students, clinically based staff who support student learning and university based educators. In terms of engagement and involvement, there is also a case for service user and carer inclusion as other significant stakeholders. None of the studies reported here include these groups within their studies.

Despite these limitations, the TCF can be seen to have made a small but useful contribution to the discussion of troublesome learning experiences for health and social care students. Consideration of TCs and troublesome aspects of these has led authors to consider how students can be more effectively supported as they journey through the liminal space towards a transformed understanding of their disciplinary concepts.

3.1.7 The Usefulness of the TCF

There is now evidence of widespread use of the TCF as a theoretical perspective suggesting its usefulness as a way of considering teaching and learning in higher education (Tight, 2014). A number of factors have been suggested that contribute to such levels of engagement. The TCF is based on a relatively straight forward, but eclectic mix of principles, making it more accessible to early career and practitioner researchers and applicable to small scale research projects (Land et al., 2016). This is of relevance to this study in terms of the project size and the experience and background of the researcher. Moreover the TCF is strongly disciplinary focused therefore enabling academics to explore the issues directly related to what they teach (Cousin, 2008b). The learning and teaching of recovery was identified as a broad area of interest with personal experience and anecdotal evidence suggesting this was a challenging area of learning for students. Supported by a raft of government policy, recovery is considered essential to contemporary nursing practice, which must be based on best available evidence (NMC, 2015). The use of this framework therefore supports a focus on a perceived important area of nursing education and practice. The TCF is particular relevant as a theory of difficulty (Perkins, 2007) as it is concerned with obstacles to learning. Emphasising the hurdles students face in their liminal journeys is particularly apt as this focuses on the student experience of learning rather than the aftermath of having crossed the threshold (Schwartzman, 2010). As a theory of difficulty the TCF considers what aspects of the subject content prove troublesome for students and provides an approach for identifying the reasons for this and how they can be addressed. In this sense the framework is both explanatory and actionable.

3.1.8 Conclusion

Part one of this chapter has explored the main theoretical framework utilised in this study, that of the TCF. In discussing the key characteristics and elements of the framework, it has been described as a way of examining student learning leading to consideration of ways to

improve such learning. The TCF has attracted some criticism in relation to its lack of clarity in relation to operational definitions and methodological approaches; however, since its introduction into higher education research the TCF has captured the attention of researchers and subject teachers across a range of disciplines. Its application within the context of healthcare, and particularly nursing, is more limited although a growing body of literature has indicated its usefulness to understanding the difficulties student experience in their learning journeys and how they can be supported on these journeys.

The TCF is used within this study to provide explanatory power to the findings discussed in chapters four and five. Part two of this chapter is concerned with the theory and practice of phenomenography, including an exploration of its links with the TCF.

Chapter 3: Designing the Research

Part 2: Phenomenography, Theory and Practice

3.2. 1 Introduction

Phenomenography as a research approach was developed primarily by educational researchers in Sweden exploring experiences of student learning. The approach emerged from ground-breaking work by Ference Marton and his team that focused on how students approached learning in relation to academic tasks (Dall’Alba, 1996). The research identified qualitatively different ways of student understanding, with the associated analysis leading to the identification of the now well known ‘deep’ and ‘surface’ approaches to learning. Whilst this research itself was not referred to as phenomenographic it did, as Entwistle (1991) pointed out, develop the analytical techniques that are now associated with phenomenography. From this empirical research tradition in the field of education phenomenography emerged as a research approach in its own right in the 1980s (e.g. Marton, 1981, 1988). Since then it has been developed and refined in relation to its theoretical stance, which is discussed in this section of the chapter.

Phenomenography is concerned with the variation in how particular phenomena are experienced (Marton & Booth, 1997). It focuses on the collective experiences of groups rather than the position held by individuals within the group (Harris 2008). Marton (1988) described phenomenography as:

A research specialisation aimed at the mapping of the qualitatively different ways in which people experience, conceptualise, perceive and understand various aspects of, and various phenomena in, the world around them. (p.178-9)

It enables identification of the different understandings a group of individuals may hold about the same phenomenon. Whilst these differences may be distinct, phenomenography asserts that they can be understood in a limited number of ways (Marton & Pang, 2008). These

differing but related understandings or conceptions are described in a set of related categories of description, which together make up the outcome space. Each of the categories of description describes the distinctively different ways of experiencing a phenomenon, whilst the outcome space demonstrates the logical relationships between them, usually in a hierarchical manner (Cousin, 2008b). These considerations related to phenomenographic study are considered in more detail throughout part two and three of this chapter.

Phenomenographers refer to their work in a number of different ways. The terms approach, specialisation, orientation and method have all been adopted and appear to be used synonymously within the literature. In early work Marton (1986) referred to phenomenography as a research approach and as a research method in the same paper. In later work this point was clarified:

phenomenography is not a method in itself, although there are methodical elements associated with it, nor is it a theory of experience, although there are theoretical elements to be derived from it.....Phenomenography is rather a way of – an approach to- identifying, formulating, and tackling certain sorts of research questions..

(Marton & Booth, 1997, p.111)

However, Marton does continue to use the terms ‘approach’ and ‘specialisation’ interchangeably. The term ‘approach’ appears the most often adopted in the literature, with Cousin (2008b) suggesting this is most appropriate as research projects are increasingly being inspired by phenomenography but not necessarily staying faithful to its purest form. In line with the majority of phenomenographic research, the term approach is adopted within this study.

3.2.2 Types of Phenomenographic Research

Research within the phenomenographic approach can take different forms with Marton (1988) describing three lines of phenomenographic research. The first of these is concerned with the more general aspects of learning, for example those examining the relationship between learning processes and learning outcomes. The second approach is concerned with learning within a particular discipline or content domain, where the student conceptions of phenomena that make up the subject area are explored. These first and second lines of phenomenographic approach involves studying phenomena where formal study has taken place. In contrast Marton's description of the third line of phenomenographic research, often referred to as 'pure phenomenography' relates to how individuals understand aspects of their world, not related to formal study "such as inflation, social security, taxes and pressure" (Marton, 1988, p.191). Bowden (2000) referred to his research approach as developmental phenomenography and identifies it as differing from pure phenomenography in that it is aimed at helping students to learn. Findings are used to develop teaching and learning strategies to aid student in developing a "more powerful understanding of the phenomena under study" (Bowden, 2000, p.4). In contrast Bowden described non- developmental phenomenography as research which focuses on phenomena with the goal of describing the range of understandings in relation to it, but without the intention of affecting change. All lines of phenomenographic research are concerned with variation in the way a particular phenomenon is experienced, which has led to the development of variation theory (Pang & Marton, 2003), which Pang (2003) has described as 'new phenomenography' as described in section 3.2.8.

This study falls within the second line of phenomenographic research described by Marton as it is concerned with exploring conceptions related to one particular phenomenon, namely recovery, within the particular subject domain of mental health nursing. It is the intention that the findings of this study will inform teaching and learning practices within mental health

nursing and therefore in this sense the research can be viewed as falling within Bowden's (2000) description of developmental phenomenography.

3.2.3 Assumptions of Phenomenography

Phenomenography is a research approach developed from an empirical research tradition, rather than from a clear set of ontological and epistemological assumptions. Marton (1988) explained how it was the critical review of their work by others that led to a clearer articulation of these assumptions. However, Svenson (1997) stressed that although these assumptions were inspired by several traditions, such as hermeneutic and phenomenological traditions, none were embraced in their entirety. Because of this he argued that phenomenography takes no metaphysical position and that views in relation to the nature of reality can vary significantly between researchers. However, as the phenomenographic research approach has been utilised, the theoretical stance has been refined. The generally accepted view within the literature is that defined by Marton which gives phenomenography a non-dualistic ontological position in that people cannot be seen as separate from the aspects of their world that they experience. Marton (2000) explained that:

There are not two worlds: a real, objective world on the one hand and a subjective world of mental representation on the other. There is only one world, a really existing world, which is experienced and understood in different ways by human beings. It is simultaneously objective and subjective. (p.105)

The experience encompasses both object (the phenomenon experienced) and subject (the person experiencing) and it is this inseparable relationship between the person and aspects of their world that is explored within phenomenography. The focus becomes what is the person's understanding of what is there in the world, rather than a search for an ultimate truth of what is there in the world. This ontological position differs from a dualist ontology often associated

with the traditional positivist paradigm where the person and the world are considered two separate and distinct entities (Yates, Partridge, & Bruce, 2012).

Richardson (1999) viewed this non-dualistic stance as problematic in that it supposes objects or events can only exist if they are experienced by someone. He argued that physical objects have persisted through time whether they were experienced by someone or not. Marton and Booth (1997) did acknowledge the physical existence of natural objects, although argued that “our world is a real world, but it is a described world, a world experienced by humans” (p.113). Therefore objects existing within the world cannot be described in a way that is independent of the description or the describer.

Associated with the non-dualist ontological position, a fundamental aspect of phenomenography is the second order perspective. Whilst a first order perspective is concerned with describing aspects of the world, a second order perspective is concerned with describing people’s experiences of these aspects in the world (Marton, 1981). Hence researchers are concerned with individuals’ understanding of the world rather than how the world really is. This second order perspective influences the nature of how research questions are formulated, instead of asking ‘why’ questions, researchers are more concerned with ‘how’ and ‘what’ questions (Yates et al., 2012). Therefore the first research question in this study addresses what variation exists in the participants’ understanding of recovery. It is the experiences of the participants, rather than those of the researcher that are explored with this second order perspective therefore it is necessary for the researcher to ‘bracket’ their own experiences and judgements. The issues related to bracketing are discussed more fully in section 3.3.4.1.

The ontological and epistemological assumptions within phenomenography are interdependent, relating to conceptions and their relationship to knowledge and reality. The ontological interest relates to an individual's consciousness of reality, with the epistemological issue relating to the individuals' expression of reality (Uljens, 1996). Understanding of the epistemological issues is based on the notion of intentionality first suggested by Franz Brentano in the 19th century. Intentionality embodies the idea that all psychic (psychological) refers to "something beyond itself" (Marton & Booth, 1997, p.84). Human experience is understood as a 'human world relationship' where all psychological acts are viewed as intentional. Experiences occur with something being experienced and knowledge is constituted through these internal relationships (Marton & Pang, 2008). To illustrate this Marton and Booth (1997) provided the example of a thought, which cannot be imagined unless there is something to think about, "a thought of a dog refers to an object, a dog that is beyond the thought itself" (p.84).

Phenomenography is an approach distinguished from phenomenology. Although both have human experience as their object of research, a number of key differences mean that "phenomenography has to be seen as no more than a cousin-by-marriage of phenomenology" (Marton & Booth, 1997, p.117). Phenomenography is concerned with the second order perspective describing people's experiences of the world. However, Phenomenology is concerned with the describing the world as it is, taking a noumenal first order perspective. Phenomenography emphasises reflective rather than pre-reflective thought and is concerned with collective meaning, highlighting the variation of experience that exists across groups of individuals. Phenomenology on the other hand is focused at an individual level and concerned with capturing the singular essence of experience, entering the unique lifeworld of the person (Barnard, McCosker, & Gerber, 1999; Alsop & Tompsett, 2006). As phenomenography has developed, aspects of phenomenological method have been incorporated in a limited way and the two approaches do share some similarities in their approaches to method (Barnard et al.,

1999). However, phenomenography does not have its origins in a phenomenological tradition, rather a pedagogical one (Svensson, 1997).

3.2.4 Knowledge Interest in Phenomenography

Phenomenography attempts to uncover the variation of human experience and is concerned with describing things as they are experienced by people (Yates et al., 2012), it is this experience that is the object of study. The basic unit of description within phenomenography is a conception (Säljö, 1997; Marton & Pong, 2005); however, several terms have been used to describe it. Marton and Pong (2005) explained the changing language as arising from the fact that “although none of them corresponds completely to what we have in mind, they all do to a certain extent” (p.336). Consequently terms such as understandings (Sandberg, 2000), experiences (Hallet, 2010) and conceptions (Marton, 1981) have all been used. Marton (2000) explained that in his publications synonyms such as perceptions, understandings and apprehensions are used in a way in which they each also stand for each other. Other phenomenographic researchers have supported this, notably Åkerlind (2005a) who used meanings, understandings, experiences and awareness interchangeably. Hallet (2014) highlighted a potential difficulty this may pose suggesting experiencing a phenomenon may be markedly different from understanding one, involving differing levels of perceptual and conceptual judgements. Marton (1997) acknowledged potential differences in what the terms refer to, but argued that the interchangeable use of the terms supports the view that the way in which the phenomenon appears to people can be found in the immediate experience of the phenomenon and in the reflective thought about the same phenomenon. There is no differentiation made between pre and post reflective thinking. As conceptions or ways of experiencing are viewed as an internal relationships between the experience and the experiencer, they are not viewed as psychological entities existing in the mind (Säljö, 1997). In contrast to the cognitivist view whereby conceptions are described in terms of psychological

processes, within a phenomenographic stance conceptions are understood as dynamic and unstable depending on the context and task in which they are studied (Prosser, Trigwell, & Taylor, 1994). They are understood in an experiential sense, regardless of the term used to describe them. Therefore within this study terms are used interchangeably in line with other phenomenographic studies.

3.2.5 A Framework for Understanding Conceptions

In developing a framework to explain the nature of conceptions, Marton and Booth (1997) suggested that a way of experiencing something is associated with a person's structure of awareness. Marton (2000) stated that a person simultaneously experiences a range of different things in a range of different ways. The totality of these simultaneous experiences is termed awareness (although this term is used interchangeably with consciousness throughout Marton's texts). Marton and Booth (1997) argued that although awareness of innumerable things may be present at any given time, this will be at differing degrees and an individual will not be aware of everything in the same way; awareness therefore has a structure to it. The structure of awareness used in phenomenography originates in the work of Gurwitsch (1964). Awareness is not seen as a dichotomy of aware/ unaware but as a layered model in which certain things come to the fore and are thematised, whilst others recede to the background, they are tacit and unthematized (Marton, 2000). Gurwitsch's (1964) layered model of awareness is made up of three overlapping domains, the theme, the thematic field and the margin. The theme refers to the object which is in focus at a given time, whilst the thematic field refers to those aspects of the phenomenon that are of relevance to the theme, co-present with it and provide the context out of which the theme emerges. The margin is those less focused aspects, unrelated to the meaning of the phenomenon but co-existing with it. As a situation changes then so will the structure of awareness. Different things come to the fore whilst others surround it and others will recede into the margin. Therefore the three domains

relate to each other in fluid, dynamic way. Marton (2000) used the example of a reader reading his text to demonstrate how these domains can be applied. Using the terminology within the framework, the text itself is the theme and the meaning of the text is in focal awareness. Issues related to pedagogy, phenomenography and research methodology may form the thematic field. The margin includes things not concerned with the text but still present, such as the room in which the reader is sitting or any worries the reader has related to life events.

In developing the framework Marton and Booth (1997) adopted the terms structural and referential to explain the aspects of an experience. The structural aspect refers to the parts of the experience, how they relate to each other and to the context in which they are situated. The referential aspect refers to the meaning of the experience. The two aspects, referential and structural, occur simultaneously in the experience and are intertwined: “structure presupposes meaning, and at the same time meaning presupposes structure” (Marton & Booth, 1997, p.87).

In developing the framework further Marton and Booth (1997) drew upon terms originating in phenomenology (although using them “somewhat differently, stretching them to meet our own approach” (p.87)) by including the internal and external horizon as parts of the structural aspect of the experience. The internal horizon is comprised of the parts present within the theme and their relationship to each other. The external horizon is that which surrounds the experienced phenomenon, made up of the thematic field and the margin. Cope and Prosser (2005) interpreted the external horizon as the context in which the internal horizon sits, with the boundary between the internal and external horizons delimiting the phenomenon from its context. Marton and Booth (1997) used the example of experiencing a deer in the woods to clarify the internal and external horizons:

Thus, the external horizon of coming on the deer in the woods extends from the immediate boundary of the experience- the dark forest against which the deer is discerned- through all other contexts in which related occurrences have been experienced (e.g. walks in the forest, deer in the zoo, nursery tales, reports of hunting incidents, etc.). The internal horizon comprises the deer itself, its parts, its stance, its structural presence. (p.87)

Phenomenography asserts that the ways of experiencing a phenomenon are qualitatively distinct, but limited in number (Marton & Pang, 2008). This assertion is based upon the idea that for a phenomenon to be experienced it must be made up of a limited number of discernible aspects. The qualitatively different ways of experiencing something relate to differing structures of awareness, where the parts, the relationship between them, and how they relate to the whole are discerned in different ways. The different aspects of what is discerned within the internal horizon has been called dimensions of variation (Marton & Booth, 1997; Cope, 2002b). Each particular aspect of the phenomenon is related to the phenomenon as a whole and each particular aspect of the phenomenon has the potential for variation. Therefore the aspect can be considered a dimension of variation with a particular value within the variation. Runesson (as cited in Cope, 2002b) explained how the way in which a phenomenon is experienced is a function of these dimensions of variation. Using the example of a blue non- transparent cup, the blue of the cup relates to a value in the dimension of colours. In order for the cup to be discerned as blue, other colours such as green, red or yellow must have been experienced. In order to experience the cup as non- transparent, cups made of other material must have been experienced, for example glass.

Ways of experiencing a phenomenon then can be considered by adopting this framework whereby the experience is understood to include both structural and referential aspects. The

structural aspect incorporates the internal and external horizons. The internal horizon being the theme of focal awareness and includes a description of the dimensions of variation present within the phenomenon. The external horizon consists of the thematic field and the margin, which provides the context from which the theme emerges. The referential aspect is the meaning inherent in the structure. The structural and referential aspects of an experience are interdependent and occur simultaneously in the experience. This framework is depicted in figure one.

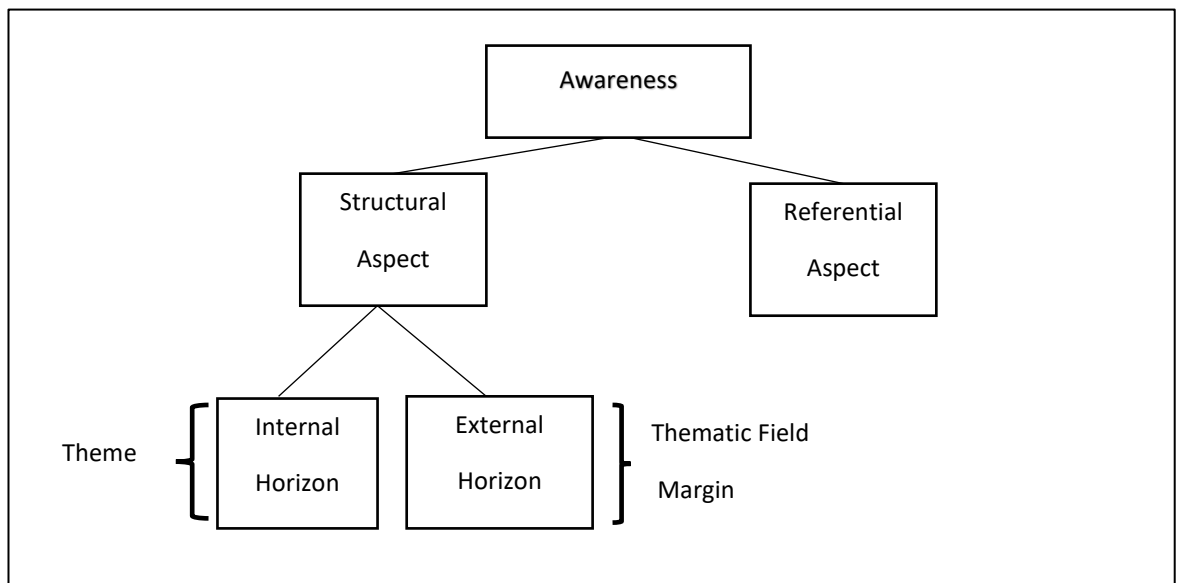


Figure 1. The Structure of Awareness

Marton and Booth (1997) referred to this framework as a “possible science of experience” (p.87). However, Harris (2011) has been critical of the loose language used to describe the parts of the framework and identified how differing understandings, in part due to inconsistent terminology used with the field, have led to differing interpretations of how the framework is applied. There is variation in which of the domains identified in Gurwitsch’s (1964) model are said to correspond to the internal and external horizon. Cope (2000) identifies the thematic field as being within the external horizon in line with Marton and Booth’s (1997) interpretation. However, Edwards (2005) places it within the internal horizon, based on an

interpretation of Marton's (2000) description of the structure of awareness. These differences may reflect the fact that Gurwitsch described the domains of theme, thematic field and margin as overlapping; however, it does demonstrate different usage of the framework. Hallett (2014) further identified that several studies use no identifiable framework at all. Utilising such a framework grounded in theory provides a structure to consider the component parts of the variation within a conception in a robust way. To provide clarity within this study, the referential aspects refer to the meaning student nurses give to the concept of recovery. Within the structural aspect, the internal horizon consists of those aspects participants described as integral to recovery and the relationship between these integral parts, through identification of the dimensions of variation. The external horizon describes the context within which participants situate recovery. In line with Marton and Booth (1997) context refers to both the material and abstract contexts described by participants.

3.2.6 Outcome of Phenomenographic Research- Categories of Description and the Outcome Space

Within phenomenography a phenomenon is viewed as "a complex of the different ways in which it can be experienced" (Marton, 2000, p.105). These different ways of experiencing something are represented by the categories of description and are brought together as a set in a logically structured way which is referred to as the outcome space. Therefore the outcome space "turns out to be synonym for phenomenon- the thing as it appears to us" (Marton, 2000, p.105). The categories of description and the outcome space form the outcomes of phenomenographic research in describing the phenomenon and the variation in the ways that it can be experienced.

Categories of description represent the ways of experiencing a phenomenon with similarities and differences in meaning reflected within each category (Barnard et al., 1999; Marton &

Booth, 1997). As Yates et al. (2012) pointed out, it is important to distinguish between conceptions or ways of experiencing and categories of description, as the two are not equivalent. Conceptions are the unit of analysis and refer to the ways in which a phenomenon or aspect of reality is understood. The categories of description are used to describe the characteristics of these conceptions, they are used to denote them (Johansson et al., 1985). Categories of description are the representation of the collective ways of experiencing where common meanings are grouped as an expression of understanding. Barnard et al. (1999) stressed that the set of categories of description communicate ways of experiencing, but that this cannot be claimed to be a complete description of how the phenomenon can be experienced or conceived:

It is generally accepted that categories of description are a form of expressing conceptions of the object of study within the context of the reality portrayed by interviewees that may, or may not, describe the entire range of possible conceptions of a phenomenon. (p.219)

Whilst the categories of description cannot be said to be an exhaustive system, they should be a complete one in that they capture the collective experience with nothing left unspoken of the participants of the study (Marton & Booth, 1997). This does not suggest that individuals are not capable of experiencing phenomena in a different way, but that the range of variation is identified in the ways of experiencing in a given context. Marton and Booth (1997) proposed three criteria for asserting the quality of a set of categories of description. Firstly each category should relate to the phenomenon under investigation and say something distinct about the way of experiencing it. Adopting the structure of awareness framework previously discussed, this is reflected in the referential aspects of the category of description where meaning is ascribed. Secondly they should maintain a logical relationship to each other. This is commonly depicted as a hierarchical structure with increasingly complex and inclusive ways of experiencing the phenomenon described, although differing ways of understanding the

outcome space are reported (Barnard et al., 1999). Finally the categories of description should be parsimonious in that as few categories as needed are used to capture critical variation.

3.2.7 Threshold Concept Framework and Phenomenographic Approaches

The TCF shares common ground with phenomenographic approaches and variation theory in relation to how students approach learning, with both frameworks having a central focus on variation in student learning. Whilst the two perspectives do share similar features, there are differences in how this variation is understood.

The shared features of the TCF and phenomenographic approaches relate to how phenomena are understood. Both perspectives consider a phenomenon to have several features that may be its physical properties, or the relationship between the phenomenon and particular social or physical environments. Both also consider a phenomenon to be understood in different ways with understanding possibly focusing on only one feature of the phenomenon (Meyer et al., 2008). However, within the TCF the social context of learning is given greater emphasis. Phenomenographic approaches consider understanding to be relational, between the phenomenon and the individual, therefore individuals will experience the various aspects of phenomena in qualitatively different ways. Within the TCF, Meyer et al. (2008) identified a key aspect of the social dimension to be how within academic disciplines some methods or theories give legitimacy to some interpretations over others, therefore influencing student understanding. In relation to TCs it is not simply the variation of the phenomenon's critical features, but how it is interpreted in relation to other disciplinary concepts that gives rise to understanding. The social dimension is further highlighted in that transformed understanding to view a TC in a different way can socially re-position the learner, providing access to certain communities or allowing students to move from one school of thought to another. In this

sense the concept of learning is viewed as “a relationship between the individual, the phenomenon, and others” (Meyer et al., 2008, p.67).

Variation theory (Marton & Tsui, 2004) arose from the phenomenographic research approach with a shared epistemology as described in this chapter, but focusing on applying theoretically informed pedagogical principles to teaching and learning contexts (Åkerlind, 2015). It proposes that learning occurs when the critical features of a phenomenon are discerned and simultaneously focused upon. Discernment occurs when there is variation in the aspects of the phenomenon of study, without variation learning cannot occur. Teaching therefore requires a focus on controlled variation of aspects of the object of learning (Pang & Marton, 2005). In contrast the TCF focuses on learning episodes, with different modes of variation in the transformational journey (discussed fully in section 3.1.3). These modes are the focus of teaching as pedagogical principles are applied to consider at what point students experience conceptual difficulty and obstacles to understanding (Meyer, Land, & Davies 2008).

The relationship between the TCF and phenomenographic approaches in relation to educational research also highlights some differences. Phenomenography is concerned with variation across groups of individuals where reported data is pooled to discover the various categories of description of a phenomenon. However, the TCF is more concerned with differences between individual students. Cousin (2008a) suggested one difficulty with the phenomenographic approach is that “findings can be read as the researcher’s experience of the students’ experience” (p.267) as research is on students. Although the TCF has no established methodological framework, Cousin argued that the disciplinary focus rather than a research focus of TCs has provided the opportunity for all stakeholders to work together as partners in disciplinary specific inquiry, which she termed Transactional Curriculum Inquiry. Although not all TC research has adopted this approach, Cousin (2010) suggested there is a

trend of academics working with students, rather than on students, to explore the nature of the difficulty of their subject.

3.2.8 Relevance of Phenomenography to this Study

3.2.8.1 Phenomenography as a chosen research approach

Mills, Bonner, & Francis, (2006) stated that researchers need to choose a research paradigm consistent with their own views about the nature of reality to ensure a strong research design in addressing the research questions. These underlying assumptions may be unconscious and taken for granted; however, Mills et al. (2006) argued that an ontological interrogation of personal beliefs identifies the epistemological and methodological possibilities available to the researcher. Considering my own position, an interpretivist paradigm was considered the best fit. The interpretivist paradigm denies the existence of an objective reality, espousing the idea that there is no one universal truth but a world of multiple realities, constructed through the meanings individuals ascribe to their experiences as they construct a social world through their interactions with each other (Durham, Sykes, Piper, & Stokes, 2015; Thomas, 2009). From an epistemological perspective, interpretivism emphasises the inter-relationship between the researcher and the participants of the study and the co-creation of knowledge within this relationship.

Associated with the interpretivist paradigm are qualitative research methodologies. Although it is over simplistic to place all qualitative research within an interpretivist paradigm (Cutcliffe & Goward, 2000), Denzin and Lincoln (2011) put forward an overarching definition of qualitative research as being interpretive and naturalistic in its approach to the subject matter, where phenomena are understood in terms of the meanings people attach to them. There is therefore much commonality and a natural fit suggesting a qualitative methodology would be appropriate.

However, the chosen approach should also be closely linked to the research questions. The aim of this study was to investigate student understanding of recovery. Two research questions are addressed:

- What is the variation in mental health nursing students understanding of recovery?
- What is troublesome for mental health nursing students in their learning experiences of recovery?

Rebar, Gersch, MacNee, & McCabe (2008) identified research questions as being broadly categorised into those that seek to describe or understand, those that seek to connect or relate and those that seek to predict or study the effects of manipulation. This project falls into the first of these categorisations and therefore required an approach which would serve the function of describing the conceptual understanding of recovery held by the participants. Such approaches can be seen to fit within the qualitative domain.

3.2.8.2 Position of myself as the researcher

Cutcliffe and Goward (2000) commented on the preference of mental health nurses to adopt qualitative methodologies in their research. They suggested that similarities exist in relation to the use of self, the creation of interpersonal relationships and the presence of ambiguity and uncertainty. These similarities they argued draw the discipline of mental health nursing into a qualitative paradigm. Although this study has been undertaken as educational research, this point is acknowledged in relation to my own position as a registered mental health nurse. Therefore because of the influence of the researcher's belief on the chosen research approach, the issue of positionality should be considered. Positionality refers to the position a researcher chooses to adopt within a research study related to their world view (Savin-Baden & Howell Major, 2013). It may be influenced by a number of factors and requires the researcher to closely examine and openly describe through a reflexive process how they have influenced the research through biases, values or experience and how they have been influenced by the

research. As Cousin (2013) asserted, the aim is not to minimise subjectivity but to “acknowledge that the self is a research tool in the inquiry” (p.4-5) and that the involvement of the researcher should be questioned as well as valued as part of the analytical process. Savin-Baden and Howell Major (2013) suggested positionality can be acknowledged in three primary ways, locating the researcher in relation to: the subject under investigation, the participants of the study and the research context, and the process. This is the framework adopted to explore positionality within this study. The reflexive process is discussed in more detail in chapter six and throughout this thesis reflexive comments are included where appropriate; however, a positionality statement is included in box one to demonstrate at this point where I have located myself in relation to my research. This statement was developed from the mind mapping exercise included in appendix one.

Box 1- Positionality Statement

I have been a mental health nurse for over thirty years, spending the last ten of these as a senior lecturer at one university teaching on pre-registration nursing programmes. As a practitioner I strongly connected with a recovery approach and remain committed to this as best practice in mental health care. For me, it changed the way I thought about service users and nursing practice, I found it very enlightening. Although I no longer work as a clinical nurse I remain concerned about what happens in practice and hope that through my role working with students I can influence this. I chose to study student nurse understandings of recovery as I view them as the next generation of nurses who can influence practice. However, as an experienced nurse, ten years of this outside of clinical practice, I have limited understanding of the student nurse position in healthcare today.

The participants in this study all know me as a lecturer and I acknowledge there is a difference in status between student and lecturer within the university setting. Working on this research project I view our relationship differently in that I am dependent on their participation to complete the study. In analysing and interpreting the data I am learning from them. I feel that we are working on something together although acknowledge that this may not be a view shared by the participants.

My views as a researcher are particularly influenced by my experiences as a mental health nurse. I am interested in what people think, feel and experience, and view relationships as central to this. I believe you can only gain understanding of these things by talking to people; people are the experts in their own lives. I am more interested in describing things than knowing why they have happened. For me it is not always necessary to know the cause of something, to know how to improve on it. I am comfortable with a naturalistic setting and with ambiguity, as well as having experience of interviewing people. Because of this position I consciously chose a qualitative research design.

3.2.8.3 Phenomenographic research in nursing

Phenomenography is not restricted to the context of education and whilst Tight (2015) doubted its influence extends beyond higher education, relevant to this study in relation to discipline is the small but growing evidence of phenomenographic research in nursing. Sjoström and Dahlgren (2002) reported on a number of Swedish studies that have adopted a phenomenographic approach to exploring nursing issues. They discussed studies seeking to gain understanding of the patients' experiences of illness related to asthma, hypertension and chronic pain. In relation to patient education they discuss two studies exploring intensive training for diabetes sufferers and educating parents of children with amblyopia. Further issues related to nursing education and clinical competence were highlighted including studies exploring student nurses' conceptions of clinical situations and how acute postoperative pain is understood. These studies all relate to a Scandinavian context and were carried out in the 1990s. The majority of phenomenographic studies related to nursing practice are Swedish in origin, which is understandable given the origins of this research approach. However, more recent studies originating in Sweden, Norway, France, USA and the UK have also been identified. The focus of these studies can be classified into four broad areas of nursing research: patient experiences of ill- health, the experiences of provision of care, understanding of nursing roles, and nurse education. An overview of these 15 studies is presented in appendix two.

The small but growing use of phenomenography demonstrates its relevance to research within the discipline, with understandings gained in relation to nursing practice and nurse education. In line with other interpretive research approaches, phenomenography cannot claim generalisability of findings; however, the findings of the studies do relate to areas of contemporary nursing practice and education with many having transferability across the nursing fields. For example, whilst Jangland, Larsson & Gunningberg (2010) explored nurse-

patient interactions within a surgical care context, all nurses across specialisms are required to give attention to the nature of their interactions with those in their care and the findings will be of interest to nurses working in a range of different clinical environments. For some studies the phenomenon of interest is of particular relevance to its areas of specialism, for example Aflague and Ferszt's (2010) study of suicide assessment by psychiatric nurses. In such cases implications for clinical practice are identified and the contribution the study's findings are discussed with recommendation for practice highlighted. In this sense the phenomenographic studies discussed can be seen to have contributed to the body of nursing knowledge.

However, what is also apparent within these studies is the criticisms previously discussed by Irwin (2006), Harris (2011) and Hallet (2014), related to the inconsistent use of terminology and the differing understandings of frameworks evident within the wider phenomenographic literature. All the studies discussed do adopt a recognisable phenomenographic analytical process in their investigations, although these vary in relation to the identifiable number of steps. The framework presented by Dahlgren and Fallsberg (1991) is the most used within the studies discussed with differences evident in relation to descriptions of findings. This variation in terminology and description of findings suggest differing understandings concerning the outcomes of phenomenographic research and the nature of the frameworks used within this approach. Some methodological variation may be expected as an approach is developed (Tight, 2015) and prescriptive definitions may be limiting (Harris, 2011). Furthermore some omissions may be due to the limitations imposed on the word length of articles or as a consequence of translation into English. However, in order for reader clarity authors should clearly define and articulate the use of their frameworks.

Notwithstanding the above, phenomenography has made a positive although currently limited contribution to nursing research both in clinical practice and education. Sjostrom and Dahlgren

(2002) pointed out that having access to people's descriptions of core professional issues can enhance awareness. Such awareness can inform nurse education when positive and negative experiences are considered to develop competency in practice. Knowledge of patients' experiences in relation to their situation is also invaluable in informing nursing curricula, with such knowledge fed into the curriculum students can be more prepared for their clinical roles.

3.2.8.4 Phenomenography in higher education

As the previous section has highlighted, phenomenography has made a small but meaningful contribution to nursing knowledge related to both nursing practice and education. Further research adopting this approach can therefore add to this growing field. Whilst relatively underutilised in nursing research, higher education is a field where phenomenography has been more developed and applied, although it remains relatively uncommon (Tight, 2012). Within higher education it has been most widely applied to research into student learning (Tight, 2015), beginning with the surface and deep approaches to learning identified by Marton and Säljö (1976) and the subsequent research that followed. This work had a significant impact on research into teaching and learning and phenomenographic approaches have been adopted across a diverse range of disciplines; for example, veterinary practice (Matthews, Taylor, & Ellis, 2010), geography (Bradbeer, Healey, & Kneale, 2004), accountancy (Lucas, 2000), chemistry (Prosser et al., 1994), music (Reid, 2001) and information studies (Yates et al., 2012). The majority of research within the disciplines has sought to apply findings to improving practice (Tight, 2015). Such developmental phenomenography (Bowden, 2000) has led to the introduction of new approaches to teaching and learning to enable students to gain greater understanding of the phenomena in question. Whilst studies related to nursing practice have previously been highlighted, further studies from differing disciplines demonstrate applicability of phenomenography to researching contested or abstract concepts such as recovery. For example, Kirk (2002) successfully utilised phenomenography to explore

the issue of information use where there is ambiguity concerning its complex nature. It is therefore an established higher education research approach, making recognised contributions to advances in learning and teaching generally, but also within the disciplines. The applicability across disciplines and its influence on teaching and learning suggests phenomenography is a relevant research approach for exploring mental health nurse education.

3.2.8.5 Current research into recovery

The current body of research into understanding the concept of recovery is largely qualitative although phenomenography has to date not been utilised. Research has focused on understanding at an individual level, often from a lived experience perspective and the variation within this has been discussed in chapter two. Using phenomenography as a way of researching student understanding of recovery, with its focus on the collective voice and its ability to explain the relationship between the variations of understanding, will fill a gap in the research. Research to date has shown recovery to be a complex and contested phenomenon. By considering the variation in collective understanding, the diversity and complexity of students' relationships with recovery can be explored, rather than assumptions made on what students believe and understand. The importance of gaining understanding of the human experience of the phenomena was illustrated by Marton and Booth (1997):

..in order to make sense of how people handle problems, situations, the world, we have to understand the way in which they experience the problems, the situations, the world that they are handling or in relation to which they are acting. (p.111)

Students' beliefs and understandings about recovery will directly influence their nursing practice, consequently influencing the care and treatment provided to those using mental health services. Phenomenography provides a method for gaining awareness of the student experience of recovery, a central phenomenon in mental health practice. Such awareness can

support nurse educators in developing nursing curricula and better prepare students for their professional roles.

3.2.9 Conclusion

Part two of this chapter has described the theory and practice of phenomenography. This approach is concerned with the variation in how phenomena are understood across groups of individuals. Its non-dualist stance is concerned with describing things as they are experienced by people. Phenomenographic approaches and the TCF have a shared concern with variation in student learning, although the differences in how this variation is understood has been highlighted. Phenomenography is considered a suitable research approach for this study. Although currently underutilised in nursing, it is an established approach within higher education where its use within the disciplines has led to consideration of ways to improve practice.

The structure of awareness framework (Marton & Booth, 1997) provides a way of understanding conceptions. The structural aspect refers to how the parts of the experience relate to each other and the context within which they are situated, the referential aspect refers to the meaning of the experience. The use of the framework in guiding and framing the analysis is described in part three of this chapter.

Chapter 3, Part 3: Phenomenographic Approach to the Research

3.3.1 Introduction

Part three of this chapter will discuss the research method and analytical process undertaken within this study. This is based upon the theoretical position and approach discussed in parts one and two of the chapter. The process of data generation and analysis are informed by relevant literature and discussed in light of lessons learned from the pilot study. The structure of the outcome space is identified based upon the empirical data from the study.

3.3.2 The Pilot Study

The adopted approach was informed by a small scale pilot study of three participants. A pilot study aims not necessarily to produce results, but amongst other things to clarify relevance of methods or schedules in data collection and uncover any barriers to the research (Beebe, 2007; Kim, 2010). Literature suggests pilot studies are more commonly associated with studies adopting a quantitative approach and there would appear to be an under usage and under reporting of pilot studies in qualitative research (Sampson, 2004; Kim, 2010). Morse (1997) asserted that because of the nature of qualitative inquiry, uncertainty regarding expected outcomes should be accepted until saturation of data is reached, which is unlikely to occur in a pilot study and therefore results may be misleading. Where the aim is not to produce results but test out methods, Morse is equally dismissive, recommending that such issues as interview practice and access to sample group should be incorporated into the main study to avoid creating additional difficulties. However, Åkerlind, Bowden and Green (2005) strongly recommend the use of pilot studies for novice phenomenographers to develop interview skills and to check that the questions asked do provide useful information to meet the study's aim. To this extent it was felt the opportunity to practise both methodological and practical issues in preparation for the main study would be a worthwhile venture. The pilot study firstly aimed to evaluate the utility of three different data generation methods: semi-structured interviews,

completed exam papers, and a written response to a scenario. Secondly it aimed to explore the usefulness of specific frameworks in data analysis. It was also envisaged that any practical difficulties would be uncovered allowing adjustments to be made prior to the main study. The findings from the pilot study are integrated into the discussion below and are described in detail in Watson (2016).

3.3.3 Participant Selection

In line with other qualitative research methods, purposive sampling is commonly used in phenomenography (Yates et al., 2012). As the aim is to expose variation in experience of a particular phenomenon, participant selection is carried out to ensure a range of perspectives are captured (Bowden, 2000; Green, 2005). Lucas (2000) warned that such an approach may be misguided as it assumes certain kinds of participants will hold certain kinds of conceptions, for example gender specific experiences, therefore potentially introducing false variation. This view is supported by Ashworth and Lucas (2000) who stated the need to avoid presuppositions about the nature of conceptions held by particular types of individuals, although they did go on to suggest that common sense precautions be taken in selecting interviewees who seem likely to have different experiences in order to maintain variety. They did also caution that any assumptions made must be made explicit, with an awareness of the possibility that they may be false. Åkerlind (2005a) maintained that variation within the population group should be represented within the participant group so that it can be said to be representative of the range of meanings within the population.

Within phenomenographic studies data is collected until the researcher is satisfied that the full variation of understanding of the phenomenon is present within the group (Irvin, 2006).

