An exploration of student nurses' experiences and development in non-judgementality, through the analysis of the learning of sexuality in preparatory adult nurse education.

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Degree of Doctor of Philosophy

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Abstract

An exploration of student nurses' experiences and development in non-judgementality, through the analysis of the learning of sexuality in preparatory adult nurse education

Background

This research explores student nurses' understanding of non-judgementality, their experiences and their ability to be non-judgemental and tolerant of the diversity in sexuality and nursing.

The researcher wanted to know how teachers can develop nurses who meet the Nursing and Midwifery Council's (NMC) expectations of non-judgementality in relation to sexuality (NMC, 2015, updated 2018). The study was conducted after the introduction of a module on sexuality for a cohort of second-year nursing undergraduates at a higher education institution in England. The two-week module on sexuality and nursing was developed and implemented for an undergraduate year. It comprised two taught days of theory and discussion, online reading and multiple-choice assessment. Its aim was to increase awareness in nursing students of the importance of patients' sexuality to their emotional and physical health and to encourage discussion on any anxieties surrounding the subject area. In this study, student nurse participants were asked to join an online discussion group during the teaching, and then, whilst in clinical placement, to complete a digital diary.

Methodology

A pluralistic methodology was used that incorporated narrative and psychodynamic theories.

Data collection

In 2016/17, 27 students were recruited to participate in the study. A range of methods were used to collect data: online discussion groups, digital diaries

and face-to-face interviews. Three groups participated in online discussions: Group 2 had two participants and Group 3 five, whilst Group 5 had no participants. As a result, only two groups of data were obtained. Eight digital diaries were completed and three interviews conducted.

Data analysis

Data were analysed using the narrative theories of Labov and Braun and Clarke and the psychodynamic theory of Michael Balint.

Findings

This research reveals the experiences of student nurses in becoming non-judgemental when caring for patients and their sexuality. I will describe several factors that constrain and enable this journey:

1. Student nurses' own backgrounds, which are diverse, shape how they meet/deal with the challenge.
2. Student nurses observe/witness judgemental practices towards sexuality in their mentors and other nurses that challenge their own, developing non-judgementality.
3. These experiences raise emotional challenges for the student nurse and their development towards non-judgementality.

Chapter 1 Introduction

Overview of chapter

In this chapter I situate the research problem in context and give an overview of the thesis. I construct an argument as to why the research is needed and how it will add to knowledge. I conclude with the research aim and objectives.

The research problem

This study explores the professional expectations of the Nursing and Midwifery Council (NMC) for nurses surrounding non-judgementality. Nurses are expected to treat all patients equally and be non-judgemental, but there is no guidance on how this is achieved within nurse education. This study explores this expectation, and I have chosen to situate non-judgementality against the background of sexuality. Sexuality was chosen because of my expertise, and experiences as a teacher. I had found nurses sometimes struggled with complicated issues within sexuality, particularly HIV and abortion, which often revealed judgemental attitudes.

This study examines a new curriculum for the year-two undergraduate nursing programme addressing sexuality. Following this intervention, this study explored the impact of this curriculum on the student nurses in the practice area through online discussion groups, digital diaries and interviews. The new curriculum was implemented because of my experiences of nurses struggling with sexuality, and this research is not an evaluation of the curriculum change but is a more in-depth exploration than the teaching would allow of non-judgementality in relation to sexuality.

In this chapter I situate the research problem through the lens of non-judgementality, sexuality, the researcher's situation and the values that shape these.

Non-judgementality

The NMC does not provide guidance on how nursing institutions should ensure that undergraduate nurses meet the standard of practising non-judgementalism or how a non-judgementality may be addressed and developed within the nursing curriculum. O'Callaghan's research illustrates the influence of the teacher's professional attitudes on students, and this is often referred to as the hidden curriculum (O'Callaghan, 2013; Chang & Daly, 2012). Nurses learn through the curriculum and through one-to-one contact with registered nurse mentors in the clinical area: this is the formal curriculum. The hidden curriculum is the area of teaching and learning that is not overtly seen in the formal curriculum. It is the lessons that nurses learn subconsciously from the behaviour and attitudes of peers, teachers and professional role models about norms, values and beliefs. These comprise the professional cultural messages communicated to nurses about what is expected, tolerated or forbidden in clinical practice (Duncan, 2010). As a researcher, I could have focused solely on the hidden curriculum. However, I chose to look at how nurses navigate the clinical environment following teaching, so that I could understand how the curriculum shapes student nurses' experiences of non-judgementality.

A qualified nurse or midwife working in the United Kingdom must adhere to the NMC standards for professional practice (NMC, 2015), which set out the expectations for the behaviour and practice of professional nurses. The NMC's current guidelines say that nurses should put the needs of patients first. They also say that nurses should:

> make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged. (NMC, 2015: 4)

The NMC standards for pre-registration nurse education endorse the NMC's Code for registered nurses by stating that:

> all nurses must practise in a holistic, non-judgemental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care. (NMC, 2010: 13)

The current NMC standards for pre-registered nurse education stipulate that the learning culture should be:

> fair, impartial, transparent, fosters good relations between individuals and diverse groups, and is compliant with equalities and human rights legislation. (NMC, 2018b: 6)

To meet equality and human rights legislation, and address inequalities, nursing needs to consider how we teach this area formally. As previously mentioned, there is no guidance on how this area should be addressed.

I have interpreted the NMC's statement as advocating that nurses be non-judgemental in their attitudes to patients and colleagues. It also implies that nurses must put aside their personal attitudes and act according to the definition of a nurse's professional manner described above.

The NMC asks that nurses be non-judgemental; this is the ability to not judge or criticise others (Cambridge International Dictionary of English, 1995). How nurses become non-judgemental, and how this is achieved or assessed, is poorly defined by the NMC. This research endeavours to gain insight into student nurses' experiences of non-judgementality. I wished to explore how student nurses develop and speak about non-judgementality. This research problematises non-judgementality, asking what this means in a profession in a multicultural society.

Multiculturalism describes a society where individuals from different cultures live together. Within nursing and education we have student nurses, qualified nurses, healthcare support workers, teachers and patients from a variety of cultural backgrounds. This research was undertaken in a university that is multicultural, but teaching has taught me that we may not all hold the same values. Traynor argued that:

> Multiculturalism encourages people to value diversity but this can sometimes mask an expectation that everyone must conform to liberal tolerant values, in public, at least. (Traynor in Allan et al., 2016: 55)

In society we are encouraged to not be homophobic. If for religious reasons nurses believe homosexuality (or abortion or other practices) to be sinful, how do they manage these conflicts? If they act unprofessionally, they are likely to disciplined, and this awareness can be understood as putting pressure on individuals to conform to particular liberal values. However, the public face of multiculturalism does not mean that individuals value diversity privately.

Sexuality

This research is influenced by my prior professional knowledge and clinical experience of 30 years' work in sexual health. I had contact with patients/clients who had received care within other clinical areas that had not recognised their sexual needs and/or discriminated against them on the basis of their sexuality. This highlighted the existence of judgemental attitudes surrounding HIV and abortion on the part of professionals, and I wanted to understand and explore such judgemental and non-judgemental attitudes towards sexual health issues. I wanted to know why some nurses hold judgemental attitudes and others more non-judgemental attitudes and how this might affect practice. As a specialist in this area, I am saddened by the lack of teaching on sexuality and the judgemental attitudes I witness in practice and among students within in the curriculum, so addressing this area was

important to me. I felt that by exploring this area I could improve the curriculum to enhance student nurses' understanding and knowledge of sexuality, helping to reduce discrimination in this area.

Wellings, Mitchell and Collumbien argued that 'sexuality is a result of the interplay of biological, psychological and socioeconomic, cultural, ethical and religious/spiritual factors' (2012: 3). Our sexuality defines who we are as individuals, whether as a patient or as a nurse. I argue that sexuality, which comprises sex, gender, sexual identity, orientation, eroticism, attachment and reproduction, is the core component of an individual's being. Heath and White (2002) defined gender as physical appearance and biological differences, but also prescribed roles and behaviour. Sexuality is how individuals express themselves, and it incorporates their attitudes and beliefs, relationships and practices (Heath & White, 2002; Wellings et al., 2012).

When discussing sexuality, the term 'sexual health' is often referred to, and this can have multiple meanings. In this research, I follow the World Health Organization definition of sexual health as:

> a state of physical, emotional and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well the possibility of pleasurable and safe sexual experiences, free of coercion, discrimination or violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2006)

Theoretical orientation

My research has been influenced by three theoretical frameworks: psychodynamic theory, social constructionism and Bourdieu's notion of social capital (Crotty, 1998; Jacobs, 1988; Bourdieu, 1972). I have applied psychodynamic theory to nursing as it recognises the emotional reactions of nurses to the complexities of sexuality that they met, how nurses developed

to cope with these, and what factors enabled or constrained their ability to be non-judgemental and tolerant of diversity in sexuality. I have been influenced by social constructionism because it recognises cultural and societal influences in nursing work. My identity, like the participants', has been influenced by my cultural background. As a White female from a Scottish Presbyterian background, I am aware that these influences have afforded me education and life experiences that others may not have equal access to.

My research has also been influenced by the philosopher Bourdieu, who argued that 'cultural capital contributes to the accumulation and exercise of power and the maintenance of inequality' (Shim, 2010: 2). Bourdieu's work shows us that education and class can reproduce inequality (Bourdieu, 1972; Sullivan, 2002; Shim, 2010). He argued that people with access to education have cultural skills that affect the care that they receive. Through education, they can interpret illness and interact with healthcare professionals differently, affecting the healthcare that they receive, in contrast to people with no access to education (Bourdieu, 1972). He believed that sexual identity is controlled by inequality through work and culture, and that these, along with habitus, social experience and education, shape our clinical encounters both as clinicians and as patients (Bourdieu, 1972). Bourdieu's influence focused my interest on cultural diversity. The diverse backgrounds of student nurses have shaped their experiences of non-judgementality and sexuality. Whilst cultural habitus shape our experiences and attitudes, the socialisation in nursing undergraduate programmes may be equally influential in shaping non-judgementality.

Values

As sexuality is a core component of an individual, and key to the care nurses give, how sexuality is addressed in the nursing curriculum has relevance for the development of non-judgementality. This research focuses on the

sensitive area of sexuality, which is full of stigma and judgements, to gain insight into how the curriculum meets the NMC's requirement of non-judgementality. Bourdieu's work shows us that inequalities in sexual identity are shaped by culture and work, emphasising the importance of addressing sexuality in the undergraduate curriculum to increase awareness and reduce discrimination (Bourdieu, 1972). Many health professionals argue that nurses do not recognise sexualities in patients or the impact of illness on sexual health (Hayter et al., 2012; Owen et al., 2011). Hayter, Haigh and Jackson argued that,

> for many clinicians and student nurses, sexual health and sexuality is filed away as a specialist area of healthcare that does not impinge upon their client group. (Hayter, Haigh & Jackson, 2013: 3238)

A good example is the research by Doherty, Byrne, Murphy and McGee (2011), which shows that patients who suffer from coronary heart disease are likely to be depressed and anxious about its impact on their sex lives, as they may fear that sexual intercourse will increase the risk of a myocardial infarction and death. Doherty et al.'s (2011) research shows that nurses do not ask cardiac patients about their sex lives or educate them about resuming intercourse because they lacked confidence, knowledge and training. If nurses do not address patients' sexualities, then they fail to give holistic care and, as illness may impact on sexual lives, this may be affected if patients or their partners become ill or die, resulting in the loss of a sexual life with that person. Sexual intercourse helps to ensure that individuals remain fit and healthy (Davey Smith et al., 1997; Frappier et al., 2013).

In addition, Owen et al.'s (2011) research argues that healthcare can be heteronormative and describes:

> some health and social care personnel as being uncomfortable around people who exemplify diversity in the sexuality. (Hayter, Haigh & Jackson, 2013: 3238)

Non-heterosexual patients' care can therefore be disadvantaged (Somerville, 2015). The concept that sexual intercourse and sexual lives are important to individuals is a difficult area for many individuals to acknowledge because of their personal, religious and social constructs, which are implicit in society and our lives. Health professionals are no exception. Patients whose illnesses affect their ability to have sexual intercourse may choose to refuse treatment if they have been fully informed of the effects of medication or surgical intervention on their sexual lives, and health professionals may find this decision-making difficult to comprehend. By medicalising the care given to patients, the focus is on the illness and its treatment; the patient's sexuality is not their focus and becomes invisible to the nurse, whose role ensures that they are directed towards the illness/surgery/treatment. This research explores student nurses' experiences following the teaching of sexuality in the curriculum; it is not an evaluation of the teaching but an exploration of students' experiences of the complexity of sexuality and their own personal constructs of sexuality.

Values are the beliefs that guide individuals to make judgements in life, whilst attitudes are the way in which we respond to something or someone that can produce appropriate or inappropriate behaviour (French et al., 2015). Whilst attitudes do not necessarily predict behaviour, they can have consequences on behaviour, so as a researcher I was interested in exploring nurses' experiences of the nursing care behaviours and attitudes that they met through the learning of sexuality and contact with patients and healthcare professionals (Myers, 1999).

Research by Chang and Daly shows that a well-developed professional identity contributes to enhanced healthcare and reduced attrition (Hunter & Cook, 2018; Johnson et al., 2012; Chang & Daly, 2012). This highlights the importance of mentor role models in the development of the professional nursing identity in undergraduate nurses. Student nurses may encounter judgemental

mentors, healthcare professionals and patients. How they grapple with these experiences in their development was an important component of this research. Hunter and Cook's research argues that,

> despite encountering a range of professional behaviours, attitudes and dilemmas, new graduates were capable of moral agency and critical thinking. However, they rapidly acculturated and described compromises to cope. (Hunter & Cook, 2018: 3157)

This may also mean that, although student nurses become acculturated and do not raise issues around professional practice, once they have left the area they will reflect, recognise and raise these issues. Groothuizen, Callwood and Allan's (2019) longitudinal research over three years shows that student nurses and midwifery students gained in confidence, courage and accountability over that period. This highlighted the difficulty that students express about raising issues in clinical practice. Hunter and Cook (2018) believed that this dissonance between expectations and the experience of clinical practice needed to be understood to improve healthcare delivery.

Cultural beliefs are thought to shape, constrain and influence our values and attitudes. My definition of culture is the ideas, customs and social characteristics of a group of people, which include their religion, language, cuisine, music and arts (Seale, 2018). Hook argued that we need to understand our cultural background and the way this 'influences our personal attitudes and beliefs' to become culturally humble in one's professional actions (Hook et al., 2013: 1). Humility, he argued, has two characteristics: the intrapersonal level, which is where we have an accurate view of ourselves; and the interpersonal level, where we are focused on others rather than self-focused (Hook et al., 2013). Hook et al. argued that:

> there are several different aspects of one's cultural background that may be important to a person, including (but not limited to) race, ethnicity, nationality, gender, age, sexual orientation,

> religion, disability, socioeconomic status and size. Some things may be more central or important to one's identity as a person, whereas other things may be less central or important. (Hook et al., 2013: 5)

Student nurses enter nursing from various cultural backgrounds, which will have different socioeconomic, religious, sexual and educational norms. These will have moulded the student nurses into the person who they are when they enter training (NMC, 2016a, b, c; Pedersen & Obling, 2019). Nurses, therefore, have many aspects to their cultural background that impact on their beliefs, attitudes and experiences. These influence them both personally and professionally.