Therefore participant numbers may vary depending on when saturation is reached. Within the literature these participant numbers vary significantly. Appendix two identifying

phenomenographic studies in the field of nursing identifies participant groups ranging from 6 to 41 participants. However, an international study by Bradbeer et al. (2004) exploring undergraduate conceptions of teaching, learning and geography analysed 153 written responses, whilst Soon and Barnard's (2001) study of conceptions of HIV counselling interviewed only two participants.

Within this study, students enrolled on the BSc Mental Health Nursing programmes at one UK University were invited to participate in the study via email. The final group consisted of 13 participants made up of 11 female and 2 male participants, which included the three participants from the pilot study. The participants from the pilot study were not interviewed again. The ratio of female to male participants reflects recent figures from the NMC showing 88.6% of nurses registered to practice are female (Nursing & Midwifery Council, 2018a). Ages ranged from 21-42 years with the average age being 27 years. The participants represented five different cohorts, at varying stages of the second and third years of the mental health nursing programme. At the time of the interview four participants were in second year, three at the beginning and one nearing the end. The other nine participants were in their third year of study, two at the beginning of third year, three around mid-point, and four nearing completion of the programme. None of the participants were in the first year of the programme. The failure to recruit first year students may be attributed to their limited experience in both academic and practice settings at the first year stage, with their experience not exposing them sufficiently to the phenomenon under investigation. However, considering the range of cohorts, ages and gender, the diversity represented within the final participant group does allow for a range of experiences and understandings to be explored. Interviews were carried out between February and May 2016. A pseudonym has been adopted for each participant and specific participant information is omitted to protect confidentiality and anonymity.

3.3.4 Data Generation

3.3.4.1 Bracketing

Within phenomenography researchers aim to explore conceptions held by participants, to understand the world from the participant perspective. This is then necessarily dependent upon the students' own lived experience of the world and researchers must recognise the individuality of experience. These reflected upon experiences are then categorised within categories of description to create an outcome space, a logically related and often hierarchical set of descriptions of the phenomenon in question (Marton, 1994; Ashworth & Lucas, 2000). To achieve this aim Ashworth and Lucas (2000) identified the need to have empathy with the student experience and for researchers to bracket their own assumptions relating to the phenomenon in question.

Marton (1994) stated that the researcher should bracket any preconceived ideas so that the focus is on similarities and differences in the ways phenomena appear to participants, rather than judging the extent to which the responses match the researchers understanding.

Ashworth and Lucas (1998, 2000) provide more detail in relation to bracketing and the kinds of presuppositions that should be bracketed. These are derived from the field of phenomenology and are identified as: importing earlier research findings, assuming pre-given structures or interpretations, presupposing the researchers own knowledge and beliefs, assuming certain research techniques prior to acquaintance with the nature of the phenomenon under study, and making assumptions about the cause of certain student experiences.

The issue of bracketing is a contested concept and Ashworth and Lucas (2000) did recognise that attempts to bracket will only be partially successful. Within the field of higher education many researchers will, like myself, also be subject teachers and will necessarily have an in-depth understanding of the subject discipline and at least some knowledge of educational

theory regarding student learning. Understandings regarding subject concepts and their associated theory are difficult to suspend when they become part of the individual's life world. In addition, empirical research is guided by both prior theory and the area of interest of the researcher (Uljens, 1996), therefore researcher neutrality maybe an impossible aim. Webb (1997) saw particular issues for researcher neutrality arguing that phenomenographic research reports findings are subject to the discourses that they study and as such will report findings that reflect accepted versions of subject knowledge based on the researcher's understanding. Nonetheless it is argued that efforts to set aside personal beliefs, prior knowledge and assumptions should be made to avoid prejudicing the data (Ashworth & Lucas, 1998, 2000; Hallett, 2014).

Orgill (as cited in Cousin, 2008) argued that it is reasonable to assume researchers have certain beliefs and experiences that will influence the research process. Orgill suggested that self-examination and open expression of these beliefs allows for more critical examination of research findings and adds additional insights into the research data. This position suggests a place for reflexivity in phenomenographic research undertakings and the reporting of them. The reflexive approach adopted in this study is discussed in section 6.3.2. Consideration of recent phenomenographic research literature suggests little attention is given to the issue of bracketing in reports, which perhaps reflects the inherent difficulties involved. Arguably these difficulties are greater when the subject discipline is of a professional nature such as nurse education. Any erroneous conceptions held by participants that have the potential to impact on patient safety cannot be left unchallenged. A more reflexive approach in acknowledging these issues and the actions taken by the researcher should they arise, allows for more open interpretation of the potential influence on the research findings. Contrary to negatively influencing the research, this approach can be seen as strengthening the research by its transparency and openness. This is the approach taken within this study.

As the focus of the interview was on the conceptions of recovery held by the interviewees attempts were made to put aside personal understandings of recovery. However, this has been recognised as a very difficult undertaking (Uljens, 1996; Ashworth & Lucas, 2000; Kim, 2010).

This difficulty was experienced within the pilot study as the following extract demonstrates:

Extract 1

David:...it's like the transformative experience of, they've experienced all these negative things and these awful things have happened as a result maybe like social isolation or whatever and it kind of strengthens them as a person and I think that is like the essence of recovery for me, when someone sort of goes through that strengthening process.

Interviewer: Is that something we might call resilience?

David: I suppose but then I suppose resilience comes from that, that's how I understand it. Like because a baby isn't resilient on its own necessarily but like once it grows..

David is seen to be discussing an aspect of recovery that is not necessarily named by him but which he sees as a process. This is then followed up by a suggestion from me as the interviewer that what the interviewee may be talking about is resilience, a recognised aspect of recovery. David's response shows that this was not actually what was meant. Failure to put aside personal understandings and the accepted disciplinary understandings of the concept of recovery on this occasion, demonstrated how researcher bias can be introduced. The pilot study interviews allowed for reflection of a personal position within the research, the opportunity to gain valuable insight into potential pitfalls, and to learn from mistakes made. The use of a reflexive journal aided this process of understanding personal biases and their potential to influence the data and is discussed in section 6.3.2.

3.3.4.2 Methods of data generation

Three different methods of data generation were evaluated in the pilot study: previously completed exam papers, responses to a written scenario, and the use of semi structured

interviews. Two of these methods were adopted for the main study with some adjustments following lessons learned from the pilot. Although rarely reported upon as a data generation method in phenomenography, Stokes, Magnier & Weaver, (2011) utilised data from exam papers along with survey responses in their phenomenographic study on conceptions of fieldwork in geography. As the participants of this study also undertook assessment via examination in relation to nursing interventions, it was thought that analysis of these papers would yield useful information regarding students' understandings of recovery. However, as a method of data generation in the pilot study the approach proved unsuccessful. In phenomenographic studies information is sought on the participants' own understandings of the concept, in this case recovery. What transpired with the exam papers was that students gave standard responses of an expected nature rather than descriptions of how they actually understood recovery in practice. As Bowden (2005) has identified there is a danger that responses can become more related to theories espoused in the literature rather than the participants' personal understanding when there is no opportunity to probe further. This proved to be the case and this method of generating data was not adopted in the main study.

Written data has been utilised successfully in phenomenographic studies as an alternative to interviews (e.g. Crawford, Gordon, Nicholas, & Prosser, 1994; Bradbeer et al., 2004). However, a potential drawback is that there is no opportunity to probe more deeply into responses, therefore as a single method for generating data it may be limited. The pilot study sought to evaluate the usefulness of responses to a written scenario as an additional data source (see appendix three). The use of a written scenario proved successful when participants were given the scenario at the beginning of the interview and allowed 15 minutes to write their responses to questions set in relation to the scenario. These responses were then discussed in detail during the interview. Marton and Pong (2005) identified that the referential and structural aspects of phenomenon are best identified when participants are able to discuss concrete

cases rather than providing abstract conceptual responses. The opportunity for follow up significantly improved understanding of participants' responses as follow up questions encouraged greater discussion and participants were able to elaborate on their written comments. This proved a valuable addition to the data generated through the interview alone.

The interview is the most commonly used method of data generation in phenomenographic research (Marton, 1988; Green, 2005; Bowden, 2000). The aim of the interview is to reveal the experiences of the participants in relation to the phenomenon of interest. It is the relationship between the participant and the phenomenon which is the focus, rather than the participant or the phenomenon itself (Yates et al., 2012). The focus on variation of experience amongst participants means that individual interviews form the starting point for a collective understanding of how the phenomenon is experienced.

Interviews generally adopt a semi-structured open ended format with a limited number of set questions, which are followed up to ascertain meaning and provide detail (Trigwell, 2000; Bowden, 2000). Follow up questions are not formed from pre-determined ideas of the interviewer but are dependent on participants' responses. Hence different interviews may proceed along different paths (Marton, 1986). With a non-dualistic perspective it follows that interviewees will interpret questions in differing ways and therefore questions are not required to be asked in exactly the same way. Ashworth and Lucas (2000) suggested "a conversational partnership in which the interviewer assists a process of reflection" (p.302) best suits phenomenographic research interviews. They stressed the importance of empathic listening and use of prompts from the interviewer to encourage participants to elaborate and pursue their own line of reflection. Marton (1994) also argued for a shared reflective dialogue, which encourages themes of the interviewee's experiences to emerge. For this a conducive supportive atmosphere is required to encourage reflection and follow up questions should be

asked to clarify meaning. Åkerlind (2005a) stressed that probing questions should uncover underlying meanings and intentional attitudes, therefore exploring concrete examples of the phenomenon is seen as useful. Åkerlind (200a, 2005b) also promoted the use of 'why' questions in phenomenographic research. In order to go beyond how the person behaved or their opinion on something (elicited from 'what questions'), she argued that establishing why that behaviour or opinion was important to the person is more likely to uncover their intentional attitude towards the phenomenon. Uljens (1996) argued that 'why' questions are unnecessary within phenomenography as there is no intention to uncover causal relationships; however, Åkerlind viewed the 'why' question as important in gaining a fuller understanding of the person's underlying meanings rather than to establish causality. The use of 'why' questions can appear interrogative and evoke defensive responses within interview settings (Morrissey & Callaghan, 2011). This may particularly be the case where there is a perceived difference in status such as student nurse and lecturer, therefore generally the word 'why' was avoided within the interviews. Questions were used where although linguistically the word 'why' was avoided, the question was still aimed at uncovering an underlying meaning. These occasions led to fuller exploration of the interviewees' understandings.

A semi-structured interview schedule was used with minor adjustments made following the pilot study. Adjustments led to a better flow of questions and aided understanding on behalf of the participants in relation to the question asked. The interview schedule is attached as appendix four. Whilst the schedule provided a focus for the interview, in line with phenomenographic research the questions asked were largely dependent on interviewee responses, with a focus on follow up questions to elicit meaning. Interviews all took place on campus which proved convenient to the participants and lasted between 35 and 65 minutes. All interviews were conducted by myself, known to all participants as a lecturer at the university where they studied.

3.3.5 Transcribing

Interviews were audiotaped and transcribed by myself. The choice to personally transcribe was made to increase familiarity with the data (Åkerlind, 2005a) and to gain insight into the process. Kvale and Brinkmann (2009) have pointed out that there is no universal standard or code for the transcribing of interviews and so the researcher must make choices regarding the style of transcription. Within the pilot study all whole words and utterances were included in the first transcription; however, this was found to impact on readability and understanding of the discussion, particularly of extended sequences. Flick (2009) identified that it is only necessary to transcribe as much as is required by the research question and that an over exact transcription can actually obscure meaning, this proved to be the case. As it is the content of the discussion which provides the analytical focus rather than the linguistic style, only whole words were included in the further transcripts with utterances such as 'ah' or 'erm' omitted, providing greater clarity of meaning. No further editing was done at the transcribing or analysis stage, although where extracts are used within the text to describe the findings, quotes were grammatically edited to assist the reader. Words such as 'like' or 'well' are omitted at this stage and punctuation is added.

The decision on what to omit or include in transcription is not a neutral one and omissions can impact on meaning. The interview is a face to face conversation where meaning is provided through both verbal and non-verbal interactions. It became apparent that non-verbal interactions such as hand gestures and expression of emotion were difficult to capture in transcription when there is a focus on capturing the spoken word. At the pilot study stage in one particular exchange a joke about a nursing theorist was shared but not fully captured by the written word and the expression of emotion, in this case laughter, was not included in the transcript. Taken out of context the meaning of this exchange became inaccessible. Ashworth and Lucas (200) placed emphasis on including anything within the transcript that is likely to

affect the interpretation of the meaning. The transcribing experience in the pilot study identified that significant expressions of emotion and non-verbal behaviour should be noted which required careful checking of the transcripts against the original audiotape.

The process of transcribing is rarely well explained with few studies considering the issue in detail (Halcomb & Davidson, 2006). However, Dortins (2002) provided an account of similar experiences in transcribing where she describes distancing herself from the interview situation and the participants as the interview conversations were re-conceptualised as research data. For Dortins (2002) “the changes of meaning involved in the translation were palpable” (p.208) and she acknowledged her discomfort with this. The experience in this study highlighted how transcribing is an interpretive process whereby transcripts become decontextualized versions of the original interview that cannot be said to reflect the reality of the interview in a complete way. Being mindful of this in a reflexive way is important as the transcripts become the empirical data for the study.

Pseudonyms were used for all participants at the transcribing stage. Where names, for example certain wards or units, were mentioned by participants these are replaced with X to maintain confidentiality. Explanatory notes or additional information, for example expression of laughter or long silences, are included in round brackets. Where occasional words are inaudible these are denoted by [inaudible] in square brackets. In presenting extracts from the transcripts ellipsis indicate where a section has been omitted as it does not relate to the point under discussion.

3.3.6 Analysis

The aim of phenomenographic research is to identify the different conceptions held about the concept and for this variation to be captured in categories of description. The categories of

description are then structured in a way that demonstrates the relationship between the categories and forms the outcome space (Marton & Booth, 1997). The outcome space holds a set of collective experience (Åkerlind, 2005c).

As with most qualitative research approaches similarities and differences exist in methods adopted. With phenomenography this is apparent within the analysis stage. Marton (1998) viewed the analysis stage as “a process of discovery” (p.198) warning against a too rigid approach with specific techniques. Dahlgren and Fallsberg (1991) also suggested a ‘slavish approach’ to be contradictory to the spirit of qualitative research where in reality there is an ongoing interplay between the stages of analysis. However, a lack of consideration within the literature of the analytical process involved has led to criticism and misunderstandings in relation to phenomenographic practice (e.g. Webb, 1997; Richardson, 1999). What has emerged is some commonality but also variation within accepted practice of the analysis stage of phenomenographic research (Åkerlind, 2005c).

Essential to the analysis stage is the ability of the researcher to remain open minded to minimise the influence of pre-suppositions and to avoid the temptation to produce categories of description too early in the process (Ashworth & Lucas 2000; Åkerlind, 2005c). The process is a strongly iterative one, whereby there is continual reading, re-reading, sorting and grouping of the data. This requires an openness to new interpretations. Marton (1988) highlighted the difference with the phenomenographic approach to traditional content analysis in that the categories used are not pre-determined but emerge from the data. Dahlgren and Fallsberg (1991) used the metaphor of a pack of cards to illustrate the difference:

Imagine that somebody is given an ordinary pack of playing cards and asked to sort them. Most probably the result would be four different groups of cards according to the four suits. A possibility is of course thirteen groups according

to denomination. In phenomenographic research the task is to divide a number of dialogues, but an important difference in comparison with the card sorting task, is the fact that the researcher does not previously know the categories according to which the task could be solved. The result instead consists of finding and defining the existing subjective categories of meaning expressed in the dialogues according to which they can be grouped. (p.152)

As emerging categories are checked against the transcripts the focus of the analysis is to identify differences between categories, similarities within the categories and identify how the categories are related (Marton, 1998; Åkerlind, 2005c). For all those undertaking a phenomenographic approach this involves a shift from individual transcripts to viewing them as a set to provide collective understanding of the data. Data from individual participants cannot be viewed in isolation from the rest of the data. Variation exists in how this collective data is used with differences in the amount of each transcript considered. Although not always well reported in the research literature, practice varies from using selected quotes (e.g. Dahlgren & Fallsberg, 1991; Harris, 2008), to using chunks of transcripts (e.g. Prosser, 2000; Hallett, 2010) to whole transcripts (e.g. Bowden, 2000).

Marton (1988) identified that analysis begins with the marking of selected quotes/ utterances that are found meaningful within the transcripts. He highlighted that during the process of interpretation, the meaning of the quote should not only be considered in relation to its content but also the context from which it came: “the phenomenon in question.....is delimited and interpreted in terms of utterances that are selected from the interview, whilst the quotes themselves are delimited in terms of the context from which they were taken.” (p.198)

Once selected quotes are identified, for Marton (1988) the focus at this point in the analysis shifts from the individual to the collective, as quotes are brought together in a ‘pool of

meanings'. Each quote has two contexts in which it must be interpreted, the interview from which it was taken and the pool of meaning in which it is placed. Therefore the iterative process in this approach involves moving to and fro between the two contexts. The interpretative work brings together quotes with similar meaning and the groups are defined by their differences, leading to categories of description. As quotes are brought together, meaning of the category develops. Through the iterative process, as meaning develops it also determines which quotes belong to that category. Meaning and belonging may change "however at a decreasing rate of change and eventually the system stabilises itself" (Marton, 1988, p.199).

Marton (1992) acknowledged this process as a difficult one for novice researchers with the risk of decontextualisation of utterances. Säljö (1997) expressed concern that content and context of quotes must be viewed as essential, illustrating with the use of case examples how utterances can be open to many interpretations and how losing context can change meaning. Similarly concerned with the issue of context, Ashworth and Lucas (2000) reported on the use of individual profiles within phenomenographic research to aid analysis. Individual profiles of interviews were developed to capture the central experience recounted by subjects and in the later stages of pooling quotes, the profiles were viewed as an important means of avoiding the risk of quotations being interpreted out of the context from which they came.

In contrast to the above approach, for other phenomenographers, whole transcripts or large chunks of transcripts are maintained as a unit of analysis rather than taking selected quotes. Bowden (2000) asserted that underlying meaning can only be uncovered by consideration of all possible perspectives and their inter-related meaning, stating that this can only be done by maintaining the data contextualised within the transcript. Åkerlind (2005b) undertook her analysis initially based on whole transcripts then in large chunks, always reading the

designated chunks as a whole during the iterative process. Again the rationale given was to provide greater opportunity for interpretation of underlying meaning.

One concern regarding the whole transcript approach is the danger that the analysis may become focused at an individual rather than a collective level (Forster, 2013). As Bruce (1997) identified, individual transcripts do not equate to categories of description. More than one way of conceptualising the phenomenon may be experienced by the same one individual and therefore recounted within the transcript. If whole transcripts are grouped according to their predominant similarities, there is a danger that this variation will be lost. In her research Åkerlind (2005b) recognised the need to continually ask herself “am I focusing too much on the individual?” (p.117) to overcome the danger of losing variation and the collective focus.

Åkerlind (2005b) also identified the difficulty of managing large amounts of data when dealing with whole transcripts. Her approach to managing this was with some preliminary analysis of a sub- set of data, before viewing the remaining data closely to refine and modify the final outcome space. The data may be viewed as more manageable within the Marton approach to analysis whereby only relevant quotes are selected. Inevitably there will be sections of transcripts of more relevance than others. Removal of unhelpful components can make the data more manageable (Svenson & Theman, 1983).

3.3.6.1 Contrasting methods of analysis

The pilot study provided the opportunity to ensure that the data collected would capture variation within student understanding of recovery. Careful reading of the three transcripts showed this to be the case, although minor amendments were made to the interview

schedule. Whilst it was not the intention to complete a full analysis of the data in the pilot study, the pilot study aimed to evaluate the effectiveness of the analytical framework described by Dahlgren and Fallsberg (1991).

Forster (2013) carried out a pilot study to explore two contrasting methods of data analysis, which he named the 'Marton' method (which is the framework described by Dahlgren and Fallsberg 1991) and the 'Åkerlind' method. Whilst both methods share the principles of phenomenographic approaches to analysis, there are differences in relation to the stages applied to analysis and the amount of data used from the transcripts in the analysis; the former taking utterances or selected quotes, the latter using the whole transcripts or large chunks of transcripts. In relation to his study on the role of information literacy in nursing, Forster found the 'Åkerlind' method to be most fruitful in allowing the complexity of ideas to emerge, whilst he suggested the 'Marton' method failed to acknowledge the context of statements which impacted on meaning. These two frameworks discussed are depicted in tables one and two.

Table 1 Frameworks for Data Analysis, Marton Method as described by Forster (2013)

Analytical Stages	Marton Method (Dahlgren & Fallsberg 1991)
1. Familiarisation	Transcripts are read several times to gain detailed acquaintance.
2. Condensation	A short but representative version of the complete dialogue is obtained by marking of the significant statements made by participants.
3. Comparison	Sources of variation and agreement are sought as the selected statements are compared.
4. Grouping	Similar responses are put together
5. Articulating	A preliminary attempt is made to describe the similarity within each group of responses. (stage 4 and 5 may be repeated several times)
6. Labelling	The various categories are identified and named
7. Contrasting	The named categories are compared for similarities and differences.

Table 2 Frameworks for Data Analysis, Åkerlind Method as described by Forster (2013)

Analytical Stages	Åkerlind Method
Step One	Transcripts are read three times, on the third reading making notes summarising key issues and themes.
Step Two	Similar transcripts are grouped together after repeated reading and re-reading of transcripts and notes.
Step Three	Rearrange groupings after further readings focusing on: <ul style="list-style-type: none"> • Search of similarities and differences in overall meaning of transcripts • Search for 'dimension of variation' in meaning that runs across transcripts which develop into categories of description • Develop themes of 'expanding awareness'

Within this study the framework described by Dahlgren and Fallsberg (1991) generally proved useful in guiding the analytical process, with some additions from the 'Åkerlind' approach incorporated at the point where it was felt useful to do so, although the 'Åkerlind' approach was not tested as such. During the condensation stage utterances that were similarly occurring across transcripts were highlighted. This often turned out to be more than a single quote as the use of follow up questions meant there was a clear relationship between responses. In places sections of the transcript were used. This was not a deliberate attempt to utilise the 'whole transcript' approach of Åkerlind, but was felt necessary in relation to context and meaning. Making notes on the transcripts through the comparison to labelling stages proved useful in "holding all the ideas in mind at one time" (Bowden, 2000b, p.56) and there was a need to constantly refer back to the transcripts to keep quotes in context. Whilst this did not constitute using whole transcripts as advocated by Åkerlind (2000b), there was a constant 'to-ing and fro-ing' from the selected quotes within the transcript to the placement of the quote within the groupings to ensure understanding of meaning. It also became clear that the framework outlined by Dahlgren and Fallsberg (1991) could not be followed in a strictly linear fashion, particularly the stages of comparison through to articulating and to make sense of the data these stages needed to occur together. However, Dahlgren and Fallsberg (1991)

themselves did recognise that interplay between the various stages occurs within the spirit of a qualitative analysis.

Aspects of both the approaches detailed by Forster (2013) were found useful; however, in contrast to Forster's findings, the framework outlined by Dahlgren and Fallsberg (1991) was considered most suitable in guiding analysis, although some additional measures have been discussed. Taking smaller utterances rather than whole transcripts facilitated the process of pooling meaning to consider the data as one collective set. It also made it easier to identify variation within individual accounts. It is acknowledged that the analysis was completed with only three transcripts and was foreclosed early, without firm categories of description or outcome space being developed. However, variation between groupings was highlighted. The aim of the pilot was therefore met in that the framework considered proved a useful structure for the phenomenographic analysis within the main study.

3.3.7 First Stage Analysis of Data

The analysis of data in the main study was carried out in two stages. The first stage addressed the research question 'what is the variation in mental health nursing students understanding recovery?' A second stage analysis followed to address the second research question 'what is troublesome for mental health nursing students in their learning experiences of recovery?'

The data analysis procedure followed that identified by Dahlgren and Fallsberg (1991) and was informed by lessons learned from the pilot study. A conscious decision was taken not to use a computer software package at this stage; the use of flip chart and coloured markers proved successful at the pilot stage in organising data and was my preferred method. The first stage analysis was started with the 10 transcripts not previously used in the pilot study. Once the initial analysis was carried out, the three additional transcripts were included and the

preliminary analysis was reconsidered in light of these. Using a smaller group of transcripts helps make the data more manageable (Åkerlind, 2005a) and it was felt viewing 'fresh data' would help prevent previous suppositions from the limited analysis in the pilot study having undue influence. The analytical procedure, although following Dahlgren and Fallsberg's framework, was a more fluid process than the demarcated stages identified in the previous section, particularly stages 3 to 5, conforming to Marton's (1998) view that a too rigid approach can hinder discovery. Therefore, a constant interplay between the stages described in the following discussion should be recognised.

3.3.7.1 Familiarisation

To begin the analysis, I listened to the recorded interviews again before reading through the transcripts at least three times. This enhanced both my engagement with the transcripts and a feeling of closeness to the participants and the data generated by them. I also commenced making notes at this early stage having found this practice useful in the later stages of the pilot. These included a summary of the transcripts and any particular 'stand out' features. This stage took longer than anticipated and I needed to consciously prevent myself from moving on too quickly. Ashworth and Lucas (2000) identified the importance of focusing on both what is being said and the manner in which it is said and as such advocate that the researcher slow down to dwell on the participants' experiences. Being mindful of this improved the analysis process.

3.3.7.2 Condensation

As with the pilot study, relevant sections of the transcripts were highlighted in response to questions posed with key words or passages underlined. At times this only involved short sections, at others large chunks of transcript were included to maintain meaning. I felt it better at this stage to over include rather than lose any important data and context was more easily

recognisable from the larger chunks of data. Where smaller sections were used, notes were made relating to the context from which the data had come. Marking in this manner also helped exclude irrelevant material where the conversation was more generalised or strayed away from the questions being asked.

3.3.7.3 Comparison, grouping and articulating

These stages are described together because of the constant interplay and overlap between them. In comparing quotes, the highlighted sections were cut from the transcripts and placed on a flip chart into groupings which appeared to be similar. The process at this stage involved a significant amount of moving and replacing data in groups as I moved from the individual meaning to a pool of collective meaning. Several attempts involving constant comparison were needed to refine the groupings which involved an ongoing reiterative process between the collective pool and the individual transcripts. This led to the groups being narrowed down to five, as the similarities within and the variation between groups was articulated.

It was apparent at an early stage that as well as similarities, variations existed between individuals' experiences, but initially this was not well defined and difficult to articulate. Using the structure of awareness framework previously described in section 3.2.5, the aim was to identify both the referential and structural dimensions of how the participants experienced recovery, with the referential aspect referring to the meaning of the experience and the structural aspect referring to the parts of the experience and how they relate to each other.

Although Smith (2010) suggested identifying the referential and structural aspects are two distinct stages in the process of analysis this was not something experienced within this analysis as there was constant interplay between both. As the iterative process continued the dimensions of variation within the internal horizon of the structural aspect became more

apparent and this helped gain clarity regarding the nature of the external horizon. This clarity of structure then led to greater understanding of meaning. For example, in the grouping stages category A was thought to include an understanding of recovery as 'being service led' as part of its overall meaning (the referential aspect). However, with further analysis and consideration of the internal and external horizons within the structural aspect, service led issues became recognised as part of the context of providing care and therefore part of the external horizon. This then led to a redefining of the categories as meaning within them became clearer. Marton and Booth (1997) stated that the researcher should focus on one aspect of the object of study, seeking its dimensions of variation whilst the other aspects are held frozen. This required identification of the different aspects of recovery apparent within the data so that the variation could be identified. This required intense scrutiny considering the context of the extract from the transcript and its relationship to similar utterances within the pool. The pooling of data eventually led to five different aspects being identified which participants experienced related to recovery. These incorporated issues related to the person, the nurse, nursing interventions, the recovery process and the nurse- patient relationship. As the analysis continued variation across the categories related to these dimensions of variation became clearer. These dimensions of variation are discussed fully in chapter four and illustrated in table eight.

It was at the articulation stage that the three further transcripts analysed in the pilot study were included. The five preliminary groupings articulated were reconsidered in light of the additional data. I read each additional transcript looking for any different or similar perspectives to those already identified. This process supported the groupings identified and these became the preliminary categories of description shown in table three. At this stage labels were attached to the categories.

Table 3 Preliminary Categories of Description

Category A	Having treatment
Category B	Making progress
Category C	Getting back to oneself
Category D	Living well
Category E	Learning to live differently

Continued analysis identified further revisions to the categories. Version two of the categories of description is shown in table four. At this stage previous category A, Recovery as having Treatment was divided into two separate categories to reflect the clinical focus and service led focus. As discussed above this was later discounted with fuller analysis of the referential and structural aspects and therefore version three reverted back to the preliminary categories.

Table 4 Version 2 Categories of description

Category A	Clinical recovery- reduction of symptoms
Category B	Service led recovery
Category C	Making progress
Category D	Getting back to oneself
Category E	Living well
Category F	Learning to live differently

Version four included refinement of the categories with more concise descriptions. A major change at this stage was the removal of the category Getting Back to Oneself. Marton and Booth (1997) stated that the categories should be parsimonious in that as few categories as needed are used to capture critical variation. The critical variation identified within category D prior to this stage was the notion of the person getting 'back' to something, while the other categories identified progression as moving 'forward'. However, the category felt unstable when considered in light of the similarities with other categories. A careful review of the extracts supporting the category led to a reinterpretation of meaning when considered within

the context of the transcripts. Whilst linguistically the word 'back' was used, taken within context the meaning encompassed a more abstract notion of resuming activities of living and making progress, therefore not a critical aspect of variation. With this modification, data from the category 'Getting Back to Oneself' was split and combined into the other categories (table five).

Table 5 Version 4 Categories of Description

Category A	Clinical Improvement
Category B	Making Progress
Category C	Living Well
Category D	Learning to Live Differently

3.3.7.4 Labelling

It became apparent that labelling was a crucial stage in the analysis process as I struggled to identify a label to capture the nature of the categories and the experiences of the participants. Smith (2010) suggested labels should only be applied once the researcher is content that the data has been condensed to its core meaning. Although at the different phases of articulating I was not necessarily convinced of the stability of the categories, I still found it helpful to apply labels. This captured the nature of the category and helped to highlight variation between the categories. Therefore labelling was applied throughout the analytical process. After version four, I felt the stability of categories had been reached; however, with the modifications made, the labels required refinement with the final labelled categories of description shown in table six.

Table 6 Final Categories of Description

Category A	Recovery as Clinical Improvement
Category B	Recovery as Making Progress
Category C	Recovery as Managing to Live Well
Category D	Recovery as Learning to Live Differently

3.3.7.5 Contrasting

The process of contrasting involved exploring the similarities and differences of the categories which resulted in determining the logical relationship between them and hence the outcome space. Again it should be emphasised that this was not a sequential process, with thoughts about the relationship between categories beginning in the analytical process at the grouping and articulating stage. This was not a conscious effort to explore structure but a naturally occurring consequence of the search for similarities and differences between categories.

Ashworth and Lucas (2000) warned against foreclosing too early on the analysis in the search for a logically related set of categories of description as the analysis maybe incomplete.

However, Åkerlind (2005b) suggested that exploring structure and meaning simultaneously can be helpful, particularly in the later stages as each inform each other. This was found to be the case within the iterative process of this analysis.

When complete the outcome space is synonymous with the phenomenon of study (Marton, 2000), in this case recovery. The categories within the outcome space represent different ways of understanding the same phenomenon and as such it is expected that links will be seen between them (Bowden, 2005). It is usual within the literature for these links to be presented in a hierarchical structure which represents increasing levels of complexity of understanding, in that the higher category subsumes the lower ones but not vice versa. As Bruce et al. (2004) highlighted, some categories are more complex and powerful and therefore are placed higher in the structure of the outcome space. However, Patrick (2000) warned that it may be detrimental to assume a hierarchical structure in advance of the analysis and it did become apparent that a basic hierarchical structure of the categories was not sufficient to explain the relationship between them. Within a hierarchical structure each category is viewed as subsuming the previous category, as the structure implies that the characteristics present in the lower categories are present in all others (Kember, 1997). However, the understanding

related to the internal and external horizons within the first category, Recovery as Clinical Improvement, was not supported in the other three categories. Although interpreted as qualitatively different, there was no clear hierarchical link. However, the other three categories were at this stage considered to demonstrate an increasing level of complexity of understanding of recovery forming a nested hierarchy. The outcome space therefore became a branched hierarchy as shown in figure 2 where category D, Recovery as Learning to Live Differently, represents the most complex way of understanding recovery within the second branch.

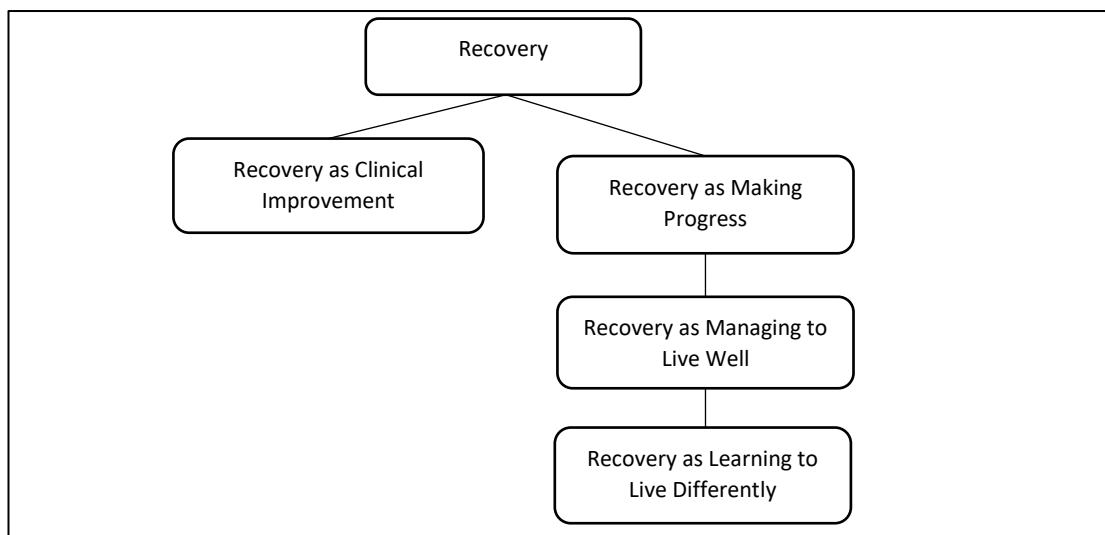


Figure 2: Version 1 Outcome Space

In reviewing the research into conceptions of teaching, Kember (1997) suggested that alternative approaches to presenting the outcome space should be considered as “it seems unlikely that all scenarios are best understood by the reader if portrayed as a list of categories in hierarchical order” (p.263). Although relatively uncommon, alternative configurations have been reported in other phenomenographic studies. In nursing, Steffnak, Nordstrom, Hart and Wilde- Larsson (2014) considered perceptions of the nurses’ role in relation to the use of psychotropic medication. Three horizontally ordered categories were reported “equal in relation to each other- at the same level and not over-lapping” (p.973), suggestive of a

branched structure. A further study related to mental health nursing roles by Aflague and Ferzt (2010) considered the conceptualisation of suicide and suicide assessment. The authors clustered their 10 categories of description into three related dimensions rather than a hierarchical relationship to describe the structure of suicide assessment. Prosser, Trigwell and Taylor (1994) in their study on conceptions of learning and teaching, found qualitatively distinct categories for conceptions of teaching which fell “into two strongly contrasting subsets” (p.228), again suggesting a branch like structure rather than a hierarchical one.

This structure of the outcome space was considered as a branched hierarchy for some time, although some doubt remained about the stability of the categories, particularly the move from version three to version four and their relationship to each other. Therefore, the whole analysis was revisited several weeks later. Further consideration confirmed the categories of description as stable and complete; however, revisiting the structure of the outcome space highlighted inconsistencies which did not fit with a hierarchical nested ordering of the second branch. Whilst variation between the categories remained as qualitatively distinct, the more complex understandings of recovery did not contain all the characteristics of the less complex categories. It was apparent that at times some characteristics were replaced rather than subsumed. A similar outcome space is described by Bradbeer, Healey and Kneale (2004) in identifying undergraduate conceptions of teaching, learning and geography. They reported a non- hierarchical structure in that some conceptions were subsumed by higher ones, but others stood as alternatives. In a review of 13 studies on conceptions of teaching Kember (1997) reported that the findings were not consistent with hierarchical ordering, suggesting that categories are better portrayed as positions within a continuum when the characteristics of the lower categories are not found in the higher ones. Cousin (2008b) also suggested categories could be placed along a continuum, in a hierarchical structure or within a combination of the two. To reflect the fact that not all the characteristics of the dimensions of

variation in the less sophisticated categories were present in the more sophisticated ones, the final outcome space was revised, with the second branch presented as a continuum rather than a nested hierarchy. The final outcome space is shown in figure three.

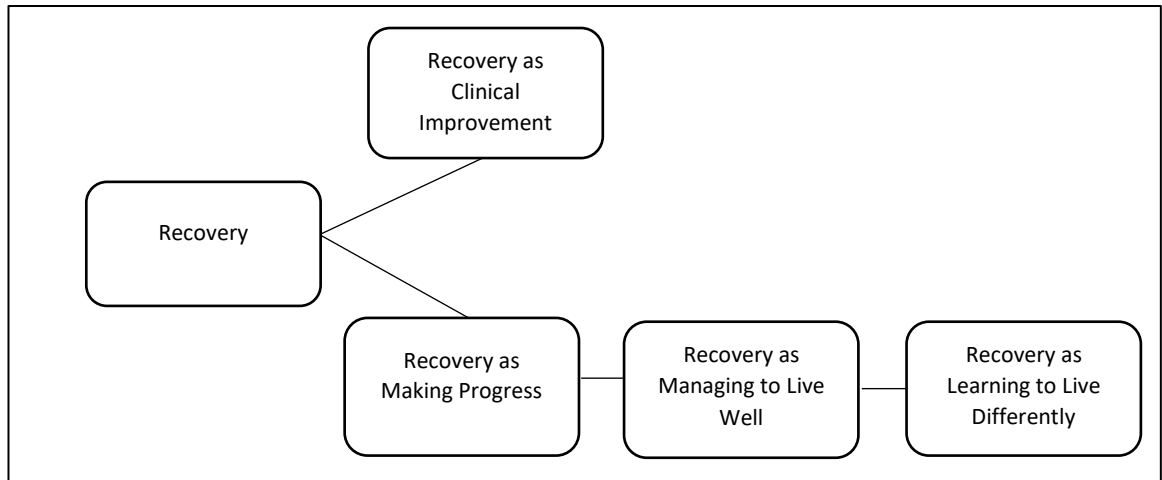


Figure 3: Final Outcome Space

3.3.8 Second Stage Analysis- Troublesomeness

To address the second research question ‘what is troublesome for mental health nursing students in their learning experiences of recovery?’ a second analysis of the data was undertaken. The transcripts were revisited and considered in light of the notion of troublesomeness as defined within the TCF. Marton (1988) identified that within phenomenographic analysis categories are developed from the data rather than being pre-determined. Therefore this second stage analysis was adapted somewhat from the framework discussed in part two of this chapter. The analysis procedure broadly followed that identified by Dahlgren and Fallsberg (1991) as previously discussed, with an iterative process of identifying similarities and variation within the data. As key words or phrases related to difficult learning experiences were selected the aim was to identify the critical features of recovery that presented as troublesome to students. An already familiarity with the data significantly aided this process as comparisons were made and selected quotes were grouped into clusters of similar meaning. Initially this process focused on troublesome knowledge;

however, it quickly became apparent that other aspects of difficulty were involved. As grouping and articulation continued, four categories of troublesomeness emerged.

Demarcation of these categories was not clearly defined as some selected quotes could be seen to involve more than one source of trouble, where this occurred the most dominant source was included with notes made to identify others associated with it. Four categories, or sources of trouble, were identified as depicted in table seven.

Table 7: Categories of Trouble

Category A	Troublesome knowledge
Category B	Troublesome practice
Category C	Troublesome learning environments
Category D	Troublesome learning relationships

The categories identified in table seven were not explored in terms of an outcome space, as the relationship between the categories was pre-determined as their troublesome nature. The categories were identified as being closely linked and are explored in detail in chapter five.

3.3.9 Credibility and Trustworthiness of the Research Design

There is continued debate within the research field regarding the use of validity and reliability as appropriate criteria for the assessment of qualitatively designed research studies. Whilst some authors judge their applicability fitting to all research paradigms, others argue for a set of criteria that better suits the philosophical stance of the method of enquiry being used and that because of their association with a positivist stance, the concepts of reliability and validity are inappropriate to qualitative forms of inquiry (Savin- Baden & Howell Major, 2013). The assessment of validity and reliability specifically within phenomenographic studies is also considered a contentious issue, with many studies not making any explicit mention of these issues within their reports (Cope, 2002b).

Reliability usually refers to the consistency of an instrument to measure the attribute or concept it was designed to measure (Streuber & Carpenter, 2011). However, in qualitative research, the researcher is most often themselves the 'instrument' which collects and measures the data, therefore this meaning has limited relevance. Within qualitative research, reliability often refers to the replicability of results, if repeated by another researcher, the likelihood that they would arrive at the same result (Cope, 2002b). For phenomenographic research this is again problematic. Marton (1986) stated that replication of results obtained through the use of phenomenography was inappropriate as phenomenography is a process of discovery with open and exploratory approaches used in collecting and analysing the data. Whilst broad methodological principles are adhered to, the interpretative nature of the approach means that the intricacies of method will not be the same. Phenomenography is also based on the premise that individuals experience the world in different ways. This must therefore also be applied to individual researchers who constitute a relationship with the data. It would follow that researchers' experience variation within these relationships therefore replication of the outcomes space is unlikely (Cope, 2002b).

Whilst it cannot be expected that phenomenographic studies would be replicated with the same outcome space reported, the process should be described in a way that the variation in the outcome space is clearly communicated to others (Marton, 1986). In testing the quality of communicating results of findings, inter-rater reliability has been used by some phenomenographers, in that researchers independent to the study are asked to review the data generation process and findings to gain some consensus between researchers. However, for the reasons explained above this approach can be seen to be incompatible with phenomenography, as knowledge exists in the relations between individuals and their worlds. Inter-rater reliability, based on a positivist stance, is not consistent with this perspective (Sandberg, 1997).

Validity refers to the extent to which the research effectively investigates that which it set out to. Within phenomenography this refers to how the research outcomes correspond to the human experience of the phenomenon, rather than how it actually exists in reality (Åkerlind, 2012). Booth (as cited in Cope, 2002b) suggested that in relation to phenomenographic studies, validity is concerned with the credibility and trustworthiness of the findings, the presentation of the outcome space and the justification of the claims made about it. Credibility refers to how convincing the findings are in representing a sense of the participants' reality. Whilst trustworthiness refers to demonstration of rigour in the processes undertaken and relevance of the study's outcomes (Ellis, 2016; Savin- Baden & Howell Major, 2013). The credibility and trustworthiness are then judged by the reader of the study. To support a full and open account so that such judgments can be made, Cope (2002b) makes eight recommendations against which this study is evaluated below:

1. The researcher's background should be acknowledged.
2. The characteristics of the participants should be clearly stated.
3. The design of interview questions should be justified.
4. The steps taken to collect unbiased data should be included.
5. The attempts to approach data analysis with an open mind should be acknowledged.
6. The analysis should be described.
7. The researcher should describe the processes used to control and check interpretations made within the analysis process.
8. The results should be presented in a way which permits informed scrutiny.

Cope suggested that the researchers' prior experiences are part of the process of data analysis despite any best efforts to remain open- minded. Therefore the researcher's knowledge of the phenomenon under study provides a context within which the analysis is situated. In relation to this study this context is provided in my positionality statement in section 3.2.8.2. Here

there is acknowledgment of my clinical background as a nurse and my current position as a senior lecturer. My interest in the concept of recovery is longstanding and of personal importance and is also acknowledged within this statement.

The characteristics of the participants of the study are detailed in section 3.3.4. This allows other researchers and nurse educators to consider the applicability of the study to other contexts. Åkerlind (2002) suggested that “the results of phenomenographic studies should be generalisable to other groups of people from a similar population” (p.12) as the variation of experience from one group should be common to another group sharing similar characteristics. Generalisation is usually associated with quantitative research in applying the findings of one study to a broader population represented by the sample and is used in predicting specific outcomes with that population (Rebar, Gersch, MacNee, & McCabe, 2004). Within qualitative research the term transferability is more often used to describe the extent to which findings are applicable to another group in a different context to where the study was undertaken. The demographic information provided allows for such comparisons and a judgement to be made by the reader on the transferability of findings.

Numbers three to five of Cope’s eight recommendations are described in sections 3.3.5 and 3.3.6 where a conscious attempt has been made to provide a transparent account of the issues involved in gathering and transcribing the data in preparation for analysis, so that judgments can be made by the reader on the measures undertaken and the issues that arose. This discussion is intended to expose potential problem areas and how these were addressed. It is concerned with honesty and integrity of the research (Savin- Baden & Howell Major, 2013).

Data analysis was conducted under the framework of a structure of awareness which provided a planned and organised way to describe findings with a sense of coherence to the data. The

analysis followed a staged procedure. This supported a constant iterative process which encouraged the checking of interpretations and prevented any desire to move on too quickly with the analysis. As a piece of doctoral research this analysis was carried out individually, although it was reviewed through a robust supervision process. Walsh (2000) suggested that a lone researcher may have difficulty in bracketing their own perceptions during the analysis stage. She goes on to suggest if the input into analysis is made explicit this potential bias can be overcome. Issues of bracketing have been explored in a reflexive way within this study and the researcher position is made explicit throughout the relevant chapter. The results from this analysis and the associated discussion are presented with full descriptions of the categories of description and illustrated throughout with participant quotes to explain and support the interpretations made. Stenfors- Hayes, Hult and Dahlgren (2013) stated that the categories should be defensible, useful and meaningful to the intended audience. The full description provided is intended to allow readers to make this judgement.

3.3.10 Conclusion to chapter

Part three of this chapter has explored the research methods and analytical process adopted within this study. This process of analysis was informed by relevant literature and lessons learnt from the pilot study. The analysis broadly followed the procedure identified by Dahlgren and Fallsberg (1991) and was carried out in two stages. The first stage analysis resulted in the identification of a branched outcome space with four categories of description. The second stage analysis identified four troublesome features which impeded student learning in relation to recovery.

To aid the trustworthiness of the study and the credibility of the findings, the analytical process was carried out in a reflexive way with consideration given to the strategies used within the stages of data generation and analysis. Other issues related to the quality of the

study are discussed in chapter six. The analysis described here resulted in the findings explored in chapters five and six.

Chapter 4: Student Understanding of Recovery

4.1 Introduction

The first aim of this study was to identify the variation in understanding of recovery in mental health nursing students. The phenomenographic approach previously detailed identified an outcome space of four categories of description, demonstrating the variation of understanding for participants. The branched outcome space indicates recovery as being understood in two distinctly different ways. Branch one contains only one category Recovery as Clinical Improvement, whilst branch two contains three categories, Recovery as Making Progress, Recovery as Managing to Live Well and Recovery as Learning to Live Differently. This chapter explores the nature of these categories of description which constitute the various understandings participants hold about recovery as related to mental health nursing practice.

In interpretative research a strict demarcation between findings and discussion can be unhelpful as the process is rarely a linear one (Thomas, 2009). Therefore, rather than being presented separately the findings and the related discussion are presented together within this chapter. Stylistically this prevents repetition, but also allows for a closer relationship between the data and points of discussion.

4.2 Categories of Description

The following section describes the nature of each of the categories of description positioned within the outcome space. The critical features of variation which distinguish each category from the others are discussed and supported by extracts from the transcripts. Entwistle (1997) argued that sufficient extracts are required so that the meaning of the category can be fully defined: "the meaning resides in the essence of the comments from which the category has been constituted" (p.132), therefore these are included throughout.

The findings are underpinned by the structure of awareness framework described in section 3.2.5. Each category of description describes a referential aspect which refers to the meaning of the experience and a structural aspect which explains how the parts of the experience relate to each other. The structural aspect comprises of an internal and external horizon. The internal horizon described in each category comprises of five dimensions of variation related to the person, the nurse, nursing interventions, the recovery process and the nurse- patient relationship. The external horizon describes the context within which participants experience recovery and recovery orientated practice. The referential and structural aspects of the conceptions held within each category describe the critical variation between categories and the logical link between them.

4.2.1 Branch One-Recovery as Clinical Improvement

The only category within the first branch of the outcome space is Recovery as Clinical Improvement. Within this category there is a focus on a medical approach to illness, where a reduction of symptoms and service user stability of condition is viewed as key to recovery. The person is understood as having a pathological disorder, with a diagnostic label that requires professional treatment. The person is seen as needing to understand that they have an illness and be accepting of professional help, as seen in the following extract:

Extract 2

Paula: I think some people find it hard to accept that they're unwell and they might not agree that they're unwell. So for some people it's about helping them to accept it, for some people it's about helping them to cope with it because if not some people will probably get more unwell.

Within this extract Paula recognises that the person may disagree with professional opinion that they are unwell which is seen as unhelpful. Therefore the goal is to change the person's mind to accept the professional view in order to prevent further deterioration. The nurse is

viewed as the professional with expert knowledge. Interventions are identified by the nurse and delivered by the nurse to the person, the person is a passive recipient of care. This 'top down' approach demonstrates a power imbalance in the relationship between the person and the nurse, where decision making lies with the nurse. Where the person has a different view, or alternative interventions which may be more person led are considered, they are viewed as less robust. This is demonstrated by Francis below:

Extract 3

Interviewer: The other thing you mentioned earlier was WRAP plans, have you had experience of using these anywhere?

Francis: I think if they're used properly then they're quite effective but how many times are you going to sit and write a WRAP plan with someone, or get them to write one and they'll bring it back to you and they've done it, but is there anything to then measure that these people are then using the WRAP plans? They just take them home stick them in a drawer and forget about them, and then relapse and come back in and they do another one, like you can't, especially in the community, you can't assess that someone's using it.

Wellness Recovery Action Planning (WRAP) is a person led self-management approach to dealing with daily living. The approach includes having a daily maintenance plan which the person follows to maintain wellness. Strategies are also identified and put in place by the person to respond to any signs that things are starting to go wrong, these are staged to manage deterioration up to crisis point. What can be seen from the above extract is that within this category this type of approach is viewed as flawed because of the lack of control by the professional. Francis expresses concerns that the person will fail to follow the plan and that without a level of monitoring from the nurse relapse may occur. Fear of failure on behalf of the person has been recognised in health professionals, with staff reluctant to embrace self-management (Mead & Copeland, 2002). Mental health professionals have also expressed concern that too much responsibility and hope is placed on such approaches, particularly

where there are perceived risks associated with self-harm or suicide (Forchuk, Jewel, Tweedell, & Steinnagel, 2003). The findings of this study suggest in some cases such concerns persist with self-management approaches restricted by the subjective opinions of staff.

As the conversation progresses, Francis goes on to identify interventions that she views as more appropriate:

Extract 4

Francis: I think it's about promoting the medication, make sure they're using it correctly. That they understand it, the benefits of it, how it works, have they got any side effects, do they want to talk about that. And then like promoting things like social inclusion, tell them 'there's a new group starting in a few weeks' and promoting coping mechanisms...

Medication management is viewed as the key intervention within this category. Nursing interventions are directed towards educating the person on the perceived effectiveness of medication, improving compliance to medication regimes and monitoring the person's response to the medication prescribed. In the above extract Francis highlights promoting medication to the person as key to recovery. Other interventions are suggested such as social inclusion and attending a group but there is little elaboration on what these might include. The use of language within the quote suggests an authoritative approach to presenting the person with treatment to accept. This nurse led approach to treatment can also be seen in the following extract:

Extract 5

Interviewer: So what kind of interventions would you be using to address this do you think?

Rachel: Obviously I would have my one to ones with him, I would go and see him. Obviously I would give psychoeducation around the medication what it's used for, does he know anything about his illness, he's been in hospital formally but does he know anything? He knows what's well and what isn't well so I would develop a WRAP plan.

Again medication management is viewed as a main intervention, here along with education related to the illness the person is suffering from. Rachel does then suggest that the person may have an understanding of themselves in stating that he (the person) would know what is well and what is not, but her response to this is for *her* to develop a WRAP plan. As WRAP plans are designed to be person led, the suggestion that the nurse would design one demonstrates the authoritative professionally led approach to interventions within this category. Further evidence of the focus on medication as a main intervention and the professionally led approach to treatment is seen in the following extract:

Extract 6

Interviewer: So just to take you back a bit there, you mentioned concordance Tom, what do you see that as being about?

Tom: Well it says here (referring to the written scenario given to participants) that he expresses a mistrust of medication and he's not taking it as prescribed or probably not even taking it at all and the purpose in his case would be to stop the influence that the voices have on him and his life. So the concordance bit is, as a nurse your role would be to try and maybe help him to work through actually taking them, and show that they're not actually going to damage him, they're actually for a positive.

Pharmacological treatment dominates mental health care; a UK survey by the Healthcare Commission (2007) found that between 98-100% of in-patients of mental health services were prescribed medications, often more than one at a time. Within medication management the term concordance is applied to an agreement between the person and the professional when a medication plan has been negotiated and agreed by both parties, with the service user an informed decision maker (Gurney, 2013). Although Tom uses the term concordance, what he is suggesting appears to be a rather 'one way street' in that the goal is for the person to take the medication prescribed rather than negotiate a shared treatment plan. Tom's description in the

extract is more in keeping with term compliance, a term used in healthcare with the goal being for the person's behaviour to coincide with professional advice (Dodds, Rebar, & Parsons, 2000). Here the person is in a subordinate position to the professional who directs treatment.

Failure on behalf of the person to comply with treatment is viewed as risky and this behaviour raises concerns for professionals. Within the category there is a focus on risk prevention, the main way this is achieved is through monitoring of compliance to treatment plans. In discussing the scenario of Darren, Rachel demonstrates this:

Extract 7

Rachel: It's hard because obviously he's just come out a few weeks ago but he's providing support for his mum, so does he need extra support around that. He is refusing to take his meds but he is still attending his appointments so yes he's not concurring with his medication but he's attending his appointments so where does that lie? He is still hearing voices though and he has threatened to take his own life before so there's obviously that element of risk there. I think he needs psychoeducation into the Respiradone (name of prescribed medication in scenario), about the side effects, you know, what it's used for. If he's refusing to take it orally why can't he take it as a depot?

Rachel expresses concern over Darren not taking his medication as prescribed and psychoeducation is suggested as a strategy to promote acceptance of medication. Rachel then goes further to suggest the medication should be given as a depot (long acting medication administered by intra-muscular injection). As this is administered by the nurse then monitoring of compliance is assured.

Across all categories of description, recovery is viewed as being different for everyone. However, within this category uniqueness is viewed as being because of the diverse range of symptoms people may experience within a given diagnosis as Paula demonstrates:

Extract 8

Interviewer: This individual thing, tell me more about that, what does that mean in relation to recovery?

Paula: You assess someone, not necessarily formally but even if you just sit and talk to someone you're assessing them, you get to know that person, if they've got an illness what sort it is, the symptoms. Someone might have schizophrenia but they might have the positive symptoms and you might meet someone who has the negative symptoms so you can't treat both the same. You have to approach them differently. I think it's about knowing what's best for them.

Within the extract the diagnosis and potential symptoms that the person may experience are of importance in identification of treatment. Although Paula states "you get to know the person", it is the different presentations of 'illness' that provide the individual treatment, rather than differences in individual people. As illness and symptom presentation direct treatment, diagnosis is also viewed as impacting on recovery, with recovery being viewed as not possible for some people. Yvette discusses this below in relation to dementia sufferers:

Extract 9

Yvette: It's different with dementia because obviously some of these people aren't going to recover. They might recover from the point of view of their section to be well enough to leave hospital again, but some of them, their symptoms are so far down the spectrum they're not going to recover in that sense of the word.

Interviewer: So you said it's different, in what way, what's different?

Yvette: Well I'll use Darren (fictitious person in the scenario given to participants), he's experiencing voices and he's had some sort of episode and been suicidal, you can intervene there and maybe help him with medication and therapy and other techniques and get him to a point where he can function. Whereas somebody with dementia you might only be able to get them to a point where they're well enough to leave hospital but the symptoms that they experience are ongoing. So that's where I see the difference.

The extract demonstrates that recovery here is dependent on the removal of symptoms, with those affected by irreversible cognitive impairment being unable to recover. Adams (2010) referred to 'therapeutic nihilism' as a view within dementia care that there can be no recovery as the focus is on the chronic and progressive debilitating nature of the disease. However, alternative views of person centred care, with a belief in optimal well-being and maintenance of meaningful relationships and activity, have been promoted in dementia care (Bartlett & O'Connor, 2007; Martin & Younger, 2000). Such ideas can be seen to resonate with the idea of personal recovery and echo the views of Adams (2008, 2010) discussed in chapter two in promoting a positive sense of self. However, it is not a perspective considered in this category. The medicalised understanding of the lack of recovery for chronic conditions prevails.

The nurse/person relationship is professionally led within this category. As the previous extracts demonstrate the nurse as the professional identifies concerns and implements interventions based on their professional judgement in response to the symptoms that the person displays. In extract 5 Rachel demonstrates this with her description of providing care to Darren: "I would give psychoeducation...I would develop a WRAP plan". The discussion is of the nurse's actions rather than the service user's. Similarly in extract 8 Paula states: "it's about knowing what's best for them" demonstrating the perceived expert knowledge of the nurse and responsibility to direct treatment.

Ellis and Day (2013) described such positioning of the nurse and service user as the 'expert relationship' in that the nurse considers themselves as having superior knowledge and insight into the person's condition, with a better understanding of the treatment goals and necessary interventions. The service user is assumed to have inferior knowledge to the nurse and is dependent on their professional help. This type of approach, they argue, may initially engage

service users but does not sustain engagement over time. Stenhouse and Muir (2017) argued that as a representative of the mental health system, the nurse's position in relation to that of the service user is always associated with power and studies have explored how the power imbalance impacts on mental health nursing (Cleary & Edwards, 1999; Faulkner, 2005). The notion of shared decision making represents a departure from this traditional hierarchical practice of power being enacted by a 'top down' approach. Shared decision making is a process by which professional staff and service users come together to clarify goals and agree the best course of action (Coulter & Collins, 2011) and is supported by a policy framework related to patient choices (Department of Health, 2012c). Chong, Aslani and Chen (2013) suggested that there has been a significant shift in how people perceive patient involvement in care; however, the rhetoric of shared decision making espoused in government policy is not evident in this category, where the position of the nurse remains one of directing treatment. Rose, Evans, Laker and Wykes (2015) have suggested that nursing is a marginalised group within in-patient settings and sits at the bottom of the medical hierarchy. Stacey et al. (2016) in considering the extent of shared decision making in acute in-patient settings also identified how nurses waited for doctors to make decisions which they then implemented. A reluctance to influence or lead decisions was highlighted, as such responsibility was seen as sitting with medical staff. This differs to the perceived role of the nurse within this category where individual and independent nursing decisions are discussed by participants. These differences may reflect differing contexts of care or the individual characteristics of the nurses in the study. Of concern is that whilst there is a willingness to engage with decision making without the authority of another professional, within this category it is not within a shared decision making framework involving the service user.

Context is provided by the way in which nursing is viewed as part of the services within which treatment is provided. Within this category the person is viewed as moving through services as

recovery progresses, nursing interventions aim to refer the person on to another part of the service to continue improvement. An example is provided by Paula:

Extract 10

Paula: I work with the crisis team at the minute. I only started Monday but I can see where it goes and that they do a lot of home based treatment, a lot of monitoring and they give family and the person self-care and if they need to ring up at any point they can, they can speak to someone. If someone, if their risk is reduced and they no longer need the crisis team they will refer them on to the community team.

A main indicator of improvement is the identification of reduced risk, this allows the person to move on to another part of the service. Nursing has contributed to recovery if the person can be referred on to continue treatment elsewhere or be discharged from services. This context of nursing care is informed by service led issues such as performance indicators and outcome measures which are predominantly financially driven and quantitatively measured. Measures such as clustering require a diagnostic label and this drives nursing practice. Le Boutillier et al. (2015) identified one perception of recovery as being that of 'service led' recovery which reflects the context of care identified within this study. These authors distinguished it from clinical recovery as the organisational goals were viewed as priority over those of the patient. Within this study the organisational context of care is understood and responded to differently in each category of description. Within this Recovery as Clinical Improvement category there is acceptance of the organisational aims, which are not viewed as conflicting with the needs of the person or the nurse and are accepted as part of practice.

This category describes recovery as professionally defined and clinically determined with a diagnosable mental illness requiring professional treatment, pre- dominantly pharmacological interventions. It therefore can be seen to correspond to the understanding of clinical recovery as discussed in section 2.2. This is the traditionally held view within mental health care and

originates from psychiatry's development as a branch of medicine. Based on a bio- medical model clinical recovery may be considered the domain of the medical profession. However, a dominant medical ideology has arguably prevailed in health care across all professional groups with a passive acceptance by nurses in mental health practice (Adams, 2010). It is therefore a model of care historically familiar to nurses, but also one that continues to maintain a position in contemporary nursing practice. This is evident in the studies discussed in chapter two (Le Boutillier et al., 2015; Waldemar et al., 2017; Cusack et al., 2017) and is supported by the findings of this study. The identification of the category Recovery as Clinical Improvement evidenced within this study suggests perceptions of clinical recovery persist in early career nurses. Le Boutillier et al. (2012) identified clinical recovery as the dominant staff understanding (with no differences between professional groups), with both Waldemar (2016) and Chester et al. (2016) identifying prevailing perceptions of clinical recovery amongst staff as more apparent in in-patient rather than community settings. There is some evidence to support this view within this study and is discussed further in chapter five.

4.2.2 Branch Two

4.2.2.1 Recovery as Making Progress

The first of the categories within the second branch of the outcome space is Recovery as Making Progress. Whilst the first branch has a focus on understanding recovery in a clinical sense, the second branch encompasses variation of understanding that can be related to personal recovery. Recovery as Making Progress is the least sophisticated category within the continuum structure where recovery is understood as the person being able to resume 'normal' life and adopt usual roles. This is individual to the person, depending on their previous roles, hobbies, interests and abilities; recovery is therefore understood as being different for everyone. However, unlike the previous category this difference is not dependent on symptoms, but on the person's experiences, wishes and abilities. Behaviour change that

indicates improvement is observed by the nurse and compared to previous behaviour to demonstrate improvement. This may be (but not necessarily be) accompanied by self-reports from the service user that they are getting better. This observed resumption of activity is described by Hannah:

Extract 11

Hannah: She was an older lady, lovely, and when she first came into services she used to make cards and stuff like that. She used to go out with her friends and stuff, drive. She stopped doing all of that, and she wouldn't drive anywhere. She was too nervous about doing it and then when it got to the point where she was discharged she was doing everything that she would usually do and more.

Within the extract above Hannah discusses the behaviour changes which indicated the lady was unwell, resumption of this usual activity (and more) indicates her recovery. In the extract below, Kate demonstrates how people may have different roles or activities but it is the fact that these roles can be fulfilled which demonstrates recovery:

Extract 12

Kate: Recovery for me would be being able to do what I was doing before, so going to university, having a job, being able to be professional. To be able to have a role within my family and for people to not look down on me and the pickiness and such. Where obviously that's different for different people depending on their aspirations what they want to do and their life.I would say for that person (discusses a lady she visited in practice) recovery meant for her no medication and just being a mam and being able to do her role.

Recovery is seen as a staged process. The person makes progress by setting small achievable goals and taking small steps. Francis and Paula capture this in the following examples:

Extract 13

Francis: I think it's more of a staged process, you can't go from being really poorly and recover. I think it's about building someone's life back up to what they used to have, and if you can bring

that person back up to what they used to have then you've helped them to recover. It might not ever get back, they might not be for example in a really well paid high flying job, and they might never get back to that, but if you can get them back into employment then they've got a sense of recovery.... you've got to be able, I think you've got to have a goal, even if it's a small goal, without a goal you can't build anything and I think those goals build up to what you want in the future and help you to recover.

Extract 14

Paula: It's taking a step in the right direction. It's going from a bad place, not necessarily to a good place but taking steps to getting better. It's not necessarily getting better but it's what's better for the individual person because everyone is different..... from what I've seen it can be little steps. So someone just smiling because if they've been depressed, it's responding to humour and things like that. That's a little bit of recovery because something's changed so they feel like they can smile. It's about that little step.

Partial or full recovery is considered possible with an end point to the journey, although this end point is not well defined, as it is different for everybody:

Extract 15

Hannah: It's getting, or people explain it as getting from one point to another but those points aren't the same for all patients.....what some people see as being unwell for other people is being well. So say somebody had, two people had schizophrenia and they both experienced it completely differently, when they're unwell they both hear voices and really it's something that consumes their everyday life. But one when they're well doesn't hear voices, and the other still does, but that they're more positive voices rather than negative. They're still both recovered but it's completely different.

Hannah describes how two people with the same diagnosis may have very different experiences and that it is this individual experience, which may be different for everyone, that defines the point of recovery. The end point may not look the same, as each person will have

their own end point. However, relapse can occur and this is seen as a backward step in that the recovery process has stopped and the person has become unwell again, although as Francis describes it can be a cyclical pattern:

Extract 16

Francis: I think you can recover but there's always that chance that something is going to happen and you will relapse. But I don't think that's for everybody and I think it depends on the person and their circumstances.....recovery is different for everybody and it can have different stages and it's an ongoing cycle. Just because you've recovered doesn't mean you can't relapse and then recover.

Within this category the focus is on making progress and therefore a lack of progress is viewed as a lack of recovery. In the following example Kate discusses her experiences of working with a person whom the care team thought wasn't making progress:

Extract 17

Kate: There was one patient who every time that I went this patient was just exactly the same. And I can remember the last time I went we did a formulation meeting where everyone was literally stumped, like well what can we do for the gentlemen? He's still delusional, he won't take medication, what can we do? So it was a case I think that they lost hope in that sense, they didn't know really which way to turn for him, and.... maybe not intentionally but they were just happy for him to just plod on. He didn't really go out, he only went out when he really felt like it.

In this example for Kate and the care team, the fact that the person's behaviour remains unchanged is described as frustrating and viewed negatively. For recovery to take place there is a perceived responsibility for the person to want to make progress, where his actions (in this case refusing medication) prevent this, then the team lose hope and are happy for the person to "just plod on". The implication is that the nurse cannot help someone who does not wish to

help themselves. In their study of what recovery means, Aston and Coffey (2012) found that nurses perceived that full recovery was not possible for those with a diagnosis of a severe mental illness and felt concerned that expectations of recovery would place a greater burden on the individual. This suggests a level of hopelessness from staff. Mead and Copeland (2002) recognised that professionals can find it difficult when trying to promote recovery and encounter resistance or apathy from the person and this can be seen in Kate's extract. However, Bassett and Repper (2005) warn that "hopelessness breeds hopelessness" (p.18). Where there is no hope from staff then 'learned hopelessness' (May, 2001) may be the consequence with the individual believing that change is not possible. People may then experience hopelessness or may only be able to sustain hope for brief periods of time, here the role of others in inspiring hope is crucial.

Hope features within this category and continues as a main principle throughout this branch of the outcome space. Hope is linked to a future orientated outlook as Francis describes:

Extract 18

Francis: Well if you haven't got any sense of the future and what it can bring, then you are kind of just stuck, like you can't move forward if you haven't got any hope for the future and hope that things can get better, then you're just stuck there in that time and how do you develop yourself? If you can't see a future then you can't think about it.

Predominantly it is the professional who decides if progress is being made and there maybe differences of opinion between the nurse and the person as Hannah describes:

Extract 19

Hannah: ... one of the patients that I've worked with he was at a point where he wouldn't get out of bed, he would be there till five o'clock in the afternoon.... we had to do a recovery star (recovery focused tool which scores behaviour) with him and he scored himself quite highly on a lot of things, but then found it really difficult when we challenged him and said 'well you

don't get out of bed, you don't do any self-catering, you have to be prompted to go in the shower' and all these kind of things and I don't think he was quite ready to accept that because he didn't react very well.

It is evident that the care team and the person disagree in relation to what the displayed behaviours mean, for staff it is an indication that recovery is not taking place, as Hannah goes on to explain the staff scoring on the 'Recovery Star' was significantly lower than the self-rating done by the person. In this sense recovery tools are used to monitor progress with a focus on the staff scoring. The need to objectively measure recovery by using 'recovery tools' has been driven by government policy such as 'payment by results' (Department of Health, 2012b) and it is questionable for whose benefit such tools are used as discussed in section 2.5. The issue of who decides what score is acceptable is also of concern if staff scores are considered the 'right' one. However, there is an element of shared decision making within this category. The nurse- patient relationship is recognised as of importance in fostering an atmosphere of 'working together' to agree goals and interventions; however, this is within boundaries set by the nurse as demonstrated by Rachel and Paula:

Extract 20

Rachel: It's (a good relationship) hugely important hugely, if you don't have that therapeutic relationship with someone then you're not going to help them recover. You've got to be an advocate for them and know how to help them recover and if they don't like it or that bond isn't there, you're not going to get anywhere, it's going to be a very slow process.

Extract 21

Paula: ... the person themselves knows how unwell they are, they know themselves the best. If you're like 'right I'm going to put this goal down for you, you need to do that' then they're going to feel a little bit disempowered, whereas if you do it with them you're offering your support, at least you're working with them..... I think honestly just setting boundaries and making them realistic for them because they might say 'well I'm going to go to Paris by the end

of the week' and you're like 'well you're not even getting up and getting dressed in the mornings so maybe start with little goals'

In extract 20 Rachel stresses the importance of a strong relationship and how the lack of it can inhibit recovery. In discussing the importance of the relationship in extract 21 Paula talks of working with the person to set goals so that there is a sense of ownership. The person's knowledge about themselves is considered important. However, as Paula continues this thread by discussing the nurses' role in goal setting, it can be seen that the 'working together' operates within the boundaries set by the nurse. Where the nurse feels the goals are unrealistic, they are negated. Although elements of shared decision making are accepted in relation to goals and interventions, this only operates within boundaries of what is viewed appropriate by the professional therefore the power of decision making ultimately lies with the professional. In the next extract Rachel gives an example of how this relates to interventions:

Extract 22

Rachel: I don't see it being a problem if someone doesn't want to take their medication, if they can give me a valid reason why they don't want to take it, because it doesn't help them recover then that's fine, but I'd want to know a reason why and I'd want to know what else I could do to help. I would get that from them and then I would take a certain protocol in order to help them.

Here the person does not wish to use medication as an intervention and Rachel describes this as unproblematic. However, for this to be acceptable to the nurse, the person would need to give a "valid reason" and offer an alternative that is acceptable so that "protocol" can be followed. In this sense, control of the relationship is evident as boundaries are defined by the nurse and there is an onus on the person to explain their decision to the satisfaction of the nurse.

Nursing interventions include a range of different approaches that are considered recovery focused. Medication is still seen as having an important role to play but other interventions which are predominantly supportive in encouraging the person to maintain or regain independence are also seen as necessary, as increasing ability to self-care is viewed as a sign of progress. Risks that the person may present with are of concern and interventions are also designed to manage any risks that the person may present with. In the following example Kate describes her involvement with a lady where supporting independence is considered important:

Extract 23

Kate: Well if give you an example, I care for a lady who has long term psychosis. Now I know other people are going in and making her bacon sandwiches, make food for her, make cups of tea for her but I don't. I'll say 'well no you're quite capable come on I'll give you a hand but I'm not doing it for you,.... if she's quite capable why do it for her otherwise she's going to lose her independence, she's going to lose something about herself, she's not going to be able to look after herself as much. So if someone is going to do it for her she might lose that 'well I've least I've made that bacon sandwich today, Kate might be right, at least I've managed to put the washing on the line, I've done something today'. Even just the little things, if that person knows they can do that they get something from that.

The ability to self-care and have a level of independence is viewed as important to maintain current level of functioning and in gaining a sense of achievement that something productive has been accomplished. Concerns over risk can be shown by examples from Linda and Kate, both in relation to the given scenario where Darren has declined to take medication:

Extract 24

Kate: He's pretty much there you know. It would have been better if he spoke to someone about coming off medication. The fact that he's just doing it willy nilly that to me is just ringing

a bit of alarm bells, because to me, if that was me, I would ask somebody, I would say look I'm wanting to do this.

Extract 25

Linda: ...he thinks that taking medication, well that he doesn't trust them, then with everything else he seems quite content like doing his voluntary work and stuff. But if he doesn't take his medication obviously there's a risk of mental health deteriorating and everything else collapsing basically, and he might blame that on the medication. I think educating him on his medication. Just saying your medications are there to do this, this and this and so on. Try to educate him on taking them and stuff and see if he does take them. But if he doesn't also educate him on different things what he could do. Obviously don't, I mean some people really like medication but if he doesn't want it you can't force him to take it, you just can't can you.

Non-compliance with medication is seen as risk taking behaviour with the chance of relapse occurring. The first choice interventions are those that would promote medication compliance, although the element of choice can be seen in that alternatives are considered. Within the previous category, medication was seen as crucial with the example given of administration by injection being suggested to monitor compliance. However, within this category although it may be the preferred option, other non-medical options are considered acceptable.

The context of care for this category holds some tensions for the nurse when efforts to deliver recovery focused care are made. The different working practice displayed by different staff members is seen as impacting on ways of working that inhibit those wanting to practise with a personal recovery orientation. Linda provides an example by discussing her experiences of working with staff who she did not feel were very recovery focused:

Extract 26

Linda: It was sort of like they'd (the staff) get them up in the morning, yeah they'd get them up in the morning give them their medication, have their breakfast then they'd be up the office

and then you'd see them again at lunchtime. They'd be like, it's just no therapeutics. If it was me I love just sitting in the sitting room just talking away with them, you know saying 'have ever thought of doing this'...

A lack of engagement and therapeutic interventions from nursing staff is described which then inhibits other staff from practising in a recovery way, this is particularly true for junior staff such as student nurses. Francis also provides an example of this in the following extract:

Extract 27

Francis: My first year hub (placement) was a rehab and recovery [inaudible] in the community but there wasn't much recovery going on. The people who were there had been there like twenty years and they were just stuck there.

Interviewer: So what was going on, what was happening if it wasn't recovery?

Francis: It was just basically they lived there. They were supposed to get up on a morning, get ready, and live a normal life and go out and do things but they didn't, and they weren't encouraged to either. Like literally they would just stay in the house. ...

Francis describes a lack of progress for those being cared for in the unit and attributes this to a lack of engagement by staff. This context of different ways of working, a culture where the perceived principles of personal recovery are not evident, causes difficulties for others wishing to practice in a recovery focused way and their contribution to helping a person's recovery is affected. Staff experience feelings of being unable to practise from their personal beliefs about recovery and conflicts in practice exist. The troublesome nature of this and the impact on the student is discussed further in chapter five.

4.2.2.2 Recovery as Managing to Live Well

Recovery as Managing to Live Well is the second category within the second branch of the outcome space. Within this category recovery is understood as living a meaningful life despite

the presence of any symptoms of illness or difficult issues in the person's life. The person feels content and fulfilled by activities, roles and relationships that they have and is able to take responsibility for what they choose to do. In the following example Kate sums up this position:

Extract 28

Kate: Yes so I'm saying recovery would be for that person their life being fulfilled to their level, so whether that's to go back to work or whether that's to volunteer at the cat place or be able to sit through three meals or whatever. Just be able to fulfil that standard that you've set yourself.

Living well is defined by the person rather than the professional. In the Recovery as Making Progress category recovery was identified through behavioural change observed by the nurse, within this category recovery is defined by the person, as measured by their own standards. Linda demonstrates the person led defining of recovery and how this may be different to that of the nurse:

Extract 29

Linda: I think I'd just say recovery isn't about changing a person to what you think is better, it's about what they think is better, what's normal for their life. It isn't about changing a person or fixing them it's about getting someone to live their life to whatever is good for them..... it's about what they think their life is and not what I think their life should be....

In the Recovery as Clinical Improvement category the person is understood as having an underlying pathological disorder and a reduction of symptoms indicates recovery. In the Recovery as Making Progress category there is a focus on behavioural signs to understand improvement. Within this category the focus is on the personal experience and the person's understanding of this experience. Rather than focusing on the symptoms of illness, the person is viewed in a holistic way and there is not a particular theory or model that underpins how the person is understood. This is demonstrated in the extract below:

Extract 30

Yvette: I would say recovery in mental health is more of a journey. I think it's bringing more of the person and more of their life rather than you know if it's a medical issue. If you have a heart attack or whatever you can treat that, get them better and send them away, give them some lifestyle advice and they're on their way. Whereas with mental health there's a bit more to it than that..... families, employment, environment, support they've got, everything. Their whole being, their whole life comes into mental health recovery I think rather than just something you need to fix.

Here Yvette demonstrates that Recovery as Managing to Live Well is about the whole person, their lives, their environment and a range of social factors that impact on how the person wants to live their life. Holism is concerned with caring for the 'whole person' not just their physical body. This involves giving attention to the emotional, spiritual, social and cultural needs of the person. Holism therefore has a strong focus on the uniqueness of the person and as McEvoy and Duffy (2008) highlighted, holistic care is "patient led and patient focused in order to provide individualised care" (p.418). It is therefore a principle consistent with a recovery orientated approach.

The process of recovery continues to be seen as a journey where stability is viewed as important. Wellness is maintained with stability of behaviours, where negative experiences occur this is viewed as a relapse, interrupting the recovery journey. As within the previous category relapse is seen as a backward step. Jane demonstrates this understanding below in describing the nurse's role with Darren:

Extract 31

Jane: I think because he's been doing so well it's trying to maintain that level of stability ... Then the nature of the voices, monitoring those, are they negative or command, are they in any way

detrimental to him, are they going to get him on that road to decline again?. ... and then as I say how to maintain Darren's long term stability.

The person must manage and cope with any experiences which could potentially cause distress to maintain the recovery journey. Linda and Tom illustrate this in the extracts below:

Extract 32

Linda:in my last placement in addictions, it's like that addiction's always going to be there but you can be recovered from it but it can be still there. I think once they're at the point where they are abstinent, it's about them coping to live with that continuously because I think that some people would think that once you're there that's it and you don't take drugs any more, but it's not. It's still going to be there in your life and there can be little triggers, so I think the recovery part would be helping them to think if that happened again and helping them to deal with that without them like having to turn back to drugs...

Extract 33

Tom: Well recovery for him, well to me would be someone who can actually live their life as normally as possible with whatever is going on.they are able to live their life with things like have a job, or volunteer or do whatever, that level of stuff. So recovery for me is not getting rid of everything because if you can live with it and you're happy and you're fine, you're able and stable, well that is recovery.

Nursing interventions within this category include a range of approaches aimed at developing coping strategies which facilitate recovery. There is a focus on the person rather than the illness and individual choices are respected as the examples below demonstrate:

Extract 34

Tom: Basically I think a person cannot recover if the intervention from the nurse or the doctor isn't dealing with them and like basically 100% focused on them as a person, because you can say everything to the person but if you're not actually like listening to what they're saying and how they're feeling then you're not actually going to be helping them do anything....

Extract 35

Jane: Talking to them, spending time with them, getting to know them as people, getting to know what their aspirations and hopes are. It's not just about imposing your hopes onto them it's about getting to know them as people

Both of the extracts from Tom and Jane demonstrate a central tenet within the category that nursing interventions are person centred rather than professionally led. Working with the individuals' wishes and personal choices the nurse facilitates the person to gain understanding and make decisions. Goodrich and Cornwell (2008) noted that too often little attention is paid to individual needs in a sensitive and compassionate manner. Demonstrating an unconditional acceptance of the person and understanding their needs within this category demonstrates the principles of person centred care.

Personal understanding is encouraged through nursing interventions. Linda explains how a session is facilitated to enable the person to gain their own understanding:

Extract 36

Linda: .. in placement I've seen a lot of CBT (cognitive behavioural therapy) being done, obviously getting people to think about their behaviours and which I enjoyed as well because when I did see it, it wasn't the nurse doing it for them, it was the nurse helping them. Like it was all about the patient identifying for themselves, which I think is good and it fits with recovery because you can't sit there and tell someone 'you do this and this results in this' cos they don't see it like that. You could be sat, sometimes in assessments and you'd see something, well the nurse would actually see something at the start and it could be three or four sessions for that person to actually identify that as the cause of something....

The role of the nurse is a facilitative one rather than a 'top down' prescriptive approach, recognising the person's views as central. As Linda describes, the person may see things differently to the nurse but this is unproblematic as the aim is to work with the person's agenda. Whilst supportive interventions continue as within the previous category, a more enabling approach is also adopted and the person's rights to self-determination are respected as Sally demonstrates:

Extract 37

Sally: I think it's part of your job to ask that and discuss that in making sessions with people. When would they be happy and when would they feel they were well enough to not need nursing care anymore or stop involvement with services. I think it's important to discuss other options with them. I always discuss recovery sessions with people...then explain why I think from a professional point of view why it might be helpful, and then give people the choice to decide if that's something they want to do or not.

The professional offers an opinion based on their expert knowledge; however, within this category it is understood that the person has the ability and right to make choices of their own regarding treatment options. Risk factors are not ignored but there is less of a focus on managing risk by the nurse and more on developing the person's ability to manage risk themselves. This is a significant shift of approach from previous categories where control of risk is managed by professionals. In discussing the scenario of Darren, Amy describes how she would look further into Darren's situation in relation to his support network:

Extract 38

Amy:and I would be concerned that he (fictitious character Darren in scenario) seems to only have one protective factor, his mother, and I would be keen to identify further other protective factors so that there's not just one, in case anything happened to her, where does he go from there....mainly you'd be asking what his life is like, does he have a girlfriend, does he have a pet, does he have any social groups, does he have any friends, any hobbies, and

interests and stuff like that. Then maybe trying to build around and up that circle so he doesn't feel alone or isolated....