Historically, the public and professional view of nursing has been one of virtue and humility (Dolan, 1997). Parallel to this outlook have been the opposing judgements held by individuals, other nurses and health professionals. An example can be seen in the *Stonewall Report on Unhealthy Attitudes*, which highlights the homophobia experienced by nurses from colleagues (Somerville, 2015). This complex relationship can make it difficult for nurses to express their attitudes and beliefs about diversity that fall outside this idealised view of nursing – or even for them to be heard. Kenneth Worthy (2008) described this as phenomenal dissociation, where there is a lack of engagement with the consequences of our actions that leads to uninformed behaviour. He argued that, whilst we must be aware of attitudinal variations, we need to see the pervasive and destructive nature of phenomenal dissociations on life (Worthy, 2008).

The *Francis Report* highlighted a lack of professionalism by nurses (Francis, 2013; Health Foundation, 2016) and may be an example of unintended behaviour and phenomenal dissociation. To ensure that nursing addressed the causes of the Stafford Inquiry, the Health Foundation argued that higher education institutions (HEIs) need to focus on how the nursing curriculum

addressed the teaching and learning of professional attitudes and non-judgementality (Francis, 2013; Health Foundation, 2016). The revalidation process of registered nurses is in its initial stages; however, an attitudinal change to the professional code has been reported, with nurses showing a greater understanding of its requirements (Ipsos Mori Social Research Institute, 2017). As a result, it is possible that nurses in the future could have a greater understanding of the professional face of nursing.

The NMC expects a nurse's professional behaviour to be non-judgemental; this implies that judgemental attitudes have a negative impact on clinical practice (Santry, 2010). However, Leon Festinger believed that the attitudes expressed by individuals do not necessarily predict behaviour, as we sometimes say the things that we think other people want to hear (Myers, 1999). This can be seen in research on social desirability bias, in which participants have given the answers that they think are socially acceptable (Bryman, 2012). To address this within the research, digital diaries and interviews were recorded to gain insight into how students formed and reformed attitudes through contact with practice, how they negotiated the non-judgemental practice they witnessed and what emotions surfaced in their stories of non-judgementality in practice. Balint's psychodynamic theory has been used as a method of analysis in this research, as it recognises the emotions within the narratives and the emotional work of nursing. Balint's practice, based on this theory, uses the emotions of a clinical encounter to encourage practitioners to reflect on them and use them to move forward with the management of the patient (Wells, 2000; Allan, 2009).

The emotions and attitudes of student nurses and their teachers are part of the hidden curriculum. This hidden curriculum influences student nurses' attitudes and how they practise, positively and negatively. O'Callaghan (2013)

showed the influence of the hidden curriculum in her work with junior doctors on behaviour and attitudes:

> it is not only explicit teaching but also the behaviours and attitudes of teachers that are noted by students, with subliminal messages having the capacity to powerfully influence student behaviour. (O'Callaghan, 2013: 309)

If the hidden area of behaviours and attitudes is not addressed within the teaching of health professionals, this could directly affect how patients are treated and cared for, which is why the NMC has integrated these values into the standards of practice. The Health Foundation argues that nurse teachers need to address nurses' attitudes to improve clinical practice by rewriting the nursing curriculum; however, more importantly, 'the real challenge is to reshape informal teaching transmitted continuously by deed and word of mouth' (Health Foundation, 2016: 15).

Therefore, this research does not focus solely on the hidden curriculum but endeavours to learn about non-judgementality through analysis and exploration of students' experiences and development. One way in which the nursing curriculum may be rewritten is to consider the concept of recontextualisation (Guile & Evans, 2010). This concept suggests that knowledge is dependent on the context, meaning that nurses do not easily access knowledge that is not causally related to the area that they are working in. The concept of recontextualisation and its effects are discussed further in Chapter 2. This is an important concept for active learning and development of non-judgementality, highlighting a need to rethink how we teach multiple learning spaces in nursing education (Evans et al., 2010).

Background to the study

There is no guidance on what non-judgementality means or how it is measured or implemented (NMC, 2015). This research aims to explore nurses'

experiences of non-judgementality and how they navigate them. This research evolved from a change in the undergraduate nursing curriculum intended to raise awareness on the importance of sexuality in delivering holistic nursing care. Once approval had been agreed, the curriculum was developed to teach students about sexuality throughout year two of the undergraduate nursing degree. This had never been addressed before. For a period of two weeks, nurses were given two full days with a lecturer and me, with online resources to be accessed between the two weeks. Prior to commencing, students were asked to read the *Stonewall Report on Unhealthy Attitudes* (Somerville, 2015) and a 'nursing and sexuality resource' on reproductive anatomy and physiology that was designed by me. The *Stonewall Report* looks at the attitudes experienced by health professionals and patients who are lesbian, gay, bisexual or transgender. The days were interactive, encouraging students to ask questions and discuss elements. The first day of teaching covered sexuality, stereotypes, homosexuality, bisexuality, lesbianism and transgender issues. It also addressed abortion and sexually transmitted infections (STIs), including HIV, and how sexuality is affected by illness and age. Following the first day, students were asked to watch and listen to patients' voices on HIV (https://www.avert.org/living-with-hiv/stories), abortion (Cochrane, 2006) and female genital mutilation (FGM). The second day covered FGM, its mandatory reporting and the reasons for and effects of this practice. Teaching involved groupwork, with scenarios relating to clinical practice to encourage discussion and help student nurses to relate sexuality to clinical practice.

The opportunity to reflect was offered as a way to introduce a psychodynamic approach to the learning and understanding of sexuality. This acknowledges that sexuality raises difficult, deeply personal, and possibly unexpected feelings in individuals. Reflection offers a way to think about and discuss these issues and give help to students if these are upsetting. Psychodynamic theory and reflection encourages:

> a consideration of the unconscious potentially enriches and deepens understanding through acknowledging the complexities, dynamics, and fragmentations of human subjects. (Holmes, 2013: 161)

By using examples from various contexts related to sexuality throughout the teaching, student nurses were supported and encouraged to reflect on how knowledge was culturally and socially constructed. Student nurses would recontextualise this knowledge across university teaching and practice setting, addressing the concept of recontextualisation (Guile & Evans, 2010). By doing this, I hoped that students would consider sexuality when they were not in a sexual health environment and, as a result, consider their patients holistically.

This study explores student nurses' experiences of non-judgementality through an analysis of the learning of sexuality within preparatory adult nurse education. My approach, positioning as a lecturer, and values have formed a foundation for the teaching intervention. The research process may well be influenced by these same values, as illustrated by O'Callaghan (2013).

Research aim

> Explore the ways in which the student nurses experience non-judgementality through an analysis of the teaching and learning of sexuality within preparatory adult nurse education.

Research objectives

- To explore student nurses' learning and development of non-judgementality, using sexuality as an exemplar.
- To investigate the factors that enable or constrain student nurses' ability to be non-judgemental and tolerant of diversity in sexuality and nursing.

- To explore how nurse education might facilitate the development of non-judgemental practice by nurses to achieve the NMC standards at the point of entry to the Register.

Contribution to knowledge

This research gives nursing and higher education an understanding of what it is like to be a student nurse in the clinical area. While it is not an evaluation of a curriculum innovation, it nevertheless shows the importance of teaching in raising awareness and modelling positive attitudes.

In this study I show, through a detailed analysis, how student nurses learn to be non-judgemental partly through their experiences of encountering judgemental attitudes in the clinical area. I also generate an understanding of the emotions student nurses experience as a result of the complex sexual health issues raised in the clinical area, and how they manage and learn from these.

Overview of thesis

Chapter 2 sets out the current state of knowledge about attitudes; it is divided into three sections: how sexuality is addressed in the nursing curriculum; nurses' recognition of sexuality in clinical practice; and nurses' attitudes to sexuality.

Chapter 3 discusses the methodological foundations of the thesis, starting out with a description of methodological pluralism along with the debates about the strengths and limitations of this approach. The chapter describes the narrative and psychodynamic theories chosen.

Chapter 4 discusses the methods of the research, including the setting, ethics, recruitment, research design, data collected and analysis.

Chapter 5 presents the findings from the online discussion.

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Chapter 6 presents the findings from the digital diaries and the interviews.

Chapter 7 discusses the findings and the complex nature of the sexual health issues student nurses face in the clinical area and how they navigate these on their journey to non-judgementality.

Chapter 8 presents conclusions and Chapter 9 presents recommendations for practice and research.

Chapter 2 Background and Literature Review

Introduction

This study is an exploration of student nurses' experiences and development in non-judgementality, through the analysis of learning of sexuality. My interest and clinical experience in sexuality revealed nurses' lack of sexual health knowledge and the misdiagnosis of patients. This knowledge helped focus the direction of this research. This combined with my access to a student population and the opportunity to add sexuality into the nursing curriculum. The research question was formulated through discussion and a literature search was conducted initially on sexuality and attitudes. The review set out to answer the question: what are nurse's attitudes and training about sexual health?

The review was an organic process that developed over time (September 2014 to January 2021), and questioning and discussions with colleagues and supervisors have encouraged me to explore and review several avenues. My engagement with literature took two forms. First, I explored theoretical literature that considers aspects of sexuality and society, notably the work of Michel Foucault. Second, I searched for and reviewed recent, mainly empirical, work on issues of sexuality in nursing and medical work. Wolcott argued that a literature review should draw 'selectively and appropriately as needed in the telling of the story' (Wolcott, cited by Silverman, 2017: 467). Silverman argued that the development of the literature review is a process that should involve questioning, critique and discussion (Silverman, 2017).

This chapter reviews theoretical and empirical papers on the topic relevant to my research questions, as well as background literature in the field that is relevant to the PhD (Coughlan, Cronin & Ryan, 2013). These background studies provide historical background to nurses' attitudes and nurse training

in sexual health, along with an overview of the context and the expectations of nurses in sexual health.

The literature search identified 29 studies, of which seven were discussion papers or systematic reviews; relevant discussion papers were incorporated into the review. This literature review reveals an increasing interest in sexual health and training, but also highlights a lack of training and understanding of sexuality, which has resulted in discrimination. The literature shows the importance of addressing this subject within the nursing curriculum in the development of professionalism in student nurses.

Throughout this PhD, the literature continued to be reviewed for relevancy to the research question. My supervisors and colleagues alerted me to articles that might be of interest. I continued throughout this research to review and update my literature search. This literature review was an iterative process of repeatedly checking and reviewing for new research but also organic, growing in different directions.

Chapter structure

This chapter focuses initially on the theoretical and historical background to issues of sexuality to provide a context for the rest of the chapter. I then describe the literature search strategy for recent empirical work, and how the review was conducted. Following this process, the thematic analysis of the findings of the literature search is discussed, which leads to three themes:

- How sexuality is addressed in the nursing curriculum.
- Nurses' recognition of sexuality in clinical practice.
- Nurses' attitudes to sexuality.

Following the thematic analysis, the theoretical framework is discussed. I follow this with a discussion of the theoretical framework which has informed my PhD.

Historical influences on sexuality

There are many influences on sexuality that may have a historical background, affecting our ability as individuals to talk about this area and moulding our attitudes. Sexuality and sexual health moved from the permissive seventeenth century to the secrecy, concealment and shame of the nineteenth century, with its laws determining indecent and obscene sexual acts. Foucault argued that by limiting sexual freedom through these discourses we are upholding repression. He believed that the ability to have sexual freedom through knowledge and speech is politically defined (Foucault, 1976), adding that 'we are conscious of defying established power' (1976: 6) by discussing it. He argued that censorship, which is perceived as the power to control individuals, is not where the power lies; instead, it lies in the discussion on censorship and its regulation. This may mean that both patients and health professionals find this area difficult to discuss, because they believe that they are defying social mores. Perhaps individuals' cultural and social backgrounds socially construct how they interact with hierarchical organisations. An example of this is where an individual's cultural background threatens death or imprisonment if a man is homosexual. As a result, nurses may find homosexuality difficult to address. Marriage was founded on rules and regulations, and 'breaking the rules of marriage or seeking strange pleasures brought an equal condemnation' (Foucault, 1976: 38). Rape, incest and adultery were treated with equal contempt. These societal and cultural influences have moulded the way in which individuals live their lives and how we interact with others, Foucault believed, as a social constructionist. He held that sexuality was historically and

culturally defined, and that it is these factors that have influenced nurses prior to their training and throughout their lives.

Whilst Foucault discussed prominent issues surrounding power within the medical arena, he did so from an empowered position. His position was that of a male social historian and philosopher, not a health professional. His masculine role had an elevated position in comparison to nursing and women. So, when Foucault critiqued the medical establishment, he could not fully understand the role of nursing within medicine or what it is like to be a woman working as a nurse, or a woman's view of sexuality and the social constructs that affect her outlook. Hennessy argued that Foucault neglected the subject of gender, but feminist theorists have been heavily influenced by his approach to discourse (Hennessy, in Evans et al., 2014).

Developing attitudes in professional practice

Attitudes have been of interest since the 1920s, when Louis Thurstone noted that they are 'complex affairs that cannot be defined by a single index' (Gilbert & Stoneman, 2016: 261). Thurstone's research focused on a questionnaire asking agree/disagree questions on attitudes designed to reveal militaristic and pacifistic views (Thurstone, 1928). He found that attitudes differ from behaviour, and this could also relate to nurses who hold negative attitudes towards abortion yet support women through this process in their nursing behaviour. In 1935, Gordon Allport argued that attitudes were developed in childhood and remained stable throughout life (Oates, 1994; Gilbert & Stoneman, 2016). Campbell endorsed this view in his research on political voting in adults. He found that attitudes towards a political party typically do not change, yet behaviour may differ, which may be seen in voting patterns. However, how individuals report their attitudes can depend on the question and their reflection of it. Attitudes can change due to a person's orientation to a subject or the way that they respond to questioning. An example of a change

in attitudes can be seen regarding HIV through the 1980s to the present. Once, HIV was a death sentence, but it is now seen as an STI that, whilst not curable, is treatable.

Ajzen's (1989) theory of planned behaviour addresses how attitudes predict behaviour, in conjunction with subjective norms (Crisp & Turner, 2014). Subjective norms are where we are motivated to conform to the perceived expectations of significant people. Ajzen argued through his theory that neither subjective norms nor attitudes, on their own, determine behaviour and that it is the 'interaction of these factors with perceived control that predicts attitudes' (Crisp & Turner, 2014: 93). The theory shows how nurses may conform to and behave in light of the perceived expectations of professional bodies, such as the NMC.

Many of the earlier theories claimed that attitude formation is a passive function, but in 1960 Katz argued in *The Functional Approach* that attitudes are actively formed on the desire to satisfy psychological needs (Crisp & Turner, 2014). To influence attitude formation there are four psychological needs: utilitarian, knowledge, ego-defensive and value-defensive. The utilitarian function is where attitudes are formed to help us to gain approval from others, and these attitudes help individuals to get along with one another. The knowledge function is where holding certain attitudes helps individuals to organise and make sense of their social worlds. The ego-defensive function is where we protect ourselves from acknowledging threatening self-truths, enabling us to maintain a positive view of ourselves. The value-expressive function is where an attitude is developed that expresses values that are important to individuals (Crisp & Turner, 2014). Through both its training and practice, nursing promotes a utilitarian approach, encouraging a professional attitude to ensure that we all work together towards the same aim.