Amy has identified that within the scenario only Darren's mother is identified as a significant other and she is concerned that there may be a lack of support for Darren should anything happen to her. In managing the risks that this might bring for Darren in terms of isolation or lack of support, Amy looks to identify other protective factors that would offer support. Rather than being professionally led, these are people or events in Darren's life that he can utilise to gain support and increase his social environment. Protective factors can play an important role in considering the risks a person may present with. They include the personal strengths, abilities and resources the person can draw on to increase resilience, optimism and hope (Butler, Commissioning, & Crossman, 2018). Forsyth and Janner (2017) suggested protective factors can be characterised into different dimensions: enhancing personal control, resilience and coping strategies, meaningful activity, and relationships and respect. In the above extract, Amy can be seen to be focusing particularly on relationships and meaningful activity in response to potential isolation Darren might experience. Such an approach can be seen to support ideas of personal responsibility and social inclusion. Working with protective factors rather than focusing solely on risk factors has been acknowledged as crucial to ROP (Holley & Pearsey, 2017) but requires a shift away from the traditional conceptualisation of risk management strategies as being professionally led, to a position of shared decision making and partnership working. The risk adverse culture currently existing in mental health services may cause staff to adopt more defensive practices (Clifford, 2011). Within this category the more positive approach of developing protective factors is recognised. Although how this is then translated into ROP creates difficulties for students and is discussed in chapter five.

Because of how the nurse and the person are positioned within this category, the nurse-patient relationship is fundamental to successful interventions. In a sense the relationship becomes the intervention as the following passage from the interview with Jane demonstrates:

Extract 39

Interviewer: Tell me more about therapeutic engagement, what that is, what that looks like.

Jane: it was just sitting down finding out who people were, what their lives were, valuing everything they said, being interested in them and I think sometimes when you speak to people especially in mental health they think 'well nobodies interested in me because I'm mad' but people don't realise how interesting they are, they've all had lives, they've all had histories and that's what I find fascinating about people, and that's what they were doing at XXX, they were all really interested in these people and what they had done. Some of them had been miners, some had been shipyard workers and it was getting all that amazing history out of people and they were so happy to engage and talk. So I think for me therapeutic engagement is finding out who that person is and getting them to talk about themselves and finding a way of expressing themselves which is therapeutic and meaningful for them.

Interviewer: So what's the impact of that then on recovery?

Jane: Absolutely huge, I think in terms of you know mood enhancement and people are happier. You know in the XXX staff are interested and want to know them and they think 'great people are interested in me'. They want to engage, they want to reveal who they are mostly, and I think people like communicating, we're very sociable animals.

Jane described how being with people, listening to people, valuing people's past experiences is viewed as the therapeutic intervention. It is this engagement by the nurse that contributes to the person's recovery by enhancing mood, or boosting self-worth, or facilitating an enjoyable social situation. There is an understanding of the therapeutic relationship as a dialogic relationship, where stories about the person are expressed, listened to and understood. Through listening to the personal story nurses can find out how that person perceives their

situation, which enables the voice of the individual to be heard. It enables staff to see the person behind the patient and demonstrates the person is valued and respected (Stenhouse & Muir, 2017; McKeown et al., 2010) reflecting the principles of person-centred care.

Within this category there is an awareness of different ways of practising, the conflicts that may arise from this and how these might be managed to enable recovery. Service related issues are recognised in how recovery is measured and how services are funded, this is viewed as in conflict with personal recovery. How this is viewed and managed is illustrated by Hannah:

Extract 40

Hannah: For a person what they believe is their recovery is totally unique to them... Because we have targets, because services cost money, we have to adhere to the FACE (a risk assessment tool) risk scores and the clustering because at the end of the day if you don't do clustering you don't get your funding. So I think a lot of the service type recovery stuff is to do with targets and money.....so they (clinical staff) would keep people in, like not really do their clustering and keep people in services because they knew it would make people unwell very quickly to be taken out of services...

With an understanding of Recovery as *Manging to Live Well* work is carried out within a context of conflicting needs. There are the needs of the service in gaining funding and managing finite resources, but also the needs of the individual in living a contented life with the appropriate professional support. In recognising these conflicting views, ways to manage the constraints the organisation places on recovery orientated practice are recognised. As Hannah describes, one way of doing this is to avoid giving the person a 'paper score' that would indicate they were ready for discharge, when this conflicts with the professional view that the person would benefit from remaining in services. The conflicting needs of the person are met in that they continue to receive a service, those of the organisation are met in that the paper score given indicates it appropriate to continue to offer services. Whilst this is related to

managing the conflicting needs, it is not without difficulty for students and is discussed further in chapter five.

4.2.2.3 Recovery as Learning to Live Differently

The final and most complex understanding of recovery found in this study is Recovery as Learning to Live Differently. Within this category recovery is a unique and personal journey directed by the person that cannot be scripted by professionals. Within the previous second branch categories, the resumption of usual roles or carrying out 'normal' activity was viewed as an indicator of recovery. Here the focus is on moving forward and becoming a different person. Amy demonstrates this in the following example, from which the title of the category was taken.

Extract 41

Amy: Well actually it doesn't matter you can recover from all sorts. So it's like having the diagnosis, but does that matter? I think it's just you're learning to live differently. You can have big traumatic life changes, you can have a diagnosis that will probably rock your world but you can learn to live with it, you learn to live differently. You might not be the person you were, but you can become a different person and that person might be just as good as, or sometimes even better than the one you were beforehand, so it's absolutely possible.

Here recovery is possible for everyone, regardless of diagnosis or the nature of the traumatic event. Recovery is not concerned with bringing back the person they once were, but by moving forward the person can develop a positive sense of self in becoming a different person. One aspect of the nursing interventions therefore within this category is seen as challenging the person to believe that change is possible and can have a positive outcome as described below:

Extract 42

Jane: ...and you're kind of helping them to get there because sometimes a lot of them think 'I'm nothing'...., but you have to say 'no you're not and this is what I see about you'. So it's about

how you see them and telling them that. I had one lad and I did a shift on one of the wards and he said 'I'm just shit me, I bet you think I'm crap' and I said 'no I don't think you're crap, I think you're a lad who's in pain, you've got a lot going on in your life but I do not think you're crap, why on earth would I think you were crap'. He didn't know what to say so I think part of it is challenging them, challenging their perceptions of themselves as well.

The story told by Jane in this extract demonstrates how 'learned hopelessness' (May, 2001) can affect the individual. The nursing intervention offered in response is to challenge the beliefs held, to put forward an alternative understanding to inspire hope. Challenging interventions can be viewed as authoritative and unwelcome if not implemented sensitively and they should be given in a supportive manner. When done so, raising consciousness by providing direct feedback can encourage the person to find a new way of understanding themselves and their experiences. Supporting a re-authoring of the personal story in this way can facilitate problem solving (McCleod, 1997).

Along with a feeling of fulfilment, there is a focus on learning from the past, an acceptance of what was happened and using those experiences to develop a positive self-identity in moving forward. Amy identifies acceptance as key to recovery in terms of moving forward and discusses this below:

Extract 43

Amy: You can't change what's been. Some people find it really difficult to move forward because it's difficult to accept what has been, but you can't change it. Sometimes when you're hearing a person and when you're sitting down with a person and you're talking to them, they keep bringing up this one thing. It's like 'I understand that and I do fully appreciate everything you've been through but we really can't change it'. It's almost like a barrier to be able to take that next step and it could be because of a number of reasons maybe because of fear, it could

be that they've lived it for so long they don't know how to move on. I think that's why acceptance is really really important and it can be a huge barrier.

Amy identifies that the journey of recovery may not be an easy one for a person to undertake or even begin and that past experiences can prevent a person from moving forward. This view is well supported in the personal recovery stories within the literature (Deegan, 1996; Mead & Copeland, 2000; Cordle et al., 2011). There is recognition of past experience and distress, but a future orientated approach is adopted in that the nurse looks to guide the person in moving forward. This approach is summed up by Davila and Secor (2016) who stated "although the past can influence the present, it cannot be changed. It is better that the recovering person understand his/her past, but not become a prisoner to it" (p.42). Amy goes on to identify the nurse's role in relation to a future orientated approach:

Extract 44

Amy:...then you know life isn't going to be the same again, it'll be very different, but then it's about helping the person identify what a different life can be like and still be good.

It is through the experience of the journey of recovery that the person learns acceptance of the past and looks to the future to become a different person. Recovery therefore is viewed as what happens on the journey, rather than an end point of a journey. This position echoes the findings of Kartolova- O'Doherty et al. (2012) and Kidd et al. (2015) discussed in chapter two of making positive connections from past life events with the future. In the example below, David explains this further:

Extract 45

David: I always like to think of it like a journey... I feel it's like getting from one point A to point B and all the stuff in between that's the recovery part. I don't really think that once you've got to point B that you're recovered, I feel like it's all about the journey..."

Here David explains recovery as a journey with the emphasis on the person's experiences along the way. There is no final destination that would signal the end of recovery, or a point where the person is 'fixed'. The journey is a continuous one. Any minor changes that the person experiences are normalised within the 'ups and downs of life' rather than pathologised as signs of returning symptoms, or viewed as relapse as emphasised by Amy below:

Extract 46

Amy: ...not being hard on yourself, I would say if you have a bad day- everybody does, and it doesn't necessarily mean that you're relapsing and everything is going to come tumbling down or fall apart, it just means you're having a bad day and it'll be fine so move on.

Relapse should it occur is not viewed as a failure, it is understood as part of the journey. Although significant distress may be experienced, rather than being viewed from a negative perspective, it is viewed as offering opportunities for personal growth in learning from the experience. This understanding of the personal journey is consistent with literature discussed in chapter 2 as a non- linear, individualised process. David describes how the experience of mental distress can be traumatic, but that this can provide the opportunity for the person to reflect on their experiences and develop resilience:

Extract 47

David: Relapse is like a transformative experience, like reflection in nursing really. ... Where someone experiences chronic mental illness, the transformative experience of all these negative things and these awful things have happened as a result, maybe like social isolation or whatever, it kind of strengthens them as a person, and I think that is the essence of recovery for me, when someone goes through that strengthening process.

David compares this transformative process to reflection in nursing practice, highlighting that recovery is not only of relevance to those with mental health issues but that it is common to human experience and can be recognised in all at different points in their life. In recognising

their own experiences of self-discovery participants were able to relate the journey of recovery on a personal level and used this to inform their practice. The participants who experienced this way of understanding recovery provided examples of their own personal journeys related to life events:

Extract 48

David: I thought I'd reached a point where I'd gone through this difficulty and I understand what happened and why that happened and why I'm betterBut then I think my journey , my personal journey is still going on, like it's still happening and I still have down days or whatever but its ongoing.

Amy: University changes you as a person. I don't think there's any one of us, where we can say we were the same person we were when we first started. I don't know if that's necessarily being recovery focused but it's certainly self-discovery about you as a person. You become more self-aware and you notice more things than you did before.

That professional staff may have their own experiences of recovery is recognised by Repper and Perkins (2017) who suggest staff should consider how these experiences can be used safely and effectively to support others on their recovery journeys. Whilst such an approach is more associated with the role of peer support workers discussed in chapter two, it would seem reasonable that where appropriate professional staff also use their own experiences to support others who may be facing similar challenges.

Understanding how the nurse can facilitate recovery is gained from the person. This requires a level of commitment from the nurse and a 'giving of self' to the relationship. The relationship becomes a mutual learning one.

Extract 49

Jane: Learning from the patients really....so just watching them, learning, listening to what they say, observing their behaviours has very much moulded what I would term recovery.....It's

about wanting to be interested in human beings, being interested in human nature, what makes people tick, why do people do the things they do, and getting to understand them so you are in a better position to help them, and maybe being some sort of use to them.

The extract from Jane above demonstrates how the nurse seeks to help the person, but this is done by learning what to do from the person, rather than by using pre-determined interventions. As with the Recovery as Managing to Living Well category the relationship is seen as important in aiding recovery as the nurse asks what help they can be to the person, rather than the nurse deciding what help they can be to the person. Rather than just being of benefit to the person, this is viewed as having mutual benefit to person and nurse. The establishment and recognition of mutuality in such relationships can help break down the barriers caused by a hierarchical 'us and them' mentality. Such conditions within relationships are necessary for the person to be able to take back control and responsibility (Repper & Perkins, 2017).

In recognising the individual nature of the recovery journey, the role of the nurse is viewed as a changing one dependent on context. The nurse must be flexible in approach responding to the changing needs of the person. Interventions may take a range of different approaches, dependent on the person, their wishes and situation. David explains this changing role below:

Extract 50

David: ... my placement is with drug and alcohol and people get to that point where they can't do it anymore. They don't want to do take drugs in the way that they do, they want to be abstinent and they don't know how to do it. So the role of the nurse in that situation is to guide someone into the service or into groups onto this path of recovery. Once that happens, once someone is in the swing of that, the journey takes its own sort of direction. It isn't so much about the nurse guiding the person as it is about maybe about being there for questions or referring back ...

In the previously discussed second branch categories, the role of the nurse has been supportive or facilitative. Within this category these roles are applied within a context of guiding the person to take back control of their own life, with the understanding that professional help maybe not be necessary.

Risk issues are considered in light of the person's right to self-determination and the safety of the person. Positive risk taking is normalised as part of people's lives and individuals are seen as having the right to make their own choices wherever possible, even if these are considered unwise by the professional. The following extracts demonstrate this position:

Extract 51

Jane: It depends on the nature of the risky behaviour. If that person has capacity and they know what they're doing and they understand the implications of what they're doing then who am I to judge really. You know, it's their life, if they've got capacity then that's for them to make their own mistakes really...

Extract 52

David: it's like you've got to sort of bring them in safely and allow them take risks because sometimes risky behaviour is part of people's lives and you're never going to stamp it out. I do think positive risk is important and then there's the element of trust thing, and I think it's the person having power and making choices but then also just in terms of learning from their own mistakes.

Taking positive risks such as described above can be uncomfortable for staff in organisations that are risk adverse; however, positive risk taking is crucial if individuals are to learn from experiences and move forward with their recovery journey. Chronic risks associated with dependency and loss of self- esteem need to be recognised and actioned against. To do so mental health workers need to adopt a broader understanding of how risk and risk

management impacts on the person (Holley & Pearsey, 2017; Morgan, 2000). To practise in such a way is not without issues and these are considered further in chapter five.

Within Recovery as Learning to Live Differently, the conflicts that can arise from the need to practise positive risk taking and meet the expectations of the organisation are recognised. There is a need to work with different understandings of recovery but have a clear focus on nursing practice in relation to recovery. Recovery, ROP and the dimensions discussed above, are not simply one aspect of nursing, but become the focus of nursing. David explains this position:

Extract 53

David: I think in terms of why to nursing its things like compassion and care and communication and all of that, it all does tie in. They're all important things and at the core of that recovery thing is the nurse patient relationship. Then you can't really have that without all the communication, honesty and integrity and all these core things, that are core to nursing, part of the code of conduct. Like working with carers, like when I think about the code all of those things add in, safe and effective practice and working with other people, maintaining dignity. All those things come into it as core to nursing and they come into recovery so I think that by default it (recovery) is the core of nursing.

David uses the Nursing and Midwifery Code of Conduct (2015) to cite what is considered fundamental aspects of nursing practice. He then relates this to the principles of ROP to demonstrate how the two are equivalent. Rather than espousing policy or theory, it is integrated into practice. However, there is also recognition of the potential conflicting roles of the nurse that can impact on practice. The troublesome nature of these conflicting roles is discussed further in chapter five.

4.2.2.4 Overview of branch two

The categories described in this second branch of the outcome space can be broadly aligned with the understanding of personal recovery described in chapter two. Within branch two, three categories of description with increasing complexity of understanding are identified. The categories cannot be viewed as a nested hierarchy where the higher categories subsume the lower ones, as increasing awareness of the phenomenon results in some critical aspects of variation being replaced rather than expanded. This increasing awareness of the principles of recovery is reflected in the dimensions of variation as more sophisticated understanding emerges. The use of a continuum demonstrates the relationship and logical connection between the three categories. Kember (1997) suggested that categories of description can be understood as positions within a continuum to demonstrate a more gradual shift in understanding as boundaries between categories are not necessarily well defined and rigid. This is the case within this second branch of the outcome space. The category Recovery as Making Progress, demonstrates the narrowest awareness of the aspects of recovery. As awareness broadens the categories hold more complexity of understanding, with Recovery as Learning to Live Differently the most sophisticated.

Chapter two identified the core characteristics of recovery as described within the literature. Within this second branch these characteristics of hope, wellness, recovery as a journey, the relationship with self and the relationship with others can be seen to varying degrees in the referential aspects of the dimensions of variation. Hope is the most widely cited characteristic in the literature (Stickley & Wright, 2011) and it also holds prominence within this study. Participants identified hope as important for those experiencing recovery but also for staff working in mental health services to not only maintain their own personal hope, but also to inspire hope in others. Where participants experienced areas of practice or particular staff members as lacking hope, this was perceived as having a negative impact on care provided.

Whilst branch one emphasises illness and its treatment, branch two does embrace the idea of wellness. Within Recovery as Making Progress the notion of still having symptoms but showing signs of recovery is described. As understanding increases in complexity the idea of salutogenesis (Antonovsky, 1987) as discussed in chapter two, is incorporated into understanding as wellness is viewed as a personal defining of contentment, fulfilment and personal growth. Within branch one the person is viewed as a passive recipient of care requiring professional treatment, a stance corresponding to practices associated with a clinical recovery perspective. Within branch two an illness related focus is gradually replaced by a person-centred approach. There is increasing understanding of the principle of self-determination and recognition of the active role a person can play in their own lives with regards to decision making and life choices. Such principles are important to recovery as diagnosis and professionally led treatment has been identified as over-shadowing and devaluing personal understanding, impacting on sense of self (Kidd et al., 2015).

The dimension of variation, recovery as a process, incorporates the characteristic of the recovery journey. Within the category Recovery as Making Progress the individual nature of this journey is acknowledged; however, the journey is seen as having an end point, with relapse being a backward step, therefore only partial understanding of the concept is evident. Progression along the continuum signifies a shift in understanding to incorporate recognition of recovery as being self-defined and the journey as an ongoing non-linear process (Anthony, 1993; Deegan, 1996). Recovery as Learning to Live Differently embraces the idea of recovery as a common human experience, one shared by people in different walks of life and not necessarily specific to mental health. This is a point supported by Repper and Perkins (2017) who recognised that any experience of a significant life event can cause a re-evaluation or re-building of a person's life to regain meaning and purpose. This is a point not widely discussed in the literature. O'Hagan (2004) recognised that some professionals view recovery as 'esoteric

nonsense' suggesting it is hard to grasp and only relevant to a minority and closed circle of people. However, the most complex understanding of recovery identified within this study views a personal journey of self- discovery as of relevance to all, depending on life circumstances.

Although individualised, the recovery journey involves supportive relationships. Valued helpers are often considered as friends, family and peers, particularly those who have experienced recovery themselves (Mancini et al., 2005; Kartolova- O'Doherty et al.; 2012; Kidd et al., 2015; Davidson et al., 2012). Within this study the value of such relationships was only recognised with more sophisticated understandings of recovery, whilst the nurse-patient relationship was recognised as significant throughout all three categories. This relationship is understood as having significant impact on the experiences of the person, a view supported by literature which suggests an association between the nature of the relationship and improved outcomes for service users (Hewitt & Coffey, 2005; Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003). The attention to the relationship reflects the idea that it is regarded as the cornerstone of mental health nursing (Peplau, 1998; Hewitt & Coffey, 2005). Based on humanistic principles, the focus of the relationship is considered to be on the needs of the patient, with the nurse's actions guided by this (Hewitt, Coffey, & Rooney, 2009). However, Stenhouse and Muir (2017) also recognised one key feature of the relationship as being its reciprocal nature, the ability to share something of self whilst maintaining a professional approach and an orientation towards the needs of the person. Such an understanding is seen in the final category of this branch and is also reflected in the literature specifically considering helping relationships within recovery (Borg & Kristiansen, 2004; Korsbek, 2016). The focus in this study on the professional relationship over other supportive relationships may reflect the context of nurse education, where there is a focus on developing the skills of the student through competency achievement. Students may understandably be concerned with improving their own ability to

provide supportive relationships rather than considering the value of others; however, a wider perspective on the nature of supportive relationships is required to fully embrace recovery.

The literature to date suggests mental health professionals have been slow to embrace the principles of recovery and ROP, with uncertainty of definitions and poorly defined staff roles (Waldemar et al., 2016; Le Boutillier et al., 2015; Chester et al., 2016) inhibiting the necessary shift in understanding and practice. Some key features of ROP as identified in chapter two can be found in this second branch of the outcome space across all three categories. Linked to the therapeutic relationship is partnership working, identified as crucial in mental health practice to support recovery (Chester et al., 2016; Jacob et al., 2017). Whilst within the first category an element of partnership working is described, it does not operate on true egalitarian principles. Whilst the person is consulted and their views considered, the boundaries are defined by the nurse hence a 'top down' approach can be seen to still operate where ultimate power lies with the nurse. This is reminiscent of traditional hierarchical practices of mental health professionals and whilst consultation maybe considered a step in the right direction, it does not meet the expectations of shared decision making. In terms of service user involvement such practice may be considered tokenistic (Terry, 2018). Partnership working is seen in the second and third categories, linked to the more sophisticated understanding of the nature of the therapeutic relationship. Here there is understanding of the need for acceptance of the person's defining of recovery, recognition of their own expertise and right to self-determination, ideas central to recovery (Repper & Perkins, 2012; Chester et al., 2016; Davidson et al., 2009).

ROP is underpinned by such person-centred philosophy (Chester et al., 2016; Jacob et al., 2016; Thornton et al., 2017), which demonstrates a move away from focusing on diagnostic labelling to understanding the needs of the person. Within this second branch all three

categories reflect a degree of person centred practice as a range of interventions (medical and non- medical) are considered important to promote independence, with humanistic principles applied to nursing interventions. Supportive interventions are understood as important to recovery in the Recovery as Making Progress category such as 'being there' for the person, but as the categories continue along the continuum these interventions become more multi-faceted. Support is considered as facilitating and guiding the person, offering encouragement to take decisions. This more sophisticated understanding of the nature of support reflects the idea of recovery coaching (Davila & Secor, 2016). Not constrained by a model or theory of counselling, recovery coaching places the person in charge of their own recovery and offers a mentor role to guide and encourage those on a recovery journey. Coaching is not confined to mental health care and is a model now widely utilised in professional sports. Within care services it is more widely used in substance misuse services where recovery coaches are often peer support workers. However, the findings of this study support the idea that the principles of the approach are also applicable to nursing practice.

Clear differences of understanding can be seen in relation to nursing interventions in terms of how risk is managed across all four categories. The minimisation and management of risk by staff seen in Recovery as Clinical Improvement in branch one, is also still present in the Recovery as Making Progress category on branch two. Within Recovery as Managing to Live Well, alternative ways of managing risk are understood with the consideration of protective factors. However, it is not until Recovery as Learning to Live Differently that the notion of positive risk taking is understood and applied to practice. This is with the recognition that there exist potential conflicts between ROP and organisational objectives regarding risk management. The apparent reluctance seen within this study to embrace ideas of positive risk taking are likely to reflect the dominant risk adverse culture within mental health care. Organisations have sought to mitigate against risk and staff have developed defensive

practices to avoid potential blame if things go wrong (Manuel & Crowe, 2014). Whilst positive risk taking facilitates individuals' choices and personal responsibility, it is arguably not encouraged by the culture of organisations, an issue discussed further in chapter five.

Although person centred practices and partnership working are key themes within ROP, collaborative practice is also highlighted within the literature to address the multi-level support required by individuals undertaking recovery journeys (Chester et al., 2016; Jacob et al., 2016). This theme of ROP is less well defined within this study as participants focused on nursing interventions within healthcare, with limited reference to community resources or external agencies. While this does not mean it is not understood as part of ROP, its limited inclusion within the data does suggest it may hold less importance for students. This may be reflective of their educational and clinical practice experiences and has implications for both.

4.3 Overview of the Categories of Description and Outcome Space

When considered in terms of their referential aspects the two branches of the outcome space can be seen to broadly correspond to the two dominant understandings within the literature of clinical and personal recovery. Within branch two, three categories of description are identified within a continuum of increasing complexity of understanding. The use of a continuum demonstrates the relationship between the three categories. The most simplistic of these, Recovery as Making Progress, demonstrates the narrowest awareness of the aspects of recovery. As awareness broadens the categories hold more complex ways of understanding, with Recovery as Learning to Live Differently the most sophisticated. The full range of variation within these understandings of recovery is demonstrated through discussion of the referential meaning within the internal and external horizons of the structural aspects of each category. An overview of the referential and structural aspects of the outcome space discussed within this chapter is detailed in table eight.

Table 8- The Referential and Structural Aspects of the Outcome Space- Critical Features Which Distinguish Categories

		Recovery as Clinical Improvement	Recovery as making progress	Recovery as Managing to Live well	Recovery as learning to live differently
Dimensions of variation (internal horizon)	Person	Person has an illness with a diagnosis that identifies treatment Person needs to understand they are unwell and require treatment Person needs professional help to become well	Improvement seen through behavioural changes Person may still have symptoms of illness Person finds hope Personal responsibility to get better	Contentment/ fulfilment are central to recovery Person as a bio-psycho-social being Person defines recovery Carries out meaningful activity Self- determination	Develops resilience Acceptance of and Learning from the past in moving forward Becomes a different person Independent decision maker
	Nurse	Nurse has expert knowledge and identifies appropriate treatment Nurse focuses on maintaining safety and minimising risks	Supports person living with symptoms Helps person to identify goals Defines boundaries in relation to goal setting/Identifies improvement	Facilitator of recovery Works with individual wishes/ needs Focus on person's choices	Changing role of nurse dependant on context Gives of self Recognises own journey and growth Learns from the person
	Nursing Interventions	Prescriptive Monitoring of condition Managing risks Help patient to understand they are unwell predominantly through education	Supportive manages risks encourages hope Range of medical and non-medical interventions aimed at promoting independence	Facilitative Range of medical/ non-medical interventions to improve coping strategies Person centred approach Developing protective factors to manage risk	Guidance Challenges the person Positive risk taking approach, normalises risk
	Recovery Process	Recovery is unique because of experiencing different symptoms Recovery is linked to diagnosis Recovery is not possible for everyone	Recovery is a journey with an end point of full recovery Different pace of recovery Relapse is a backward step Recovery occurs in stages	Recovery defined by the person Journey with stability viewed as important Managing, coping, dealing with distress	Journey is ongoing Recovery is what happens on the journey Learn from relapse- part of journey A common human experience
	nurse- patient relationship	Relationship between nurse and service user is professionally led	Shared decision making operating within boundaries set by nurse Recognition of importance of the nurse-patient relationship	Working in partnership with the person Nurse facilitates the person to make decisions Nurse – patient relationship becomes an intervention	Mutuality in relationship
	External horizon	Recovery within nursing	Works within Organisational context in moving the person through services as improvement occurs	Works within conflicts that exist because of different ways of working which impacts on practice	Works within different needs of the person and the organisation with conflicting needs managed to benefit both

The dimensions of variation present within the internal horizon of the outcome space demonstrate how different aspects of the phenomenon are discerned. The internal horizon within this outcome space can be seen to be comprised of five dimensions of variation, all aspects of recovery. It is interesting to note that participants experience recovery as not only being related to the person and their journey, but also the role of the nurse and their relationships with the person. Hence recovery and ROP are experienced as part of the same phenomenon. This may reflect the fact that the participants experience recovery within their professional role. Here nursing practice is supported by underpinning knowledge, hence the two are difficult to separate as knowledge of recovery is essential to inform ROP.

Adopting a phenomenographic approach within this study has allowed for the full variation of participant understanding to be revealed. Whilst aligning to the ideas of personal and clinical recovery, the categories in the outcome space demonstrate a more complex picture than simply two alternative understandings. Branch two demonstrates different levels of understanding broadly aligned with personal recovery. The continuum demonstrates their relationship to each other and to personal recovery, as an increasing level of sophisticated understanding is evident within the dimensions of variation.

The literature suggests professional mental health staff continue to hold different understandings of clinical and personal recovery (Waldemar et al., 2016; Le Boutillier et al., 2015; Chester et al., 2016). This is despite the fact that personal recovery is widely endorsed through government policy (e.g. Department of Health, 1999, 2000, 2001, 2009, 2011). This difference in understanding is confirmed in this study with branch one demonstrating an understanding aligned with the notion of clinical recovery. Furthermore the literature suggests confusion and misunderstanding of what constitutes personal recovery amongst mental health

professionals (Waldemar et al., 2016; Le Boutillier et al., 2015; Chester et al., 2016). However, this study allows for a re-interpretation of this misunderstanding as 'partial' understanding. Although not structured as a nested hierarchy, the final category of branch two Recovery as Learning to Live Differently is the category that demonstrates greatest awareness. The other two categories demonstrate some similarities, but the variation between them reveals less sophisticated awareness.

4.4 Conclusion

This chapter has explored the nature of the outcome space identified from the analytical process described in chapter three, part three. The referential and structural aspects of the four categories of description within the two branches of the outcome space have been explored, with these findings considered in light of current literature. Recovery as discussed in chapter two can be seen as central to the disciplinary knowledge of mental health nursing, yet the findings here suggest it is problematic for some students as the phenomenographic approach to this study has identified what students with more sophisticated understanding of recovery grasp about the concept, that those students with a narrower understanding do not. However, what phenomenographic research cannot do is provide a potential explanation of this partial understanding for those students with a less sophisticated awareness. This variation in understanding and a potential explanation is explored further in chapter five.

Chapter 5: Recovery and Troublesome Learning

5.1 Introduction

This study has demonstrated that there are different ways of experiencing recovery. The phenomenographic approach discussed in chapter four has illustrated how these experiences can be understood as different categories of description with varying levels of sophistication of understanding. Within this chapter, this variation is now considered utilising the threshold concept framework (TCF). The chapter goes on to explore the troublesome nature of the learning journey in relation to recovery as experienced by participants. The nature of the obstacles to learning is the second focus of this study with the research question ‘what is troublesome for mental health nursing students in their learning experiences of recovery?’

5.2 Recovery as a Troublesome Concept

The TCF and phenomenographic approaches to learning share a focus on variation in student learning. However, the TCF provides a way of considering how students approach and manage difficult learning, through consideration of the points within the learning journey, the liminal modes, at which students experience conceptual difficulty and barriers to understanding (Meyer et al., 2008). This is particularly apt as rather than focusing on processes, the framework considers obstacles to student learning (Martindale, 2014).

The TCF, the characteristic of troublesome knowledge and the liminal space are discussed in section three, part one. The notion of liminality can be used to provide an explanation for the branched outcome space and rather than a nested hierarchy, the identification of a continuum in branch two. When considering the four identified modes of liminality (discussed in section 3.1.3), the categories of description within the outcome space can be aligned to positions within these modes, as depicted in figure four. Recovery as Clinical Improvement can be seen

to fit with the dominant understanding of recovery that has historically existed within professional practice, but also because of its dominance it has become an understanding widely accepted within lay society, a taken for granted assumption about the nature of recovery. Therefore it can be considered as understanding within the pre- liminal mode. Within their accounts most participants recognised holding such a view of recovery prior to commencing their nursing programme.

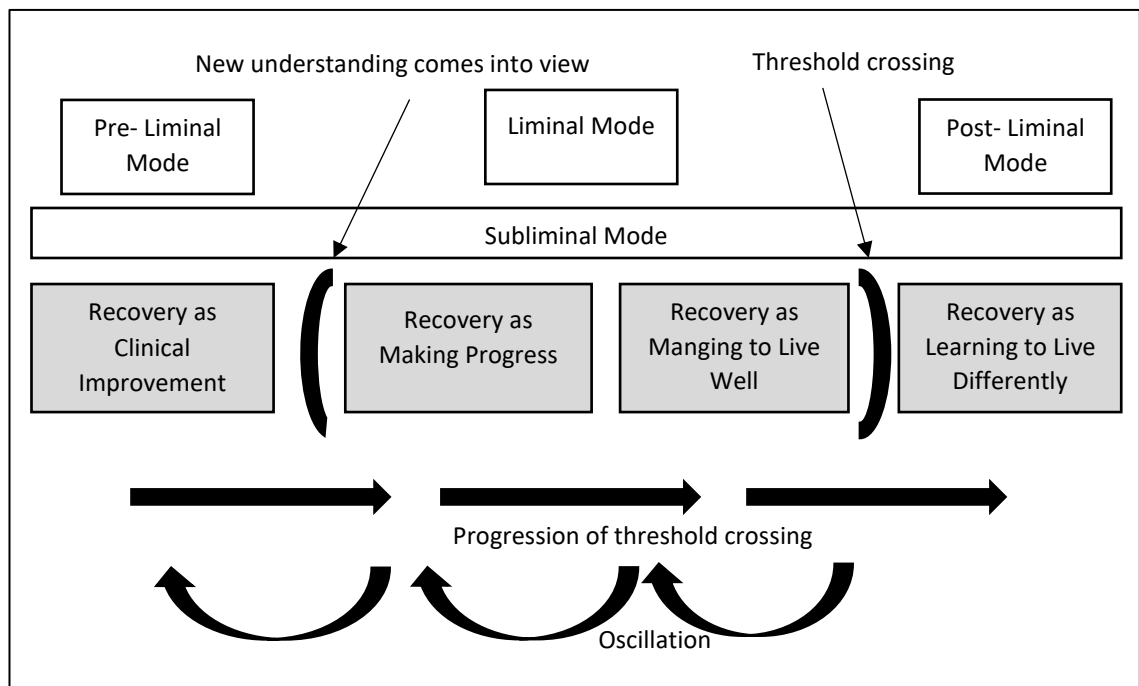


Figure4: Categories of Description within the Modes of Liminality

The categories of description Recovery as Making Progress and Recovery as Managing to Live Well can be aligned to the liminal mode where students have entered the liminal space and are exposed to a new way of understanding recovery. Here they experience deficits in their existing awareness of the concept as they are required to relinquish old ways of understanding. One category, Recovery as Managing to Live Well, is more sophisticated than the other and demonstrates progression through the liminal space towards the threshold. This progression can be seen as students either develop more sophisticated understanding, or accept alternative understandings. However, what the categories of description reveal is that

individuals demonstrate different understandings within the same account. Although most participants described changes in their understanding of recovery, several of them continued to express understanding related to Recovery as Clinical Improvement in their accounts. However, once the liminal state is entered there can be no permanent return to a pre-liminal state, therefore any regression is temporary (Meyer & Land, 2005). Similarly, all but one participant demonstrated aspects of their understanding across more than one of the other categories. These multiple understandings are expected in phenomenographic research; however, if the categories of description are understood as occupying a place within the liminal space, then this variation can be understood in terms of mimicry and oscillation. The ontological and epistemological reasons for this oscillation and mimicry vary and can be associated with the troublesome nature of recovery discussed later in this chapter. Recovery as Learning to Live Differently is the category of description holding the most expansive level of awareness of the concept. The nature of the critical aspects of this category hold a level of complexity of understanding that most aligns with the principles of recovery espoused in the literature and in policy guidance, although it is acknowledged this includes a level of professional opinion based on expert knowledge. It therefore can be viewed as a position of having crossed the threshold with transformation of learning and self, thus aligning with the post- liminal state.

The subliminal mode relates to the extent to which the learner is able to grasp the underlying game and involves tacit understanding of how people think within a discipline (Meyer et al., 2008). This resonates with the external horizon of the structural aspect of the categories of description which provides the context within which recovery is experienced by participants. If considered as how students' progress through the liminal space, those with only partial understanding can be seen to struggle with conflicts arising from differing ways of practising. In crossing the threshold to a new conceptual understanding of recovery, students can be seen

to manage conflicts, accept the ambiguities within practice and the changing context of nursing. This is in line with the idea of moving from a novice to expert understanding within the discipline of nursing (Benner, 1984). It can also be considered as a 'way of thinking and practising', a term used to describe the depth and breadth of what students might learn if engaged in a particular subject area in a particular context (McCune & Hounsell, 2005), in this case the discipline of nursing within clinical practice.

Viewing the phenomenon of recovery within the threshold concept framework moves the focus of attention away from the collective experience to that at an individual level. This is useful in order to develop further understanding of the student experience and to consider potential obstacles to learning. Phenomenography does not seek to measure the prevalence of certain conceptions or match individuals to categories. Participant accounts may contain different and multiple understandings, as understanding is described in experiential terms, based on the relationship between the person and the world. However, the individual is described as having the capability to understand in certain ways in a dispositional sense (Marton, 1992). In moving beyond phenomenographic analysis, it was evident that all participants excluding three, could be assigned to one dominant way of understanding recovery as shown in table nine. To determine if participants could be assigned a dominant category of description, their included extracts in each of the categories at the analysis stage were revisited. Where there was evidence of understanding related to a category, this is identified with a tick; where there was evidence of a dominant category this is further evidenced with a dot. As acknowledged by Ashwin, Abbas and McLean (2016, 2014), such an approach is not part of phenomenographic research, rather a use of the phenomenographic outcome space, used here for an explanatory purpose. Whilst the data shows where the students may be placed in terms of their learning journey, it does not explain the nature of their journey.

Table 9- Student understanding of recovery- dominant categories

Recovery as:	Rachel	Francis	Paula	Tom	Yvette	Kate	Hanna	Gaynor	Linda	Sally	Jane	Amy	David
Clinical Improvement	✓	✓	✓	✓	✓								
Making Progress	✓ •	✓ •	✓ •	✓	✓ •	✓ •	✓	✓	✓	✓			
Managing to Live Well				✓	✓	✓	✓ •	✓	✓ •	✓ •	✓	✓	
Learning to Live Differently											✓ •	✓	✓ •
understanding evident within the category ✓ dominant understanding present •													

In considering the nature of understanding held by individuals, it can be seen that five participants held understandings within the Recovery as Clinical Improvement category, although none held this as a dominant view. Within their accounts most participants expressed the belief that their views had changed since commencing the programme and none overtly stated a perception of recovery within a clinical framework, yet at times these understandings were expressed. Therefore despite being exposed to a new understanding of recovery, some participants appear reluctant or unable to abandon old perspectives, with oscillation between the emergent understanding of recovery within the liminal mode and their previous understanding within the pre- liminal mode. All participants do demonstrate willingness to enter the liminal space and engage with the concept of personal recovery, therefore there is no complete rejection of a new understanding. However, this enthusiasm to engage with the concept is seen in other studies of mental health professionals (Waldemar et al., 2016; Jacob et al. 2016) and has not always translated into practice. Additionally, it must be acknowledged that those who participated in the study may be those already enthusiastic about recovery and

therefore motivated to learn. Not all students may be willing to embrace the uncertainty of conceptual change and may 'pause at the gate' (Cousin, 2006a).

Ten participants can be seen as holding understandings within the Recovery as Making Progress category, with this being the dominant category for five of these. Recovery as Managing to Live Well was evident in nine participants' accounts and was the dominant category within the accounts of Hannah, Linda and Sally. Only two of those participants describing an understanding within Recovery as Managing to Live Well, Jane and Amy, were not found in the Recovery as Making Progress category. Whilst only three of those showing evidence within their accounts of Recovery as Making Progress, Rachel, Francis and Paula, were not evident in Recovery as Managing to Live Well. Consequently the majority of participant within the study can be seen as holding understandings that are within the liminal space, the majority of these showing oscillation between the two categories within this mode. The place of these students within the liminal space may indicate a progression towards the threshold; however, others may be in a suspended state, experiencing stuckness and unable to progress.

The only category of description to be aligned with the post- liminal mode is that of Recovery as Learning to Live Differently. The accounts of Jane, Amy and David showed evidence of this category, with it being the dominant category for Jane and David. For David this was the only category of description evident within his account and he was able to reflect on his changed understanding, demonstrating transformation of learning and threshold crossing. Jane and Amy showed oscillation between the two most complex categories showing their progression through the liminal space; however, they cannot be said to have achieved the irreversible transformation associated with threshold crossing. As this progression can be protracted over time Jane and Amy can be understood as not yet exiting the portal into the new conceptual

space. Personal recovery is the predominant approach represented by the categories of description when mapped onto the learning journey using the TCF. However, the variation within this understanding has been demonstrated, with oscillation within the liminal space. Whilst it is encouraging that Recovery as Clinical Improvement is not the dominant understanding shown, that this variation exists is of concern for educators and clinicians as there are incomplete understandings of recovery for those soon to be registered nurses.

It may be expected that as students progress through their studies they will gain experience, knowledge and competence; and that the more senior students would demonstrate more complete understanding. However, this is not borne out within the data. Two participants having understanding within the Recovery as Clinical Improvement category are nearing completion of the programme; whilst within the Recovery as Learning to Live Differently category, one of the participants is nearing the end of second year. With only three students describing Recovery as Learning to Live Differently within their accounts it is clear that the majority of students, including seven third year students, remain in the liminal space with incomplete understanding of the concept. It is beyond the scope of this project to investigate the nature of the relationship between programme point and student understanding; however, it can be seen that the majority of students experienced difficulty in grasping the concept of recovery despite the length of time or experience they had gained within their nursing studies.