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In 1964, Festinger coined the term ‘cognitive dissonance’ to describe the inconsistency in an individual’s attitudes and behaviour that causes discomfort and produces a desire to reduce these feelings (French et al., 2015). Cognitive dissonance is the feeling of discomfort that individuals might experience when their behaviour contradicts their existing attitudes. This discomfort will arise only when there is a strong prior opposing attitude, and it motivates us to resolve this predicament. There are three factors that affect cognitive dissonance: justification, choice and investment. Justification is where individuals defend why they behaved against their attitudes. Choice concerns the freedom to select our behaviour, and individuals with no choice argue that they contravened their attitudes out of necessity, and cognitive dissonance does not arise. Finally, investment means that the more that individuals have put into their attitude, the stronger are the effects of cognitive dissonance (Crisp & Turner, 2014; French et al., 2015). An example is where nurses may hold anti-abortion attitudes yet keep within the professional boundaries of their duty of care regarding patients undergoing that procedure. French referred to this as culture shock: this ‘re-evaluation of our own culturally derived values and attitudes may result in some psychological disorientation’ (French et al., 2015: 76). French described that, during culture shock, there is ‘initially elation followed by negative feelings, succeeded in turn by recovery and adjustment’ (French et al., 2015: 76). Individuals may emerge from culture shock stronger; however, for some people the disorientation will be traumatic.

All the theories on attitude change discussed have focused on internal discrepancy. More recently, theorists have been interested in the effects of persuasion on attitudes via external messages, such as adverts and campaigns. The elaboration-likelihood model and heuristic–systematic model are dual-process models of persuasion. They both argue that there are two ways in which a persuasive message can cause attitudinal change: the central (systematic) route; and the peripheral (heuristic) route (Crisp & Turner, 2014).

The central route is where individuals are motivated to think carefully about the messages conveyed, and are influenced by the strength and quality of the arguments. The peripheral route is taken when individuals are unable or unwilling to analyse the message's content. They may focus on its amount or attractiveness, and do not require an understanding of the message and so the behaviour of those taking the peripheral route is less predictive of behaviour (Crisp & Turner, 2014). Individuals who are more reflective are more likely to take the central route, a cognitive process that nurses are encouraged to adopt. However, cognitive overload, time pressure and a lack of relevance to the individual may determine the processing route, with implications for teaching, the time allocated to the subject area and how it is taught. If there is a lack of time and relevance, it may mean that the messages are processed via the peripheral route.

More recent theorists such as Worthy, French and the researcher Traynor have voiced a 'moralistic' view of attitudes (Worthy, 2008; Traynor, 2014; French et al., 2015). Kenneth Worthy's theory on phenomenal dissociation outlines a lack of engagement with the consequences of behaviour (Worthy, 2008). He argued that:

> knowledge of the harmful consequences of one's actions is not enough to inhibit destructive actions, immediate sensual experience of one's consequences and the spheres where those consequences are expressed are crucial ingredients in limiting destructiveness and fostering caring relationships. (Worthy, 2008: 157)

Traynor argued that nursing is seen as 'character-based moral work', encouraging a simplistic explanation of nursing failures based on moral failure (Traynor, 2014: 547). He maintained that it is naïve to expect nurses to hold the values and attitudes that determine adherence to professional practice without being influenced by the work context. Theorists have shown that attitudes neither affect behaviour simply nor are recorded easily. As a result,

this research is not a study of student nurses' attitudes but is research that explores nurses' experiences of non-judgementality, which is an attitude. To capture this attitude, I devised research methods that allowed student nurses to express their experiences of non-judgementality. Using online discussion groups show how nurses present within a group, illustrating the societal pressure to conform or otherwise. Digital diaries and interviews reveal the voice of the nurse and how they felt in the clinical environment. By collecting multiple types of data, I hope to gather data that capture the nurses' experiences.

Summary

Historically, sexuality has been influenced by society and the regulation and censorship of the area. Foucault (1976) argued that the ability to have sexual freedom through knowledge and speech is politically defined. We have seen how society influences attitudes, through regulation in areas such as homosexuality and abortion. It is argued that the review of our own cultural values and attitudes may result in some psychological disorientation (French et al., 2015). Worthy (2008) believed that negative attitudes do not necessarily result in discriminatory behaviour; however, this might make the exploration of attitudes problematic.

Search of contemporary research literature

Search strategy

A citation search was initially carried out to find out the most productive search words to use. These initial words included words for sexual health, genito-urinary medicine, reproductive health, reproductive sexual health, and sexuality. Alternative descriptive words for attitudes were searched for; these included prejudices, attitudes, knowledge, awareness, barriers, perceptions, experience, education and non-judgemental; words for teaching, curriculum and training; and, finally, words for nurses, students, health students and

healthcare. These searches revealed that the most relevant words used in the citations search were sexual health, training and attitudes.

Search terms

The terms sexual health and or training and or attitudes were used to carry out a literature search. Using the Boolean operator 'or' was used to identify all the citations that contained either term, and the Boolean operator 'and' was used to identify all citations that contained all terms.

Data collection and selection

Searches of the databases CINAHL, Medline, Ovid, British Nursing Database (BND) and PsycINFO were conducted in 2015 and repeated in 2018. The limitations of the searches included full texts, and the years 2008 to 2015/2018.

During this time, grey literature was searched for. This is the documents produced by governments, bodies such as the Department of Health, NICE and the NMC, along with unpublished PhDs. The researcher is on the editorial board for the *Journal of Sexual and Reproductive Healthcare* and reviews articles for the *Journal of Clinical Nursing*, which has given her access to relevant material. Searches were also done via Google with the search terms and under the names of authors who had written on the subject area. Articles were also found from relevant articles reference lists; for example, Hinchliff et al. (2018) led to the discovery of Hinchliff, Gott and Galena (2005), whilst Evans's (2013) article led to finding research by Astbury-Ward (2011). I have endeavoured to show citation sources from retrieved papers in the comment column of Table 3.

In 2018, my search of the BND revealed 73 articles on nursing sexual health and attitudes in the last 10 years, the Ovid database revealed 10 articles and

the CINAHL search produced 62 articles for the search terms sexual health, reproductive health, attitudes and students.

In 2020 the search was repeated using CINAHL, Ovid and the BND. Table 2.1 shows these searches. The BND revealed 1648 records, which were reduced to 42 relevant records; the CINAHL search revealed 34 records, which reduced by two for duplication and 26 irrelevant records, leaving six records. An Ovid search produced 233 records, which were reduced to 12 with the limitations of having been published between 2008 and 2020 and having full text records. Figure 2.1: PRISMA Flow chart shows how articles were screened.

Table 2-1 Complete search history

Search ID	**Search terms**	**Databases used and limitations**	**Results**
S1	Sexual health and attitudes AND Training	CINAHL Full texts 2008–2020	34
S3	sexual health AND nurses attitudes	OVID Full texts 2008–2020	233
S4	sexuality AND nurses attitudes AND pd(20080101-20201231)	British Nursing Database Full texts 2008–2020	1648

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S5	Nurses non-judgemental attitudes.mp.	OVID Full texts 2008–2020	0
S6	Non-judgemental attitudes to sexual health.mp	OVID Full texts 2008–2020	0

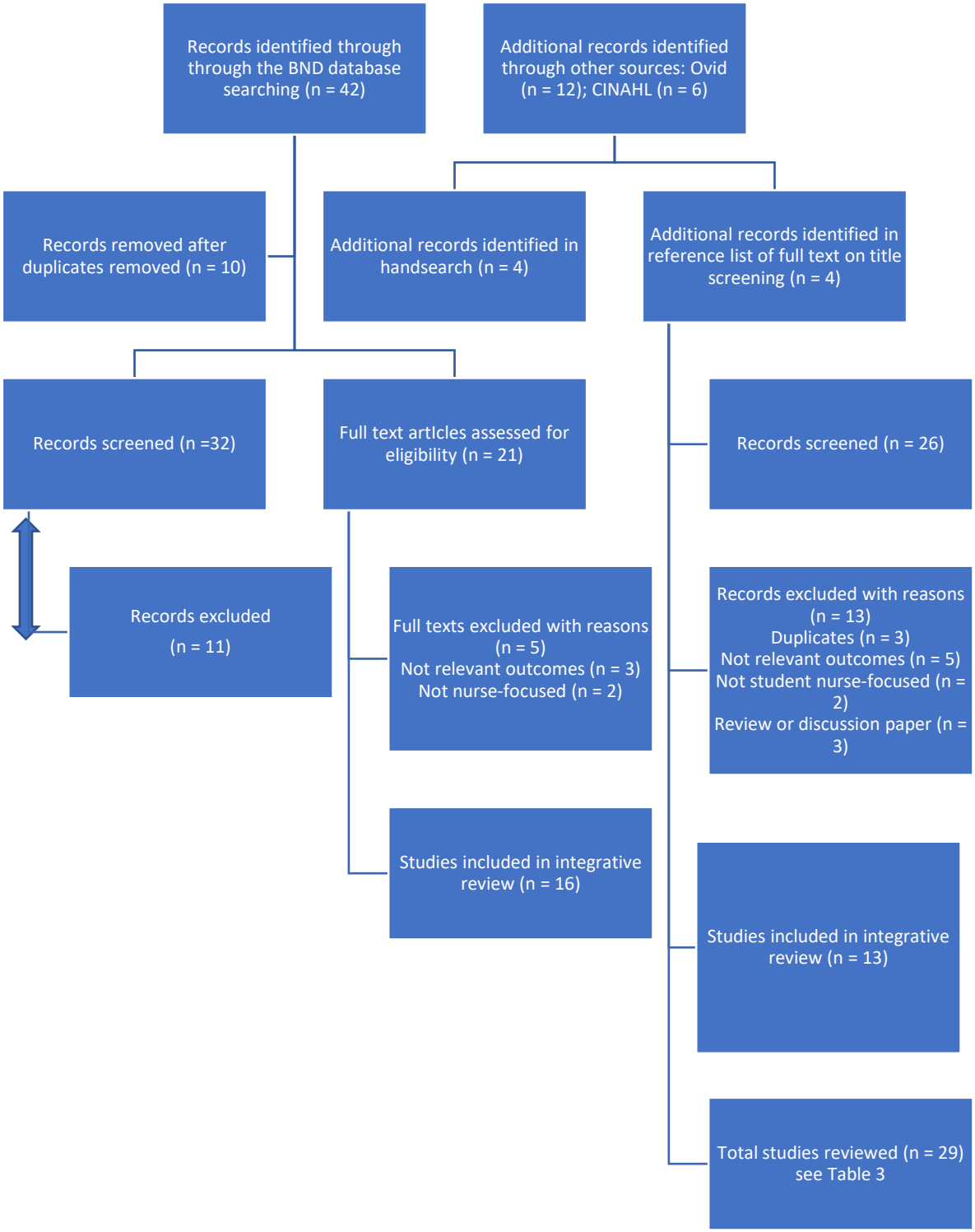

Figure 2-1 PRISMA Flow chart

Inclusion and exclusion criteria

The searches were then reviewed and articles that were not relevant were eliminated. These included articles that were not related to nursing or focused too closely on sexual health clinics; some articles were duplicated in other

searches. Relevant articles were included that focused on other health professionals in training such as medical students.

Table 2-2 Search criteria

Inclusion criteria	**Exclusion criteria**
Published in English	Language other than English
The set time frame was set between 2008 and 2020	Articles published before 2008
Adults, age > 18 years old	Children, age < 18

Table 2.3 gives an overview of the 29 articles included in the literature review. Within these there are seven articles that are discussion or systematic reviews, and four of these articles led me to find relevant research through their references. For example, through the discussion paper by David Evans (2013), I identified his research and the work of Astbury-Ward (2011). Of the 22 articles identified (excluding the seven reviews and discussion papers), two articles led to finding other relevant research.

The articles found are mainly qualitative studies from the USA, the UK, Finland, Sweden, China, Canada and Australia and involve student nurses. They focus largely on research into LGBT issues. Studies found that student nurses and registered nurses have knowledge of LGBT patients but they are unprepared for addressing related issues (Simpson et al., 2018; Richardson et al., 2017; Jomeen & Whitfield, 2010). Some studies such as Korhonen et al. (2012) and Stephens (2015) illustrate the influence of culture, society and religion on attitudes and the importance of addressing these within sexuality. This is discussed further in the critical appraisal section following Table 2.3.

Table 2-3 Overview of studies

Citation/ level of evidence	Purpose	Design, setting, sample measures	Key findings	Comments
1. Nursing students' perceptions of barriers to addressing patient sexuality concerns. (2008). Magnan, M.A., Norris, D.M. *Journal of Nursing Education,* 47 (6): 260–8, AN: 00005111-200806000-00004.	Nursing students' perceptions of barriers to addressing patient sexuality concerns.	Sexuality Attitudes and Beliefs Survey used to assess students (n = 341) enrolled in either a traditional or accelerated second-degree baccalaureate programme.	66.4% of students believe patients do not expect nurses to address the concerns. Findings revealed accelerated second-degree students were more restrictive in their attitudes toward addressing patient sexuality concerns.	Used in literature review. USA study.
2. 'We treat them all the same': the attitudes, knowledge and practices of staff concerning old/er lesbian, gay, bisexual and trans residents in care homes. (2018). Simpson, P., Almack, K., Walthery, P. *Ageing and Society,* 38 (5): 869–99.	The needs of LGBT residents in care homes accommodating older people have been neglected in scholarship.	Survey of 187 service managers and direct care staff.	Employees' attitudes generally indicate a positive disposition towards LGBT residents; this appears unmatched by the ability to recognise such individuals and knowledge of the issues and policies affecting LGBT people.	UK study.