These findings echo those of Nicola-Richmond et al. (2018) investigating TC teaching and learning in occupational therapy. Participants in their study believed it unlikely that students had fully grasped the identified TCs at the point of programme completion, suggesting TC acquisition was dependant on further clinical experience after graduation. Hudson et al. (2018) in their study of radiology students learning, also identified clinical practice as essential to the

transformation required for threshold crossing, so that connections between theory and practice could be established. Whilst different professional groups, with differences in programme design, the findings from these two studies do suggest positive clinical experience is necessary in health related disciplines for TC acquisition to be achieved. There is evidence to support this view within this study.

That students are encountering difficulties in gaining an understanding of recovery is apparent from the transcripts, with all participants referring to some aspect of learning related to recovery which presents with a degree of difficulty. Following the analysis discussed in section 3.3.8, four categories were identified related to the difficulties student experience when learning about recovery. These have been labelled as Troublesome Knowledge, Troublesome Practice, Troublesome Learning Environments and Troublesome Relationships. These four categories are closely linked to each other. Nursing knowledge is acquired to inform safe and effective nursing practice. Knowledge and practice cannot be separated in a practice based discipline such as nursing, as growth and change within the discipline are dependent on both (Ajani & Moez, 2011). Learning relationships take place within the learning environment and have been shown to have a significant impact on the development of knowledge and practice (Newton, Henderson, Jolly, & Greaves, 2015). However, for the purpose of presentation of findings and discussion they are discussed as separate categories within this chapter, with extracts from the transcripts used to support the assertions made regarding the troublesome nature of learning in relation to recovery. Troublesome aspects of more than one type are often evidenced in the statements of students (Meyer & Land, 2006; Baillie & Johnson, 2008); however, a main category of troublesomeness has been assigned to each extract provided to aid the discussion of findings. As with chapter four, to facilitate a closer relationship between the data and points of discussion there is no strict demarcation between findings and discussion, they are presented together within each category.

5.3 Troublesome Knowledge

Evan and Donnelly (2006) recognised that within nursing practice knowledge is essential for judgments and clinical decision making to occur and stated that recognising the relationship between skills and knowledge is essential in understanding the complexities of nursing practice. The clinical activity carried out by nurses is supported by knowledge acquired through education, experience, research and intuition (Benner, 1984), any skill performed by the nurse is supported by underpinning knowledge.

Land et al. (2010) suggested that learning journeys begin when students are faced with troublesome knowledge and that progression cannot be achieved without over-coming it. The troublesome nature of learning provokes the student into moving away from their prevailing view to allow for new ways of seeing things (Land, 2011). Perkins (1999) first presented the notion of troublesome knowledge and identified the five different categories of ritual, inert, conceptually difficult, foreign or alien and tacit knowledge (discussed in section 3.1.2). Meyer and Land (2003, 2006) identified troublesome language as a further associated category. These six categorisations provide an organising framework to explore the potentially troublesome nature of knowledge related to recovery.

5.3.1 Ritual knowledge

Ritual knowledge is that which has a routine way of giving answers to questions. Examples of ritualised knowledge can be identified within the student transcripts. All participants when asked about recovery identified the notion of individualism, with recovery 'being different for different people', as a central tenet. However, in some cases this identification did not demonstrate deep understanding of this concept. The following extracts from Rachel and Francis provide examples of how the concept of individualism is related to recovery:

Extract 54

Interviewer: So if you had to define recovery, what would you say?

Rachel: I couldn't define it because it's different for everybody, it's complex.

Interviewer: What makes it so complex do you think?

Rachel: Because everyone's different, everyone's totally different.

Extract 55

Francis: It was just that whole idea of recovery is different for everybody and it can have different stages and it's an ongoing cycle...I think it's difficult to understand that level of everybody being different, and you can't really put a label on where it is, because for each person it's different, and I think that's what makes it difficult.

Both participants identify that the recovery journey can be different for different people and recognise the conceptual difficulty of recovery. The position of being different is repeated in the responses for both participants when questioned further; however, the responses remain superficial with little explanatory prose given as to what this means for the person or for nursing practice. There is a routineness to the responses in that students appear accustomed with using the statement of 'being different', but do not demonstrate an understanding of the complexity of this. There are clear links here between ritual knowledge and conceptually difficult knowledge within the extracts, as Meyer and Land (2006) pointed out the troublesomeness students encounter may be a combination of the different categories of knowledge. The difficulty for the students in defining recovery is demonstrated (e.g. "it's complex", "that's what makes it difficult"), with the lack of depth of understanding filled with ritual knowledge in the repeating of everyone 'being different'.

Individualism and the recognition of everyone as being different is associated with the idea of holism. Holism is concerned with caring for the 'whole person' not just their physical body and

is related to person- centred care. Holism became influential in nursing during the 1970s and Health Education England (Shape of Caring Review, 2015) also advocated the importance of holism within future curricula. It is therefore unsurprising that it is a concept given a central position in nursing curricula, where students often revisit the idea in relation to different aspects of nursing knowledge and practice. As third year student nurses, both Francis and Rachel will have encountered the concept on a number of occasions within their academic learning and demonstrate some familiarity. How concepts are brought into view has been highlighted as having important implications for student learning. In a study exploring the troublesomeness of opportunity cost in economics, Shanahan and Meyer (2006) concluded that for students 'first impressions matter' and that efforts to simplify the expression of a threshold concept may actually prevent full understanding, leading the students onto a path of ritualised knowledge, preventing transformation. This may have important implications where teaching is delivered in a spiral curriculum (Bruner, 1960) with concepts being introduced and repeatedly covered with increasing levels of complexity throughout the curriculum. This is done so with the belief that understanding develops with appropriate structuring and presentation of concepts (Bruner, 1960). However, in line with Shanahan and Meyer's (2006) suggestion, what may be being demonstrated in this case is that rather than progressing from simplistic to complex understandings, the basic introductory content is being reinforced without further development of understanding. Consequently, the students have become stuck in the liminal space unable to master the concept of recovery, as they have not grasped the nature of one of its fundamental principles.

The superficial nature of the understanding shown in the use of this ritual knowledge can be associated with the surface approach to learning (Marton & Säljö, 1976, 1997) where there is a tendency for passive acceptance of ideas and intention to reproduce information in order to answer set questions, in this case prompts from the interviewer. However, Perkins (2007) also

identified that when faced with conceptually difficult knowledge one strategy that may be employed by students is that of oversimplification. Nuances are flattened and depth of knowledge is disregarded in favour of a relatively routine and superficial version of the knowledge in question. This may be the case for Rachel and Francis where the use of ritual knowledge of 'everyone is different' allows for avoidance of engaging with the conceptual difficulties of individualism and holism.

In considering the liminal journey students undertake in gaining understanding, these ritualised responses may also be understood as a form of mimicry. Mimicry may have some learning benefits for inexperienced nurses. In a study examining newly qualified nurses' experiences of delegation and supervision of others, Allan et al. (2015) found that these inexperienced staff looked for ritual practice and routines (which the authors equate with mimicry) to follow as a way of learning within the ward environment. Practices included copying the behaviour of other qualified staff and making lists. The authors suggest that mimicry in this sense is a 'safe' behaviour used by some learners, one possibly to be encouraged as an effective way of achieving competency. However, the authors also acknowledge that a degree of personal reflection and engagement with learning is required or the use of routine and ritual may not offer learning opportunities. If such practice takes the form of functional naivety (Meyer & Shanahan, 2003) with the routines and rituals providing enough structure for ritualised learning that allows the learner 'to get by', then mastery may never be achieved. If such mimicry involves attempts at understanding and an awareness of gaps in knowledge, then this may offer a safe space for students to further develop their learning. Rachel and Francis do acknowledge the conceptual complexity of recovery suggesting difficulties in their learning. Such acknowledgment of difficulty may demonstrate an understanding of their position within the liminal space and a willingness to engage with further learning.

5.3.2 Inert knowledge

Inert knowledge in nursing practice would refer to the failure to apply underpinning knowledge to actual practice. The failure to link recovery knowledge to applied interventions in practice can be found in the transcripts. The following separate extracts from Tom are used to illustrate this point:

Extract 56

Tom: So they're able either with medication or through talking therapies or whatever, they are able to live their life with things like have a job, do whatever or volunteer or do whatever... So recovery for me is not getting rid of everything because if you can live with it (referring to illness) and you're happy and you're fine, you're able and stable, well that is recovery.

Extract 57

Tom: Well it says here (referring to written scenario about Darren) that he expresses a mistrust of medication and he's not taking it as prescribed or probably not even taking it at all and the purpose in his case would be to try and stop the influence that the voices have on him and his life. So the concordance bit is, yeah he's not taking it so as a nurse your role would be to try and help him to work through actually taking them, and show that they're not actually going to damage him, they're actually for a positive.

In extract 56 Tom is voicing his ideas of what recovery might be. He suggests individuals may use a range of different strategies, may choose a range of meaningful activity in their lives, with recovery being about living in a contented state rather than being 'illness free'. These ideas would sit within a personal recovery framework and Tom appears to be demonstrating a level of understanding of the concept. However, in extract 57 Tom has been asked to describe the nursing interventions in relation to Darren, the fictitious service user in the written scenario. Davies and Mangan (2007) highlighted how utilising decision making activity related to experience of relevance to the student can identify whether the student is using the

concept to make sense of the situation. In this case the ideas expressed in extract 56 have not been applied to the clinical situation. Tom describes nursing interventions as promoting medication through concordance, with the nurse promoting medication as a positive, rather than encouraging informed decision making from Darren himself. Whilst espousing views on a choice of different interventions in extract 56, this is not applied to the practice situation when asked to discuss the scenario in extract 57. Tom brings recovery orientated ideas into the discussion when required in the research interview situation, but the lack of application of this in the practice based scenario highlights the knowledge as inert. It is available when asked for, but not applied in the interactions between nurse and service user within a practice context.

What Tom appears to be demonstrating is a failure to transfer learning from the classroom context to the clinical environment rendering his knowledge inert. Transfer of learning is linked to proactive knowledge, which Perkins (2007) associated with the TCF. Tom's use of inert knowledge and failure to transfer learning supports the identification of his position within the liminal space. Crossing the threshold would require "energetic engagement with knowledge and alertness to where it applies" (Perkins, 2008, p.13), which Tom does not demonstrate within the extracts. In this sense the inert knowledge demonstrated here can be viewed as the opposite of proactive knowledge. Perkins (2007) suggested difficulties with transfer of knowledge may be related to the learning experiences which do not support it, highlighting studies which demonstrate how reflective abstraction, connection making and problem based learning approaches are more likely to produce transfer of learning, yet often these approaches are underutilised.

Cousin (2006a) recognised that inert knowledge can be used by students to fill gaps in knowledge, particularly when it is also conceptually difficult. The conceptual difficulty in relation to recovery is discussed in the following section, although evidence of inert knowledge

being used to fill gaps in knowledge is also evident from the participants' accounts. Paula discusses her difficulties in grasping theoretical concepts and provides an example of such usage:

Extract 58

Paula: I'm not very good with theory. I know what happens and I know what needs to be put in place, but if someone was to ask me 'how you do know that' I'd struggle really... you get people who are really good with the theory and they can like say names out of their head but I can't, I'm not very good.

Interviewer: If I put you on the spot and said can you name any theorists or theories related to recovery could you think of any?

Paula: The simplest one I can think of is probably Maslow's hierarchy how you start at the bottom and working your way up. But really I learnt that at college, but there are others that probably if you were to say to me now 'so and so' I'd say 'oh I knew that'.

When asked to recall any particular theory Paula refers to Maslow's hierarchy of needs, although of relevance to nursing practice it is not something specifically associated with recovery. She then goes on to explain that this was something she learnt at college rather than university. Despite having earlier alluded to university providing her with theory behind interventions, it would appear that Paula is struggling to actually identify what this might be. When asked she has drawn on knowledge acquired in a different educational context and applied this to the current context. When 'put on the spot' Paula has relied on inert knowledge in order to provide a response. The use of inert knowledge in this way means Paula may feel that she has answered the question and so may not be cognisant to the fact that there are gaps in her knowledge, using inert knowledge in this way can prevent students from developing further understanding. How students respond to conceptual difficulty may vary. As well as the strategy of oversimplification students may view themselves as having limited ability to successfully tackle complexity, adopting a 'you get it or you don't' mind-set (Perkins,

2007). This would appear to be the case for Paula in that she describes herself as “not very good with theory”. This then serves to justify withdrawal from conceptual difficult knowledge, adopting a more surface approach, utilising inert knowledge instead of engaging with troublesome learning.

Evans and Donnelly (2006) asserted that there exists a preoccupation with nursing skill over nursing knowledge and that such a focus on ‘learning to do’ over ‘learning to know’ has limited the advancement of nursing practice. Where knowledge is not developed in line with skill there will exist a gap between theory and practice. Knowledge maybe rendered inert if priority is given to skill development with knowledge given lower status. This will impact on the students’ abilities to link theoretical concepts to practice as demonstrated by Tom, or as in Paula’s case remembering underpinning theory may become difficult. Whilst this may be due to its conceptually difficult nature, it may also be that knowledge becomes viewed as of little importance if the priority is given to skill development. Similarly, a focus on ‘doing’ over ‘knowing’ may cause the underpinning knowledge to appear more abstract and conceptually difficult if students are unable to relate it to practice.

5.3.3 Conceptually difficult knowledge

As previously discussed the nature of recovery can be difficult to grasp and there are a number of different concepts which come together to form the body of recovery knowledge.

Therefore, several different pieces of information need to be understood in a unified way. The difficulty of this is evident in the student accounts of recovery. Evidence of conceptually difficult knowledge as linked to ritual and inert knowledge has been discussed. The two previous quotes from Rachel and Francis (extracts 54 and 55) related to the use of ritual knowledge demonstrate how conceptually difficult recovery can appear to students, “It’s

complex” and “I think that’s what makes it difficult” are examples echoed by other participants.

Perkins (1999) suggested that subtle distinctions can be one source of troublesomeness related to the complexity of knowledge. This is evident in the following passage from Linda where the distinction between recovery as done by the person and ROP, causes difficulties in understanding.

Extract 59

Interviewer: And is there anything that you would say makes recovery difficult to understand, to get your head around?

Linda: Yeah because it’s different for everybody. You could do one thing for one person and it works fantastic. You try and do the next thing with another person and it fails, and then obviously you doubt yourself that you’re not doing it right or should you have done something different. It’s hard to know what recovery is then.

Here Linda demonstrates how two component parts of the phenomenon of recovery are experienced, with a blurring between recovery as done by the person and ROP as done by the nurse. Whilst there are obvious links between the two, there is also an important difference. Recovery is not something done by the nurse, recovery is done by the person with the nurse potentially acting as valued helper through ROP. However, Linda talks of recovery as an intervention, something that the nurse does to the person. Linda expresses doubts about the right thing to do in relation to interventions with different people and acknowledges her difficulty with knowing what recover is, because what she sees as failings of the interventions. In failing to discern the difference between recovery and ROP, a deeper understanding is lost. The troublesome nature of recovery knowledge here can be seen to relate to the subtle but distinct idea of recovery as being person led rather than professionally led. A further example

of the complexity of recovery knowledge and failure to fully grasp the concept is evident with the following extract from Yvette:

Extract 60

Yvette: To me recovery isn't, it's not necessarily about getting rid of the condition or getting rid of the symptoms, it's about getting someone to the point where they can function and live a normal, a normal life and carry on their daily activities and function socially, like hold down a job, have a social life, have a relationship all those sorts of things.

At face value Yvette may appear to have a grasp of recovery in that she recognises that it is unrelated to a particular condition or set of symptoms; however, she goes on to suggest recovery is about living a 'normal life'. As Deegan (1996) asserted to be 'normal' is not part of the recovery process, to suggest there is a normal that individuals should aspire to be is incongruent with the idea of self-determination and there is a danger of reinforcing negative stereotypes. Yvette goes on to suggest activities that would fit with 'normal' such as holding down a job. Whilst building a meaningful life is recognised as important to recovery (Repper & Perkins, 2009) the decision on what is meaningful is one for the individual to make. For Yvette to hold these expectations on 'normal' is a misunderstanding which she appears unaware of. Although Linda recognises her difficulty (although not why it exists), Yvette does not appear to recognise that she is holding misconceptions. The brief extracts below serve to illustrate a similar misconception in that recovery relates to 'returning to something':

Extract 61

Gaynor:recovery's not a cure and recovery is very personal to you, and it's you getting back to you, whatever you is.

Extract 62

Kate:(referring to Darren in the scenario).He's volunteering, he's getting up, he's having a purpose, he's doing what he wants to do, and he's in preparation returning back to his life.

The extracts include activity associated with recovery such as “recovery’s not a cure” and “he’s having a purpose”. However, the idea of the person “getting back” to something or “returning back to life” suggests returning to a former state of health. As Aston and Coffey (2012) pointed out this may prevent service users from considering themselves in recovery under this definition. This returning to a former state may limit opportunities for the person in terms of what they feel is available to them in their future. Again this difference in understanding may appear subtle but it relates to an important principle of recovery. What students demonstrate in these extracts is a partial grasp of the components of recovery although they fail to connect these in a way as to see the whole picture.

The nature of pre-liminal variation may provide some explanation of the conceptual difficulty experienced in relation to recovery. Pre-liminal variation refers to the prior knowledge of the subject held by students, their tacit understanding of recovery. Variation in this conceptual understanding prior to exposure to new knowledge is inevitable and it cannot be assumed that students will share common understanding of concepts. Although the signifiers (the words used as labels for component concepts) may be common to all, the potential for variation of individual understanding of these signifiers is significant (Land, Rattray, & Vivian, 2014). Most students expressed a pre-liminal ‘lay perspective’ of recovery as something associated with cure from illness or disease, although a minority of participants expressed different understanding. Whilst students’ prior knowledge of recovery was not specifically measured, some participants related their prior experiences of recovery to their current understanding. For example, Yvette had previously worked in care services and described gaining an understanding of recovery from this experience. Yvette felt that she had a good understanding of personal recovery; however, analysis of her transcript suggests she held incomplete understandings in that the dominant category expressed was ‘Recovery as Making Progress’, with variation expressed across three different categories. In this sense Yvette can be seen to

be oscillating in the liminal space, although this does not appear to be how she understands her own position in relation to learning. Yvette's prior learning experience may be acting as an obstacle to learning in that she believes she has acquired the required knowledge. Such unawareness or misapprehension, unless exposed, may prevent mastery ever being achieved. In examining the troublesome nature of language knowledge, Orisini- Jones (2008) similarly found students' tacit knowledge to be problematic. In her study many students had previously been taught grammar in a different educational context, new functional grammar terminology to which the students were then exposed, challenged their existing understanding and their sense of security. These tacit understandings then were identified as part of the troublesome aspect of the student approach to understanding sentence structure.

5.3.4 Foreign/ alien knowledge

The counter-intuitive nature of alien knowledge presents as an obstacle to learning and is apparent within the accounts told by participants regarding knowledge of recovery. In the following extract, David is discussing how his beliefs about the nature of relapse and its relationship to recovery was challenged.

Extract 63

David:When I was on placement in second year, a social worker told me and I've never really thought of it like this, that relapse is part of recovery. It's really important that someone can learn from failure and that was really important, that was quite a big thing for me to think about. Because you kind of just expect 'I'm going to come in like super nurse and I'm going to guide someone through and they're going to be fine' and it's not that easy is it?

In lay terms relapse is commonly understood as a deterioration in health and therefore has negative connotations. However, recovery is not a linear process and relapse is not viewed as a failing (Anthony, 1993; Deegan, 1992). Instead it can provide opportunities for learning, developing coping strategies and resilience. David describes how this different understanding

was offered to him by a mental health practitioner which challenged his held belief. To think of relapse as having positive aspects to it is counter intuitive and David's expression "that was quite a big thing for me to think about" demonstrates how challenging alien knowledge can be. David's last sentence in this extract also demonstrates how once exposed to new understanding this not only challenged his prior knowledge of relapse and recovery, but also his identity as a nurse, as this led him to reconsider what this would mean in terms of nursing practice. David is the only participant to have fully crossed the threshold and this statement demonstrates the ontological shift associated with threshold crossing, where there is not only transfigured thought but also a transfiguration of identity (Meyer & Land, 2006).

Alien knowledge can also be identified in relation to risk management. This area is discussed in more detail as part of the category Troublesome Practice; however, the links with alien knowledge are clear. Within mental health care risk management has become a central issue and is concerned with the systematic collection of information that informs actions to minimise the risk of harm to service users or others (Eales, 2009). Part of the drive to emphasise risk management strategies has been the public perception of the need for protection, largely related to media portrayals of mental illness being synonymous with dangerousness (Manuel & Crowe, 2014; Georgaca, 2014). Consequently, the pre-liminal position for nursing students may be a belief on the need to control 'risky' behaviours. There is also significant evidence to suggest this is a perception held and practiced by many health care professionals (Clancy & Happell, 2014), despite the fact that the Department of Health (2007) highlighted that "over defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term and can be counterproductive, creating more problems than it solves" (p.8). Participants of the study describe experiencing differing held opinions by clinical staff in relation to risk management as demonstrated by Paula:

Extract 64

Paula: Sometimes there can be confrontation between professionals because someone may see recovery differently to another professional. Because you do positive risk taking for example and you get one nurse who'll say that the patient wants to go out on leave, they'll be like 'no they're not going on leave there's too many risks' but then another nurse might be like 'well actually they've improved lately if we give them a little step then you won't know unless you try'.

Conflicting opinions appear to cause discomfort for students as they wrestle with the issues related to risk management. Positive risk taking is described as 'risky' for the nurse which again can appear counter intuitive for novice nurses who would not necessarily expect aspects of practice to involve risk taking. However, the common sense notion of preventing risk taking behaviours runs counter to ideas of positive risk taking associated with recovery. Within recovery there is a focus on self-determination which will include an element of positive risk taking. Positive risk taking is part of an overall strategy that recognises that not all risk can be eliminated. Service user choice and self-determination involves an element of risk, where the potential benefits of this outweigh the potential risks, it is encouraged as in the person's best interests. This understanding of positive risk taking as part of recovery may well appear counter intuitive to students, especially if commencing their nursing education with pre-conceived beliefs around the need for public protection and desire to safeguard the individuals in their care, particularly if they encounter clinical staff who also maintain this position.

5.3.5 Tacit knowledge

Meyer and Land (2006) identified that much learning is implicit within the curriculum and in practice, but that such tacit knowledge still needs to be grasped. The difficulty in relation to recovery is articulated by Gaynor:

Extract 65

Gaynor: It's hard isn't it (referring to recovery), it's some kind of tacit knowledge isn't it, so, it's really hard to verbalise or write down ...

When encountering a situation experienced practitioners do not look upon it as having different aspects to which different forms of knowledge can be applied. Instead they respond to the feel of the whole problem without consciously using linear sequential thinking processes. However, when called for, these practitioners are able to provide a rationale for any action taken (Schön, 1983). Schön referred to this expert performance as 'reflection in action' and 'reflection on action'. Welsh and Lyons (2001) suggested 'reflection in action' is about intuitive judgements. In nursing practice knowing when and how to use a particular skill or intervention can be viewed as intuitive or tacit knowledge. To newcomers such as student nurses such nuances of practice may be inaccessible, particularly when first engaging with new learning. Participants within this study suggested that there were elements to recovery that they found difficult to grasp, which appear to be related to the tacit nature of elements of recovery focused knowledge:

Extract 66

Gaynor: I suppose I needed that placement to see the difference between primary and secondary care for myself because it's alright just looking at something in a text book but you need to put that theory into practice.

Extract 67

David: ... it's just an abstract thought isn't it? When it's introduced as recovery and this is the structure we use, it's still fairly abstract you sort of, you've got to sort of visualise it. I think it's when you start applying tools or you see it in practice that's when it sorts of hit you...

Both Gaynor and David describe difficulties experienced in understanding recovery and how exposure to authentic learning environments aided their understanding in that the more tacit

understandings of recovery are then exposed. Because tacit knowledge is not transparent it often is made up of unexamined understandings, but when shared with people of a similar background, such as in a community of practice, the reasoning involved is understood (Meyer & Land, 2006; Evans & Donnelly, 2006). Much of nursing remains invisible and mental health nurses in particular have trouble articulating what they do (Evans & Donnelly, 2006; McSherry, Loewenthal, & Cayne, 2015). McSherry et al. (2015) suggested that much of the difficulty lies in the fact that central to mental health nursing is the therapeutic relationship and that what exists within relationships cannot be put into words: “there are elements of mental health nursing that fall outside of language and thus cannot be spoken” (p.85). If theoretical frameworks or formal knowledge cannot then clearly articulate this element of nursing practice then this type of knowledge has to be acquired through learning in practice through contact with service users, role modelling from experienced staff and learning through a process of repetition. As such this can then become tacit knowledge. This has significant implications for students in understanding recovery as the nature of the relationship is central to ROP. The therapeutic nature of the relationship within ROP must be understood for the student to progress with learning. If this tacit knowledge is gained through practice then opportunities for learning must occur in practice, yet evidence from this study suggests these opportunities are not always available to students. Lack of opportunity becomes a barrier to further learning:

Extract 68

Francis: To be honest it's not really something that's discussed, I don't know, no-one has ever sat down and said what do you think about recovery, do you think this person's going to recover...

Whilst Gaynor and David found practice provided insights into the tacit nature of recovery based knowledge, for Francis and other participants these opportunities were not provided.

Where recovery and ROP was not explicitly brought into focus by mentors or other clinical staff, then some students struggled to grasp these elements of nursing practice.

The tacit nature of knowledge within curricula has been addressed by Clouder (2005) in relation to caring in healthcare and Shanahan and Meyer (2006) in relation to economics. Clouder argued for the concept of caring as a threshold concept, one that she argued is not explicitly addressed in healthcare curricula. The language of caring has been poorly defined and it remains elusive (Paley, 2001) and Clouder suggested that it remains implicit in the work carried out by health professionals. As such students are not adequately prepared for care giving within a practice context, where troublesomeness is related to the taking responsibility for care, direct contact with the person requiring care and the nature of the person's response to care. Shanahan and Meyer (2006) highlighted how some economics students without the tacit understanding drawn from experience in commercial settings gave an 'arm's length' response when questioned about opportunity cost, failing to understand the 'underlying game'. If students' experience in practice is limited then they may not have acquired tacit knowledge related to this area and may be unable to comprehend the "grey area", gaps in knowledge may then lead to gaps in practice with negative consequences. These authors draw attention to the difficulties students experience when not exposed to tacit understandings, either through previous life experiences or because it is only implicitly addressed within the curriculum. This is also highlighted by participants in this study in relation to university based learning:

Extract 69

Linda: Yeah there's definitely been lectures and stuff, I mean don't ask me which lecture (laughter) but yeah it comes up in conversation ... and a lot of the assignments we do as we're coming towards the end you think about what tools have been used, what tools have been

used in practice, so there is definitely, although it might not be specifically recovery but when you break it down and look at it, it is about recovery.

Linda highlights how university learning has included aspects of recovery, although this has not been explicitly so. As a third year student Linda is able to examine the content of sessions and recognise the recovery orientated elements of these; however, other students may find this less clear. In the extract below, Rachel suggests it is an area not covered enough at university.

Extract 70

Rachel: I think it needs to be in education more.... you learn about WRAP plans and recovery stars... but I think to look at why it's done, why it isn't done and then look for some downfalls that you would see in it. So, if someone doesn't want to recover then why not sort of thing? What does the literature say about recovery? People have different beliefs about it in practice, depends where you are.

Rachel recognises direct recovery orientated interventions that have been covered as part of the curriculum, although she appears to be suggesting a gap in how these are then connected with practice. The different held beliefs about recovery and how this relates to the literature are areas that appear to cause difficulties for Rachel when she considers recovery in practice. Whilst practical aspects appear to be addressed, the more elusive elements of recovery such as its deeply personal nature, arguable one of its most complex aspects, are not explicitly so. This expert tacit knowledge is then not made accessible to all students, who may well then need to rely on existing tacit knowledge gained from pre-liminal understanding.

Whilst a lack of tacit knowledge may then be problematic, Eraut (2000, 2004) has also highlighted how if faced with complex knowledge, particularly that of a propositional nature, students may well revert to using existing tacit knowledge. Propositional knowledge maybe too abstract or requires time to learn, whereas existing tacit knowledge is immediately

available. The complexity of knowledge relating to recovery has already been discussed, if understanding is troublesome then students may draw on tacit knowledge for instant use. This may be in use in relation to risk management, where the difficulties students encounter in relation to alien knowledge has been highlighted and is discussed further related to troublesome practice (section 5.4). In relation to risk management Welsh and Lyons (2001) identified how both formal and informal knowledge is essential for effective risk assessment, in that evidence based formal knowledge needs to be combined with the tacit knowledge of practitioners in meeting the needs of those with complex mental health problems. Jane acknowledges this:

Extract 71

Jane: So they may feel well, and maybe they are, but it's that risk, how at risk are they, so again it's a grey area. It's one you have to, where you have to be intuitive and reading between the lines you know. Yeah, I think I'm more kind of, well if someone says they're well, but I don't know it's just very grey..

The 'grey area' Jane refers to can be seen as an example of where tacit knowledge may be used to fill gaps in understanding. If positive risk taking appears counter- intuitive or too complex, then tacit knowledge regarding risk averse working practices may over-ride any new understandings associated with a recovery framework. In this sense "tacit knowledge is not a sideshow but central to important everyday action" (Eraut, 2000, p.118).

Tacit knowledge then can be seen as 'double trouble'. It is considered essential for students to grasp that which is not explicitly addressed through formal learning (Meyer & Land, 2006), or there will be gaps in understanding. However, existing tacit knowledge may act to prevent student consideration of new understandings or further knowledge attainment, creating further obstacles to learning. Tacit knowledge can be seen then to directly affect practice. The

use of tacit knowledge is linked with the aspects of troublesome practice, which is discussed in detail in section 5.4.

5.3.6 Troublesome language

All encounters with troublesome knowledge will have a discursive characteristic (Land et al., 2014) and for student nurses there are difficulties with the discursive practices associated with recovery. When considering recovery in a semiotic approach it can be seen that the signifier (recovery) has not changed. As discourses of personal recovery have emerged the existing signifier of recovery used in both medical practices and within everyday language has been adopted. However, students are required to discard their existing understanding of this signifier in favour of a new understanding (Land et al., 2014). A different context of recovery must be understood for learning to progress. This may be conceptually challenging and whilst students are applying the same signifier, there is variation in understanding and discursive practice as demonstrated by the four categories of description discussed in chapter four.

The use of professional language is well recognised in healthcare. Allen et al. (2007) noted how student nurses acquire professional language through learning and reflection on learning, in both academic and practice contexts. For students to gain an understanding of these forms of expression and their associated ways of thinking, then they must be exposed to it, have clinical placements with teams who adopt it. For some students this presents as a barrier in relation to learning about recovery as can be seen in the extract below:

Extract 72

Sally: generally I don't think we talk about it enough at all, I don't think it's discussed as much as it needs to be. I think my issue with things is that you come in and we give people this label but we don't discuss the fact that you can recover from this and I wish that would happen

more, and I think where I am at placement at the moment we've not done too much, we do do stuff on recovery but it's not as much.

Sally describes a lack of exposure to recovery orientated discourse within her placements.

Whilst there may be a desire to engage with recovery and its ways of thinking and associated language, if it is not adopted by the clinical teams then it becomes difficult for student nurses to do so, having no guidance or modelling from the practice team to support learning. The language associated with recovery is significantly different to 'professional' language heavily influenced by the medical model. This again poses obstacles for student nurses if familiar with such traditional terminology and expecting to use it. Jane discusses this difference:

Extract 73

Jane: Well you know you have this thing about all the medical stuff of you should be curing everybody and you know that's what hospitals do, hospitals cure people you know. But since that I've realised it's not about curing, it's about getting people to a level which they're comfortable with. So curing is not the be all and end all, it's not the whole panacea of health care you know. It might be from a physical perspective but from mental health it's getting, finding out where people are happy and comfortable.

Jane is describing how on commencement of the programme she had an expectation of what helping people with recovery would be, as can be seen it is heavily influenced by the medical model and its associated language with recovery being akin to cure. In describing how her understanding has changed there is an associated change in language with 'everyday' language such as 'happy' and 'comfortable' replacing cure. Whilst Jane appears at ease with this language, others may not be. The language change is further demonstrated by David:

Extract 74

David: I really do I feel like it's like a journey, and I suppose that's a bit flowery that isn't it but it is really

David has adopted a recovery orientated approach to his practice and he refers to a 'journey' in common with recovery orientated language. However, he then describes this term as 'a bit flowery' suggesting he recognises its lack of 'professional jargon'. As language defines group membership (O'Connor, 2005), David's expression can be viewed as an announcement of his affiliation, which may potentially deny membership to another group, one where medical discourse is prominent. Here the 'softer' language of recovery orientated approaches seen in both Jane and David's extracts may be perceived as having less professional standing because of its lack of technical and scientific jargon. The link between language and group membership is discussed further in relation to troublesome learning environments in section 5.5.

Certain discourses emerge that privilege certain ways of knowing within disciplines. In mental health care the bio-medical model of illness with its associated scientific language has historically dominated practice and nursing has largely adopted this language. This medical discourse promotes the idea that mental distress can be understood in the same way as other kinds of disease, the product of biological dysfunction (Gupta, 2007). This way of understanding mental health issues has such prominence that it has also become a socially available discourse, with those experiencing mental distress may understand their experiences as having a biological manifestation (Georgaca, 2014). Media coverage of incidents involving those in mental health services has also largely adopted the medical discourse where the language of risk, dangerousness and public protection is used in response to what is perceived as biological conditions of chronicity and disability (Georgaca, 2014; Lakeman, 2013). Georgaca (2014) discussed the findings from a number of studies which highlighted how once a service user is placed in a position of having a serious and often chronic biologically based disorder, then the professionals gain legitimacy in acting as expert practitioners in deciding upon and

providing treatment by applying procedures in an assumed objective manner. The medical discourse places the service user in a subordinate position to that of the professional.

Whilst medically dominated discourses have gained prominence, recovery orientated discursive practices have emerged that challenge the traditional ways of thinking and practising associated with the medical model. This is significantly different to the language of chronicity and disability associated with the medical model, as the focus is on recovery of the person not the illness (Lukoff, 2007). In a study examining discursive processes in recovery orientated teams, Barrenger, Stanhope and Atterbury (2015) noted how teams engaged in language that diffused situations, normalised behaviours and facilitated positive discussions about service users rather than pathologising their behaviours. Discursive practices such as withholding judgements, giving the benefit of the doubt and celebrating successes were adopted by team members with reported positive impact on practice. Aston and Coffey (2012) highlighted this issue with the move away from the medical model and the changing language used to describe service user experiences. Whilst their study found differences in understanding of recovery and preferred terminology for describing the process, there was a clear determination to move away from medical terminology. Hence terms such as 'journey' 'pathway' and 'discovery' were depicted as more relevant. Deegan's (1996) description of recovery as 'a journey of the heart' has been widely received along with her emphasis on opportunity, personal control, hope, acceptance and support. This language is in marked contrast to medical terminology such as diagnosis, symptoms, cure and prognosis.

This notion of troublesome language is not as well supported within the data as other categories discussed within this section as troublesome, nevertheless extracts have been included along with discussion to show its potential as an obstacle to learning.

5.3.7 Concluding comments on troublesome knowledge

Perkin's description of troublesome knowledge, along with the additional category of troublesome language has provided a framework for exploring the nature of difficulties students may encounter related to recovery orientated knowledge. Examples from the transcripts demonstrate how these categories can cause difficulties for students in their learning. Conceptual difficulty can arise when pre-existing held beliefs are challenged by alternative ways of understanding. The use of the strategies discussed in this section may be used by learners as adaptive methods to avoid the conceptual difficulty of a topic, but such a strategy can result in an inability to transfer learning (Perkins, 2007). For the participants of this study as student nurses it has been demonstrated how this relates to a failure to transfer classroom taught theory to actual interventions in the practice setting.

5.4 Troublesome Practice

Experience in clinical practice is an essential component of the pre-registration nursing programmes. Nursing is essentially about practice, the delivery of safe and effective interventions. However, nursing practice cannot be separated from its underpinning knowledge and has been developed in light of its updated evidence base. For many areas in mental health nursing this has seen a shift away from task- orientated care, for example 'doing the observations', to one focused on the individual therapeutic relationship, where nursing care is carried out within these relationships (Rolfe, 1998). As such mental health nursing can be viewed as a very human activity, where nurses engage with those receiving care at a personal level. By its very nature this level of engagement can present as emotional encounters for nurses, both positive and negative. Although not directly related to student nurses, the emotional toll of working with people in recovery has been identified with staff reporting feeling overwhelmed by the complexity of need and a lack of clarity in assisting recovery (Rice, 2009); also, fears of a lack of recovery and increased risk of self-harm (Forchuk,

Jewell, Tweedell, & Steinnagel, 2003). What emerges from this study is that ROP has particular aspects to it that can be troublesome for student nurses in that they experience uncertainty and negative emotional reactions as a result of practising in this way. In the following extract Jane is discussing how opinions between professionals and service users can sometimes differ and provides an example of what that means for nursing practice.

Extract 75

Jane: I think it's how that impacts on family, people who are living with them you know on the outside. It's like somebody who's living on their own and they are voice hearing with negative command, and they're quite at risk, whether it be harm to themselves or others. I think it's getting that balance isn't it, it's getting that person well enough to function without being a huge risk to themselves or others, or mainly to themselves really, so it's kind of gauging that level of risk all the time. So they may feel well, and maybe they are, but it's that risk, how at risk are they so again it's a grey area. It's one you have to, where you have to be intuitive and reading between the lines you know. Yeah, I think I'm more kind of, well if someone says they're well, but I don't know it's just very grey. ...but it's a tough one.

Jane demonstrates how risk and risk management is very much part of contemporary mental health nursing, with positive risk taking in collaboration with the service user being viewed as part of ROP; however, it is not an uncomplicated process. She refers to 'getting the balance' and this being a 'grey area', demonstrating that issues around risk are rarely clear cut clinical decisions but require a level of clinical interpretation that cannot always be gained from guidelines or protocols. It can be a subjective decision, open to interpretation, which potentially others may disagree with. Jane refers to being 'intuitive and reading between the lines' which can be hard to articulate to others, especially in a world of evidence based practice and formal protocols. Troublesome practice here is closely linked to the use of tacit knowledge previously discussed; however, from a practice perspective there are issues for

students which can create uncertainty in how to manage the potential conflicts or ambiguities which can arise. In the following extract David describes this further:

Extract 76

David: There's a lot of big issues I think when it's a risk. I think with recovery, I think you want to get it right and maybe take positive risks and all of that but then I feel like that professional side is so much at odds with the interpersonal side because in a lot of ways nursing is policed really, by the CQC (Care Quality Commission) or NMC (Nursing Midwifery Council) or trusts or whatever. So as much as you might want to take a positive risk with someone say if they wanted to disengage, you've got to kind of encourage them not to disengage, on the professional side you've got to be seen to be making an effort don't you.

David describes the conflicts he has experienced with his desire to practise in a recovery orientated way and with the expectations he perceives are placed on him by the employing trust, the professional body and the regulating authority. For David there is a desire to take positive risks although he recognises the constraints of the 'policing' of nursing practice. He describes how personal choices by service users (in this case to disengage from services) can be difficult to accept. Nurses may find themselves in a position where they may feel unable to support these choices, not because of professional judgement or personal values, but that to do so would hold risks for the nurse in terms of being answerable to the organisation, the professional body or the regulators. Both Jane and David demonstrate how there exists uncertainty and potential anxiety for nurses wishing to practise in a recovery orientated way; however, the uncertainty associated with encouraging personal choices and taking positive risks impacts on student nurses and their actions in practice.

Service user involvement in treatment decisions can raise further issues in relation to risk that student nurses feel uncomfortable with where there exist differing held beliefs by the student

nurse and the service user. In the following two extracts David and Linda discuss the emotions they have experienced as a result of holding different views to those of service users.

Extract 77

David: .. I know it's on their terms and I don't mean 'how dare they disconnect or disengage' but I think it's difficult as a nurse to accept that sometimes, because you think 'it's the right thing for you if you just keep coming or if you just keep doing it'. I think it's tragic in a lot of ways, it makes you feel really sad that you could have really helped someone and they don't want it.

Extract 78

Linda: Oh I came and I was going to change the world, I thought I was going to heal people and then you realise you can't. There were times on placement in first year that I felt really flat because people didn't want to get better, that's what it felt like. But as I've gone through and I've reflected, it's not that they didn't, they did want to get better but my idea of better is different to theirs, and where I've got this view from now is it's about what they think their life is and not what I think their life should be.