3. Student nurses' competence in sexual health care: A literature review. (2017). Blakey, E.P., Aveyard, H. *Journal of Clinical Nursing* 26 (23–24): 3906–3916.	To explore the ways in which sexual healthcare is perceived and experience by student nurses in clinical practice.	A literature review of the published literature was conducted following a search of online databases. Articles were selected for analysis according to inclusion and exclusion criteria. Eight articles were critically appraised and thematically analysed.	Student nurses report having a positive attitude towards sexual healthcare; however, many felt uncomfortable about addressing sexual health and are reluctant to initiate a conversation because of a lack of knowledge about sexual health and a lack of role models at university and on clinical placement.	Included in literature review. The reasons behind a lack of sexual healthcare delivery by student nurses.
4. Do student nurses feel a lack of comfort in providing support for lesbian, gay, bisexual or questioning adolescents: what factors influence their comfort level? (2017). Richardson, B.P., Ondracek, A.E., Anderson, D. *Journal of Advanced Nursing,* 73 (5): 1196–207.	Aim of this study was to find out if student nurses feel comfortable in providing emotional support and information	Quantitative and qualitative methods. Descriptive study. Questionnaires were completed by 152 nursing students and nine took part in semi-	Student nurses felt discomfort in using language related to LGB sexuality with adolescents. Discomfort was influenced by personal beliefs and the perceptions of others. However, all students had a positive attitude towards LGB.	Included in literature review. UK study held in same university as this research.

	for LGB adolescents.	structured focus groups.		
5. Relationship between the knowledge, attitude, and self-efficacy on sexual health care for nursing students. (2015). Sung, S.-C., Huang, H.-C., Lin, M.-H. *Journal of Professional Nursing,* 31 (3): 254–61.	The purpose of the study is to address the need for nursing education on sexuality by exploring the relationship between nursing students' knowledge, attitude, and self-efficacy for patients' sexual healthcare.	A total of 190 senior nursing students were purposely enrolled to the study by answering a self-report questionnaire, and the data were analysed using structural equation modelling (SEM).	The results: positive correlation of the relationship between knowledge of sexual healthcare (KSH) and attitude to sexual healthcare (ASH; … = 0.35, t = 3.31, P.001), the relationship between KSH and self-efficacy for sexual healthcare (SESH; … = 0.29, t = 2.98, P.01), and relationship between ASH and SESH (… = 0.34, t = 4.30, P.001).	Included in literature review. Nursing educators need not only provide students the knowledge and skills on sexual healthcare but also educate them about positive attitudes on sexuality to enhance their efficacy in dealing with patients' sexuality matters in future nursing practice.
6. The knowledge and attitudes of student nurses towards patients with sexually transmitted infections: Exploring changes to	Evidence suggests that nurses can struggle to care for patients with	A two-phase mixed-methods study, using a sequential explanatory strategy, collected	Students who had increased SH educational reported higher degrees of knowledge and a more positive attitude towards patients with an STI.	Included in literature review.

the curriculum. (2014). Bell, A., Bray. *Nurse Education in Practice* 14 (5).	sexually transmitted infections in a non-judgemental way.	quantitative questionnaire data (n = 117) followed by qualitative group data (n = 12). Data were collected from one cohort of students before a curriculum change and then from a subsequent cohort of students.	Both cohorts of students identified that education in this subject was essential to challenge negative attitudes and positively influence patient care.	
7. Nursing students knowledge, attitude and readiness to work for clients with sexual health concerns. (2009). Kit Fong Kong, S.K., Lai Ha, W., Loke, A.Y. *Journal of Clinical Nursing,* 18: 2372–82.	To investigate nursing students' knowledge and attitude and readiness.	N = 377 students in year two and final-year post-registered nurses; 53 post-registered nurses.	Satisfactory knowledge but hesitancy to address area.	Included in literature review.
8. *A Survey of Teenage Sexual Health Knowledge, Behaviour, Attitudes in East Yorkshire. Talk to Us*. (2010). Jomeen, J.,	Evaluate the impact of interventions of the East Riding	2036 students aged 13–16 in East Yorkshire schools. Questionnaire.	Treat all people with respect whatever their sexual preferences: girls 77%; boys 68.5%.	Included in the literature review.

Whitfield, C. East Riding of Yorkshire Council and NHS.	teenage pregnancy strategy.			
9. University students' knowledge of and attitudes towards HIV and AIDS, homosexuality and sexual risk behaviour: A questionnaire survey in two Finnish universities. (2012). Korhonen, T.K.J., Houtsonen, J., Valimaki, M., Suominen, T. *Journal of Biosocial Science,* 44 (6): 661–75.	Students' knowledge and attitudes towards HIV and AIDS, homosexuality and sexual risk behaviour.	Two Finnish-speaking university students (N = 9715, n = 950). Questionnaire on sexual risk behaviour response rate was 35% (n = 333).	Students were familiar with HIV and AIDS, including transmission. Some misconceptions re: HIV and AIDS. The oldest students and women had a more positive attitude. Male students had more homophobic attitudes. Students who reported that religion had an important role in their lives had significantly stricter attitudes towards sexual risk behaviour.	Included in literature review.
10. 'One size doesn't fit all': Understanding healthcare practitioners' perceptions, attitudes and behaviours towards sexual and reproductive health and rights in low resource settings: An exploratory qualitative study. (2020). Tumwine, G.P.J., Larsson, M., Gummesson, C., Okong, P.L., Ostergren, P.-O.,	How HCPs perceive SRH rights.	28 interviews of HCP from Bangladesh, Zambia, Zimbabwe, Ethiopia, South Sudan	HCP preparedness to address SRH influenced by societal normal and personal values.	Included in literature review.

Agardh, A. *PLOS ONE,* 15 (6): E0234658 https://doi.org/10.1371/journal.pone.0234658				
11. Identification of barriers to sexual health assessment in oncology nursing practice. (2010). Julien, J..O., Thom, B., Kline, N.E. *Oncology Nursing Forum,* 37 (3): E186–90.	To explore oncology nurses' attitudes about and knowledge of sexual health.	A USA descriptive, cross-sectional design. A convenience sample of 576 RNs working in acute care, ambulatory, and perioperative services were approached during an annual mandatory training day.	Significant difference was found based on age and nursing experience. Younger and less experienced nurses had higher scores, indicating greater discomfort in discussing sexual health with patients.	Included in literature review.
12. Older adults' experiences of sexual difficulties: Qualitative data from the English Longitudinal Study of Ageing (ELSA). (2018). Hinchliff, S., Tetley, J., Lee, D., Nazroo, J. *Journal of Sex Research.55:2* 152–1632.	Older adults' experiences of sexual difficulties.	Qualitative data questionnaire open comment box, of which there were 1084 participants (n = 680 women; n = 404 men).	Participants reported that sexual difficulties could have a negative effect on well-being. Few participants had sought help; those who did received helpful and unhelpful experiences.	Included in literature review. This article led to me find Hinchliff, Gott & Galena (2005), which is also included in the literature review.

13. Sexual health beliefs, attitudes and perceptions among black and minority ethnic youth. Coleman, L., Testa, A. (2008). *Education and Health,* 26 (2): 32–6.	Exploring sexual health attitudes of BME youth.	50 interviews of BME young people aged 16–23.	Conflicting social norms and values; learning about sex and attitudes; religion vs ethnicity.	Included in the literature review.
14. Promoting sexual health and wellbeing: the role of the nurse. (2013). Evans, D.T. *Nursing Standard,* 28 (10): 53–57.	Review article.			Article led to finding Astbury-Ward (2011) research and Evans doctorate.
15. Confronting sexual stigma and prejudice: theory and practice. Herek, G. (2007). *Journal of Social Issues,* 63 (4): 905–25.	Discussion article			Led to reading Herek (1999). Included in literature review.
16. Undergraduate nursing student's attitudes towards caring for people with HIV/ AIDs. Pickles, D., King, L., Belan, I. (2012) *Nurse Education Today,* 32: 15–20.	To determine attitudes of Australian nursing students towards caring for people with HIV/AIDS.	Questionnaire: 396 students; response rate of 94.7%.	95.7% positive attitude to HIV and AIDS, 4.3% negative attitude. Statistically significant for students from China, Asia.	Included in literature review.

17. Communicating about sexual concerns within cardiac health services: Do service providers and service users agree? (2013). Byrne, M., Doherty, S., Murphy, A.W., McGee, H.M., Jaarsma, T. *Patient Education & Counselling,* 92 (3): 398–403.	We compared the views of cardiac healthcare providers and patients in terms of their experiences of communication about sexual issues.	Cardiac patients (n = 382) completed telephone surveys and hospital cardiac rehabilitation staff (n = 60) and general practitioners (n = 61) returned postal questionnaires.	Patients reported that sex was rarely discussed; 70% of GPs reported not addressing sex with their patients and the majority of cardiac rehabilitators (almost 61%) reported that sexual problems were poorly addressed in their service.	This led to finding article by Doherty et al. (2011) on cardiac rehabilitation staff views about discussing sexual issues with coronary heart disease patients: a national survey in Ireland. *European Journal of Cardiovascular Nursing,* 10: 101–7.
18. *Improving Emergency Health Care Workers' Knowledge, Competency, and Attitudes toward Lesbian, Gay, Bisexual, and Transgender Patients through Interdisciplinary Cultural Competency Training*. (2018). Bristol, S., Kostelec, T., MacDonald, R. *Journal of Emergency Nursing,* 44 (6): 632–9.	To evaluate aggregate ED healthcare team knowledge and attitudes toward pre- and post-cultural competency training education.	A pre-/post-intervention design was used to assess the impact of LGBT cultural competency training.	Pre-survey data 85.3% (n = 81) of staff had no previous LGBT education specific to the needs of the population. Post-survey data demonstrated a total index mean increase of 8.8% (P b 0.001) in the areas of knowledge and skills, openness.	Included in literature review.

19. Nursing, sexual health and youth with disabilities: a critical ethnography. (2013). McCabe, J., Holmes, D. *Journal of Advanced Nursing,* 70 (1): 77–86.	Exploration of the experiences of nurses providing sexual healthcare to adolescents with physical and/or developmental disabilities.	Ethnographic study in Canada including interviews (n = 9); observation and documentary evidence.	Nurses strive to maintain caring role, but many aspects of this role inhibit the promotion of sexual health. Sexual health is often medicalised.	Discussed in the literature review.
20. Sexual health in primary health care – a qualitative study of nurses' experiences. (2016). Klaeson, K., Hovlin, L., Kjellsdotter, A. *Journal of Clinical Nursing,* 26: 1545–54.	Illuminate nurses' experiences and opportunities to discuss sexual health.	Nine interviews with nurses in primary care in Sweden.	Societal norms, related to age and attitudes.	Included in literature review.
21. Emotional congruence in learning and health encounters in medicine: addressing an aspect of the hidden curriculum. (2013). O'Callaghan, A. *Advances in Health Science Education,* 18: 305–17.	Discussion paper on emotional congruence in learning and health encounters.		Importance of role models and teachers' attitudes.	Included in literature review.

22. The re-construction of women's sexual lives after pelvic radiotherapy: A critique of social constructionist and biomedical perspectives on the study of female sexuality after cancer treatment. (2013). White, L.D., Faithfull, S., Allan, H. *Social Science and Medicine,* 76: 188–96.	Factors that influence the clinical assessment of treatment-induced female sexual difficulties.	Ethnographic. Interviews of 24 women, five partners and 20 health professionals.	Challenge of discussing sexual concerns. Health professionals lack of expertise, time and referral pathways. Sexual difficulties invisible.	Included in literature review. Recommended by supervisor.
23. Editorial: Representations of sexuality: a snapshot of 5 years of scholarship in the Journal of Clinical Nursing. (2013). Hayter, M., Haigh, C. Jackson, D., *Journal of Clinical Nursing,* 22: 3237–38.				Led to reading Hayter, M; Jackson, D; Carter, B; Nyamathi, A. (2012). The three developmental phases of addressing sexuality in nursing care: Where do we go from here? *Contemporary Nurse,* 42: 187–9.
24. When holistic care in not holistic enough: the role of sexual health in mental health settings. (2018). Hendry, A., Snowden, A., Brown, M. *Journal of Clinical Nursing,* 27 (5–6): 1015–27.	Systematic review			Found through reviewer role for *Journal of Clinical Nursing*. Included in literature review

25. *Why Don't Moral People Act Morally? Motivational Considerations*. (2001). Batson, D.C., Thompson, E.R. https://doi.org/10.1111/1467-8721.00114	Discussion paper.			Led to me reading Batson et al. (1997), which is used in the literature review.
26. Attitudes and Values of Nurse Educators: An International Survey. (2007). Haigh, C., Johnson, M. *International Journal of Nursing Education Scholarship*, 4 (1): 14.	Insight into the values and attitudes of contemporary nurse educators.	Questionnaire of 37 questions sent to 19 countries.	74 completed response rate of 18.5%. Nine countries represented. High level of honesty, altruism and academic achievement	Recommended by supervisor. Included in the literature review.
27.100 years of STIs in the UK: A review of national surveillance data. (2018). Mohammed, H. et al. *Sexually Transmitted Infections,* 94: 553–8.	Analysis of national surveillance between 1917 and 2016		Increasing STIs In BME evidence suggest socioeconomic deprivation.	Included in the literature review. Email notification through work.
28. Attitudes about sexual disclosure and perceptions of stigma and shame. (2002). Cunningham et al. *Sexually Transmitted Infections,* 78: 334–8.	To determine the association between shame and stigma about STIs.	142 African Americans aged 13–19 telephone survey.	Stigma about disclosing STI to doctor or nurse.	Referenced in the literature review.

29. Changing student nurses values, attitudes, and behaviours: A meta ethnography of enrichment activities. (2015). Stephens, M.J. *Nursing Care,* 5 (1). https://doi.org/10.4172/2167-1168.1000320	Meta-ethnography was to analyse and synthesise literature on the impact of four undergraduate pre-registration programme enrichment activities.	Twenty-nine papers, across seven countries, with more than 755 student nurses.	To develop students so they have attitudes and values congruent with the profession, academics and registered practitioners need to focus on creating enrichment activities alongside the regular curriculum that are: based on cultural issues that challenge beliefs and assumptions,	Included in literature review.

Summary of articles

The articles were reviewed for relevancy to the research aim. This reduced the number of included articles to 29. Articles were then read in detail for relevant research findings regarding themes on attitudes, student nurses and sexual health. The literature reviewed revealed a wide range of methodologies, including mixed methods (two studies: Richardson et al., 2017; Bell and Bray, 2014) but were mainly qualitative, including three articles using ethnography. There were four studies that conducted surveys and a further 11 that used questionnaires. The subject area of sexual health and attitudes is an area that possibly lends itself to qualitative research, and questionnaires often used free text boxes.

Sample sizes varied from small studies such Klaeson et al. (2016), who interviewed nine nurses in Swedish primary care about the influences of society and age, whilst Tumwine et al. (2020) interviewed 28 healthcare professionals, finding that the influences of societal norms affected preparedness. Both studies have been utilised as they revealed areas that were unaddressed in sexual health. In comparison, studies by Pickles et al. (2012) had a sample size of 396 undergraduate nurses and Korhonen et al.'s (2012) research from two Finnish universities had sample sizes of N = 9715, n = 950; both used a questionnaire on attitudes surrounding HIV. Korhonen et al. (2012) found that participants who reported that religion had an important role in their lives held stricter views on sexual health. Pickles et al.'s (2012) study found statistically significant negative attitudes on HIV from participants from China, East Asia, South East Asia, Central Asia and the Middle East in comparison to students from other countries. I felt that these studies gave potential reasons for why negative attitudes may be held, adding to my understanding of the topic of my PhD.

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I categorised the papers into two broad themes. These were: barriers to addressing sexual health and facilitators that supported addressing sexual health. On the theme of the barriers to addressing sexual health there were 16 articles on negative attitudes, one of which discussed stigma; five articles on lack of knowledge; five articles on lack of teaching; and two articles with the theme of a lack of role models. Other negative themes included a lack of equality in health and education, treating everyone the same, personal values and societal norms. The literature review revealed eight articles that identified facilitators that supported addressing sexual health on the theme of knowledge, 11 articles on positive attitudes, and three articles on positive role models.

One article discussed themes on equality within health and education (Mohammed et al., 2018), and one article (Simpson et al., 2018) argued that, by treating all patients the same, healthcare professionals were discriminating against individuals by not recognising their personal needs. Tumwine et al. (2020) looked at healthcare professionals' preparedness and found that personal values and societal norms created negative barriers to addressing sexual health.

The literature review revealed more articles than expected on how LGBT issues are addressed in healthcare. I had to discern which were the most relevant to my research, as my research does not focus solely on this area. The increase in attention to LGBT issues within research reflects increasing awareness within education and health, and this is an area that has increased in volume with the repeated searches.

After this initial categorisation, I completed a thematic analysis of the findings from the literature I reviewed. This resulted in the construction of three themes, which I will now discuss.

Review of literature (thematic analysis)

The literature review is presented under three themes:

- How sexuality is addressed in the nursing curriculum.
- Nurses' recognition of sexuality in clinical practice.
- Nurses' attitudes to sexuality.