Non- engagement with services or treatment by service users can be viewed as irrational behaviour and a symptom of illness. The premise here is that rational people want to be well, treatment makes people well and therefore rational people accept treatment. Where the risks are deemed great enough, treatment can be enforced using powers of detention. Where this is not deemed appropriate, ongoing refusal of particular care can result in withdrawal of all services. However, the right to self-determination is an identified principle of recovery (Repper & Perkins, 2009) and the reasons for none engagement are many and varied. There is also ample evidence that non-adherence to treatment regimes occur in a number of different conditions including heart, lung and blood disease, cancer and infectious diseases (Corrigan, Rusch, Ben-Zeev, & Sher, 2014), it is not specific to mental health. But as David and Linda demonstrate in their extracts, upholding these decisions may leave the nurse with negative

emotions. For David this carries a 'tragic' element in the example given where people may decide against treatment that the nurse thinks is in their best interests. Linked to this is a feeling of sadness at the perceived lost opportunity to help someone. Linda describes her experiences early in the programme when her expectations of 'healing' people were not realised, with it taking time for her to understand the personal perspective of the service user in relation to their idea of 'better' being different to hers. As a first year student nurse Linda was left with a negative emotional reaction to this, feeling 'really flat'. Whilst her understanding of wellness developed as her programme continued, the emotional response she initially experienced had enough impact for her to remember it as a third year student.

Further challenging encounters for the students are expressed within the transcripts. In discussing Wellness Recovery Action Planning (WRAP), a recognised recovery orientated tool. Hannah describes the difficulties she sees with this activity:

Extract 79

Interviewer: Have you seen WRAP implemented in practice?

Hannah: Not very well....I think a lot of people are scared to do it both patients and staff....Because it's a big thing to do..... If they're already on their way to recovery why would you want to sit down with them and go 'well this is what we've got to do and by the way it could make you feel worse'? That's normally, especially for nurses, that's normally something we leave for other professions like psychologists and psychiatrists. I think most of the nurses I've met are really nurturing and want to make people feel better so when you get into a situation where there's a possibility that you're going to make somebody feel worse that's really hard, ...it's not something you come across very much in nursing.

Interviewer: do you think that is part of recovery, being faced with difficult things?

Hannah: yeah but it's not always the first thing that you think of, that its part and parcel of what we do and it needs to happen, not what I would think first, well I don't want them to feel worse.

Hannah expresses the view that both staff and patients may be 'scared' by undertaking a WRAP plan. She relates this to the possibility that it may make the person feel worse. WRAP involves the identification of wellness tools, the development of coping strategies to deal with signs of deterioration and plans to deal with adverse events including a mental health crisis (Copeland, 2015). Hannah believes engaging in this has the potential to make the person feel worse, which she sees as at odds with the 'nurturing' characteristics of nursing. So much so that she suggests a shift of responsibility to other professionals if the potential to upset the patient exists. In any human encounter there exists an element of uncertainty and as Eales (2009) identified, in mental health nursing practice risk is dynamic and cannot be eliminated. However, for Hannah this risk of the person having 'a setback' because of engagement in the WRAP planning is enough to prevent the intervention from happening in the first place. Whilst she recognises that recovery can involve difficult things, she is uncomfortable with the part the nurse may play in this, an alien position to her understanding of nursing. This makes an element of ROP difficult for her to engage with.

Clouder (2005) identified how as healthcare students engage in practice learning they encounter challenges to their common sense understandings of what 'caring' means, they are then required to reposition themselves both conceptually and ontologically to the moral, ethical and personal challenges they face. Similarities can be made with the experiences of the participants in this study. The extracts from David, Linda and Hannah demonstrate how student expectations of nursing may differ significantly from what they then experience in practice, as their personal perceptions of the nurturing and care giving role of the nurse were challenged. For Hannah the idea that nursing interventions may purposefully be directed at challenging service users' held beliefs, or encouraging exploration of potentially distressing experiences appears taboo and something she appears reluctant to engage in. The extracts

from David, Jane and Linda also demonstrate discomfort with elements of ROP. However, here there is a suggestion of an ontological shift having occurred, as the participants express acceptance of their own emotions in relation to practice and a repositioning of their professional identity in relation to what ROP entails.

Central to recovery are the ideas of self- determination and self- management (Repper & Perkins, 2017). There is an expectation that service users will have an active role in decisions about their care and treatment, which may include the person taking choices that the professionals may not necessarily agree with. It is not for professionals to take on a protective role but up to the person themselves to make choices, even if these include elements of risk (Mead & Copeland, 2000). This challenges professionals, including nurses, to adopt new ways of working, different to those of the traditional paternalistic model in which professionals directed treatment packages. This includes positive risk taking in collaborative relationships with service users, an area discussed in the extracts in this section. Positive risk taking is encouraged by central policy as part of an overall risk management strategy. Under the clinical governance framework, patient safety and risk management became a central issue in contemporary healthcare, including mental health nursing (DoH 2001, 2007a, 2007b; Horlick Jones, 2005). Clinical risk assessment is a key component of this, although practitioners have differing views on its usefulness to practice. Clancy and Happell (2014) conducted in-depth interviews with a range of clinicians and managers of mental health services. They found clear tensions for staff in relation to accountability for their practice in considering issues of risk and person- centred care. Concerns were raised that prioritising risk management strategies interfered with the provision of quality person- centred care, as staff felt restricted in their practice. Similar conclusions were drawn in a study of mental health nurses by Manuel and Crowe (2014) who again found nurses experienced concerns about being accountable for their practice. Nurses described considering patients' therapeutic needs against the potential risk of

being blamed if something went wrong. The authors concluded that an organisational culture of risk management had led to the adoption of defensive practice where there was a perceived need for self- protection by nursing staff.

Risk has become seen as a negative matter in mental health service provision as organisations have developed risk adverse cultures to mitigate against it, largely because of fiscal constraints or the fear of litigation (Buchanan- Barker & Barker, 2005; Kettles, 2004). In the event of an adverse incident, clinicians are required to account for their actions with their decisions open to scrutiny, often in the arena of an internal investigation, but potentially in a coroner's court. This has led to clinicians adopting defensive practices overlooking the best interests of the service users, instead focusing on correct paperwork and referring decision making to others as a means of personal protection (Clancy & Happell, 2014; Godin, 2004; Manuel & Crowe, 2014).

This culture can be seen as at odds with the principles of recovery and it is perhaps not surprising that some nurses may be reluctant to facilitate a model of practice that encourages service user choice and active participation in shared decision making, with the perceived risks of being blamed and held accountable if something goes wrong. Nurses are in a position of serving the public and organisational interests in terms of managing risk (Manuel & Crowe, 2014,) but are also required to facilitate ROP that includes positive risk taking. In their extracts David and Jane demonstrate the uncertainty and potential anxiety this can bring for nurses, especially those less experienced such as student nurses. The traditional model of working with its professional control over decisions on treatment may seem a 'safer' option with the potential for students to be stuck in the liminal space, unable or unwilling to accept the uncertainty and perceived personal risks associated with a new way of working with risks that recovery entails.

The extracts used to demonstrate troublesome practice identify a range of negative emotions student nurses can experience when exposed to ROP. All participants of the study identified having experienced some negative emotional responses. This may cause stress, distress, or uncertainty, particularly if the students' held beliefs about nursing are challenged.

Occupational stress within nursing has been well researched and high levels of stress are recognised across all nursing fields. Prymachuk and Richards (2007a) recognised that prevalence of stress is difficult to determine because of the variety of methodologies used within the various studies; however, it is estimated to be between 27- 29% amongst nurses. This led Tully (2004) to conclude that "nursing is indeed a very stressful occupation" (p.44). Whilst the causes are many and varied, studies do highlight lack of resources, staffing problems, dealing with 'difficult patients' and a lack of organisational support (Prymachuk & Richard, 2007a; Sutherland & Cooper, 1990,) as significant influences. Stress and distress amongst nursing students is less well researched, particularly within the field of mental health nursing, although there are concerns in the literature regarding the wellbeing of learners. Literature suggests prevalence rates of between 20-55% of potentially harmful stress levels (Prymachuk & Richards, 2007a) although again this is difficult to determine. Commonly reported stressors include both academic, clinical and personal factors.

In a study of mental health nursing students, Tully (2004) found all participants were experiencing significant distress relating to their nursing programme, although not always related to clinical practice. Using a range of instruments, participants were found to experience a number of clinical stressors that caused emotional distress. Levels of responsibility related to clinical practice and relationships with service users were highlighted. In line with other studies, participants were found to have increasing levels of distress as they progressed through their programmes. Possible explanations for this include increasing

professional demands as the students became more experienced, increased personal expectations and greater insight into service user's situations as their knowledge and awareness increase. It would appear that nurses are not a homogeneous group in relation to experiences of stress and distress with the literature suggesting some fields of nursing experience higher levels than others. Hughes and Umeh (2005) reported higher levels of stress amongst adult nurses, when compared to those in the mental health field. However, the questionnaire used within this study, whilst containing elements relevant to both fields, would appear to be more relevant to those in adult nursing practice. For example, 'death and dying' was included as a category to measure distress and response to support, which is likely to be experienced more by adult nurses than mental health nurses. Consequently, those in the mental health field may not perceive this as such a distressing factor in their work. Categories more relevant to mental health nursing practice such as developing relationships with those with complex and challenging behaviours and experiences were not evident. Yet the ability to respond to emotionally charged patient encounters has been identified as a significant trigger for stress in mental health student nurses (Mann & Cowburn, 2005).

Prymachuk and Richards (2007b) also found lower rates of psychological distress in mental health nursing students than those in the other fields of adult and learning disability nursing, although again the uniqueness of clinical practice related to these differing fields does not appear to have been explored in any depth. Major sources of distress within this study were found to relate to personal issues, child-care and the way in which students coped rather than academic studies or clinical placements (Prymachuk & Richards, 2007b). Conversely there is evidence to suggest that clinical practice may be the most stressful part of nurse education, with relationships with patients and the clinical workload experienced as particularly demanding (Chernomas & Shapiro, 2013; Mann & Cowburn, 2005; Moscaritolo, 2009; Nolan & Ryan, 2008). Galvin, Suominen, Morgan and Connell (2015) also found that mental health

nursing students described the nature of mental health work as difficult to deal with. Being with particularly unwell individuals, listening and providing support were experienced as emotionally demanding, particularly for the younger students on first time placements.

Whilst the literature suggests different levels and causes of stress amongst nursing students, mental health nursing students are vulnerable to emotional distress as a direct result of their interactions and interventions with service users. Engaging in therapeutic relationships, often with vulnerable individuals with complex psychological needs requires competency. Time spent in this type of engagement must be used actively in addressing service users' issues (Hewitt & Coffey, 2005). ROP places the emphasis on the expressed wishes or needs of the individual as a way of achieving better outcomes (Rapp & Goscha, 2006) which can be particularly emotionally demanding for student nurses where there exists uncertainty and concern regarding service user choices and presenting risks. Emotionally challenging encounters may be expected when engaging in relationships where there exists a level of distress; however, students may be concerned not only with their own emotional responses, but what emotions their interventions may trigger for the service user, as discussed in relation to extract 79.

From the transcripts it is evident that participants recognise the emotional demands of engaging in ROP. As Rattray (2014) identified, the level of discomfort experienced by students will affect their ability to traverse the liminal space. How willing or able they are to engage, will contribute to whether they will succeed in crossing the threshold, or become stuck in the liminal space. The extracts in this section all demonstrate a level of discomfort in relation to ROP. However, all participants demonstrated a desire to engage with ROP, although with differing levels of enthusiasm. Consideration of the affective dimensions to learning can help in

understanding their ability or willingness to do so despite the emotional demands placed upon them.

Prymachuk and Richards (2007b) put forward the concept of hardiness as a way of explaining their findings that mental health student nurses were notably different from other fields of nursing students in relation to the levels of stress they experienced and their ways of coping with it. These differences were found to be advantageous to student well-being. Hardiness is defined as a personal quality with three key characteristics; “the perception of situations and events as challenging rather than threatening; a strong sense of commitment (whether to work, family or community); and a sense of being in control” (Prymachuk & Richards, 2007b, p.399). However, the discussion presented in their report provides limited evidence for hardiness as an explanatory concept. A sense of commitment is considered a ‘given’ as nursing has a strong public service ethos. A sense of being in control is linked to the stereotypical views within nursing of mental health nurses being ‘laid back’, this being linked to coping as equivalent to control. The evidence for the perception of challenges rather than threats is not clearly explained within their study. Additionally, the authors do not explore whether hardiness is associated with the student and they bring it into mental health nursing with them, or whether exposure to mental health nursing enables students to develop it. The concept of hardiness has also been reported to have construct validity and measurement problems (Low, 1999). These factors impact on its explanatory power in considering the ability of some students to engage more than others with troublesome practice.

Ratray (2016) proposed the concept of psychological capital (PsyCap) as a means of understanding the affective dimension to learning. PsyCap as a concept has developed from the field of positive organisational behaviour. It has multiple and distinct dimensions to it. Although distinct, these dimensions all have an underlying link which ties them together,

making it a higher- order construct (Bao, 2015). These distinct dimensions of hope, optimism, resilience and efficacy are reflected in the definition offered by Luthans, Youssef- Morgan, & Avolio, (2007) who defined PsyCap as:

an individual's positive psychological state of development and characterised by: (1) having confidence (self- efficacy) to take on and put in the necessary effort to succeed at challenging tasks: (2) making a positive contribution (optimism) about succeeding now and in the future: (3) persevering towards the goals, and when necessary, redirecting paths to goals (hope) in order to succeed: and (4) when beset by problems and adversity, sustaining and bouncing back and even beyond (resilience) to attain success.(p.3)

Luthans, Avolio, Avey and Norman (2007) noted that as a construct PsyCap is 'state like' rather than 'trait like' in that although there may be some stability to each dimension, they are open to change and development and that although each dimension has conceptual independence, it is how they relate to each other that affects human behaviour. PsyCap has predominantly been considered in relation to organisational psychology and has received limited attention in education or nursing. Rattray (2014) conducted a small scale study with first year undergraduate students undertaking an education module. Using a modified version of the PsyCap inventory, findings showed that students with higher levels of psychological capital also had higher scores in relation to academic self-efficacy and self-regulated learning. In addition, a moderate correlation was also found between student performance in a written assessment and the psychological characteristics measured. In nursing, Bao (2015) investigated the levels of compassion fatigue in a survey of American nurses working in acute care settings. Findings suggested that there was a moderate to strong negative correlation between compassion fatigue and PsyCap. The study concluded that improving nurses' PsyCap can be a protective factor in preventing compassion fatigue. As previously discussed nursing is not a homogenous

group with differences across the different fields and this study was not conducted in mental health settings. However, mental health practice also provides acute care settings where the level of patient need and the intensity of the nursing interventions is greatest, therefore the study's findings has some relevance. A further study by Laschinger and Grau (2012) sought to understand the impact of the work environment on newly qualified graduate nurses looking at a range of work life issues. Findings suggested those nurses with greater PsyCap experienced lower levels of emotional exhaustion, less cynicism in their work, less bullying experiences and a better person- job fit. The participants were all nurses with less than one year's post-registration experience, so although the population were not student nurses, the limited length of their qualified nurse status suggests comparisons can be drawn. Levels of work engagement have also been explored in relation to PsyCap. In a study of qualified adult nurses, Bonner (2016) examined data from self-reported questionnaires which demonstrated a strong correlation between increased PsyCap and increased work engagement. The study included nurses with a range of experience and qualifications, with the most junior staff being found to have the lowest levels of PsyCap and lowest levels of engagement. Again this can be considered of relevance to student nurses, usually the seen as the most junior members of the nursing team.

In considering the affective dimension of liminality student willingness or ability to engage in ROP can be understood in terms of their levels of PsyCap. Those with higher PsyCap will be more able to engage with the complexities of ROP. In discussing this troublesome dimension to learning TCs, Felten (2016) suggested it is how students interact with knowledge that is emotionally charged. In relation to recovery this interaction particularly takes place within ROP. The ambiguities of ROP and the potential threat to the students' professional identity discussed in this section, may present as too much of a personal risk for some students. Such disengagement can be understood as a proactive attempt to protect themselves from negative

emotional experiences and the potential uncertainty that ROP can bring. Upholding the principles of recovery through ROP can be emotionally charged and students experience elements of this as troublesome, as demonstrated in the extracts provided. If students are to engage with recovery and ROP then attention needs to be paid to this affective dimension to learning.

5.5 Troublesome Learning Environments

Learning environments within healthcare organisations have been well researched; however, achieving a 'good' learning environment continues to cause difficulties (Eraut, 2007; Newton et al., 2015). These difficulties have been recognised in relation to the complexities of practice, limitations on staff time and the availability of resources (Benner, Sutphen, Leonard & Day, 2010; Henderson et al., 2010; Henderson, 2012). Nursing students currently spend 50% of their three year programme in clinical practice, working alongside a qualified mentor to support their learning. Consequently a significant proportion of their learning is expected to take place away from the university, in the clinical environment. It is this clinical learning environment that the students in this study reported as posing difficulties in relation to learning about recovery and from practising in a recovery orientated way. Students experienced wide variation in terms of their experiences on placement, with both positive and negative learning situations encountered. Eraut (2007) found similar issues for nursing staff in examining the work place experiences of early career professionals: "some of the best and worst learning environments we observed were in the same departments of the same hospitals" (p.419). This variation was also evident in this study. Whilst the issues highlighted by previous studies were also referred to as part of practice learning, obstacles of particular importance in relation to recovery were organisational priorities and demands, staff competency, team cultures and staff attitudes.

Healthcare services were described by participants as being financially driven and target focused rather than recovery focused. How organisations operationalise services has been described as 'disconnected' from the theory of recovery (McCleary et al., 2014). Increasingly the use of clustering tools, outcome measures and rating scales are used to determine which parts of the service are accessible to service users and students become familiar with a range of rating scales and outcome measures as their use in practice is now commonplace (Lakeman, 2004). However, participants experienced such measures as being used for the benefit of the organisation in terms of meeting key objectives, rather than to aid clinical decision making. This caused confusion for students in how service users' recovery was viewed and responded to. Examples were given where scoring on assessment scales indicated the person's recovery and therefore readiness for discharge from that service, although staff felt discharge would be counter therapeutic. Participants found this approach directly at odds with the person centred approach espoused in university. Hannah describes how clustering and risk assessment scores are requirements of the organisation:

Extract 80

Hannah:.. because we have targets, because services cost money, we have to adhere to the FACE risk scores and the clustering because at the end of the day if you don't do clustering you don't get your funding. So I think a lot of the service type stuff is to do with targets and money.

Some students experienced staff taking measures to circumvent the protocols associated with clustering in order to best meet the needs of the person in services as Hannah again explains:

Extract 81

Hannah: Once a person got to a certain stage and in a certain cluster they couldn't be in XXX services anymore because they only took cluster 16 and 17 patients, so as soon as you ran outside of that, that was it. The service user either went to community mental health teams, their GP or nothing. But they would keep people in, not really do their clustering and keep

people in services because they knew it would make people unwell very quickly to be taken out of services..

Students viewed these types of approaches by staff as 'acting in the service users' best interests' although they were aware that this was out with protocol. The difficulty for the students appears to be that they view the organisation as being unsupportive to the principles of recovery. Rather than being involved in recovery orientated practices, students were exposed to the competing agendas of personal recovery and the service need to have measured outcomes, which they found hard to reconcile. This was also described in relation to the time limited interventions offered by some teams:

Extract 82

Sally: I think how I feel about it is there's a gap now, or there will be a bigger gap in services where you can't provide that sort of nursing intervention or discuss recovery in a way that you'd want ...Now we're not given the sort of time to do that, so people end up keep coming back I suppose. I think now that we've only got a set amount of time it's quick to sort of plan the discharge but then you've got to pass them back. Some of the problems, I don't know like anxiety, they haven't had the change to discuss or talk about in detail or any sort of recovery strategy to learn what they might find helpful at home.

Students expressed frustration at these constraints in that they felt unable to deliver the best care to service users. Students also experienced services being withdrawn or closing down which they understood as the organisations focus on financial concerns. Tom was offered the opportunity to be involved in a Cognitive Stimulation Group in a service for older age adults, which he described as a very positive learning experience and of great benefit to those who attended. However:

Extract 83

Tom:...according to the directors it's not very cost effective because it takes a long time and there's not many results that show that it's actually helping people to recover, so they were talking about closing it down".

Fiscal constraints and finite resources were experienced as impacting on student learning of recovery. NHS organisations are under significant financial strain (Aziz, 2017) and service reconfiguration is an ongoing process as trusts struggle to remain within tight budgets. The impact for student nurses is that they are often placed in clinical teams that are undergoing reorganisation with reduced resources and limited budget. The student experience in this study was at times a lack of focus on recovery as staff strive to meet the same targets with reduced resources.

An area of concern for students within the learning environment is the competency of the staff within the clinical teams they are placed. Again students experience variation which impacts on their learning experiences. Most students commented on the perceived differences between what they are taught in university and what they witness or experience within practice, many for the reasons discussed above. However, all participants made reference to variation in staff competency. Tom describes his experiences in relation to this:

Extract 84

Tom: Well I think for us, or quite a lot of people who are coming into the service now have views that are much more holistic and alternative focused. If you have people who have worked in the service for a long time who have stayed in the service for a long time without doing extra things or moving on with research, then they're staying in the mind-set where they were trained, so they're using that mind-set so there is slight conflict..

Several students experienced working with staff who had been qualified a long time. Whilst this can bring a wealth of positive nursing experience, participants described the negative aspects of this in that some of these staff were not up to date with contemporary thinking, lacked knowledge and skills in psychological interventions and did not value newer alternative approaches. The participants' experiences suggest that in these cases there was a reliance on the bio-medical approaches of traditional practice particularly pharmacological interventions, with alternatives being viewed as unworthy. This is illustrated by Rachel:

Extract 85

Rachel: ... If I go onto a ward now and the qualified has been there forty, fifty year or something, they have a totally different view. They've always been brought up with medication and I 'm like 'well there are other things out there like CBT, DBT, mindfulness'....

That students' learning experiences in clinical practice can differ significantly is well recognised (Eraut, 2007; Newton et al., 2015) and was evident in this study with a variety of positive and negative experiences described. Of note was the differences described by the participants in relation to how different staff teams or parts of the service approached recovery. As well as issues related to staff competency, participants describe these differences as being down to both the team cultures and attitudes of individual staff members. In the following extract Francis describes her experiences of being placed with a team with a specific remit for providing a rehabilitation and recovery service.

Extract 86

Francis: It was just basically they lived there. They were supposed to get up on a morning, get ready, and live a normal life and go out and do things but they didn't, and they weren't encouraged to either. Like literally they would just stay in the house...

Interviewer: What was that about then do you think, how did that come about?

Francis: It's got to be something to do with the culture of the staff, it's got to be, because that person did not go in there thinking I'm going to a rehab and recovery house I'm going to spend the rest of my life here.

Francis expresses a strong view about the lack of ROP within this clinical placement and clearly relates this to the culture that had developed with the team of staff. Students expressed their expectations that they would see active engagement by staff in ROP and that they would be involved in specific activities to promote recovery. Often however, their experiences did not match their expectations as again illustrated by Linda:

Extract 87

Linda: It was sort of like they'd (referring to staff) get them up in the morning, give them their medication, have their breakfast then they'd be up the office and then you'd see them again at lunchtime...it's just like no therapeutics.

A lack of engagement between staff and service users was evident in a number of transcripts. For Linda the lack of therapeutic engagement was witnessed with staff spending the majority of their time in the ward office, the only contact with service users being around personal care and basic needs. Other participants experienced 'lip service' being paid to the use of recovery orientated interventions. A particular example was the lack of collaboration between staff and service users in completing the Recovery Star tool, with staff completing these alone at a computer without any negotiation or discussion with the service user. Whilst this 'ticks a box' for the staff team in terms of providing auditable evidence of recovery practices taking place, in reality there is little connection between the documentary evidence and ROP that will benefit the service user. Whilst the concepts of collaboration and working in partnership are theoretically rooted in the discourses of mental health nursing (Freshwater, 2017) the findings of this study would support the view that they are less firmly embedded in clinical practice,

hence students are often faced with experiences in practice that contradict the teaching in university.

Recovery approaches have been embraced by some parts of clinical practice more enthusiastically than others. The range of experience is described by Jane:

Extract 88

Jane: To be honest the wards I've been on haven't been, the community team are much more focused on recovery but not the wards, although I think I've told you before about the day hospital, they were superb, the staff were all highly trained. The staff were all passionate about what they did, they were all interested and that made such a massive difference when you have that interest, that passion. It's just the whole ward culture, the whole ethos of you know, the working environment.

Although a prevailing organisational culture may exist, what Jane describes is sub cultures within the organisation where different approaches and attitudes are evident. Whilst some areas provide students with very positive learning experiences, students describe others where resistance to new ideas or ways of working prevail and there is a more traditional approach to practice. This was experienced in terms of interventions that were provided, the approaches of staff and the type of relationship that existed between staff and service users. Jane again illustrates this point when discussing the different ways in which risk is managed within teams:

Extract 89

Jane: ... Since I've been with the crisis team their view of risk is so different to other peoples. Their view of risk is, 'is that person going to kill themselves today, is that person going to harm anybody else today', serious risk you know. Whereas on the wards they are so risk adverse it's absolutely ridiculous... I can totally appreciate the patients' frustration when say they're not trusted to pop out to the shop or pop here, I mean I know you've got the mental health act

thing but I think it's not conducive to recovery in an environment where you don't trust patients to make their own decisions.

Jane voices her frustration at the approach to managing risk within the in-patient setting, viewing it as "not conducive to recovery". Negative emotional feelings such as frustration have been discussed as impacting on learning. Additionally, if clinical areas adopt such practices then students will not be exposed to more ROP of positive risk taking and personal responsibility by the service user. Lack of exposure limits opportunity to practise and learn.

As well as non-engagement by staff, students experienced more active resistance to ROP within their learning environments. Several students recounted experiences of being prevented from carrying out particular interventions by their mentors or other staff members without any significant explanations. Comments such as "we've tried that before", "that won't work on him", or "you need a certificate to do that" were given as reasons as staff denied students the opportunity to try alternative approaches or different interventions:

Extract 90

Amy: ...especially with some experienced nurses what you can find is you're a bit like 'can we do this and can we do that', and they like 'no because we've already tried'. So you ended up just giving medication. So that can be really difficult to overcome. It's a bit like 'well I know you're experienced and stuff like that but sometimes having a fresh pair of eyes can make a difference' but 'no' so ok then. So I think that can put a potential barrier in the way of you wanting to do something with the person on a one to one basis because in your head you're trying to think 'well I really want to do this but I can't because I've been told it's already been tried and it's already been done and it's the way they are'.

Amy's experience demonstrates that when students have the knowledge and skill to carry out certain interventions they can be prevented from doing so if this does not fit with either the

ethos of the ward or the individual staff member. Support from the staff team is essential for students to make the most of learning opportunities. If this is not present, then the student can experience difficulty engaging with the staff team and learning opportunities are lost. Here the learning environment is closely associated with the nature of the learning relationship between students and the clinical team and is discussed further in section 5.6.

Despite policy endorsement in relation to personal recovery the experiences of participants in this study suggests practice does not always align with policy. Discourses of clinical recovery are still dominant within some areas of nursing practice. This creates troublesome learning environments in that opportunities to observe, learn and participate in ROP is limited for students, as they experience variation in practice and cultures that causes confusion and frustrations.

Lipsky's (1980) concept of Street Level Bureaucracy can help explain this divergence of policy and practice and the variation in student experiences. Lipsky (1980) sought to explain why public organisations did not operate in line with policy directives or central frameworks. In doing so he highlighted the central role of public workers (including health care workers) at 'street level' and argued that the routines, behaviours and perceptions of frontline staff was influential in how policy was operationalised. Street level bureaucrats operate in areas where there is inadequate resourcing, growing demand for services and ambiguous organisational expectations. Consequently they experience uncertainty and conflict, coping by developing practices and routines that help gain control over the complex and stressful challenges they face. Because of their professional status, street level bureaucrats are able to exercise discretion in their day to day work and have limited scrutiny by managers. Therefore, their actions and decisions in a sense become the policy of the organisation. Although these actions may not actually conform to policy directives, it is the actions of the street level bureaucrat

that controls practice and therefore directly influences the consumer (Erasmus, n.d.; Bergen & While, 2005).

Participants within this study worked with front line staff delivering direct patient care.

Registered nurses act within a professional code identified by the Nursing Midwifery Council (NMC). This identifies the professional regulatory rules that nurses must adhere to. Acting according to their knowledge and judgment within this scope of practice identifies nurses as professional autonomous practitioners, with the expertise to make independent clinical decisions. The very nature of mental health nursing makes it difficult to articulate what nurses in this area of practice do (McSherry et al., 2015). The complex nature of human behaviour means there is uncertainty with a need for individual approaches that cannot be scripted.

There is therefore a level of freedom in exercising clinical judgment that due to the nurses' professional status can be difficult for managers to challenge, this poses difficulties for them as they attempt to meet policy objectives. Wells (1996) has argued that to avoid conflict, management strategies in the NHS are often concerned with influencing rather than controlling practice and that policy ambiguity and a lack of prescriptive guidelines is apparent in a number of policy documents. This allows for interpretation by local teams and individual practitioners. Lipsky (1980) was concerned with how this level of discretion is used at street level.

Whilst Lipsky emphasises the discretion of street level bureaucrats, others have argued that changes within public organisations have heralded a rise in management control. Howe (1991) suggested that the changing context of public services has resulted in a definite shift away from practitioner discretion to practice that is defined and driven by managers. However, Lipsky (1980) argued it is the context of conflict between frontline staff and managers that makes discretion possible. The desire for management control can be seen by the plethora of

audits and performance indicators now in operation within the NHS, many of which are measured by documentary evidence alone. The nature of troublesome learning environments discussed in this section demonstrate how staff can present documentary evidence demonstrating one thing (policy compliance), when in actual practice something quite different has occurred. Hannah's account (extract 81) of how staff adjust clustering scores to maintain people in services based on clinical judgement rather than the person's actual score is one such example of street level bureaucracy in action. Staff complete the necessary paperwork and it would appear that the policy agenda is being met; however, at the level of direct patient care, this is significantly distorted. This level of discretion at street level is also demonstrated by Sally's account (extract 82) where it is apparent that such 'special measures' of over-riding quantitative scoring with clinical judgement are not available to all, as those with conditions "like anxiety" are referred back to GP services. It may be that the discretion being applied is to favour some service users over others in cases that are viewed as deserving more sympathy.

Wells (1996) suggested this type of behaviour by nursing staff is an attempt to compensate for resource constraints and project a responsive attitude to service users. He argued that such behaviour actually suits managers and policy makers who may not wish to be seen as responsible for any shortfalls in the provision of care. A lack of close scrutiny by managers may well be in their best interests as they may not be concerned with processes, only what is actually produced (Evans, 2011; Wells, 1996). It follows that if outcomes are in line with eligibility criteria and performance indicators, then managers may have little concern for how these are achieved, consequently allowing nurses to continue within a nursing framework consistent with their personal philosophies. The findings from this study demonstrate how this allows the discourse of clinical recovery and its associated practices to continue to dominate nursing practice in some areas.

The discretionary power of street level bureaucrats allows them to act on personal biases (Erasmus n.d.). This is demonstrated by students' desires to implement alternative interventions being blocked or viewed as unworthy by the more senior nurses. Amy's description of this (extract 90) shows how the range of interventions or approaches available to service users can be rationed by staff. There is a level of self-interest here for staff as they restrict resources and continue with usual routines. Street level bureaucrats look to reduce the complexity of their work (Lipsky, 1980) and by restricting the range of interventions, nurses are continuing the status quo and control over the working environment is maintained.

According to street level theory, street level bureaucrats also look to exercise control over their clients. One such way would be to control the amount and the nature of contact with clients. Lack of engagement described by several students can be understood as a rationing or conservation of resources in order to maintain such control. Linda's description (extract 87) of staff only spending time with service users to complete routine personal care tasks serves to limit the amount of interaction between staff and service users and the context in which it takes place. From Linda's description, staff are only readily accessible to service users at certain times, for personal care such as getting out of bed or attending to dietary needs. At other times staff are described as being in the office, a place that can be seen as a staff domain and not readily accessible to service users, especially if the door is closed.

Consequently the opportunity for service users to raise issues, make requests or seek support is limited. As Jackson and Stevenson (2000) highlighted, service users are reluctant to disturb those staff who appear to be busy. At the times when staff are available there are other more immediate needs such as washing and dressing, consequently requests for additional time or interventions may then be viewed as inconsequential.

Erasmus (n.d.) identified how street level bureaucrats shift the onus of decision making to where clients are absent as a way of avoiding dealing with negative reactions or demands. This was experienced in the way that recovery star tools were completed by nurses alone rather than in collaboration with the service user, despite guidelines being available on how this should be done. In this case any conflict or disagreement between staff and service users is avoided and the documentary evidence still exists that the task was completed to satisfy any audit requirements. However, the service to the service user bears little resemblance to the principles of recovery in that there is no option for self-determination or personal decision making.

The findings of a study exploring student nurses' perceptions of the role of the mental health nurse (Rungapadiachy, Madill, & Gough, 2004) were consistent with those of this study in relation to lack of engagement by some staff. Participants in their study described a lack of involvement from nurses which the students associated with a lack of skill and negative attitudes to caring for service users. Staff were described as distancing themselves from service users and being more concerned with their own needs rather than those of service users. Lack of resources and the bureaucratic nature of the mental health nurse role were acknowledged. However, the authors concluded that there is a 'why bother' approach in mental health nursing associated with some nurses' attitudes to what they believed mental health nursing to be, with little progress made in the implementation of psychological based interventions. However, the concept of street level bureaucracy offers some explanation as to why such attitudes may develop. Street level bureaucrats face particular challenges including inadequate resources and ever growing demand for their work (Evans, 2011). Inexperience or lack of personal resources to deal with this demand and the complexities of practice may result in staff physically distancing themselves from service users as a coping mechanism in avoiding complex interactions. Attempts to deal with situations may be perceived as self-

gratification as staff strive to protect themselves from stressful encounters. The level of discretion and the relative degree of freedom afforded to street level bureaucrats (Wells, 1996) allows such behaviours to continue and hence practice continues unchanged. Most areas of mental health practice adopt a team model for delivery of care and such teams become influential in terms of organisational culture (Barrenger et al., 2015). Lipsky (1980) argued, as demonstrated in this discussion, the work of individual team members can subvert or enhance the culture that is structurally provided through organisational practice. Structural aspects may provide an orientation towards recovery principles, but staff attitudes, values, beliefs and skills related to recovery are central to determining how ROP will operate at street level (Buchanan- Barker & Barker, 2008; Le Boutillier et al., 2015; Waldemar et al. 2016). It is these behaviours of staff that students observe in practice.

Jane's perception of community teams as being more inclined to adopt recovery principles than in-patient settings is borne out by the literature (Waldemar et al, 2016). Jane uses the term 'culture' to explain the differences between inpatient and community based areas of practice (extract 88). Francis provides a further example of how culture is considered to influence practice in a negative way:

Extract 91

Francis: it's got be something to do with the culture of the staff it's got to be, because that person did not go in there thinking I'm going to a rehab and recovery house and I'm going to spend the rest of my life here. They can't have, you wouldn't think that would you? There was people there who lived and died there so there's nothing recovery about it. They used things like the recovery star and the WRAP plan but they didn't involve the patient in it.

Culture has been recognised as having particular significance in mental health practice since Goffman's description of the Total Institution (Lakeman, 2013). The large institutions became the main providers of psychiatric care following the Poor Law Amendment Act of 1834 (Wright

& Bartlett, 2008). These large self-contained hospitals were relatively isolated from the wider community and developed their own routines, rituals, norms and traditions. These large institutions continued to operate well into the late 20th century and much of their traditions can still be seen in some areas of practice today (Lakeman, 2013). However, Lakeman refutes the ideas of cultural homogeneity in contemporary mental health services at an institutional level. Drawing on the work of Fancher, he suggested they should be viewed as 'cultures of care' with variation between services: "it appears that mental health sub cultures seem to accommodate quite different and sometimes seemingly contradictory ideas and positions of members" (p.12). Whilst being influenced by the wider mental health community, localised teams, even those within the same organisation, can develop significantly different cultures with differing values, beliefs and norms. These sub cultures are loosely bound to the overarching culture and change is incremental in response to changes in the overarching culture. The pace of change will differ for different sub cultures and hence as new ideas or ways of working infiltrate the wider community, these will be adopted by some groups quicker than others and with varying degrees of success. Variation in practice, routines and norms was experienced by several of the participants of this study. Viewing localised teams as having their own 'culture of care' is useful for understanding the variation in practice experienced by the participants of this study.

How sub cultures develop within one organisation can be further explored with the notion of 'thought collectives' (Fleck, 1979). According to Fleck a thought collective is a community or network of professionals working in a specific domain, with a recognised level of expertise. Thought collectives can be formed from a range of disciplines and from a variety of backgrounds, with members developing and sharing the same thinking style. Fleck explained:

If we define thought collective as a community of persons mutually exchanging ideas or maintaining intellectual interaction, we will find by implication that it also provides

the special 'carrier' for the historical development of any field of thought, as well as for the given stock of knowledge and level of culture. This we have designated thought style. (p.99)

According to Fleck (1979) any current state of knowledge is the result of the historical and social processes of the collectives that built it. Knowledge can change over time but it is shaped by its past. For Fleck there is no neutral or impartial observation of phenomenon, thought styles guide how phenomena are seen, felt and acted upon by the group members sharing that style. Any new experiences are viewed in accordance with that style and no attention is given to other possible explanations. Fleck referred to this as a "harmony of illusions" (p99). The thought style therefore ensures a persistent belief system within the collective. According to Fleck individuals are rarely conscious of this process but because of its prevailing power, they cannot be at odds with the thought style if they are members of the collective.

The longer the thought style has been maintained by the collective, the more certain it is to its members (Fleck, 1979) and therefore can be more difficult to change. The history of psychiatric care demonstrates how efforts to have it accepted as a scientific discipline have placed it as an accepted branch of medicine with an associate evidence base. This had been a dominant style of thinking within the institutional practices from the early days of the asylum care up until the large scale closure of the institutions in the late 20th century. As Lakeman (2013) identified in many places it continues to thrive. This bio- medical approach to understanding mental distress can be understood as a fixed thought style that more traditional areas of practice i.e. in-patient wards, have maintained. Whilst thought collectives can be made up of different disciplines, there is an esoteric circle of core members who hold a central position and have greater voice (Martins, 2016). For in-patient areas this had traditionally been

medical staff and arguably remains so today. The maintenance of a bio- medical approach to care protects the position of the medical professionals in particular. Grounded in the historical and social development of psychiatry, recovery here is understood as the absence of clinical symptoms. This bio-medical thought style brings with it a clinical understanding of recovery and associated medical language and interventions. The discourse is one of diagnostic labelling and classification of symptoms, where medical interventions such as pharmacology are legitimised.

Within this study it is the in-patient areas that are described by participants as holding this position, supporting the findings of Waldemar et al. (2016). Community services are described as working with a more personal recovery orientation. Community based services do not have such a long tradition in mental health practice, only being firmly established following the Care in the Community Act of 1990 (Wright & Bartlett, 2008). This lack of tradition may render them more open to alternative ways of thinking, if the thought style is less entrenched. The makeup of community based clinical teams also varies from more traditional in-patient areas with a greater mix of professionals having permanent positions within teams. Hence the esoteric circle may be more eclectic in relation to its values and the professional backgrounds of its members. Similarly the focus of community teams necessitates that they work with a wide range of services, for example social services, housing departments, custody diversion schemes or voluntary organisations. This facilitates greater communication with those outside of the thought collective. Martins (2016) argued that such 'inter-collective' communication is responsible for shifts and changes in thought style. Such communication of thoughts across different collectives allows for shifts in meaning and exposes collective members to alternative interpretations of experiences. Personal recovery is not a concept 'owned' by healthcare. Its origins lie in the service user moment and its principles have been adopted by many different organisations within the wider mental health community. This greater 'inter- collective'

communication for the community services over in-patient facilities may explain the more rapid pace of change in relation to embracing the principles of recovery experienced by participants.

In addition to the small esoteric circle, a larger exoteric circle exists within thought collectives. The exoteric circle consists of those who share the thought style, although indirectly and they do not play an active role in its formation. For members of the exoteric circle, access to the thought style is mediated by the esoteric circle, for example through lectures or subject literature (Martins, 2016). For student nurses an introduction to thought styles can occur in a number of ways, including through formal university teaching and within clinical practice. Within clinical practice it is important for students to engage with the clinical team for a positive learning experience to take place (Newton et al., 2015) and it is in the students' self-interest to be seen to be a 'team player'. Not least because their competency based assessment criteria demands that they be graded as 'skilled' in working collaboratively with others. This may be a motivating factor in students accepting the thought style and becoming part of the exoteric circle, sharing the thought style of the clinical team would enable students to feel engaged and accepted by that team. This is a point articulated by Gaynor:

Extract 92

Gaynor: ...but when you think about the culture of working in the teams, you tend to just go with the culture of that team. One of the nurses said well it's going to be hard for me to come in and do that...so that's a bit of a worry going into practice.

For more junior student nurses with no previous clinical experience, first placements may be of particular importance, such situations may be influential in shaping the students' thinking. Here students will be exposed to the thought style through team meetings, handovers, case conferences, meetings with their mentors etc. in which they hear the beliefs and witness the

associated actions of senior staff who make up the esoteric circle. With no alternative thought styles to draw upon, this first encounter may make a particular impact, as the student may at this stage know no different. Hence a clinical recovery orientated way of thinking may be given to the student. This potentially may be difficult to change in future placements.

Fleck (1979) suggested that people may belong to more than one exoteric circle as thought collectives intertwine and relate with each other. Student nurses may encounter differing thought collectives as they experience different areas of clinical practice and work with different teams. They may therefore become part of the exoteric circles of collectives with both clinical recovery and personal recovery thought styles. Students within this study have highlighted the differing ways of understanding recovery they have experienced across different areas of clinical practice. As they strive to engage with the team in their current placement students may, albeit at an unconscious level, accept the dominate thought style of that team. Students maybe unaware of their changing position, as Eraut (2007) noted, culturally acquired knowledge is often 'taken for granted' by novices who are unaware of its influence on their behaviour. However, they will demonstrate changing understanding of recovery in their discursive practices and in the approaches they adopt with service users. Such changing positions have been demonstrated in this study and Flecks (1979) concept of thought collectives provides an explanatory description of some students' oscillation in the liminal space. Where students do recognise these differing thought styles and their associated practices, reconciling the two may be impossible causing difficulties for students in forming a cohesive understanding of recovery, consequently unable to traverse the liminal space. Personal recovery and clinical recovery hold different meanings and can be seen as contrasting schools of thought. If students are to understand recovery in a new way this will socially reposition them, providing access to some collectives and reducing their inclusion in others. Such shifts would be necessary for the student to gain access to a community with a personal

recovery thought style. The importance of social relationships and how a student identifies themselves as a nurse can be seen here in relation to learning. How learners perceive the social implications of learning recovery will impact on their willingness to approach a threshold in their thinking (Meyer et al., 2008) or let go of a prevailing view which provides existing membership to a collective.

How nurses view recovery has been recognised as crucial in relation to the implementation of successful recovery focused mental health services (Chester et al., 2016; Jacob et al., 2016) and it has been argued that as the largest professional group, nurses are well placed to lead a culture change (Department of Health and Aging, 2012). However, the negative attitudes of some nursing staff has been linked to poor levels of competency (Hansson et al. 2011; Nordt et al., 2006; Rungapadiachy et al., 2004). The findings from this study support this view, with participants linking a lack of motivation and interest on behalf of some staff in developing skills, further professional competence or acquiring new knowledge. The extract from Tom (extract 84) in relation to staff competency is typical of several comments from participants regarding this, where the perception is that the longer staff have been in practice, the less willing or motivated they are to update their knowledge and skills, although there were some exceptions to this. This has been discussed in relation to the concepts of street level bureaucracy and thought collectives. However, regardless of the underlying factors, where staff are unable or unwilling to embrace the values and practice associated with personal recovery, obstacles to learning will continue in troublesome learning environments.

This gap between the principles and theories espoused in academia and the actions of those in practice has been well recognised in nursing and is referred to as the 'theory practice gap'. This gap is most noticeable for student nurses when the principles of practice promoted in the curriculum are not aligned with the principles operating within the clinical practice area (Ajani

& Moez, 2011; Rolfe, 2003). Seminal work by Melia (1984) highlighted the variation between educational priorities in espousing professional values and that of the clinical setting in focusing on getting the work done. This can be viewed as two different thought styles with evidence suggesting this is still of relevance today. Henderson et al. (2012) reviewed six international quantitative studies looking at student perceptions of the practice environment. Each study adopted the Clinical Learning Environment Inventory (Chan, 2002, 2003) in order to learn how students apply knowledge to the practice context. Findings show how task orientation and set routines remains a strong culture in some areas of nursing, with the concept of innovation not strongly featured as resistance to changing routine practices was evident. Whilst studies have highlighted that student nurses do view theory as vital to practice, students also perceive that learning really takes place when there is an opportunity to apply what has been taught in the educational context in the practice setting (Newton et al., 2009, 2015). This was also highlighted in the current study as illustrated by Gaynor and David (extracts 66 & 67).

For some students in this study it is evident that such opportunities are not provided as recovery principles are not part of the 'routine practice' and in line with Henderson et al.'s (2012) findings, there is little interest or motivation in changing practice where a strong bio-medical thought style to nursing exists. This was illustrated by the comments from both Tom and Rachel (extracts 84 & 85). However, whilst participants in this study report that those staff who have been in services a long time are more likely to be resistive to change, Stuber et al. (2014) suggested the opposite to be true. Through a self-reported recovery competency scale, community based staff with more years practicing in mental health were identified as more likely to report greater competency than colleagues with fewer years experience. Whilst there may be an expectation that those with more years experiences would have greater difficulty adapting to alternative approaches, their results suggest staff with greater experience are

more able to gain different perspectives because of their longer relationships with service users and through longer term supervision and education.

That learning environments can present as sources of trouble has been demonstrated in this section. Organisational priorities and the perceived financially driven context of healthcare is viewed by participants as creating tensions in the practice setting. Participants experienced variation across practice settings with some individual staff members failing to engage in ROP and therefore causing obstacles for students wishing to do so. Culture and sub-cultures within organisations can be seen to differ in their dominant thought styles. Whilst some value learning and engagement with the principles of recovery, others support a more bio- medical approach to practice, upholding customary beliefs about care and associated nursing practices. Such cultures present as troublesome to students in that they experience conflicting ideas and changing practices which cause confusion and a lack of clarity in understanding.

5.6 Troublesome Learning Relationships

The final category of obstacles to learning in relation to recovery identified within this study is that of Troublesome Learning Relationships. It is the troublesome nature of the relationships within the clinical learning environment that was highlighted by participants. Although closely associated with the troublesome learning environments, the emphasis placed on these relationships by participants warranted a close inspection and discussion within its own right. Relationships between team members, between the student and team members and between service users and team members were discussed by participants in this study as of relevance to the learning process. For all participants in this study the current model of clinical education is that of mentorship. Considering each student is expected to spend a minimum of 50% of their time working directly with their mentor, it is unsurprising that the mentor-student relationship was highlighted as of particular importance in the learning process. It is the quality rather than

quantity of support that is important to effective learning (Bifarin, 2016) and students in this study experienced both negative and positive relationships with their mentors and the rest of the staff team. Amy describes her experience in one placement where she felt well supported by her mentor:

Extract 93

Amy: My mentor, she was a really positive person and she never gave up, I mean a band six, been a mental health nurse for years, but even with personality disorders who everybody finds hard, she was like 'no come on we can do this we can absolutely do this' and she was just so positive.

The supportive context of the relationship for Amy related to the attitude of her mentor, both to her own work and to supporting Amy to deliver care in difficult circumstances. Service users with a diagnosis of personality disorder can present with behaviours viewed as challenging by some nursing staff (Weight & Kendall, 2013); however, the positivity and persistence shown by her mentor enabled Amy to continue working with the person, therefore continuing to learn. For Yvette a different experience occurred:

Extract 94

Yvette: I think some of them that I've come across in placement are quite sort of, well they're quite, this is going to sound awful but they're quite, well 'I'm in a position of authority' and you can see it in the way they come across, the way they talk to the families, they talk to the patients and with you, 'you will do what I say, get it done'

In contrast to the supportive learning relationship described by Amy, Yvette experienced an authoritative approach from some staff in which instructions were given with an expectation that these would be carried out without questioning. For Yvette this communication style was non-conducive to her learning as she found it difficult to form a positive relationship with

these staff. Lack of confidence in the relationship with the clinical staff can lead to withdrawal by the student. This was a particular issue for Linda on one placement:

Extract 95

Linda: I would say sometimes some people weren't always recovery focused. I think, this is going to sound really bad but sometimes you would see people just couldn't be bothered any more.... I think some staff, I think it was to do with they were at the end of their tether and I don't know. I never really asked why because I never really wanted to know, get involved in stuff that was going on, but people just didn't seem to want to do it anymore couldn't be bothered to work anymore, they were near retiring. It sort of makes you feel disheartened, not where you want to be you know what I mean. I didn't want to be around them if they were going to be like that because it didn't, because that isn't good for me.

Whilst both Yvette and Linda experienced negative interactions with some clinical teams they are both hesitant in discussing this; "this is going to sound awful" and "this is going to sound really bad", demonstrate their recognition of inappropriate interactions from staff with both students and service users which they wish to distance themselves from. For Linda this involved actively withdrawing from those staff due to negative feelings their behaviour evoked in her. The lack of engagement by staff with service users and apparent disinterest in recovery for Linda demonstrated poor practice that she did not wish to be associated with. When the clinical team, particularly the mentor, are instrumental in identifying learning opportunities for students (Henderson & Eaton, 2013) then such lack of cooperation with a recovery orientated approach will have an impact. Whilst Linda is cognisant of the lack of staff cooperation with a recovery orientation and purposefully disengages from them, more junior students may not have such insight into this behaviour and inappropriate learning may take place as students observe and model their own behaviour on their observations. How students respond to such events varies, with some students recounting how they were able to question clinical staff whilst others felt more inhibited in doing so. This is illustrated by Rachel and Yvette:

Extract 96

Interviewer: So when you work with people like that, does that impact on your learning do you think?

Rachel: If you're with them, and you're constantly with them you end up, well you can pick up on their behaviour but I chose not to, I challenge them, I ask 'why are you doing it that way, this works for her, she's told me this works for her, so why can't you do it that way'

Interviewer; So what kind of response did you get?

Rachel; 'What do you know you're only a student'

Extract 97

Yvette: It's quite hard as a student ... because I think some people have a tendency to use the 'she's just a student' and assume that you know nothing, whereas it's been hard for me at times because I do have a decade, more, of experience working with you know, all sorts of issues so I have got an opinion and I have got some knowledge and I can back it up...I've got something to say for myself. But it's hard because you don't always want to challenge and you have to take a step back.

Rachel was able to challenge, ask questions and put forward the service user perspective. However, whilst Rachel was able to challenge the negative approach of another staff member, Yvette felt less inclined to do so. Less experienced or less assertive students may feel they need to follow the lead of the qualified nurse or may not recognise the behaviour as less than best practice. Challenging can be difficult and students may fear the consequences of any challenge. Within this study there was clear evidence that some students did not wish to 'to rock the boat', an understandable position when students are viewed as the most junior of staff and are dependent on their mentors for a pass/ fail report at the end of placement. Dispositional theory suggests that learners are disposed to making different choices in relation to how they think and behave. They are considered to have "broad characterological tendencies that influence how they use their knowledge and skills" (Perkins & Tishman, 2006,

p.3). Adopting a dispositional perspective, students can be seen to be disposed to making certain choices in relation to learning and how they use what they learn, rather than being simply based on ability or acquisition of knowledge (Perkins & Tishman, 2006). In the context of the student/ mentor relationship any tendency to passively accept or challenge the actions of the mentor will vary from student to student. Any disposition not to challenge can be reinforced by the power imbalance inherent within the relationship. This then can prevent opportunities for skill development and constrain learning.

In extract 96 Rachel highlights how students can pick up on others' behaviour as they work alongside them. For inexperienced nurses the opportunity to work alongside more experienced staff has been highlighted as a valued learning strategy (Eraut, 2007) and role modelling has been highlighted as significant in the learning processes in clinical practice (Pollard, 2008). The participants of this study recognised both positive and negative role models, Hannah discusses her experience below:

Extract 98

Hannah: Well they always say at the beginning of your training that you'll know the people who you want to be like, or you don't want to be like and I think there's a couple of people that I've worked with in the past that I wouldn't want to be like them because they're not really recovery focused at all, its task orientated and I don't like that.

Hannah describes encountering negative role models in practice. As a more experienced student nurse she was able to draw on other experiences and knowledge to identify their task orientated approaches as inappropriate and made a conscious decision not to adopt such behaviour herself. Although Hannah learnt how 'not to behave' she was not given the opportunity to develop skills for appropriate practice by these staff members.

For some students even placements which were viewed as enjoyable and a good learning experience, still held difficulties in relation to supportive learning relationships. For Linda this came down to a lack of staff support because of staffing levels and workloads:

Extract 99

Linda:...Short staffed but that's not an issue for me, it's an issue for the team but it makes it better for me because there's stuff that I can be doing which helps them that's obviously rewarding, but I'm busy all the time so basically I'm learning all the time. The only, what is a bit of an issue is obviously when I am doing stuff sometimes I'm doing stuff on my own, and I'm a bit unsure and it's busy and there's not many people to ask so that's a bit of an issue but other than that it's great.

Linda expresses some benefits to the situation in that she was kept busy, which she equates to learning. Linda felt valued by the staff, which aids a sense of belonging when students are trying to establish themselves as part of the clinical team. However, whilst recognising learning opportunities, Linda expresses concern about working unsupported and in a position where she finds it difficult to seek advice or support. That students can be neglected when workload is high or staffing levels low has been recognised (Newton et al., 2015) and their findings are supported here.

The culture of the organisation and the sub- cultures of different areas of clinical practice influence the nature of the relationship between students and the staff within their learning environments. For the participants of this study relationships appear to be influenced by attitudes to recovery and level of competency in ROP in the individuals within those teams. The quality of this relationship in the clinical environment has been highlighted as important to the learning process. Previous studies (Bradbury- Jones, Sambrook, & Irvine, 2011; Rebeiro, Edward, Chapman, & Evans, 2015) have highlighted how the attitude of registered nurses to students can influence student confidence, competence and learning; positive mentor- student

relationships have been found to enhance the learning experiences of student nurses (Levett-Jones, Lathlean, Higgins, & McMillan, 2009; O'Driscoll, Allan & Smith, 2010).

The nature of the learning relationship between student and mentor can be understood using the concept of scaffolding. Scaffolding is closely associated with the socio-cultural theory of Vygotsky and particularly the zone of proximal development (ZPD), which has similarities with the notion of the liminal space as discussed in section 3.1.4. The ZPD can be defined as the distance between the student's current level of competence and the level of potential development to achieve more if supported by a more knowledgeable other. The difference between the actual level of competence and potential development is dependent on effective scaffolding (Daniels, 2001; Liechty, Minli, & Pegarraro, 2009). Because of its wide application across different educational contexts scaffolding has become a broad term used to describe learner support (Puntambekar & Hubscher, 2005). However, based on Vygotsky's work, scaffolding can be understood as a dynamic process of flexible support provided to a learner by a more knowledgeable other to stimulate learning. The student is not a passive recipient of support, as the process is an interpersonal one in which both parties are active participants (Liechty et al., 2009; van de Pol, Volman, & Beishuizen, 2010). Because of the dynamic nature of scaffolding its nature varies related to the situation and responses of the student, therefore the techniques involved cannot be applied in the same way to all situations. However, recognised techniques include modelling, posing questions, providing feedback (van de Pol et al., 2010), reflexive practice, simulation and problem based learning (Kelsey & Hayes, 2015). Liechty et al. (2009) suggested that the more knowledgeable other will most likely be a mentor in practice who "explains, listens to questions, encourages and offers just enough guidance to encourage independence that results in expanded zone of proximal development" (p.482).

In a literature review exploring scaffolding in teacher- student interactions van de Pol et al. (2010) identified three components of scaffolding that needed to be in place for it to be effective. Firstly 'contingency', which refers to adapting the support to be at the same or slightly higher level of the student. In order to deliver this support at the appropriate level the student's current level of competence must be known. The second component 'fading', refers to the gradual withdrawal of the scaffolded support depending on the development and competence of the student. Thirdly 'transfer of responsibility' is identified, this occurs with contingent fading and is concerned with the student taking increasing control over their own learning. Scaffolding techniques need to be in place for these three components to be effective. However, from the data within this study there is a clear student perception that this was not always the case. Yvette's experiences of authoritarian clinical staff do not match the idea of scaffolding being an interactive process in which both student and mentor participate to enable recognition of competence and potential development. Communication for Yvette within the relationships described in extract 94 was a top down instructional approach with the aim of completing tasks rather than facilitating student development. Eraut (2007) identified asking questions as a proactive learning activity, although one that was not encouraged on many wards involved in his study of early career professional learning, where newly qualified nurses were reluctant to ask questions unless they had a good trusting relationship with who they were asking. Yvette's experiences as a student nurse is an example of the experiences of participants within this study and echo these findings. Following instruction is a necessary nursing skill; however, understanding the rationale for certain interventions is also important in terms of transferable learning. Where questions are discouraged, or where the student lacks confidence in the relationship with their mentor, gaining these insights will be inhibited as communication is restricted. The lack of scaffolding strategies limits opportunities to identify contingency, commence fading support or enable

students to take control of their learning. This authoritarian attitude of staff and non-collaborative approach in allocating work therefore presents as an obstacle to learning.

For Linda (extract 99), the lack of supervision was not dependent on gradual fading of support in recognising her growing competence but due to staffing shortages. Eraut's (2007) study of early career professionals identified the structure and allocation of work as a significant factor in learning in the workplace because it affected opportunities to develop relationships where feedback and support could be established. For Linda the absence of staff and supervision meant she was unable to gain feedback on her development and therefore felt uncertain in relation to her level of competence. The troublesome nature of ROP and its potential to emotionally impact on students has been discussed. Where there is a lack of scaffolded support in the learning relationship, students may feel unable to carry on with such interventions if there is uncertainty about their interventions, their own responses or those of service users. The lack of supervision and fading support experienced by some participants in this study may have occurred for a number of reasons. However, there is potential for mentors as expert nurses having crossed the threshold related to recovery, to have lost the understanding of its troublesome nature or recognise the transitional state of some students. The irreversible nature of threshold crossing and the transformation involved can inhibit 'experts' from recalling experiences of being in a state of liminality (Meyer & Land, 2005).

The students within this study viewed the context of the learning relationship as aimed towards helping them to achieve their practice competencies, but also identified more informal learning as assimilating the attributes observed in the behaviour of mentors into their own practice. This informal learning is a component of professional socialisation, a process in which students adopt the values, attitudes and characteristics of the profession (Mackintosh 2006). Levett-Jones et al. (2009) suggested that one of the main aims of the clinical component of nurse education is professional socialisation. It is the mentor who is key to

facilitating a positive socialisation as they support students to be accepted into clinical teams and influence the students' ability to engage in learning opportunities (Rejon & Watts, 2014). Socialisation has a strong learning component, significant within this is informal learning such as observing others, asking questions and working alongside more experienced staff (strategies identified as part of scaffolding). A review of the literature on professional socialisation in nursing suggests as much as 80% of learning occurs in this way (Rejon & Watts, 2014).

For informal learning to be effective, competent role models and satisfactory clinical experience is necessary (Dinmohammadi, Peyrovi, & Mehrdad, 2013; Wilkinson, 2018). Evidence from this study suggests this is not always the case in relation to recovery and ROP. This was also a point highlighted by Wilkinson (2018) in his study of junior medics training, discussed in section 3.1.6. Wilkinson highlighted how observing someone else delivering care could be the catalyst for transformation learning to take place. How nurses practise, their behaviours and attitudes, are observed by student nurses. As Perry (2009) pointed out "knowingly or unknowingly their words and actions become living lessons" (p.36). Within this study, role modelling emerged as of particular significance to the participants. All participants referred to this in some form as influential to their learning of ROP. Bandura (1997) described role modelling as a process in which individuals can learn new behaviours without the trial and error of doing it themselves, asserting that most human behaviours are learned from observing behaviour modelled by others. In nursing this social learning occurs in part through observation of more senior or experienced staff by students. It is influenced by the relationship between the student and the role model, the usefulness of what is modelled and the student's competence to undertake the role (Murray, 2005). Murray has argued that with increasing demands on their time, role modelling may be the most effective teaching strategy for clinical staff. However, what emerges from this analysis is that students experience both positive and negative role models, with the potential for behaviours to be followed regardless of how that

behaviour is perceived. Linda (extract 95) discusses how she was able to recognise non- useful behaviour being modelled by some staff and how she disengaged from the relationships with them. This may not always be the case if the behaviours are more subtle, or the student is not able to recognise the lack of usefulness of what is being modelled.

Schön (1987) suggested observing a mentor's behaviour enables students to internalise this behaviour and build on previous knowledge and experience through a process of reflection. However, not all students will have developed strong reflective skills and the most junior students will have limited clinical experience to draw from. Hannah (extract 98) describes how she identified staff she would not wish to model her behaviour on due their lack of recovery approach. As a third year student she had previous clinical experience to draw upon and a degree of competency in reflection. Whilst some role modelling may involve conscious decisions to adopt (or not) the behaviour of others through the reflective process described by Schön, individuals can also unconsciously acquire and internalise behaviours in the learning environment. Evidence suggests this may be whether these behaviours are desirable or not. A study by Parthian and Taylor (1993) found that both good and bad communication techniques modelled by staff were both learned effectively by student nurses in trauma situations. In exploring relationships within the clinical environment, Randle (2003) found that senior student nurses learnt to bully junior students, adopting the behaviour observed in qualified staff. This occurred even though these students had found this behaviour unacceptable themselves as junior students. Students synthesise bits of behaviours, potentially from a number of different staff unconsciously, adopting what they view as 'normal' amongst the clinical team (Cheetham & Chivers, 2005). This type of informal learning plays a significant part in skill and knowledge acquisition and the students in this study voiced strong feelings regarding positive and negative role models. Although positive role models were highly valued

by the participants, there is a consistent message that some students experience a lack of modelling of ROP by clinical staff.

The findings of this study echo those of Blackburn and Nestle (2014) who found that for paediatric surgical trainees the relationship with their training consultant was of utmost importance in gaining access to learning opportunities. Working alongside clinical staff, particularly mentors in an effective learning relationship is valued by the participants of this study and recognised as supporting their professional development and skill acquisition. Poor learning relationships, where there is a lack of scaffolded support and modelling of inappropriate behaviours, leads to negative feelings and disengagement. Where students are discouraged from asking questions or seeking advice because of the poor relationship, they are inhibited from taking an active role in their own learning. The troublesome nature of the concept of recovery and its associated practices requires supportive learning relationships if students are to acquire the knowledge, skills and confidence to practice in this way.

5.7 Overview of Troublesomeness

As with all students the liminal experiences of the participants within this study are individual and varied; however, all participants referred to some elements of difficulty in their learning journeys associated with recovery. The notion of troublesomeness is a frequent feature across studies which have considered health and social care related disciplines as discussed in section 3.1.6 (for example Blackburn & Nestle, 2014; Martindale, 2014; Hudson et al. 2018; Wilkinson, 2018). In line with these studies the troublesome nature of the concept of recovery is not only related to epistemological obstacles of content. Four categories of troublesomeness are identified from the data where common difficulties can be identified in relation to knowledge, practice, learning environments and learning relationships. Therefore the complex nature of professional learning is not simply linked to disciplinary knowledge. The troublesome aspects

experienced by participants also involves; the affective dimensions of learning how to carry out recovery orientated interventions; the cultures within practice teams and the attitudes of the staff within these teams; and the quality of the learning relationships students have with practice based staff, particularly their mentors.

As nursing students spend 50% of their course in practice it is unsurprising that troublesome issues related to learning arise in this context. Practice environments are established to provide health care and are not specifically set up for learning. Students must adapt to both academic and practice environments as they move between theory blocks in university and practice placements, meeting the differing expectations of educators and clinical mentors. Student nurses attach importance to inclusion and having a sense of belonging in practice teams (Andrew et al., 2009; Levett- Jones et al., 2009). They are required to become accepted members of their profession through the process of professional socialisation, all of which requires an identity shift. However, where sub- cultures exist with differing thought styles and associated discursive practices students can struggle to understand where they may fit. A lack of understanding of the differences in approach to recovery can create confusion, a refusal to accept one particular thought style can create difficulties in relationships with practice staff. Where either of these apply, students can experience liminal struggles with oscillation or stuckness occurring. How they personally manage such struggles will vary and affect their ability to attain threshold crossing.

Fortune and Kennedy- Jones (2014) suggested that such troublesomeness should be anticipated within learning and argue for curricula which encourage students to engage in struggles to understand and connect with conceptually difficult ideas. Evans and Kevern (2015) described how a pre-liminal state can be viewed as one where limited knowledge and unchallenged assumptions prevail. The liminal journey involves the potential for new

understandings and whilst unsettling, can also be viewed as an opportunity for growth, rather than an interruption in the learning process. Such opportunities can be challenging and as described by the participants of this study, the associated emotional experiences can be profound. Similar experiences were highlighted by Blackburn and Nestle (2014) where surgical trainees described the effect of negative experiences on their learning. Where misjudgements or adverse incidents occurred, trainees experienced a significant emotional response, although these were described as then leading to a period of reflection and further learning. This positive outcome from a negative emotional experience can only be gained if the learner has the ability to successfully manage the affective dimensions to learning, in this case possession of the necessary reflective skills, junior learners in particular may not.

Considering troublesomeness within the TCF can be viewed as theory of difficulty (Perkins, 2007) in that it allows for a causal analysis of what makes learning difficult, providing an explanation of the obstacles students encounter. Conceptual difficulty has been identified within this study in relation to recovery. Knowing the “hurdles of content” (Perkins, 2007, p.33) is helpful in considering more targeted teaching/ learning strategies. However, the obstacles related to student learning of recovery are not simply related to content, wider pedagogical issues have been identified. When considering issues outside of content, Perkins (2007) suggested that one common strategy is to ‘blame the student’ with intrinsic factors such as attitudes to learning often cited as a barrier. However, participants of this study located trouble outside of their personal control, related to practice and relationships within the environments they were placed. The data did not reveal resistance to the concept of recovery at an individual level, although it is acknowledged that the participant group may be those students highly motivated and interested in the concept. Murphy (2006) identified personal motivation as an essential requirement for student learning to occur. However, it has been recognised that initial motivation on entering nursing programmes may wane,

particularly in non-supportive learning environments (Dean & Kenworthy, 2000; Welsh & Swann, 2002). The experiences of participants in this study suggest some of the cultures of care, with their associated thought styles and discursive practices, can create such non-supportive learning environments. It would be reasonable to suggest when sustained over time, this can negatively impact on students' motivation to learn.

5.8 Conclusion

Within this chapter recovery has been located as a troublesome concept. Utilising the TCF demonstrated how students can be positioned within their learning related to recovery and threshold crossing. The troublesome nature of student learning in relation to recovery has been identified. The obstacles to learning are shown to be associated with the troublesome nature of recovery knowledge, the affective aspects of recovery orientated practice, the learning environments in which recovery is experienced, and the relationships students encounter within these learning environments. These key findings have been discussed utilising a range of literature and theory from various contexts including education, nursing, organisational management and psychology, all of which offer some explanation as to why such obstacles to learning occur. Whilst content is within the direct influence of educators, troublesome issues within practice environments are more difficult to directly address. However, strategies to adequately prepare students for the potentially troublesome nature of ROP, the learning environments and the relationships within these environments should be considered and are discussed in chapter six.

Chapter 6: Conclusion

6.1 Introduction

In this final chapter conclusions are drawn with the key findings of the research summarised. The quality of the study is considered in relation to the contribution of theory, reflexivity, the knowledge contribution of the study and its limitations. Recommendations for further research and teaching practice are made.

6.2 Key Findings of the Research

The aim of this study was to contribute to the understanding of how mental health nursing students experience recovery and the nature of their learning journeys. Two research questions were addressed:

- What is the variation in mental health nursing students' understanding of recovery?
- What is troublesome for mental health nursing students in their learning experiences of recovery?

In chapter four variation of student understanding of recovery within the outcome space was identified and discussed. The two branches of the outcome space broadly correspond to the two differing understandings of clinical and personal recovery highlighted within the literature, and evidenced as present in clinical practice (Chester et al., 2016; Le Boutillier et al., 2015; Waldemar et al., 2016). However, in exposing the full variation of understanding within the categories of description a more complex picture than simply two alternative understandings was presented. A phenomenographic approach has allowed for differentiation between the two alternative understanding of personal and clinical recovery, but also for more complete ways of understanding of personal recovery to be differentiated from those less so. Four categories of description were identified with Recovery as Clinical Improvement being the only category within branch one. Recovery as Making Progress, Recovery as Managing to Live Well and Recovery as Learning to Live Differently were all identified within branch two. These

categories demonstrate increasing levels of sophistication in understanding the concept. Identifying the dimensions of variation within these categories revealed how participants discern the aspects of recovery. The literature discussed in chapter two shows how recovery is widely viewed as related to the individual and their unique journey. However, within this study experience also included aspects related to the nurse, nursing practice and the nurse-patient relationship. This may reflect the fact that recovery is experienced within the professional role of being a nurse, where nursing practice is supported by underpinning knowledge and therefore is difficult to separate. However, it does highlight how participants of this study are positioned in relation to recovery.

Whilst a phenomenographic approach identified the nature of participants' understanding of recovery, it did not provide an explanation for why such understanding is held. To develop understanding of this the TCF was utilised with the four categories of description mapped onto the modes of liminality within the TCF. This variation within the pre-liminal, liminal, post-liminal and sub-liminal modes demonstrated how only partial understanding of the concept of recovery was held by most participants within the study, with only one participant demonstrating full threshold crossing. This is of particular concern to nurse educators, as without the transformed understanding related to threshold crossing, the students cannot progress with their learning (Meyer & Land, 2006). Similar concerns have been raised in other health related disciplines (Barradell & Peseta, 2018; Hudson et al., 2018) as discussed in section 3.1.6, with the need for positive clinical practice experiences highlighted as pivotal to students making the connections between theory and practice and achieving TC acquisition.

All participants identified troublesome aspects of learning related to recovery and this has been explored in detail in chapter five where four categories of troublesomeness were identified; Troublesome Knowledge, Troublesome Practice, Troublesome Learning

Environments, and Troublesome Relationships. Student learning journeys begin when students are faced with troublesome knowledge (Land et. al, 2010). Recovery within mental health care is a contested concept although clear direction is now provided in Department of Health policy that the principles of personal recovery should be adopted within practice. However, this understanding challenges both historical views in health care and lay perspectives, which requires students to adopt a new way of seeing recovery. This presents difficulties for students who may have difficulty in grasping the concept when faced with its complex, alien and abstract nature. Participants of this study engaged in strategies involving inert and ritual knowledge in their attempts to navigate the liminal space.

The troublesome nature of the participants' learning experiences were not only in relation to the epistemological obstacles of content, as obstacles to learning were identified by all students in relation to practice. If practice "makes visible the abstract nature of the concepts" (Hudson et al., 2018 p.60) then obstacles to learning within the clinical environment are significant. An affective dimension to learning has been highlighted in that recovery orientated practice carries with it potential for negative emotional experiences, which if not managed effectively by the student, can prevent or limit their involvement and consequently their learning. Learning in practice is particularly influenced by the environments within which it takes place and the relationships between students and clinical staff as discussed in sections 5.5 and 5.6. For participants of this study particular issues related to learning environments were highlighted. The context of care created tensions for students in that the organisations in which practice learning took place were experienced as being financially driven and target focused rather than recovery focused. Students found this at odds with the approaches advocated in university. Experiences varied with both positive and negative encounters in clinical practice; however, all participants made reference to how ROP was not universally adopted across all services. This was identified as related to variation in the levels of staff

competency, but also the differing cultures of care experienced across services where recovery was approached in different ways. A point highlighted by the literature discussed in chapter two (Chester et al. 2016; Le Boutillier et al., 2015; Waldemar et al., 2016). Participants highlighted that how for some areas, clinical recovery remains the dominant thought style and therefore opportunities to discuss or practice personal recovery were reduced. Supportive learning relationships are required for students to acquire the necessary skills and confidence to practise in a recovery orientated way. Where these existed they were highly valued by participants in this study. However, poor learning relationships were also reported with a lack of scaffolded support and modelling of outdated practices lacking a recovery focus. These were found to inhibit students from actively engaging in their learning. Given the importance of role modelling within clinical practice to threshold acquisition (Wilkinson, 2018), such factors can be seen to present as significant obstacles to learning.

The findings presented here offer new insights into student nurse understanding of recovery and the nature of the troublesome aspects of their learning journeys. As students attempt to navigate the liminal space, obstacles to learning need to be overcome if difficult learning is to be managed and threshold crossing achieved. With the majority of students identified as being in the liminal mode with only partial understanding of recovery, it can be concluded that these obstacles present as significant challenges.

6.3 Quality of the Study

In chapter three the theoretical framework and research approach adopted for this study were explored. This included a consideration of the usefulness of the TCF and a critique of its limitations. Phenomenography was considered in light of its relevance to this study, with the credibility and trustworthiness of the research design discussed. Further factors which add to the quality of the study are discussed below.

6.3.1 Contribution of theory

Thomas (2009) suggested that theory should be considered as both a product and a tool. To develop theory can be the desired outcome of a study, or it may be used for the purpose of explaining what is being researched. Within this study theoretical perspectives have been used to provide meaningful explanations on the findings and to consider how these relate to the findings of other literature. A range of theories were drawn on to inform this study, within this section the contributions of these theories are discussed.

Within the phenomenographic design of the study, conceptions (or understandings) are explained with the 'structure of awareness' framework (Marton & Booth, 1997). Using this framework has exposed the variation in understanding of recovery which can be associated with the clinical and personal perspectives identified within chapter two. However, by considering the dimensions of variation (within the internal horizon) and the context within which these are experienced (the external horizon), a more complex picture than simply two alternative understandings has been exposed. By allowing for examination of the different aspects of recovery and consideration of its context within nursing, the framework has provided greater clarity of the student experience in identifying understanding in terms of a continuum of complexity.

Moving beyond a phenomenographic approach in considering the student journey, the TCF was useful in providing possible explanations for the variation of understanding uncovered. Both phenomenography and the TCF support the idea of a non-linear student journey as both consider phenomenon to be understood in different ways. Phenomenography asserts that students can hold different understandings because of a changing structure of awareness related to context. The TCF with the notion of liminality has offered an explanation of these different understandings in terms of the modes of variation. The TCF as a theory of difficulty

(Perkins, 2007) has highlighted the barriers to learning in relation to recovery and offers some explanation as to why some students maintain an understanding of clinical recovery within the pre- liminal mode, also why others oscillate within the liminal space with only partial understanding of the concept of personal recovery. This is particularly useful for nurse educators who from their own transformed perspective, potentially having achieved threshold crossing some time ago, may struggle to understand the difficulties students face (Meyer & Land, 2005).

The concept of scaffolding and the zone of proximal development, a concept sharing similarities with the notion of the liminal space (Cousin, 2008a), was used in considering troublesome encounters in the student learning journey. Van de Pol et al. (2010) identified three components to scaffolding; contingency, fading, and transfer of responsibility. These components provided a useful framework to consider the nature of the learning relationships and provided an explanation of how authoritarian and non- collaborative approaches from a 'more knowledgeable other', inhibits active participation in learning on behalf of the student, as the students' potential development is dependent on effective scaffolding (Daniels, 2001; Liechty et al., 2009).

In considering the learning journey PsyCap (Luthans et al., 2007a) was also used as a possible explanation of why some students engage more enthusiastically than others in entering and navigating the liminal space and traversing the threshold. The nature of ROP has been shown to have an emotional toll on students. PsyCap offers a means of understanding the affective dimension of liminality by considering student psychological factors and how the troublesome nature of ROP may impact on student learning. As PsyCap is not considered a fixed trait but a state open to change and development (Luthans et al, 2007a), its consideration opens up possibilities for student nurse educators. Although participants of the study situated the

troublesome nature of learning recovery as related to extrinsic factors, the notion of PsyCap suggests efforts to increase the intrinsic factors of self-efficacy, resilience, hope and optimism, may facilitate student engagement with the liminal journey.

Although liminality within the TCF is considered as an individual student journey, a social dimension to learning is acknowledged in that how concepts are understood is influenced by how these concepts are given legitimacy and understood by others (Meyer et al., 2008). Land et al. (2008) suggested the TCF to have a particular affinity to Wenger's (1992) work on communities of practice; however, within this study this has been further explored with the notion of thought collectives (Fleck, 1979). Fleck asserted that knowledge is the result of the social and historical processes of the collective that built it. The theory is of particular relevance to this study considering the history of mental health care, largely provided in enclosed psychiatric institutions, closed to the wider community. The notion of thought collectives has highlighted how within such a culture the clinical recovery thought style, with its associated discourse and practice, has developed and been maintained. This has then provided some explanation for the challenges students face when the competing thought styles of clinical and personal recovery are encountered.

The difficulties students encounter has also been considered in the light of Lipsky's (1980) idea of street level bureaucracy. Again the social aspect of learning has been highlighted in considering the contextual nature of nursing practice that mental health nursing students are required to engage with. This has provided some explanation of how organisational and central policy promoting recovery is managed at a grass roots level through consideration of the behaviours of clinical staff. Criticism of the concept of street level bureaucracy has suggested it is irrelevant to contemporary care services because of a rise in managerial power (Evans, 2011). However, its use within this study has demonstrated how frontline staff can and

do exercise discretion in relation to what actually happens in practice. As such it provides a powerful explanation of how the attitudes and behaviours of staff adds to the variation within the student learning experiences.

6.3.2 Reflexivity

Increasingly the term reflexivity is seen in qualitative research reports and for the majority, the concept is accepted as good practice. Reflexivity refers to a process whereby researchers consider their own position and their influence upon a research study (Savin -Baden & Howell Major, 2013). It enables personal preconceptions to be identified, with consideration of how they are brought into the research in the first place. It questions how these preconceptions may affect all stages of the research process and how they are dealt with (Sin, 2010). As Lincoln and Guba (1985) argued, the issue is not whether the researcher has influenced the research process, but how this influence is addressed. Reflexivity is now a key issue for qualitative research with regard to the trustworthiness of the studies. This led Greenbank (2003) to argue that educational research is not value free, that reflexive accounts should be included in all types of research and that those who do not include such accounts should be criticised. Reflexivity is not a term widely reported in phenomenographic studies to date. However, Sandberg (1997) concluded that to be as faithful as possible to the individuals' conceptions of the phenomenon, researchers must demonstrate how they have controlled their own interpretations throughout the research process. To do this he advocated the need for 'interpretative awareness', which explicitly deals with the subjectivity of the researcher, thus a similarity to reflexivity can be seen.

Despite the broad agreement on the usefulness of reflexivity in increasing the trustworthiness and integrity of the study, advice on how 'to do' reflexivity is more limited, perhaps reflecting its individualised nature and the potential for it to be a difficult undertaking. Reflexive

experiences related to this study occurred at different times and in different ways, often unintended. Reflections on informal office discussions between colleagues also engaged in doctoral level research, often led to further insights that were then considered in relation to my own research. Formal supervision was crucial in sounding out ideas, and providing a 'safe place' to express doubts or concerns and receive constructive feedback. A research diary was used from the beginning of the research process. The decision to use such an approach was largely based on previous experience, I had used this method during a masters research study and realised the benefits. The diary was simply an A4 book, which I usually wrote in pencil as I find it quicker and less restrictive to do so. It mainly consisted of free text, although occasionally I used diagrams to illuminate connections or emoji's (e.g. a smiley face) to express emotion. Entries were made at various points, no set times were allocated. Significant events included after every interview with participants and covered all stages of the research process.

I considered the diary a conversation with myself. Some entries are deeply personal, for example in considering the impact of life events on my emotional well-being and considering the potential impact of this on the research. Others were more practical, enabling me to consider methodological issues or how to manage my time. Many entries, particularly in the early stages of the process reflected my difficulties of navigating the liminal space of doctoral study as I struggled with understanding the applicability of theory, or the complexities and variation in phenomenographic research. All entries allowed me to express emotion, acknowledge problems, explore alternative ideas and constantly consider my own position. At times such considerations were full of doubt, at others more optimistic. Each entry played a part in organising my thinking as the diary provided the necessary space to be reflexive. Rather than re-create these reflexive accounts here, a selection of entries has been included in appendix five to allow the reader access to the original context of the entries. A positionality statement is included in section 3.2.8.2.

6.3.3 Contribution to knowledge

The Chief Nursing Officer for England expects that the values and principles of recovery are embedded in all areas of mental health nursing practice (Department of Health, 2006) yet adoption of such principles has been slow and patchy. Cusack et al. (2017) found that nurses viewed the dominance of a symptom focused clinical recovery orientation as the primary obstacle to ROP, yet it has been suggested that a clinical and personal orientation to recovery can co-exist within medical practice (Mountain & Shah, 2008). However, this study has demonstrated how the significant variation between the two understandings, as evidenced in the different branches of the outcome space, can lead to significantly different approaches to nursing practice. Nursing is not a branch of medicine but a discipline in its own right, with its own body of knowledge. Whilst medicine may look to incorporate aspects of personal recovery into its practice (Royal College of Psychiatrists, 2009), it remains a discipline underpinned by a medical model concerned with diagnosis, symptoms and cure. Within this study the nursing students' understandings of recovery were shown to incorporate aspects relating to the person, the nurse, nursing interventions, the nurse- patient relationship and the recovery process. This demonstrates how recovery is experienced within the professional role of the nurse where recovery knowledge and recovery orientated nursing practice are viewed in an integrated way. Within the second branch of the outcome space this integration of knowledge and practice demonstrates a significantly different conceptualisation of personal recovery to that of clinical recovery as demonstrated within the first branch. Nursing therefore need not be constrained by the underpinning approach of the medical model. The findings presented here demonstrate how contemporary nursing knowledge and practice can be informed by all principles of recovery.