How sexuality is addressed in the nursing curriculum

Blakey and Aveyard's (2017) literature review discussed how, even though student nurses may have had positive attitudes to sexual health, they nonetheless felt uncomfortable in addressing this area and are reluctant to initiate conversations. They argued that, to address this deficit, a positive role model is needed, along with education on sexual health knowledge and skills (Blakey and Aveyard, 2017). Evans's (2013; 2011) work is discussed below; it highlights nurses' lack of educational preparedness relating to sexual health. It shows how nurses felt unable to reflect on their own personal attitudes, which if not addressed could lead to them prejudging patients and, as a result, not helping them appropriately. Areas that provoke conflicting attitudes are abortion, sexual acts, sexuality and STIs. These areas of conflict may relate to nurses' personal belief systems and be reflected in the care that they give. This can be explained through Leon Festinger's cognitive dissonance, which will be addressed later in this chapter (French et al., 2015).

Astbury-Ward (2011) undertook a survey of the provision of training in human sexuality in UK schools of nursing. The aim of this empirical study was to identify how many universities included human sexuality in their pre-registration nurse training, how much time was allocated and how it was delivered and assessed. A 20-item questionnaire was sent to the deans of 68 UK universities providing preparatory nurse education. Of those 68 universities, 41 completed the survey. This study gathered qualitative data

using open questions and the responses were analysed for differences and similarities. Of the 41 returned questionnaires, 38 identified human sexuality as part of the curriculum for pre-registration nursing and three did not address the subject. Of the schools that addressed the subject area, 29 provided 15 hours of teaching or less and three gave it 21 hours or more, over three years of the undergraduate teaching programme. The findings of the questionnaire show that, whilst sexuality was recognised within teaching, only 11 programmes formally assessed it. The results revealed that teaching was in small groups (31), as well as didactic teaching (29), with self-directed methods (18) and workbooks (9). The term 'self-directed' was not defined. Astbury-Ward concluded from this work that there is a gap between the provision of sexuality in nursing and society's need for it. She highlighted the UK's increasing evidence of rising abortion rates, STIs and grooming. This means that we need to address these areas within nursing more fully than we do currently. Astbury-Ward argued that, if we address sexuality in more depth in nurses' education, they will be able to educate patients and thus reduce these risks.

Evans's research (2011) into how sexual health is addressed in nursing education questions how specific discourses in sexual health and illness inform the provision of nursing education and how nurses are adequately prepared to meet the sexual health needs of their clients. This empirical study has three elements: a postal survey of sexual health teachers in higher education, of which 24 were completed; 16 focus groups of 136 registered nurses undertaking the sexual health foundation module at a London university; and semi-structured self-completed questionnaires from 14 registered nurses and midwives. Of the 24 out of 55 HEIs that responded, 17% taught only the pre-registered nurse training level, 46% only the post-registered nurse training level and 33% both. Respondents were asked whether they felt that in their

education establishment the sexual health provision for pre-registration was appropriate. Five (20%) responded ‘yes’ and 13 (54%) ‘no’, and there were missing data from six respondents. Of the post-registration nurse teachers, 15 (62%) responded that they felt that the provision was appropriate and four (16%) felt this area of sexual health provision was not addressed. Only three out of the 136 participants in the focus groups had had formal education in sexual health. Two of those who had had formal training in sexual health had received no education on HIV/AIDS. Evans concluded that nursing education needs to be fit for practice in sexual health. He believed that pre- and post-registered nurses should have clinical placements in sexual health. Teaching should be more holistic, with increased training of non-sexual health teachers to ensure the promotion of sexuality throughout training.

This research supported earlier work by Kit Fong Kong et al. (Evans, 2011; Kit Fong Kong et al., 2009). Kit Fong Kong et al.’s (2009) research on year-two and final-year pre- and post-registration nursing programmes in Hong Kong used a questionnaire to understand attitudes, knowledge and ability to work with patients with sexual health concerns (Kit Fong et al., 2009). Their work of 377 participants, of whom 53 were post-registered nurses (n = 310 female; n = 67 male) showed that participants had satisfactory knowledge, but only 53.7% of participants felt comfortable addressing sexual health concerns with patients. Kit Fong Kong et al. (2009) argued that having knowledge about sexual health is not enough to ensure confidence in addressing this area. They advocated that the involvement of clinical staff and mentors as exemplars would help establish and foster confidence in nursing students (Kit Fong Kong et al., 2009).

A survey by Pickles, King and Belan (2012) of 396 Australian undergraduate second-year nurses on their attitudes towards caring for patients with HIV/AIDS had a response rate of 94.7%. The majority claimed positive attitudes for caring for people with HIV/AIDS (95.7%), and only 4.3% expressed negative

attitudes (Pickles et al., 2012). No statistical difference was found by age or gender; however, there was a statistical significance by those students' citizenship of China, Asia and the Middle East (Pickles et al., 2012). This may mean that students from some countries hold negative attitudes towards patients with HIV/AIDS, and it highlights the importance of addressing this area in the curriculum.

Bell and Bray's (2014) research on the implementation of theory on STIs in the nursing curriculum involved a group of 68 third-year adult nursing students training in a university in the UK. A mixed-methods approach was used involving a questionnaire (N = 117), and qualitative group data through 'graffiti groups' (n = 12). Their research had two phases: the first, in 2007, collected data (n = 68) through questionnaire and graffiti groups (n = 6) on the attitudes and knowledge of the participants. The second phase, in 2010, collected data (n = 49) examined though questionnaire and two focus groups (n = 6) on how the curriculum had changed attitudes and knowledge. Bell and Bray's (2014) research revealed that with increased knowledge the attitudes of student nurses towards patients with STIs were more positive. However, their research highlighted some interesting attitudes expressed by the students, such as the need to know patients' HIV antibody status when caring for them (phase 1 n = 51; phase 2 n = 44), and that it is acceptable for pregnant nurses to refuse to care for HIV-positive patients (phase 1 n = 28; phase 2 n = 18). Bell and Bray's research (2014) identified the need to explore both positive and negative attitudes through small-group debate, allowing students to challenge and express their views in a safe environment, resulting in a more positive attitude to patients with STIs.

Richardson, Ondracek and Anderson's (2017) questionnaire of 152 student nurses (child field) explored the level of comfort and professional responsibility towards caring for LGB adolescents. These authors set up nine

focus groups to explore the questionnaire themes. Richardson et al. (2017) found that student nurses felt comfortable discussing issues related to sexuality but found LGB issues created discomfort. They found that this 'discomfort' was affected by personal beliefs and the perceptions of nursing colleagues and LGBT patients and their families (Richardson et al., 2017). This work is particularly interesting as it was conducted at the same university as my research, and highlights the influence of nursing colleagues on behaviour.

Research on nurses' attitudes and their effect on professional practice highlights the importance of recognising and addressing these in the curriculum (Astbury-Ward, 2011; Evans, 2011; O'Callaghan, 2013). O'Callaghan's (2013) literature review and discussion on the hidden curriculum focused on the emotional context of learning and clinical practice, which, if educationalists acknowledged it, would transform learning. She argued that:

> It is not only explicit teaching but also the behaviours and attitudes of teachers that are noted by students, with subliminal messages having the capacity to powerfully influence student behaviour. (O'Callaghan, 2013: 309)

Attitudes may affect how nurses learn and interact with patients and other members of the multidisciplinary team, facilitating or hindering how they work (Thomas et al., 2014; Klaeson et al., 2016). Klaeson et al.'s (2016) research exploring nurses' experiences and opportunities to discuss sexual health with patients in primary healthcare involved nine semi-structured interviews with nurses in Sweden. Klaeson et al. (2016) found that lack of training and knowledge contributed to nurses' ability to address to address sexual health. They concluded that:

> Social norms in society were an obstacle for health professionals' opportunities to feel comfortable and act professionally. The nurses' personal attitude and knowledge were of great

> significance in determining whether they brought up the topic of sexual health. (Klaeson et al., 2016: 1545)

Nurses found it easier to talk to patients who were younger than them, because they assumed a parental role. They found it difficult to speak to patients of their age or older, commenting they did not think older patients would be sexually active (Klaeson et al., 2016).

Finally, Tumwine et al.'s (2020) research on perceptions, attitudes and behaviour surrounding sexual and reproductive health, which included in-depth interviews of 28 participants (n = 18 male; n = 10 female) comprising doctors, nurses, midwives and managers from Bangladesh, Ethiopia, Zambia and South Sudan, concluded that:

> Even though healthcare practitioners perceive sexual and reproductive health as fundamental rights, their preparedness to ensure that these rights were upheld in service delivery is influenced by personal values and society norms. This could lead to actions that enable or block service delivery. (Tumwine et al., 2020: 1)

They believed that training should address value clarification in order for healthcare professionals to increase awareness of deeply rooted attitudes and how these can affect care (Tumwine et al., 2020).

Nurses' recognition of sexuality in clinical practice

Research by Magnan and Norris (2008) into the attitudes and beliefs of student nurses in addressing patients' sexuality concerns found that 67.9% did not have time to address them, and 66.4% believed that patients did not expect them to (Magnan & Norris, 2008). This was a large survey of 341 student nurses, and it noted that accelerated nurse programmes found more 'restrictive attitudes towards addressing sexuality', highlighting that such programmes may offer less time to address professional attitudes in their curriculum (Magnan & Norris, 2008: 260). Another survey of 576 registered

nurses, this time working in oncology in America, found that younger nurses with less experience had the greatest discomfort in discussing sexual health with their patients (Julien et al., 2010). The results revealed that the nurses claimed to understand how cancer may affect patients' sexuality, but they also believed that patients would not expect them to ask about sexual concerns, and deferred to a doctor (Julien et al., 2010).

Hinchliff, Gott and Galena's (2005) research with 22 general practitioners highlighted that their ignorance of non-heterosexual sexual practices and language caused barriers for discussion, concluding that further training was needed (Hinchliff et al., 2005). Highlighting that nurses may hold naïve views about doctors' knowledge of sexuality, the deference to doctors in Magnan and Norris's research may result in patients' concerns about sexuality not being addressed by anyone (Magnan & Norris, 2008). Both Magnan and Norris and Julien et al. revealed that nurses perceive barriers to addressing sexuality in the clinical area, even if they think that they know about it (Magnan & Norris, 2008; Julien et al., 2010). This highlights a lack of positive role models in this area for student nurses to identify with.

Both Evans's and Astbury-Ward's research highlights patchy teaching of sexual health in nursing programmes and a need to create nurses who care for their patients holistically by addressing sexuality (Evans, 2011; Astbury-Ward, 2011). Blakey and Aveyard argued that the deficit of positive role models in sexual health education needs to be addressed, and this supports Ingram-Fogel's argument that basic sexual health knowledge would enable nurses to communicate on this subject. I hope that I am creating a meaningful contribution to the inclusion of sexuality teaching within preparatory programmes of nurse education.

Ingram-Fogel argued that nurses need to overcome their embarrassment to enable them to address sexual issues (Ingram-Fogel & Lauver, 1990). She believed that doing so and having sexual health knowledge and sensitivity would support the recognition of sexual problems. Ingram-Fogel argued that a basic level of knowledge should enable nurses to help clients with their feelings and worries, giving an awareness and acceptance of their own sexual health values and level of communication skills (Ingram-Fogel & Lauver, 1990). She believed that it is not enough to base one's sexual health provision on one's life experience as that this is likely to increase and perpetuate incorrect beliefs about sexual health.

Research on nurses' ability to recognise sexuality in clinical practice shows the complex nature of their role. McCabe and Holmes's (2013) ethnographic research conducted in a paediatric rehabilitation unit in Canada explored nurses' interactions in providing sexual healthcare to adolescents with physical disabilities, such as spina bifida, muscular dystrophy and cerebral palsy (McCabe & Holmes, 2013). This research was conducted over four months and included nine interviews, observation of the institutional settings, and documentary evidence. McCabe and Holmes (2013) felt that the sexual needs of adolescents were unmet and, as individuals, they were more likely to be vulnerable to sexual abuse and have less knowledge of the area. Nurses discussed many barriers to providing sexual healthcare: the lack of time, privacy and resources. They described difficulties in providing a service for adolescents that challenged their families' beliefs and values. It was found that, whilst the nurses provided intimate care to adolescents, they did not recognise this as such, and thus they had a privileged position. Their lack of recognition of the sexual nature of intimate care meant that nurses medicalised intimate care, seeing it as an object of work. They were found to use biological theory as a reference point in addressing sexuality. By doing so,

they tended to normalise certain behaviours, such as heterosexuality, at the expense of other sexualities. Finally, as a result, the nurses did not give holistic care but left adolescents more vulnerable to abuse (McCabe & Holmes, 2013). As intimate care is a large component of nursing care, it is of concern that McCabe and Holmes's work highlights this lack of insight into care for patients.

McCabe and Holmes revealed the medicalisation of intimate care in the concept of recontextualisation (McCabe & Holmes, 2013; White et al., 2013; Guile & Evans, 2010). This theory suggests that all knowledge is dependent on context and is not straightforwardly transferred to other contexts. This may explain why nurses may not address, for example, sexual anxieties with patients who are receiving services unrelated to sexual health. For knowledge generated in one context to be transferred to another, it must be recontextualised. This happens by engaging with the new context and changing the concepts, experiences and practices attached to that knowledge (Evans et al., 2010).

Foucault argued that the health professional's clinical gaze is directed at visible illness, and this neglects the invisible: sexual health may be such an area (Foucault, 1973). Foucault believed that the way in which health professionals work is socially constructed, with knowledge formulated through social norms with a cultural and historical basis influencing how they practise clinically. As a result, health professionals exert power through their professional knowledge on what they consider to be normal or abnormal.

White, Faithfull and Allan's (2013) ethnographic research on factors that influence clinical assessment of treatment-induced sexual difficulties included in-depth interviews with 24 women, five partners and 20 health professionals, using a social constructionist approach. Their work illustrates the context of knowledge relating to the reconstruction of women's sexual lives following

pelvic radiotherapy (White et al., 2013). They found that clinicians focused on the management and side effects of the cancer treatment and were either unaware or unable to address its long-term implications on the women's sexual lives. White et al.'s (2013) research shows how they exert power by setting the agenda for how illness is managed and treated, and also what is considered not appropriate to pursue. Foucault believed that the more complex the society, the more denatured illness becomes, and that illnesses were simple prior to civilisation (Foucault, 1973; White et al., 2013). This implies a complexity that may result in health professionals failing to address all aspects of an illness.

Guile and Evans (2010) argued that, for workplace knowledge to be used in different contexts, we need to engage with experiences and practices in new contexts. Attitudes are incorporated in knowledge; however, the context affects nurses' attitudes. Guile and Evans (2010) believed that teachers need to use real-life scenarios to enable learners to prepare for professional work and assist in pedagogic recontextualisation (Guile & Evans, 2010). This means that nurses need an immersive experience of patient encounters as an essential aspect of learning about patients who are diverse. This helps undergraduate nurses to translate theory to practice and to construct knowledge in various clinical contexts. Miller and Grush's research found that individuals who are self-conscious are more self-aware of their attitudes (Miller & Grush, 1986), and by enhancing self-awareness an increase can be seen in the consistency between their words and actions. This endorses the role of self-reflection in the nursing curriculum to increase self-awareness.

Nurses' attitudes to sexuality

Whilst research shows that nurses may medicalise elements of their work or be unable to access knowledge in dissimilar contexts, these are not the only factors to impact on their abilities to address sexuality. Nurses and patients

may hold differing attitudes on sexuality, gender and age that may have a societal and cultural influence. Research on age has highlighted cultural stereotypes that depict ageing men and women as not sexually active (Hinchliff et al., 2018). My experience of teaching both undergraduate and postgraduate nurses has revealed students' surprise, with signs of embarrassment, that men and women over the age of 50 have sexual intercourse. Hinchliff et al.'s (2018) research used qualitative data from the English Longitudinal Study of Ageing (ELSA) questionnaire open comment box, in which there were 1084 participants (n = 680 women; n = 404 men). Hinchliff et al.'s (2018) research shows that sexual health is important to older men and women psychologically, socially and physically. It found that for older adults' sexual activity is both pleasurable and 'very or extremely important' to them (Hinchliff et al., 2018: 152). There was less emphasis on penetrative sexual intercourse, and the types of sexual activity had a broader definition. However, older men and women are often viewed by society as asexual and their sexual activity is met with disdain. An ageing population has triggered a United Nations and World Health Organization review of ageist stereotypes (Fleck, 2013; Lusti-Narasimhan & Beard, 2013). Hinchliff et al.'s research revealed that participants experiencing sexual difficulties, who had sought help because of a negative impact on their relationships, had reported both helpful and unhelpful experiences. The majority who had sought help from health professionals found them unhelpful, and identified examples of ageism, assumptions about sexuality and embarrassment (Hinchliff et al., 2018).

Stigma and prejudice are rife; heterosexuality is viewed as the dominant and preferred sexuality in our society, creating an underclass of other sexualities that do not meet the norms and values of heteronormativity. Herek discusses how heterosexism legitimates sexual stigma (Herek, 1999, 2007; Hayter, Haigh & Jackson, 2013). Stigma is described as:

> A strong felling of disapproval that most people in a society have about something, especially when this is unfair. (Cambridge International Dictionary of English, 1995)

Normally, sexual orientation is not obvious to the public, and many sexual minorities conceal or regulate information relating to their sexuality. Sexual stigma induces concealment and, whilst any prejudice regarding race and ethnicity is considered offensive, sexual prejudice is not frowned upon in the same way. This is seen in the *Stonewall Report* (Herek, 1999, 2007; Somerville, 2015). Lesbian, gay, bisexual and transgender people are increasingly viewed as minority groups. Herek's work found that in 2005 38% of gay men had suffered stigma enacted through violence. He also discusses internalised stigma, where individuals 'harbour negative attitudes toward self and toward her or his own homosexual desires' (Herek, 2007: 5). For patients and nurses who are struggling with their sexuality and have negative attitudes towards it, the consequences for their physical and psychological health can be severe, resulting in risky behaviour, STIs and HIV.

However, attitudes within society are changing, as seen in Jomeen and Whitfield's research (2010). This research, using a questionnaire on knowledge, behaviour and attitudes involving 2036 young people aged between 13 and 16 in East Yorkshire, showed that girls under 16 were more likely to believe that they would treat all people, whatever their sexual preference, with respect (77%) than boys of the same age (68.5%) (Jomeen & Whitfield, 2010).

Bristol et al. (2018) conducted research with emergency department healthcare professionals and found that, by addressing LGBT knowledge, they increased openness and awareness of issues affecting the LGBT community (Bristol et al., 2018). Simpson, Almack and Walthery (2018) conducted a survey of 187 care home managers and direct care service staff. Their research

revealed that, while staff held positive attitudes to LGBT residents, they had little understanding of the issues that may affect them. Simpson et al.'s (2018) work highlighted:

> How service providers fall back on the notion of 'treating everyone the same'. Two consequences of such an approach, however well-meaning, are that it perpetuates heterosexism and limits service development that would ensure culturally sensitive, safe and inclusive provision. (Simpson et al., 2018: 874)

Both Richardson et al. (2017) and Simpson et al. (2018) revealed the importance of culturally sensitive teaching, which enables discussion and the development of nurses.

Stigma still surrounds heterosexual sexual activity, and this is seen in young people's reluctance to divulge sexual activity and STIs due to shame (Coleman & Testa, 2008; Cunningham et al., 2002). Coleman and Testa (2008) conducted 50 in-depth interviews with Black and minority ethnic groups (n = 24 male; n = 26 female). This research clearly showed the influence of religion, rather than ethnicity, on sexual beliefs and attitudes. Black and minority ethnic groups have a risk of gonorrhoea and chlamydia three times higher than the general population (Public Health England, 2015). Mohammed et al.'s (2018) review of national surveillance data addressed why STIs are highest in Black and Asian minority ethnic (BAME) men and women, and found that there is increased inequality in healthcare and education, describing an:

> Inextricable link between socioeconomic context of neighbourhoods and the health outcomes of their residents. Sexual health is no exception, and evidence suggests that socioeconomic deprivation plays a role in ethnic disparities in STI diagnosis rates. (Mohammed et al., 2018: 556)

Young people described sexual norms and values that conflicted between the families and cultural and religious groups that they belonged to and the outside world. This research was supported by research in Finland on university students (Korhonen et al., 2012). Korhonen et al.'s (2012) research of 9715 students at two Finnish universities involved a questionnaire on sexual risk behaviour with a response rate of 35% (N = 333). It found that students who were religious had stricter attitudes to risky sexual behaviour (Korhonen et al., 2012). It is within these current contexts of stigma, stereotypes and prejudice that all individuals mature, and history has influenced this development.

Another area that is stigmatised is mental health. A systemic review by Hendry, Snowden and Brown (2018) highlighted the vulnerability of patients with mental health issues and the failure to address sexual health needs to this group (Hendry, Snowden & Brown, 2018). Such patients may be more vulnerable to abuse and, in response to their illness, for example bipolar disease, may also become promiscuous and put themselves at increased risk of pregnancy and infection. They may be distressed and ashamed at their actions once their bipolar is managed. This shows the need for all undergraduate nursing teaching to address this area in the nursing curriculum, as the subject of sexual health is not confined to adult nursing but is equally important in mental health nursing.

Sung, Huang and Lin's (2015) research on knowledge, attitude and self-efficacy on sexual healthcare involved 190 senior nursing students in Taiwan, who completed a questionnaire. They found that there was a positive correlation between the relationship between knowledge and attitudes on sexual healthcare. Their research argued that educating nurses about sexual health is not enough; educators need to include positive attitudes on sexuality to

enable them to be effective in dealing with patients' sexuality in the clinical area (Sung et al., 2015).

Summary of literature review

The literature research has revealed inconsistencies in the teaching of sexual health, and the difficulties nurses have in addressing this subject in the clinical area without knowledge. Lack of knowledge and understanding have been shown to perpetuate discrimination, whilst enriching activities and discussion with positive role models have shown to reduce these (Batson et al., 1997).

The findings from the literature suggest that questions remain for nurses and nurse educators around the effects of nurses holding attitudes to their patients that diverge from professional expectations.

Theoretical framework

In the theoretical framework I discuss one of the three theoretical influences that have framed my research, which is psychodynamic theory. Social constructionism and the work of Bourdieu are discussed in Chapter 3. The effect of psychodynamic theory on this research has increased throughout this study and has been a core component of this work. Psychodynamic theory recognises nurses' emotional reactions to the complex nature of sexuality. It is the only theoretical framework and methodology to capture the intrapersonal area of emotions, which other theories overlook.

I have trained and worked as a psychodynamic counsellor, and this study is framed by psychodynamic theory. It has influenced how I work as nurse, a lecturer and an individual, and during this research it has become a core component of the methodology and analyses of the data, providing recognition of student nurses' emotions.

Suzanne Everett 9834205:

Psychodynamic theory was developed in the early twentieth century, based on work by Freud, Adler and Jung, Klein, Winnicott and Bion (Jacobs, 1988). The term 'psychodynamic' embraces these theorists' work (Jacobs, 1988). The theory is based on the individual's conscious and unconscious desires and beliefs. Freud believed that personality consists of three areas: the id, the superego and the ego. The id comprises pleasure-seeking instincts, which are the bedrock of our biological needs. The ego surrounds the rules of parents and society, which we need to obey, and how, under societal or parental demands, we suppress our desires if these would put us in an unfavourable position. The superego comprises our feelings of guilt when the values of the ego are violated (Dryden, 1990). Freud put forward the theory that, under stress, individuals produce a defence mechanism known as reaction formation. This is where, as a defence, to mask our unconscious feelings that might induce anxiety we (unconsciously) produce the opposite feelings and behaviours (Roth, 1994). Psychodynamic theorists argue that childhood experiences shape our personality, and therapy in this area attempts to reveal unconscious thoughts and desires.

Psychodynamic theorists argue that relationships are far from simple, as they involve transference and countertransference of feelings between individuals in relationships including researcher–participant relationships (Jacobs, 1988). The researcher's acknowledgement of these feelings is a useful indication of what the participants are experiencing. Transference is the redirection of feelings onto someone else (Dryden, 1990), whilst countertransference, in this research, is the transfer of feeling from the researcher to the student (Dryden, 1990). Holmes's research on interviews about migration used the recognition of countertransference:

> Strong feelings in the researcher were considered as possibly reflecting subjects warded-off feelings in relation to particular topics. (Holmes, 2013: 160)

Holmes's work drew on the work of Michael Balint; he argues that these feelings can be compared to other elements in the data, giving a depth and intersubjectivity between participant and researcher (Holmes, 2014: 166). This research will involve countertransference. I have chosen to use Balint's theory to analyse my research data as it acknowledges the emotions and feelings in the research. Balint's psychodynamic theory brings understanding to the unconscious feelings experienced in nursing care (Montford & Skrine, 1993). Listening closely to the reflections of student nurses in the digital diaries, interviews and online discussion groups puts the researcher in touch with the feelings that were experienced by the patient and the healthcare professional at the time. Clifford argued that these provide a powerful learning forum (Clifford, in Barnes et al., 1998).

Isabel Menzies Lyth's empirical study of a nursing service in a London teaching hospital was influenced by psychodynamic theorists, particularly Bion, whom she worked with. She argued that the social systems of the organisation entailed significant anxieties for nurses, and defences against these are part of their lives (Menzies Lyth, 1960). Menzies Lyth and Jaques (De Board, 1978) discuss the ritualistic behaviour of the social defence system in hospitals, instigated to reduce individuals' stress. They concluded that task-laden work inhibits nurses from using their initiative or from becoming autonomous, and increases their stress though their inability to adjust their workload. To reduce the burden of conflict created by a hospital establishment, the nurses project unwanted aspects onto other health professionals. Menzies Lyth argued that a social defence system results in inefficient performance, such as:

> bad nursing practice, excessive staff turnover, failure to train students effectively for their future roles. Further, the high level of anxiety in nurses added to the stress of illness and hospitalization for patients and had adverse effects on such factors as recovery rates. (Menzies Lyth, 1960: 460)

Freud, Klein and Bion all stressed the role of anxiety and defences in personality and ego. The avoidance and defences adopted to contain anxiety are extended, putting stress on the individual. Menzies Lyth highlighted 10 defensive techniques used in nursing to avoid anxiety:

1. Splitting the nurse–patient relationship.
2. Depersonalisation, categorisation and denial of the significance of the individual.
3. Detachment and denial of feelings.
4. The attempt to eliminate decisions by ritual task performance.
5. Reducing the weight of responsibility in decision-making by checks and counter-checks.
6. Collusive social redistribution of responsibility and irresponsibility.
7. Purposeful obscurity in the formal distribution of responsibility.
8. Reduction of the impact of responsibility by delegation to superiors.
9. Idealisation and underestimation of personal development possibilities.
10. Avoidance of change. (Menzies Lyth, 1960: 439–62)

The Menzies Lyth study illustrates how nurses split the nurse–patient relationship through the evolution of social and work practices as a defence against anxiety (Weatherell, 1997). Menzies Lyth did not specifically research nurses' experiences; her thesis surrounds the unconscious emotions evoked through the nurse–patient relationship and the unconscious defences used to alleviate these (Menzies Lyth, 1960). It may be that these defences are

employed by students in the classroom to cope with material that they find difficult.

The conformity and task-based care referred to in the 1950s and 1970s by Menzies Lyth can be still detected in the *Francis Report* of 2013, and it reveals how disempowered nurses are, as a profession (Francis, 2013). The *Francis Report* paints a picture of a difficult environment for nurses to address subjects that are not task-based, owing to the heavy workload and the increased stress of addressing sensitive areas.

Hochschild argued that the conformity seen in the Francis Inquiry arose as a defence against the emotional labour of the work (Hochschild, 2003). She put forward a theory of the role of emotions in paid clinical work to argue that there are three stances in the emotional exchange of coping with the emotions of upsetting work:

1. The worker identifies wholeheartedly with the job, and therefore risks burnout.
2. This worker clearly distinguishes themselves from the job and is less likely to suffer burnout, but may blame themselves for making a distinction and denigrate themselves.
3. The worker distinguishes themselves from the act and does not blame themselves, and sees the job as positively requiring acting. (Hochschild, 2003: 187).

Hochschild argued that there is an issue of authenticity where emotions that were once personal become part of public contract jobs, and that its impact is on the individual. If, as an individual, you hold anti-abortion views that would be viewed as a judgemental attitude and that your nursing role asks you not to hold, then you are left with the emotional impact of this conflict and are unable to express these views and be authentic. Women have traditionally

performed altruistic caring roles in looking after others and, as a result, have tended to lose track of the boundaries of these roles (Hochschild, 2003). Hochschild put forward the theory of healthy estrangement and clear separation to emotions, called 'emotional dissonance', which she believed helped nurses to cope with the distress of the emotions:

> This sense of emotional numbness reduces stress by reducing access to feelings through which stress reduces itself. It provides an exit for overwhelming distress that allows a person to remain physically present on the job. (Hochschild, 2003: 188)

Hochschild's theory explains how nurses cope with the distressing nature of their work and the boundaries that are generated to protect them.

Carl Rogers's work on self-awareness and empathy through experiential learning created an understanding of nurses' experiences: 'at last someone understands how it feels and seems to be me without wanting to analyse me or judge me' (Rogers, 1983: 125). Rogers believed that individuals have the freedom to learn, and this personal freedom creates a sense of self (Rogers, 1983). His work holds that individuals who do not have freedom to learn are more likely to conform and be controlled by their environment and have feelings of inadequacy and low self-esteem. By contrast, individuals with freedom to learn have a strong sense of self and autonomy and be less likely to conform and, as a result, can judge people's feelings and attitudes more accurately.

When considering the implications of Rogers's work on the nursing profession, the ideal would be to create nurses who have a greater capacity to understand the patients in their care and have personal autonomy. This would enable them to raise issues of concern and not to follow other's mistakes. The Stafford Inquiry described a task-focused nursing system in which the nursing force conformed and did not speak up, even when it recognised poor care. The

inquiry showed nurses who were not valued in the healthcare workforce and who devalued themselves (Francis, 2013).

There has been a small amount of work using psychodynamic approach, and more recently growing interest in the field of emotions in healthcare and emotions in nursing using psychodynamic approach. Examples include Tunnadine (1992) and Skrine's (1997) early work focused on Balint seminar groups. McGrory, Barnes et al.'s (1998) research used two groups of 32 student nurses undertaking clinical placements. Group A received 10 Balint-style discussions with a teacher throughout the clinical placement, whilst Group B received none. Findings included a theory–practice gap, where they noted that:

> When teachers use discussion groups in working with students, they are likely to experience discomfort as they hear accounts that describe a very different reality from that hoped for by the teacher. (Barnes et al., 1998: 174)

It is of course possible that teachers may present an idealised view of the clinical area if they no longer work in this area. Wells's (Barnes et al., 1998) biographical work with older patients showed that space to discuss and reflect, encouraged nurses to think about the care they were giving and increase understanding of patients. These studies show the importance of giving nurses time to reflect on clinical practice.