Previous studies considering staff understanding of recovery have focused on clinically based practitioners, predominantly those holding a professional qualification. Student nurses are

required to spend 50% of their time university based, with 50% based in a range of practice settings; they are expected to fully contribute to both. They therefore occupy a unique position within the mental health care setting, yet as a group, their specific experience of recovery has been a neglected area of research; this study addresses this gap. The majority of literature in relation to recovery takes the form of narratives or research adopting qualitative methods. There is a risk therefore that further qualitative research simply adds to an already extensive body of personal, professional and research stories without providing greater understanding. However, phenomenography has not been adopted as a research approach within published studies related to understanding of recovery to date. Within this study, such an approach has allowed for differentiation between the two alternative understandings of personal and clinical recovery, with consideration of how this impacts on student nurse practice; but also for more complete ways of understanding of personal recovery to be differentiated from those less so. Whilst the literature to date suggests confusion and misunderstanding of personal recovery (Waldemar et al., 2016; Le Boutillier et al., 2015; Chester et al., 2016), the findings presented in this study suggest this can be better described as different levels of complexity of understanding. Branch two of the outcome space identifies three different categories of description demonstrating increasingly sophisticated levels of understanding of personal recovery: Recovery as Making Progress, Recovery as Managing to Live Well, and Recovery as Learning to Live Differently. A focus on the variation within these categories has avoided the potential to view a uniformity in understanding of personal recovery, as opposed to clinical recovery. Such a variation and complexity of understanding, as described within the outcome space, has not previously been reported. These findings therefore offer a new insight into student understanding of a concept central to contemporary nursing practice. A more complete understanding can then be promoted through educational initiatives with student nurses.

The implications of recovery for mental health nurse education is only recently being explored and this study contributes to this discussion. Whilst the published literature to date has focused on how recovery can be taught to improve understanding, this is the first study to consider the obstacles to learning that students encounter in their learning journeys related to the concept. Consideration of the student experiences through the liminal phases of their learning journeys identified four categories of troublesomeness: troublesome knowledge, troublesome practice, troublesome learning environments, and troublesome learning relationships. This adds to the notion of troublesome knowledge within the TCF by identifying the additional obstacles related to the clinical learning environment that student mental health nurses encounter. The findings therefore allow for wider consideration of the barriers to understanding related to both the academic and clinical learning context in order to support students to transform their conceptions of recovery. As the next generation of registered nurses, students need to be equipped with the necessary knowledge and skills to move the recovery agenda forward and influence practice. Recommendations for how this can be addressed in relation to student nurse education are explored in section 6.4.

Phenomenography and the TCF share a focus on variation, yet there is currently limited work where the two have been combined. Åkerlind, McKenzie and Lupton (2014) combined phenomenography, variation theory and the notion of TCs to inform higher education curriculum design. In a three stage design, disciplinary concepts were identified using the criteria of TC characteristics; action research adopting a phenomenographic approach identified variation in student understanding of these concepts; finally learning activities were designed using variation theory. Combining elements of phenomenography and the TCF was also a methodology adopted by Kabo and Baillie (2009) in considering social justice as a TC in engineering. In their study no traditional phenomenographic outcome space was developed as

the liminal modes (reframed as a liminal spectrum) were used to provide the structure of the outcome space.

Within this study an outcome space within a phenomenographic tradition has been developed to describe the critical variation of understanding and the relationship between these different understandings. Multiple understandings are expected in phenomenographic research and are captured within the outcome space. When considering the phenomenographic outcome space along with the TCF, the categories of description have been described as corresponding to different positions within the modes of liminality related to the students' learning of recovery, where variation of understanding within individual student accounts can be understood as oscillation and mimicry (as seen in figure 4, p.208). Therefore, the TCF contributed by providing a framework to explain the outcome space in terms of student positioning and their journey within the liminal space. This facilitated the exploration of the troublesome aspects of learning students associated with recovery as obstacles to learning where identified. Combining phenomenography and the TCF in this way to identify the critical variation in understanding and provide some explanation for this variation, offers a previously unreported approach. As such this study extends the small body of knowledge regarding their combined usefulness.

Much of the research adopting the TCF has focused on academic perspectives (Rodger, Turpin, & O'Brien, 2013). This study is based on the experiences of the students and has fully considered the student perspective in exploring how the concept is understood and the obstacles to learning that are experienced. These experiences of the liminal journey will be very different to those of the disciplinary experts who have already crossed the threshold (Meyer & Land, 2008). Understanding of these student experiences is considered crucial to informing the most effective forms of pedagogy.

6.3.4 Limitations of the study

Whilst the quality of the study has been addressed, there do exist a number of limitations.

Firstly, this is a single centre study where participants were taught within the same curriculum, although they experienced different clinical placements. The involvement of other participants from another centre with a different curriculum may have identified findings with greater variation of experience. The participant group was also relatively small with only second and third year students recruited to the study. Had first year students been included again the findings may have been different. The participants were at different stages of the programme and no attempt has been made to explore in depth any connection between programme point and student understanding. The findings also represent the student experience of recovery at a point in time. A longitudinal study following one cohort of students, generating data at different points in the programme would have identified any changes of understanding over time. However, recruitment and dropout rates may have been an issue with such an approach.

The categories of trouble identified by students in relation to learning about recovery all relate to extrinsic factors, which is in contrast to Martindale's (2014) study of troublesome learning for nursing students in relation to research and evidence based practice, where intrinsic factors such as low motivation were identified. It must be acknowledged that this may relate to the participants being the most interested or highly motivated towards research or recovery and potentially not representative of all students in the population of the study. This is an unknown factor, although the potential for bias is acknowledged.

Whilst phenomenography aims to identify the experiences a group of individuals may hold about a phenomenon, it is not possible to directly access these experiences because of the relational nature of individual experience which cannot be shared by another. The data

analysis in this study is based upon the participants' descriptions of these experiences. The interpretative nature of the analysis and description of findings becomes the researcher's experience of the participants' described experience. This may be viewed as a consequence of the non-dualist stance adopted within phenomenography and cannot be entirely overcome.

6.4 Recommendations for Further Research

6.4.1 Recovery as a TC

This study did not set out to empirically determine recovery as a TC. Rather it has utilised the TCF to enhance understanding of the student experiences of learning about recovery and where the obstacles to this lie. There is no empirical research to date to support recovery as a TC. However, the work of Stacey and Stickley (2012) discussed in section 3.1.6 provides a robust theoretical argument to support the idea. What has been demonstrated in this study is that students must relinquish any pre-existing 'common sense' perspectives of recovery if they are to approach a new way of understanding. Recovery challenges traditional views and associated nursing practices and its troublesome nature has been demonstrated. The transformation required to embrace this change reflects the TCF in that it leads to "new and previously inaccessible ways of thinking about something" (Meyer & Land, 2006, p.3) and students "must rework prior understanding" (Davies & Mangan, 2007, p.721).

Davies and Mangan (2007) proposed the idea of web of TCs within a subject area. Whilst a TC is transformative, understanding of it may also be transformed by subsequent acquisition of other TCs, hence learners develop a sense of the 'bigger picture' by integrated new learning. This way of thinking about TCs is of relevance to mental health nursing. Whilst recovery itself may represent a TC, some of the associated concepts of it have themselves been identified as TCs by others (although without empirical evidence). The concepts of social justice and person centred care are put forward by Levett-Jones, Bowen and Morris (2015), whilst McAllister,

Laster, Stone and Levett- Jones (2015) propose overcoming stigma and person centred care to be TCs. These concepts are all of relevance to recovery. A link can also be seen to the idea of caring, put forward by Clouder (2005) as a TC. It would be expected that other basic concepts would link into this web. Marsland and Pollock (2010) have suggested that key concepts such as self- direction and positive risk taking are brought together under the umbrella of recovery. However, the relationship between the TCs is central in providing the framework within which the other concepts are used (Davies & Mangan, 2007). In furthering this idea it may be that recovery represents a superordinate TC, of pivotal importance in that some of its component parts are also TCs in their own right. Recovery has been demonstrated to be a complex and multifaceted concept, applicable across mental health nursing. Understanding recovery therefore can lead to student understanding across a range of related concepts. This suggests recovery has an integrative nature where learning of this concept is not in isolation, as learning goes beyond this to the related concepts. If considered in this way, a framework may emerge that structures teaching and learning around the acquisition of these TCs.

Contemporary ideas of recovery did not originate within the discipline of mental health nursing, or indeed within any of the healthcare disciplines. Rather it emerged from the knowledge of those who had experienced it and shared their stories to inspire hope in others. To label recovery as a TC may then be viewed as a commandeering of the concept by professionals, when its strength can be seen to lie in its ownership by those who travel its path. Therefore recovery cannot be viewed as disciplinary bounded, rather it is a way of understanding of relevance to a wider collective. When considering the dimensions of variation within the outcome space of this study, it can be seen that participants when considering recovery, view it within the context of their nursing practice and the organisations within which they work. In this sense the notion of TCs could be extended by considering ROP as a 'threshold practice'. Rather than focusing on the cognitive aspects of learning, threshold

practices consider the interplay between the tacit nature of practice, the emotional and social dimensions of the student transition and issues of identity formation (Gourlay, 2009). Although Gourlay's work was concerned with the practice of academic writing, there is a clear applicability of the idea to recovery as experienced by students within this study. In chapter five, the troublesome nature of tacit knowledge and how it is used in practice was highlighted. A consideration of ROP as a threshold practice could open up those aspects of tacit practice that students struggle to understand. Discussion of troublesome practice within the clinical environments where practice learning takes place and the learning relationships within these practice settings, has highlighted the emotional and social dimensions of practising in a recovery orientated way. Much of the literature related to recovery does not originate from a practice setting as a significant proportion of it is led by those who are experts by their personal experience, with services not necessarily being involved in this recovery. However, for participants of this study recovery as a phenomenon is experienced within the context of nursing and as having the dimensions of the person, the nurse, the recovery journey, the nurse- patient relationship and nursing interventions. Considering ROP as a threshold practice could potentially address the link between the theoretical aspects of recovery and the associated nursing practices, whilst remaining cognisant of the fact that recovery is not done by professionals, although its associated nursing practices are.

Such discussion may have raised more questions than answers and it is beyond the scope of this study to address these issues. However, it does illuminate areas of interest for further discussion and research with dialogue between educators and students in order to bring together multiple views.

6.4.2 Academic experiences of recovery

This study has solely focused on the student experiences of recovery. An interesting avenue to explore would be university based academics' experiences of recovery. Marsden and Pollock (2010) observed that a variety of different methods are being used to teach recovery in universities and question whether this reflects a level of uncertainty regarding recovery and its evidence base within academia, suggesting a potentially troublesome area for teachers as well as students. The literature discussed in this study has demonstrated how uncertainties exist for practitioners regarding recovery. Transformation of services has been slow and culture change continues to present challenges. Prevailing cultures and practitioner attitudes to recovery has been shown in this study to have a significant impact on student learning of the concept. This situation may be reflected in the university context if differing positions exist amongst educators on the nature of recovery and a recovery orientated approach. Phenomenographic investigation of academic experiences could explore this.

6.4.3 Student experiences of recovery

As previously highlighted this study is a single centre study with a relatively small participant group. Whilst the findings should be of interest to other similar settings there is a need to develop a stronger evidence base in relation to student experiences of recovery, which currently is an under researched area. Multi-centre studies would be advantageous in capturing the range of variation in student understanding across different centres and curricula.

Longitudinal research would also be of benefit in capturing student experiences as they progress through their pre-registration studies and beyond. Here any changes in experiences and the significant influencers on these could be explored. The participants of this study are now all registered nurses. This study highlighted how only partial understanding of recovery

was held by most of the participants, some nearing completion of the programme. One option for research follow up currently being considered is how learning journeys in relation to recovery continue, progress or differ after qualification as a registered nurse. Again a phenomenographic approach could be utilised.

Although not commonly reported in phenomenography one potential method of generating data not adopted in this study is that of participant observation. Data generation through participant observation within the practice learning environment could potentially provide the opportunity to directly observe situations where students are engaged in practice to record observations, interactions and experiences related to recovery. Time, access constraints and the multiple placement sites would have made this approach impractical in this study.

6.5 Recommendations for Practice

The evidence generated from this study should be considered in light of its context of a relatively small number of participants from one university. However, nurse education programmes across the UK must adopt the competency framework for registered nurses set by the NMC and require validation of programmes from this governing body. It is likely therefore that there will be similarities across programmes with the findings and recommendations from this study potentially transferable to other areas. Five recommendations for practice are put forward as a result of the findings of this study.

6.5.1 Curriculum review and development

The first recommendation is that the TCF be used as a basis for developing pre-registration nursing curricula in relation to a recovery orientation. The TCF exposes areas where students are most likely to experience difficulty in disciplinary knowledge. This study has highlighted

areas that deserve particular attention in relation to recovery, where variation of understanding and obstacles to learning exist. Hence modifications and re-design of the curriculum can be considered in light of these findings to enable students to negotiate more successful learning transformations. Because of the disciplinary nature of TCs, it may be unwise to generalise on what such re-design should involve across other programmes. This may also be true for recovery across nursing programmes. Although one concept, its very nature demands that a local evaluation is required; one responsive to the needs of the particular students, the areas of clinical practice and the needs of the population who make use of these services. However, the TCF can, as Meyer and Land (2005) point out, offer an approach for focusing on the critical micro- perspectives of variation in learning engagement in such varied and complex settings. The findings of this study should be judged on their transferability to other pre-registration nursing programmes, with local review as necessary.

Recovery orientated competencies are reflected within the Standards of Competence for Registered Nurses (NMC, 2010) which currently influences pre-registration nursing curricula, particularly in the mental health specific section. The NMC in reviewing these standards have published new standards of proficiency (NMC, 2018b), which apply to all NMC registered nurses, regardless of specialist area. Whilst the principles of person centred care, collaboration and partnership working are referred to within these standards, recovery is not specifically mentioned, presumably because of its perceived lack of applicability across all fields of nursing. There is therefore a danger that the impetus to drive forward a recovery orientated agenda in mental health nursing will stall. It is therefore essential within mental health nursing programmes that these standards are considered within a recovery orientation to promote the key principles involved. There is an expectation that the new standards of proficiency (NMC, 2018b) will be fully implemented by 2020, with nurse education providers required to review their curricula to ensure compliance. It is therefore an opportune time for curricula re-design.

At a local level both theoretical and practice based competencies need to have explicit reference to recovery orientated approaches. This is considered essential for students to integrate theoretical concepts with actual practice. This approach will also help address the troublesome nature of tacit recovery knowledge and practice as experienced by students and highlighted within this study.

Academic teachers have a tendency to develop content heavy curricula which can lead to over-stuffed and fragmented curricula, requiring students to absorb and reproduce vast amounts of information (Cousin, 2006b, Monk, Cleaver, Hyland, & Brotherton, 2012). The TCF offers an approach that focuses on the “jewels in the curriculum” (Land et al., 2006), those key disciplinary concepts which require mastery and define the powerful reformative points in the students’ learning journeys (Land et al., 2006; Cousin, 2006b). Such a focus allows teachers to make decisions on what is fundamental to the subject being covered and therefore refined decisions about curricula can be made (Cousin, 2006b). A framework considering an interconnected web of TCs (Davies & Mangan, 2007) that structures learning may support students in integrating their learning more extensively.

Cousin (2008b) has argued that any review of curricula using the TCF should involve a dialogue between educators, students and practitioners, using the term ‘transactional curriculum inquiry’ to describe such consultation and collaboration. If a key feature of the TCF is to identify difficulties in the subject, then student involvement in voicing their experiences of such difficulties would appear essential. This study has demonstrated how students can, when encouraged, articulate these difficulties. As nursing programmes involve an equal split of learning hours in theory and practice, it would also appear essential for representatives from the nursing profession in practice to be involved so as not to miss an important perspective in embracing disciplinary knowledge.

Identification of the variation across categories of description has identified what students find difficult and the obstacles to learning therefore informing the curriculum in relation to recovery. However, attention must also be given to how students' attention is best drawn to the aspects of recovery that they fail to discern. This requires a focus on teaching/ learning activities.

6.5.2 'Teach smarter'

How the TCF can assist redesign of curricula has been discussed, devising new forms of pedagogy to teach TCs is more difficult (Baillie, Bowen, & Meyer, 2013). As Perkins (2007) pointed out, a theory of difficulty does not necessarily write a recipe for an intervention that goes with it. However, undertaking a causal analysis highlights why troublesome spots occur towards improving teaching and learning. Perkins suggested based on this causal analysis, educators can then 'teach smarter'. Educators must be aware of the different ways in which student nurses experience recovery and raise their awareness that other ways exist to encourage a deeper understanding. Educators must therefore tolerate and recognise where partial understanding exists, encourage expression of uncertainty and promote a community of learning so that students appreciate they are not alone in experiencing difficulty (Land et al., 2006). This according to Meyer and Land (2006) requires a range of learning approaches and as recovery is attuned to attitudes and values, a varied and inclusive approach is required that stimulates transformational learning (Stacey & Stickley, 2012).

Stickley et al. (2016) identified that the literature offers little in directly applying the concept of recovery to mental health nurse education. In chapter two this limited literature was highlighted. Suggestions for improving student understanding have included involvement of those with lived experience of recovery in nurse education (Byrne et al., 2013; Maher et al.,

2017; Lesser & Paleo, 2016; Stacey et al. 2015); the use of enquiry based, and problem based learning (Stacey et al., 2015; Stacey & Stickley, 2012); the use of narratives (McAllister, Laster, Stone & Levett- Jones, 2015; Levett- Jones, Bowen, & Morris, 2015); and group supervision (Stacey & Stickley, 2012). It is therefore essential that student nurse educators consider these proposals in their teaching delivery, utilising the evidence base and where appropriate evaluating this evidence base in light of their own experiences. As this evidence base is currently limited, it is appropriate that recommendations for teaching practice draw on broader educational theories.

One such educational theory recommended is that of variation theory (Marton & Tsui, 2004). Developed from phenomenography, variation theory shifts the focus from variation in understanding to how variation can be presented in teaching and learning activities to facilitate student learning. This approach presents variation in a structured, rather than ad hoc way in that only one critical feature is varied at a time whilst others remain constant. As understanding develops, 'fusion' is achieved as all the critical features are varied simultaneously to demonstrate how the different features interact and integrate with each other (Åkerlind, McKenzie, & Lupton, 2014). By employing the findings of this study, different learning situations can be created, utilising the learning activities discussed above, where dimensions of recovery are explored in a deeper way to enable students to identify the critical features and how they relate to each other. Such an approach can also render visible those troublesome aspects of recovery that may be implicit within the curriculum.

6.5.3 Recovery orientated leadership in academia

Further research has been recommended into the nature of academics' experiences of recovery. However, there is a personal responsibility on nurse academics as registrants and educators to maintain contemporary knowledge of the discipline. They must take personal

responsibility in grasping the guiding principles of recovery or concepts such as hope, self-determination and partnership working will simply become buzzwords, with little application to practice for students. Nurse educators are therefore invited to examine their own understanding of recovery, how this is applied in their teaching and reflexively consider how they might model the principles of recovery through their own behaviours within their university roles. If recovery is to be promoted, then the educational programmes within which it is taught should be recovery orientated themselves.

Nursing leadership to promote recovery may be key in transforming clinical services (Slade, 2009); however, academic leadership can also be influential in promoting a recovery orientated approach within a wider setting. Through lobbying for change at a policy level in key meetings, conferences, forums and professional associations, academics can maintain a focus on promoting the recovery agenda. Nurse academics are ideally placed to foster collaboration between the various stakeholders in recovery. Through their role in education and links to practice learning, they occupy an 'insider- outsider' position to support teaching and research, and co-ordinate collaboration through community engagement (Cleary, Lees, Escott, & Molloy, 2016). Such measures are recommended to promote positive change.

6.5.4 Developing PsyCap in students

Learning in relation to recovery has been demonstrated to have an affective dimension to it with potential negative consequences for students. This is particularly related to troublesome practice, but can also be seen in other areas of difficulty. Within mental health practice a human connection between the nurse and the service user is essential for interventions to be successful and when dealing with people in distress, an emotional impact on the student may be unavoidable. Clouder (2005) suggested this human connection, experienced at a personal level, was the catalyst for moving through the liminal space and threshold crossing. However,

if experienced in a negative way students may be unable or unwilling to engage with such learning. Yet the NMC Standards of Proficiency (2018b) state nurses must “understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues” and that they should “demonstrate resilience...in routine, complex and challenging situations” (p.5).

Firstly then it is necessary to raise awareness amongst educators, practitioners and the students themselves of the potential impact of the affective dimension to learning and plan to respond positively to this. Educational forums, formal sessions within the curriculum and mentorship updates could all provide arenas for awareness raising. However, options should be considered in light of the specific programmes and needs of those involved.

Within section 5.4 PsyCap was put forward as a way of understanding why some students manage the affective dimension to learning better than others, with an empirical basis suggesting that increased PsyCap is linked to improved learning and performance. It is therefore necessary to consider how principles of positive psychology can be embedded in curricula and pedagogy to facilitate the necessary engagement. Students require psychological coping strategies to deal with these difficult aspects of learning (Rattray, 2018). One approach to this is the PsyCap Intervention (PCI) proposed by Luthans et al. (2006). This involves purposeful and structured ways for students to develop the interconnected capacities within PsyCap of hope, optimism, efficacy and resilience. The approach involves a range of strategies including goal settings, identifying pathways, focusing on achievement over non-achievement, planning for obstacles and positive self-talk. Activities include sharing of stories, role modelling and positive feedback to change perceptions of influence through cognitive, emotional and behavioural processes that allow a reframing of setbacks and consideration of options (Luthans et al. 2006). Such approaches will be familiar to those in mental health nursing as recognised nursing interventions likely to be taught within most pre-registration curricula. In a

similar vein, the capacities within PsyCap to a large extent reflect the principles of recovery discussed in chapter two. Traditionally these approaches and principles have been considered in the context of providing care to those in distress who require mental health services. The recommendation here is that these same principles and approaches are considered as a way of supporting students, with the PCI approach being incorporated into pre-registration curricula. How this can be done may vary but possible strategies include coaching, group supervision sessions, forums for sharing of stories from practice and personal reflection. Whilst this recommendation is made in relation to mental health nursing curricula where there is familiarity with the concepts, it is recognised that educators with less familiarity may feel less equipped to consider how PsyCap can be incorporated into their programmes. This should be addressed through education and training.

6.5.5 Preparation for practice

Within this study some of the obstacles to learning were located by participants within the clinical learning environment and the learning relationships within these environments. Such practice issues are difficult for university based educators to address; however, responsibility cannot simply be passed on to practice based clinical educators. Students can face difficult transitions as they move between university and practice based settings, with the theory/practice gap often cited as being problematic (Kellehear, 2014). Students need to adapt to the differing demands and expectations of university and the practice setting and may feel unprepared for such shifting sands. Resolution can only be achieved by shared understanding of these differing expectations and demands. There is therefore a need for dialogue between the major stakeholders, including academic and clinical staff, managers, students, service users and carers.

Collaborative ventures have been tried with varying degrees of success (Kellehear, 2014) and may depend upon the motivation and willingness of those involved to engage in constructive dialogue. However, it is recommended that all major stakeholders are involved in curriculum development, implementation and review, to ensure contemporary thinking and practices are addressed. Anecdotal evidence from personal practice suggests students highly value practitioners and service users' involvement in the academic setting for teaching, sharing stories and communicating their expectations. Service user involvement is generally recognised as good practice in nursing education and examples of such initiatives have been highlighted in section 2.8. Such endeavours should be promoted. Likewise academic staff should have clear and formalised routes into clinical settings with the opportunity for shared meetings with students and mentors, with opportunities for collaborative practice based research. Such activity can enhance the relationships and understanding between university and practice staff to address potential student difficulties and provide students with greater insights.

Clouder (2005) highlighted a reluctance to acknowledge the emotional aspects of practice within nurse education. The need to address the affective domain of learning has been highlighted in section 5.4 to build student PsyCap. In addition Clouder suggested that students should become "immersed in the realities of practice" (p.514) to learn from experience, rather than standing back as observers. However, learning opportunities within the clinical environment can be limited with restrictions on student activity, decreasing numbers of clinical placements, fears of making mistakes and litigation (Brown, 2008; Kameg, Mitchell, Clochesy, Howard, & Suresky, 2009). There is therefore an increasing interest in the use of simulation within taught components of nursing programmes to provide the necessary attention to clinical skills. Such practical sessions should include high-fidelity simulation scenarios that

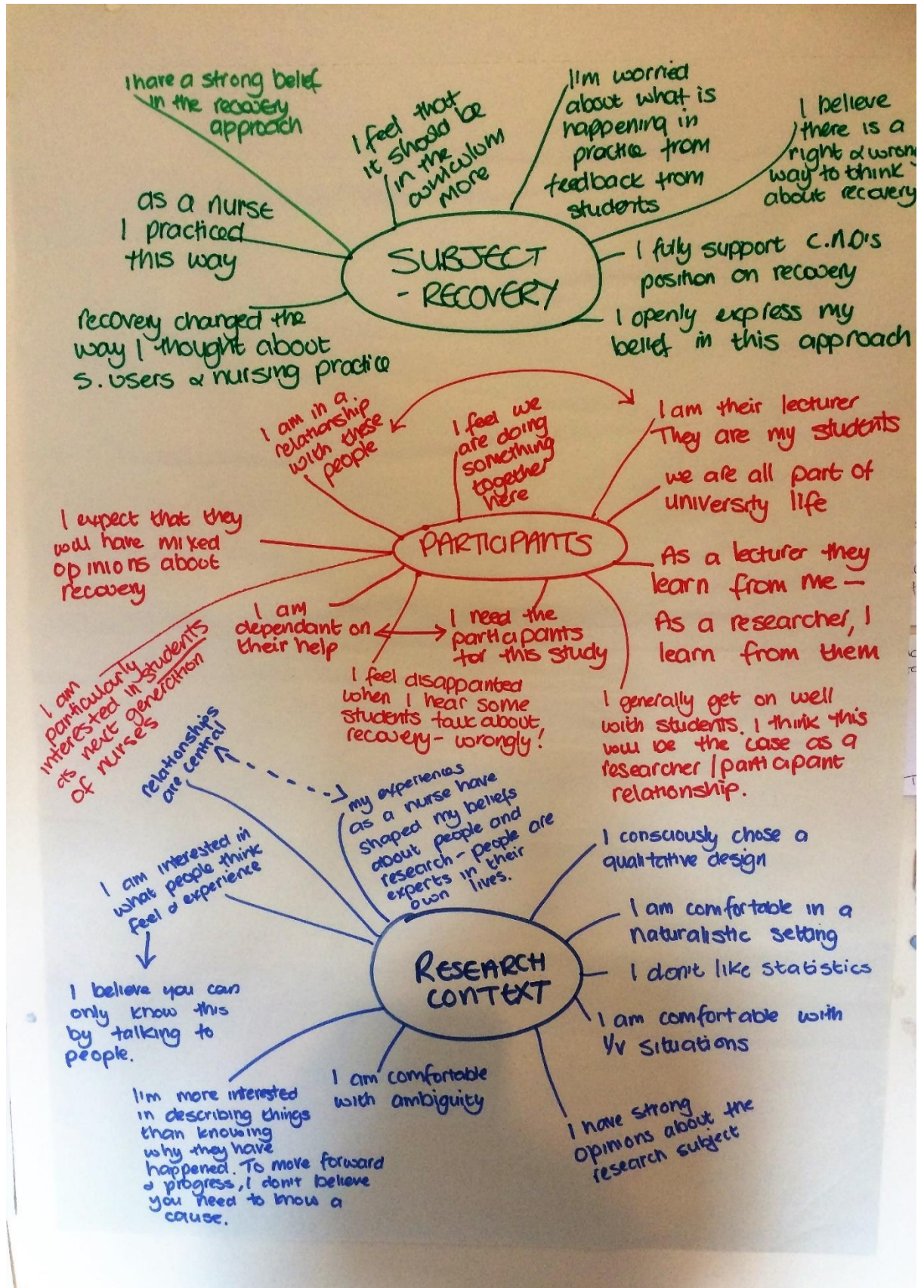
address the affective domain of learning, give students the opportunity to recognise and work with their own emotions, as well as the emotions of those receiving care.

6.6 Conclusion

This study has contributed to the existing body of literature related to recovery in that it has highlighted the fact that mental health nursing students understand recovery in varying ways. This variation in understanding includes differences in how the person and their recovery journey is viewed, but also how mental health nursing students understood their roles as nurses and the nature of nursing interventions and relationships. This is an area currently under reported in the literature with limited specific focus on student nurses. The position of student nurses within the nursing workforce is unique in that they are students enrolled on a university programme, yet are expected to fully contribute to practice in a clinical environment outside of the university setting. Their learning journeys are influenced by differing organisations with different priorities and demands. It has been demonstrated how this can cause difficulties for students when the principles and theoretical underpinnings of recovery espoused in university are not then experienced in practice. Whilst recovery as a concept presents as troublesome knowledge, there are significant obstacles to learning associated with the affective and social dimensions to learning. Within this study these are predominantly experienced in the clinical learning environments where ROP takes place. Therefore, curriculum redesign and revised teaching practices are insufficient on their own to address the difficulties students' experience. Collaborative efforts are required across practice and academia to address the obstacles to learning and ensure the recovery agenda is advanced.

Appendices

Appendix 1: Mindmapping exercise for positionality statement



Appendix 2: Overview of phenomenographic studies in nursing

AUTHOR	COUNTRY OF ORIGIN	AREA OF INVESTIGATION	SAMPLE	ANALYSIS FRAMEWORK	HOW FINDINGS PRESENTED
Johansson et al (2007)	Sweden	Perceptions of influencers on sleep	35 patients	Dahlgren and Fallsberg (1991) 7 steps	3 main descriptive categories, 2 further sub-categories
Schroder et al (2007)	Sweden	Perceptions of quality of care	12 family members	Marton (1994) 4 phases	5 descriptive categories containing 16 conceptions
Jangland et al (2011)	Sweden	Perceptions of roles and interactions with pts and families	17 registered nurses	Larsson and Holmstrom (2007) 5 stage analysis	4 categories of description hierarchically structured in an outcome space
Aflague and Ferszt (2010)	USA	Conceptions of suicide and suicide assessment	6 psychiatric nurses	Dahlgren and Fallsberg (1991) 7 stage analysis	10 categories of description clustered into 3 dimensions
Gustafsson et al (2010)	Sweden	Perceptions of daily life in girls with eating disorder	18 adolescent girls	Marton and Beaty (1993) 4 steps	3 categories each containing 2 conceptions in a non-hierarchical outcome space
Christiansen (2011)	UK	Student experiences of digital stories in learning	20 student nurses	Iterative process explained with reference to other studies	4 categories hierarchically structured in an outcome space
Phil et al (2011)	Sweden	Conceptions of physical limitations of heart failure pts	15 patients	Dahlgren and Fallsberg (1991) 7 stage analysis	4 referential aspects 3 structural aspects
Weimand et al (2012)	Sweden and Norway	Life sharing experiences of relatives	18 family members	Dahlgren and Fallsberg (1991) 7 stage analysis	1 main category summarising 2 descriptive categories each containing 2 conceptions
Borup (2015)	Sweden	Perceptions of 'Mothers Groups'	16 mothers	4 steps described with reference to other phenomenographic studies	3 descriptive categories each equal to each other, each containing 3 sub-categories
Josse- Ekund et al (2014)	Sweden and Norway	Perceptions of influencers on patient advocacy	18 registered nurses	Dahlgren and Fallsberg (1991) 7 stage analysis	3 hierarchically related descriptive categories containing 8 perceptions presented in an outcome space
Steffnak et al (2014)	Norway and Sweden	Perceptions of psycho-tropic drug use in adolescents	20 registered nurses	Alexandersson (1994) 4 step analysis	3 horizontally ordered descriptive categories containing 8 conceptions in an action chain
Andersson et al (2015)	Sweden	Conceptions of caring	21 registered nurses	4 step analysis based on Marton and Booth (1997)	4 descriptive categories hierarchically

					related in an outcome space
Forster (2015)	UK	Experiences of information literacy	41 registered nurses	7 step analysis based on Akerlind (2005)	7 categories of description with 7 dimensions of variation, each category is expressed as a 'persona'
Dupin et al (2015)	France and Sweden	Conceptions of research education	10 registered nurses	7 stage analysis inspired by Dahlgren and Fallsberg (1991) and Olsson et al (2012)	One main category with 3 descriptive categories each containing 2 conceptions
Skar and Soderberg (2015)	Sweden	Perceptions of the concept of health	233 student nurses	4 stage analysis described	3 descriptive categories including 8 conceptions

Appendix 3: Clinical scenario used in interviews for data generation**Written Scenario**

Darren is currently under the care of a Community Mental Health Team following a formal hospital admission, necessitated by Darren attempting to take his own life in response to voices he was hearing. He has been feeling pretty well recently and is spending time doing voluntary work in preparation for returning to employment. He lives on his own, but has regular contact with his elderly mother for who he provides support.

Although prescribed Respiradone, Darren has expressed a distrust of medication and is not currently taking it as prescribed. He is continuing to attend appointments, and as the community nurse you are meeting with him today.

In relation to the above scenario, please consider the following questions:

What do you see as the main issues regarding Darren's current situation?

What interventions would you consider appropriate at this time?

What might the main issues be for Darren over the next few weeks?

Appendix 4: Interview schedule

1. Introductions

Welcome

Explanation of process, freedom to withdraw or stop interview

Clarify consent, understanding of information, issues of confidentiality

Check any further questions

2. General experiences of learning on the programme within the university

Discuss modules, sessions, assignments. Any particular high points, problems

Example question: generally what are your experiences of the programme to date?

3. Learning about Recovery

Within modules, sessions etc. Explore student recognition of recovery within the programme.

Example question: can you remember a session at university that has explored the idea of recovery?

4. What is Recovery?

Encourage student description, explanation, any change of understanding.

Example question: If you were describing what recovery is to someone who has never come across it before, what would you say?

5. Any difficulties in learning about recovery

Explore getting to grips with the concept, any struggles to understand, what was helpful in overcoming this.

Example question: has there been a time when you felt stuck with the idea of recovery, as if you were struggling to understand what it meant?

6. Impact of learning about Recovery

Explore how recovery has integrated with other concepts in nursing. Any change in practice or thinking.

Example question: Since learning about recovery, has this affected how you understand other ideas in nursing?

7. Any additional student comments

Invite further comment.

Example question: is there anything that perhaps we haven't talked about that you think is important in relation to recovery?

Appendix 5: Extracts from Reflexive Diary

8-10-14

Have not got a clue what I am doing! feel lost, over-whelmed & like taken on something way above my capabilities or interest

Sitting reading appin today - stuff I can barely remember reading before, just not stepping forward at all. Need to sort out ethics, annual profession.

But most of all really want to sort out theoretical framework & methodology - its driving me mad.

Do I need to go back to question?

Have I got too many questions - check this out tomorrow

9-10-14

Questions seem ok - checked against phenomenographic approach & seem to fit.

Timmermans chapter in new book was good - made sense of TC as developmental so grasping the TC is not in this sense a paradigm shift but a developed transition. Explained TC characteristics within developmental theory. I understood it! It made sense!

interest in TC's!

Are my questions 2 different research studies ???

10-2-15

Reading about phenomenography.
Getting good idea of the process -
even feel a bit excited at
doing it !!

~~Different~~ So opening to adopt
a phenomenographic style to
1/2

- student lived experience
- focus on student understanding
- bracketing - this won't be
easy

So where does TC fit with
this?

Phenomenographic style still good
with TC framework - might
need to begin analysis to see
if still opening to use

- do I need TC framework ??
- does liminality provide the relationship ???

10.5.16

OK need to feel more organised

Todo

- Save final transcripts to stick
- ~~save~~ make notes
- make notes re each transcript
 - overall feeling
- select five which feel different to begin analysis - start result
- need to know more on discommen get martin & Booth book. Coach Lane has it.

* Question for supervision

phenomenography - variation across groups

T.C. (liminality) - variation at individual level

? Can I explore both in same piece of work.

- Kabo & Baillie have a book which includes liminality but they call it something different. Might buy.
- Still struggling with dimensions of variation - I don't understand. Need to go back to Martin

22.5.16

Is there something structurally about

- service led
- professionally led
- collaboratively led
- person led

maybe! but perhaps not what
I'm looking for at the minute

25.5.16

Go back to the data!!!

Recovery is through stages

Recovery / Relapse cycle

Recovery through Treatment

getting back to self

fulfilled life

Doing normal jobs

Moving on

learning to live differently

Unique to person

this is an
across all =

Recovery by professionals

Dealing with Symptoms

Change / Progress

different staff approaches

Recovery Person led

Service Recovery

different in different services

Living well

Emotional Investment

linked to diagnosis

Personal Belief ^{of} ~~of~~ ^{about} ~~of~~ person
Engagement

Recovery through Collaboration
values a belief of nurse

23 different areas - I only have
13 participants!!!!

20-6-16

thinking about liminality - how does
the concept come into view?

my participants all had some
kind of understanding of the

concept - by knowledge, previous
work - does this cause an

epistemological barrier in the

language used & prior experience?

links to blue book p 28-29

- patterns of pre-liminal variation -

I might have some data on this

From Spensson

- refine categories

- do outline space - may not
need to be hierarchical - check
David Kember, conceptions of
teaching

- think about other theory to
explain / explore categories - move
on to liminality

- then tackle troublesome

23/11/16

So I think I'm ready to go back to the data I have a clearer idea in my head of the analytical framework - as I write more doubts !!!

so thinking it through - there is the framework by Osherson & Faulstich to describe the process of analysis - then there is structure of Osherson framework to guide & frame the analysis - does this make sense? ? ?

steps taken - D of F

what is analysed in this steps - ^{Answers} ~~Mark~~

I don't believe it!! The internal horizon is the same as dimensions of variation !!!

This what I have struggled with all week!

so now what I need is dimensions of variation (internal horizon) & External horizon (how recovery relates to nursing & organisational context)

so look again at D of V then

13-1-17 (Friday 13th!)

Lordy how long does this take?? 2 weeks of RST & only 258 words written 😞

I'm worried I'm trying to do too many things - identify CoD's
 - link to liminal spectrum
 - identify obstacles

Is this too big?? → supervision

Also thinking about where I say the threshold is - how do I know I'm right?? → thinking about putting that part of analysis to 'panel of experts' - see what they think -

~~ask in~~
~~supervision~~
~~?~~
~~?~~

ask in
 supervision

13/11/17

Above necessary - my own liminal space - need time to process information & organise thinking on stuff

the doctor but is this right?

- Another point

what actually goes into the literature review??

- recovery
- ? nature of student learning?
- ? T.C. is literature?

Another point

what's the difference between
social constructionism 7
+
social constructionism 0

'after ha'.

read a couple of chapters of wellington book - I feel a bit calmer. The message seems to be you can have variation in presentation, content etc but I definitely feel I need to talk to ~~myself~~

Plan - finish drafting troublesome section.

13-9-17

Wrote positionality statement today -
Interesting!

It's been in my head for a long time,
maybe from beginning, but made me
think during process of writing ~~up~~
about the spider diagrams
- like reflection on reflection!

I'm thinking now why do I want
to know how students understand
recovery? Why this topic, why this way
Should revisit:

- personal interest - definitely in recovery
- because I think my view of recovery
is right & too many people in
practice have it wrong?? maybe?
- Personal gain - a PhD - yeah gotta
be honest about that. My efforts
are not altruistic
- Students are an easy population
for me to work with?
true but I'm interested in
them too
- I want to make improvements to
teaching so we improve
learning - yes. I hate \$ coming out
of class thinking that was a
waste of time!!

13-11-17 ✱ Now - wrong place

Thinking about - me as a nurse

- me as a lecturer
- me as a researcher

It seems to me that me as a nurse has been particularly evident / influential in my interpretation of data & construction of the outcome space. Nursing knowledge has been necessary to understand the meaning of what is said. How to interpret has been heavily influenced by my own experiences as both a student nurse (although a long time ago) & a nurse.

Me as a lecturer - its easy to take a 'holier than though' position on things. I ~~can~~ feel myself getting 'mad' at the students stories about poor practice, even at the analysis stage. I had to keep saying to myself - ~~that~~ "its not your story"

I'm very used to taking a critical stand against poor practice - I do it all the time in class, need to stop self doing this as researcher
go to next bit

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