Van Roy et al. (2014) used Balint seminar groups to explore general practitioners' (GPs') subjectivity. Their research comprised two groups of six to 12 GPs with one or two seminar leaders. Van Roy et al. (2014) analysed the data for themes, and then used Lacan's theoretical distinction to look for the relationships between symbolism and imagery. They found that GPs were stuck in a fixed image, but through the Balint seminar work they were encouraged to explore different subject positions, which enabled them to

broaden their outlook and discover other issues involved in the situation. They commented that Balint seminar groups allowed group members the space to reflect, and reconsider consultations without constraint (Van Roy et al., 2014). This research supports previous discussed research emphasising the importance of space to reflect.

Player et al.'s (2018) study on twice-monthly Balint seminar over two years included 18 resident American physicians (94.5%) who completed 30- to 60-minute semi-structured interviews. They found positive themes of acceptance and empathy, and understanding of the role, along with negative themes of the repetitiveness of the seminar work (Player et al., 2018). Their research shows the importance of Balint in developing health professionals clinically.

Dashtipour, Frost and Traynor's (2020) research used a psychosocial approach to explore nurses' idealised views of compassion. Using the analysis of focus groups comprising 49 student nurses, they drew from psychodynamic theory to explore the unconscious influences of the idealisation of compassion. Dashtipour et al. (2020) found that student nurses recognised the high pressure of the nursing role; however, they found qualified nurses to be uncaring. Whilst they disapproved of qualified nurses, they identified with an idealised compassionate nurse. They concluded that a strong focus on discourses of compassion in nursing might lead nurses to fail to reflect on the organisational constraints on patient care and understand such constrained care as a result of personal failure on the part of individual nurses. This research highlights the way that an idealised view of nursing might be used by student nurses as a defence against the anxiety of their work.

Recently, a blog by Pattni, Phillips and Saha (2020) described using the Balint seminar groups as means to support healthcare professionals through the Covid pandemic. The seminar groups were held virtually via Zoom, and

allowed staff to express grief and concerns about death and how this is dealt with:

> Providing opportunities for staff to reflect regularly on their experiences, rather than using single session debriefs, also has the potential to foster resilience, reduce burnout, and lower the risk of post-traumatic stress disorder. (Pattni et al., 2020)

All the research shows that the use of Balint seminars has a supportive role, allowing clinicians to verbalise the emotions in their work and potentially reducing stress.

Menzies Lyth's work shows how nursing as a profession promotes conformity, and the NMC's Code of Practice further restricts nurses' practice through rules and regulations (NMC, 2015 updated 2018); however, without these regulations the profession would be open to poor and unsafe practice and these rules are there to safeguard the public. So, nursing requires nurses to conform in order to maintain safe clinical practice. But, if individuals conform, does this result in a lack of personal authenticity at a cost to themselves? If individuals do not have a strong sense of self, does sexual health represent a personal threat and does their conformity prevent them from addressing this area?

By using Balint's psychodynamic theory, I hope to gain an understanding of nurses' experiences of non-judgementality and how these both constrain and enable them in their nursing journey.

Summary of psychodynamic theory

Psychodynamic theory recognises unconscious emotions and feelings, and, within this field, the work of Balint has been used in this research. Balint's psychodynamic theory brings understanding to the unconscious feelings at work in nursing care (Montford & Skrine, 1993).

Menzies Lyth's (1960) work shows that, to reduce the burden of conflict, nurses project unwanted aspects. I have acknowledged these projections in this research, through transference, which is the redirection of feelings onto someone else (Dryden, 1990), whilst countertransference, in this research, is the transfer of feeling from the researcher to the student. By using these principles, I have gained multiple layers of data, highlighting student nurses' experiences.

Summary of chapter

This chapter has revealed inconsistencies in the teaching of sexual health and a lack of preparedness by nurses to address the subject. Knowledge alone is insufficient to help address this lack of preparedness, but discussion and positive role models have been shown to reduce this.

Psychodynamic theory recognises the unconscious emotions and feelings at work within nursing. Increasingly Balint seminar work is being utilised to recognise these emotions to support healthcare professionals after the Covid-19 pandemic in the hope this will reduce the burden of burnout.

Recognising emotions and their impact on ourselves and our patients is a component of professionalism. Addressing these along with professional attitudes and values formally in higher education is important in the development of professionalism in nursing.

Chapter 3 Methodology

Introduction

In this chapter, I discuss my epistemological position of social constructionism in relation to selecting a pluralistic methodology to answer the research questions. Next, I address pluralism and my choices of methodologies. My role and reflexivity in this research are examined. Finally, the methods used to analyse the data are discussed.

The methodologies, the methods of data collection and the methods of analysis are outlined below:

- Methodology comprises narrative and psychodynamic approaches.
- Methods of data collection comprise digital diaries, online discussions and interviews (Chapter 4).
- Methods of analysis draw on the ideas of Labov, Braun and Clarke and Balint (Chapter 4).

Research aim

> Explore the ways in which the student nurses experience non-judgementality through an analysis of the teaching and learning of sexuality within preparatory adult nurse education.

Research objectives

- To explore student nurses' understanding of non-judgementality, using sexuality as an exemplar.
- To investigate the factors that enable or constrain student nurses' ability to be non-judgemental and tolerant of the diversity in sexuality and nursing.

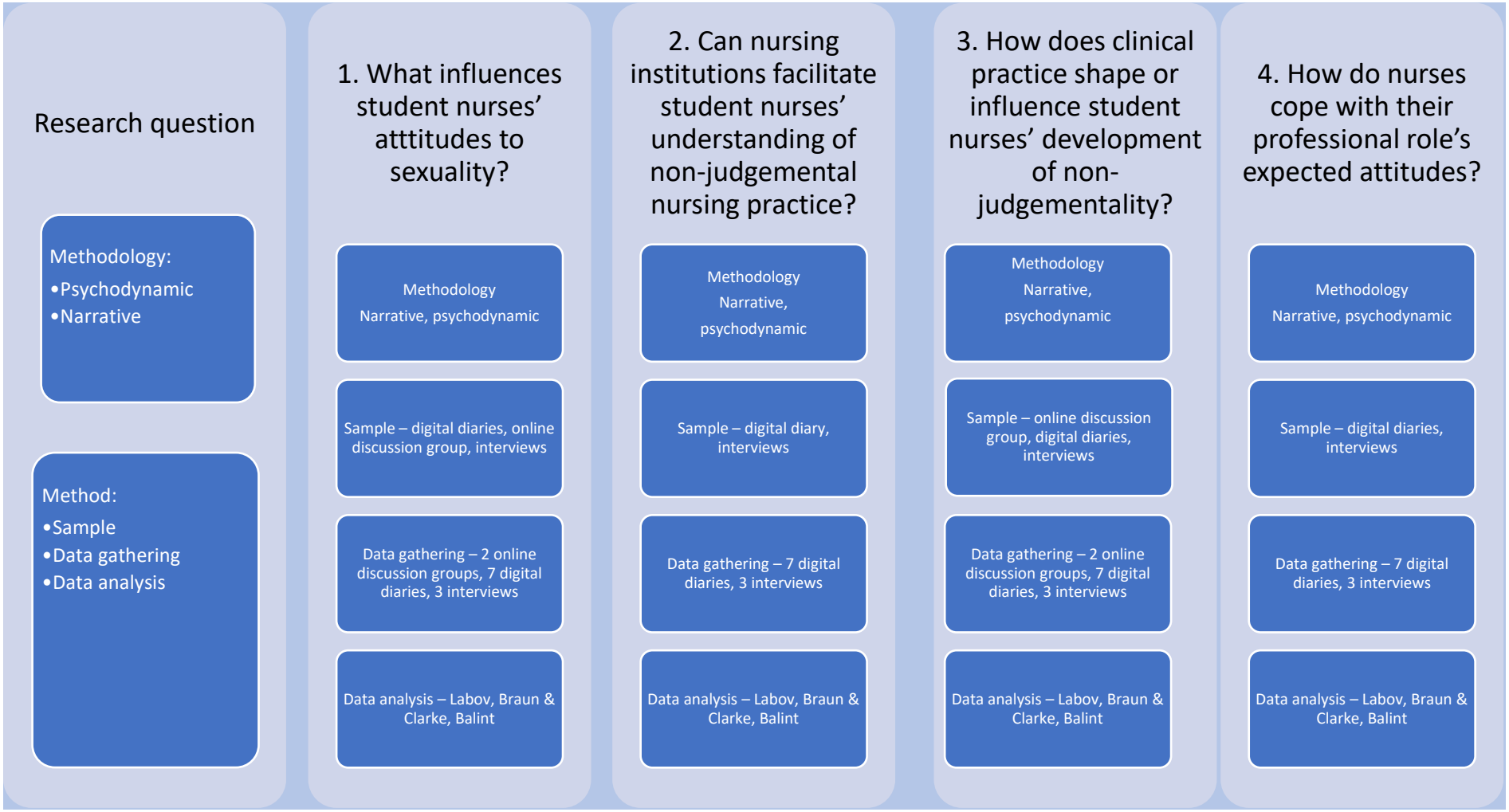
- To explore how nurse education might facilitate the development of non-judgemental practice by nurses to achieve the NMC standard at the point of entry to the Register.

Research questions

To address the research aim, four research questions were devised. Table 3-1 shows where these questions are addressed and by which methodology and method.

1. What influences student nurses' attitudes to sexuality?
2. Can nursing institutions facilitate student nurses' understanding of non-judgemental nursing practice?
3. How does clinical practice shape or influence student nurses' development of non-judgementality?
4. How do student nurses cope with their professional role's expected attitudes?

Table 4-1 Research questions and where these are addressed



Methodological review

The epistemological position of this research is social constructionism, which I believe reveals how nurses make sense of their experiences of learning and development of non-judgementality and manage them.

Social constructionism

This research is framed by social constructionism, which questions how actions and thoughts are constructed and sustained (Silverman, 2014). Social constructions are unconsciously created then reproduced, and may constrain future action; they are ideas that are created and accepted by people (Seale, 2018). I opted for social constructionism as my epistemological position and it informs the selection of a pluralistic methodology, as its epistemology is related to the methodology and methods of research (Crotty, 1998). The meanings and perceptions that participants give as part of the data, their overall cultural view and the methods that are chosen by the researcher, along with the interpretation and the identification of themes given, are all social constructions that relate to the epistemology of social constructionism (Crotty, 1998). Barkway argued that:

> social constructionism emphasises the hold our culture has on us: it shapes the way in which we see things (even feel things) and gives quite a definite view of the world. In the light of that, while the shaping of our minds by culture is seen as what makes us human and endows us the freedom we enjoy, social constructionism suggests that culture is limiting as well as liberating. (Barkway, 2001: 193)

These social constructions also create an inner world of intersubjectivity between the researcher and the participant, due to the language used by participants and the meanings attached by the researcher. Crotty argued that the epistemological view of constructionism is that:

> truth or meaning comes into existence in and out of our engagement with the realities in our world. There is no meaning without a mind. Meaning is not discovered but constructed. (Crotty, 1998: 8–9)

He argued that different people construct different meanings and that these vary according to culture, generation and subject.

I have chosen social constructionism as a framework because it addresses how we make sense of our everyday world. Silverman held that,

> instead of treating social facts or social worlds as either objective parameters or as subjective perceptions, constructionists approach these as achievements in their own right. Both inner lives and social worlds are epiphenomenal to the constructive practices of everyday life. (Silverman, 2014: 26)

This means that I am interested in how nurses produce order and meaning in their social worlds, and how they constantly construct, manage and engage in nursing's practical activities (Silverman, 2014). I want to understand nurses' experiences in relation to how they unconsciously practise and produce order in their development and understanding of non-judgemental practice. Culture may influence participants through religion and other social worlds. A participant may have personal experience of a culture in which abortion or homosexuality is illegal, affecting their perceptions and constructions of these issues. By introducing a new curriculum, student nurses are afforded the opportunity to attend to sexuality within nursing practice and reflect on their personal constructions and reconsider them. These personal constructions may conflict with the new constructions that they encounter in the new curriculum and in their clinical practice. Through this, I am trying to understand how nurses develop understandings and constructions of non-judgemental nursing practice. I also recognise that the participants have multiple realities that are influenced by different cultures and that these need to be acknowledged by me and incorporated into the data analysis. By using social

constructionism as an epistemology, I felt that cultural influences would be acknowledged, where they would not be in an objectivist epistemology. I chose to use a pluralistic methodology as it provides multiple research perspectives to reveal social constructions.

In exploring this area I became interested in theorists who recognise cultural influence. The French sociologist Pierre Bourdieu's theories of social class and education offer an explanation of the influences of the interconnectedness of the person, culture and society. Bourdieu put forward theories on the dynamics of power, including cultural capital and habitus. Cultural capital has a central role in societal power, creating a form of hierarchy and inequality, whilst the theory of habitus concerns the socialised norms that guide behaviour and thinking (Bourdieu, 1972; Gaventa, 2003). Bourdieu showed that cultural capital is not individualistic; there is a tension between a person and society and the group. He argued that 'cultural capital contributes to the accumulation and exercise of power and the maintenance of inequality' (Shim, 2010: 2). His work shows that education and class can reproduce inequality (Bourdieu, 1972; Sullivan, 2002; Shim, 2010), arguing that people with education have cultural skills that affect the care that they receive; this also affects how both patients and professionals interpret illness.

Habitus, social experience and education shape our clinical encounters both as a clinician and as a patient. Bourdieu argued that social structures constrain social action by individuals, resulting in limited individual social constructions. He also argued that male domination tends to restrict female sexual interests and their verbal consciousness, which means that discourse about their sex is forbidden or dominated by male values of virility (Bourdieu, 1972; Skeggs, 2004). He believed that in the public space the misrecognised and the unrecognised, which are the unsaid and the subtle relations of domination, are largely invisible. An example is the heteronormative nature of society, which

results in homosexuality and transgender being unrecognised and discriminated against (Skeggs, 2004).

Pluralism

The methodology of this research is pluralistic. I chose this approach as it allowed me to look at nurses' experiences of non-judgementality from different perspectives, allowing me to use both narrative and psychodynamic approaches. An advantage of using a pluralistic approach is that it allows different avenues to be pursued within one study. Frost (2011) captured this advantage:

> Pluralistic research is about keeping a number of dialogues going at the same time and in a systematic way. In this respect, the term polyvocality (Chandler, 2002) captures the outcome of dialectics in the plural. Polyvocality refers to the shifting of narrative voice, the person telling a story, from person to person, thus providing different points of view of the same event. (Frost, 2011: 126)

Within this research a pluralist approach has allowed the participant's stories to be told through the narrative approach, whilst recognising the emotions within the stories through the Balint analysis using the psychodynamic approach. Pluralism has allowed the use of three methods of data collection: online discussion groups, digital diaries and interviews. Each of these methods gave me the opportunity to understand student nurses' experiences from different perspectives: as a group within the online discussion group, and individually through digital diaries and interviews (see Chapter 6). The analytic approach informed by pluralism drew on Labov (Labov & Waletzky, 1967/1997) and Braun and Clarke (2013) to analyse the narratives and Balint's psychodynamic theory to bring understanding to the unconscious feelings experienced in the digital diaries and the interviews (Montford & Skrine, 1993; Skrine, 1997).

No methodology is without bias; critics of pluralism put forward four arguments against it: the purism–methodolatry debate, methodological transparency, the relationship between epistemology, ontology and method, and finally reflexivity. I will discuss these criticisms, and how I have considered these within the research.

Pluralism means that this research relies on no single methodology or methods, thus avoiding methodolatry, where the use of one methodology implies that it is superior to other methods (Haslam & McGarty, 2014). Frost points out that using any single methodology raises the question of what another would have captured, so by using a pluralistic methodology there is increased transparency and richness (Frost et al., 2010). Critics of the purism–methodolatry debate argue that purism allows consistency and purity in the application of one method, which pluralism may not reliably do with multiple methodologies and methods. Pluralists argue that the use of mono-methodological research may limit findings and prevent innovation (Barnes et al., 2014). Callwood argued that in a pluralistic approach 'each paradigm and associated methods offers a legitimate and meaningful perspective, generating in-depth multidimensional knowledge and understanding' (Callwood, Cooke & Allan, 2014: 1451). Exponents of pluralism argue that the multidimensional nature of the methodology increases reliability and validity. However, Frost argued that this is irrelevant, as data illuminate and enrich; therefore, pluralism should not be seen to validate (Frost et al., 2010). Exponents of mixed-methods approaches focus on 'complementarity', believing that they are revealing the 'broader picture'. I have chosen pluralism because it gives me the freedom to use two methodologies and associated methods to gain different insights into student nurses' development and understanding of non-judgemental practice. These nurse developments and understandings emerged in their groups, in practice settings and in individual

reflections, which gave me 'layers of data', giving different perspectives on the participants' voices.

I feel that pluralism offers transparency to the reader and allows the participant's voice to be heard on a subject area that is complex owing to its sensitive nature. Transparency is seen through the polyvocal nature of the research through the online discussion and individual diaries/interviews. Sexuality is a personal part of an individual's personality, with many facets. There is an undisclosed area that is either consciously or unconsciously hidden and a public area that is seen. Individuals may find the subject area of sexuality intrusive and embarrassing. Sexuality influences attitudes and what we think of individuals, which is why we may consciously hide elements to conceal elements of our personality that we think may be seen negatively (Sprecher & McKinney, 1993). Critics of pluralism argue that methodological transparency is problematic, with multiple methods and methodologies. However, Barnes et al.'s (2014) research on methodological pluralism in qualitative research argued:

> Whilst the papers we analysed varied with respect to the extent to which their methodological procedures were transparent and set out in sufficient detail to enable replication or audit, this variation did not strike us as fundamentally problematic, nor as necessarily being any greater than that which can frequently be seen in mono-methodological studies. (Barnes et al, 2014: 38)

I have tried to address this by using methodologies that are well established in the area I want to research. For example, psychodynamic methodology is a recognised theory within counselling and emotional work. I have also chosen theories that I and my supervisors have knowledge and prior experience of, to reduce the risk of incoherence.

Frost argued that the role of emotions within research is important and that pluralism addresses the absence of emotions or at the very least the lack of transparency of their presence in mono-methodological studies:

> The role of emotions in the researcher is one not often discussed in the context of conducting research. The lack of attention to the in the research literature can bring an inherent assumption that researcher emotion is not something that occurs in well-conducted research or if it does that it is something that should not be declared. (Frost, 2016: 157)

To address Frost's point, I have incorporated a psychodynamic approach within the pluralist methodology in this study and directly included emotions as data through the inclusion of a researcher's diary (see Chapter 6), which details my feelings and my understandings of and responses to participants' feelings.

It can be difficult to recognise emotions, particularly unacceptable feelings. To address this in the study, the researcher's diary (see Chapter 6) explicitly and reflexively records my feelings and those of my participants and resulting discussions in supervision. My training as a counsellor has supported me in the recognition of emotions, both mine and those of my participants. I have been careful to create boundaries around the participants' feelings and emotions, and not confuse them with my own. The combination of a researcher's diary and supervision has helped me to become aware of my own emotional responses and positionality and how these might affect my analysis and understanding of my data.

In pluralistic research, the roles of the participant and the researcher in the interview are the storyteller, and the researcher in the telling, resulting in multiple views of the data (Frost, 2011). So, pluralism may involve different methodologies, data sources and researchers to access meaning within the data. One reason for interpreting data pluralistically is to reduce any bias

arising from the use of just one method or researcher. Critics have argued that multiple methodologies may lead to an incoherent relationship between epistemology, ontology and method (Barnes et al., 2014). Whilst this is a potential problem for mono-methodological research, pluralism has a greater potential, with multiple methodologies, for this incoherence to occur. I addressed this from the start of the study by reflexively recording my positionality, my emotions and responses to the data throughout the study. To present this reflexive journey, I have included the whole of the transcripts of the digital diaries, interviews, and online discussion groups and my commentary and reactions to these data through the researcher's diary.

When I started this research, I chose pluralism, narrative and ethnomethodology methodologies. As the work progressed, I realised that these methodologies were not capturing the emotions of the digital diaries. I felt psychodynamic theory could address the material's emotional content in a way that the use of ethnomethodology might not, so I incorporated this into the research. The ethnomethodological influence can be seen, however, in Appendix A. Pluralism allows for flexibility, and its approach allows for a multi-layered insight to be formed (Frost, 2011). Narrative theory will reveal participants' personal stories and, by using psychodynamic theory, I will capture the intrapersonal emotions of the stories, thus gaining greater insight as a researcher. The pluralistic methodology allows the multiple meanings of the data to be revealed, whilst the narrative methodology shows the participants' language and story, and the psychodynamic theory shows the emotional content.

Frost used the pluralist example of a narrative being analysed by grounded theory and discourse analysis. These methodologies brought different interpretations to the narrative of Mary, a young mother (Frost, 2011). Grounded theory brought the theme of her traditional gendered roles as a wife

and mother, whilst discourse analysis showed the uniqueness of her relationship with her child. Each methodology on its own would have told a different story but together they gave a layered insight into Mary's life as a mother (Frost, 2011).

A variety of methods may be used to produce richer data through a variety of sources when using a pluralism methodology, thus providing a broader perspective. Narrative research analyses data to show multiple layers of construction and performance through the participants' stories. By using data from multiple sources, a greater understanding of nurses' experiences can potentially be revealed and how these constrain or enable them in clinical practice. The layers can be a sequential presentation of several voices or develop into collages of data displaying different voices around a theme (Frost, 2011). Multimodal data such as photographs, diaries and written accounts may be presented as polyvocal data. Layering can also be presented as a pastiche, fragments of which can be displayed with the researcher's reflections. This can be powerful when there are different voices, including the researcher's reflexivity (Frost, 2011). Frost warned that this can fragment the material and obscure the meaning of the data (Frost, 2011). Barnes et al. (2014) argued that a strength of pluralism is that it allows deeper reflexivity through multiple analysis and methodologies, and through the researcher's activities and reflections. This depth of reflexivity can be seen in the researcher's diary, showing the recognition of emotions, and the transference and countertransference of these within the analysis. I discuss these within psychodynamic theory below.

My approach to this research uses a combination of the data interpretations and the voices of participants that are revealed, and my position within the research. I hoped that this would give coherence and avoid fragmentation and lend clarity to my choices within the research. I chose pluralism for its layering

material from many perspectives in a pastiche as I thought that these would be important to hear the authentic voices of the nurses, and mixed methods could not produce that effect.

Frost argued that researchers who undertake pluralistic research need to consider who is a beneficiary: is it the researcher, the participant or the group that the research represents (Frost, 2016)? She asked who the stakeholders are – the researcher, through the work's completion; the participants, through the knowledge; and the nursing group, through dissemination of the results. The stakeholder is the university, and the NMC a covert stakeholder or 'lurker'.

This research involves data collection methods in the form of digital diaries, interviews and online discussion groups that produced data that could be analysed by both narrative and psychodynamic theories. Both theories have been used to draw on the strengths of each method used in the pursuit of addressing the research question (see Chapter 7). I now provide more detail on each approach.

Psychodynamic theory

This research uses psychodynamic theory, whose main concepts surround verbalising the unconscious, the emotions underpinning social interaction. By using this theory I hope to increase recognition of the researcher's subjectivity and the subjectivity in the participants' experiences, which shape their development of non-judgementality, as a valuable resource in the analysis of the data. Subjectivity is the individual's personal perspective of the way they view their world (Frost, 2011). Psychodynamic theory takes a phenomenological philosophical approach that recognises participants' experiences and consciousness. It sees an individual as having both a conscious and unconscious identity. Recognising the unconscious and the emotions underpinning social interaction can give valuable insight into a participant's

narrative and personal experiences. Psychodynamic theory can inform methods to capture the intrapersonal emotional element of participants' experiences.

The use of emotions involves Freud's theories of transference or countertransference, which feature in all relationships. Transference is the unconscious transmission of emotions from one person to another, whilst countertransference is the projection of the analyst's or, in this case, researcher's emotions onto the participant (Dryden, 1990). Holmes argued that the use of emotions in research through unconscious transference and countertransference is important to understand participants' inner world; however, it creates an intersubjectivity (Holmes, 2014). Intersubjectivity is the relationship between people, in this case the researcher and participant. Holmes argued that it can be problematic to use the countertransference and intersubjectivity created in the context of the research. The participant is projected to the forefront of the data, whilst the researcher is neglected:

> mistakes that the interviewer makes are explained in terms of projective identification, that is, the participant induces the researcher to behave in this way. (Holmes, 2014: 169)

Holmes argued that using countertransference can give a deeper understanding of the participants' experiences, yet a more critical stance is required to acknowledge participant bias and the challenge of co-participation in research (Holmes, 2014). There is the risk that I emotionally misinterpret the emotional projections, giving the wrong interpretation to the feeling. I may be led by the participant into prescribed roles and, in this case, this could be the role of either tutor or nurse. Gemignani found that the feelings that arose in the researcher were hard to acknowledge: 'whether I wanted them or not, my emotions were phenomenologically present' (Gemignani, 2011: 702).

Addressing the difficulties of intersubjectivity can be difficult. I have trained and worked as psychodynamic counsellor, throughout this process undergoing supervision and counselling that have given me greater insight into this complex relationship and my own defences and feelings. However, I recognise that mistakes in interpretations are inevitable. Holmes acknowledged that researchers who have trained in psychodynamic theory have a deeper understanding of their personal defences and will have a better understanding of the material, thus reducing countertransference (Holmes, 2014). Jervis (2009) summarised:

> for researchers to really understand respondents' experiences, they must first feel them. This inevitably involves transiently losing themselves in their countertransference. What is important is that researchers should then recover their objectivity and try to make sense of the feeling evoked in them, which might require them to seek the help of other. (Jervis, 2009: 157)

By using psychodynamic theory, I explore nurses' learning and development of non-judgementality and how this constrains or enables them. I believed that psychodynamic theory would help to bring the emotions within these experiences to the forefront and give a greater understanding of nurses' journey. Psychodynamic theory would capture participants' emotions, which other methodologies, such as narrative, overlook. This would give a greater understanding of nurses' experiences.

Narrative

Narrative research uses personal experience-centred narratives. They are assumed to be sequential and meaningful and an interpretation of experience; however, Squire argued that researchers have expectations concerning what is contained in a narrative and what makes a good narrative (Squire, 2013).

How the narrative is told is defined and regulated by cultural influences, which may also reveal existing ideologies and relationships of power and inequality. The setting of the narrative can provide resources and restrictions. It may be a social setting or, in this research, an institutionalised context. Participants are active narrators of their story and its interpretations and experiences, referred to as first-hand narratives. Student nurse participants may feel restricted in revealing poor practice or attitudes that may be frowned upon in nursing; however, rather than verbalise their feelings, they may express embarrassment, shame or anger. This is the everyday structure and practice of nursing. It is important, as it is how student nurses construct meaning through everyday structures and practices in the clinical area. This helps us to understand how nurses' professional identity is created and how it may be influenced by the hidden curriculum.

In 1967, William Labov and Joshua Waletzky developed a rigorous method for analyses of personal experience narrative (Patterson, 2013). Narrative research may be event-centred or experience-centred, and these types may overlap. Event-centred research focuses on Labov's work on recounting past events, whilst experience-centred research explores stories that are general or imagined and may vary in length, from interviews to life histories (Andrews, Squire & Tamboukou, 2013). Both event- and experience-centred narratives are accounts of an individual's internal thoughts and feelings to which the narrative gives external expression, and are containers of meaning. Event-centred research believes that individual and internal meanings and interpretations are constant, whilst experience-centred research holds that meanings and interpretations vary over time, so an episode can produce different stories from the same individual. Finally, there is a third form of narrative research that addresses the co-constructed nature of narratives found in emails or conversations. This type argues that accounts are not

expressions of internal states but socially constructed stories that are constructed dialogically (Squire, 2013).

Some researchers are interested in the social effect and personal agency of stories and the concept of performance. There is criticism surrounding the relative importance of 'small stories and big stories'. Big stories, it is argued, provide richer data than small, but big stories may contain long transcripts from interviews that lack social interaction and conversation, which may influence the narrative. Phoenix (2013) observed that, 'as a result, an increasing number of discourse and narrative analysts attend simultaneously to "small" and "big stories"' (Phoenix, 2013: 73).

Narrative is intrinsically social, revealing relationships with others, employment and social welfare histories (Wengraf, 2001; Squire, 2013). Squire used the example of a couple from South Africa with HIV, where the boyfriend refused to test when his girlfriend was found positive. Squire's research focuses on interconnectedness in cultural and personal narratives. She discusses through narrative the sociocultural influences of biography and the co-construction of narrative. These may have a social effect on a story and serve a helpful purpose for people (Squire, 2013). Traynor's work illustrates the purpose of narrative for nurses; it is not necessarily the truth, but it helps to support nurses' image of themselves (Traynor, in Latimer, 2003).

Edward Said observed on the influence of culture that:

> the power to narrate, or to block other narratives from forming and emerging, is very important to culture and imperialism, and constitutes one of the main connections between them. (Said, 1994: xiii)

Said's argument is aimed at the 'macro' narrative, yet he held that the formation of the larger narrative is influenced by the 'micro'. This may mean that a participant may limit what is said in a diary and block others from

speaking in a discussion group, thus controlling the group narrative. Seale (2018) argued that a narrative constitutes a densely layered cultural script, supporting the use of the methods chosen for this research to reveal cultural influences. It may be that some participants are culturally disempowered. My role as a researcher is to allow their narrative to emerge. I am aware that my position of power as a researcher may influence the narratives that I receive from participants. It is therefore important that I create an environment that fosters reciprocal and empowering interaction in order produce rich data (Cohn and Lyons, 2003). As Ewick and Silbey discuss,

> the structure, the content, and the performance of stories are defined and regulated within social settings often articulate and reproduce existing ideologies and hegemonic relations of power and inequality. (Ewick and Silbey, 1995: 212)

Hegemonic narratives therefore represent the influences of social, cultural ideologies. They are embedded in the social fabric and represent the social life that is taken for granted (Elliott, 2005). Elliott argued that research that does not recognise hegemonic influences and how they shape individual lives is at risk of reinforcing dominant ideologies and power differentials in society (Elliott, 2005). To address this, she argued that research should be sequential and chronological and 'include implicit assumptions or claims regarding causal links' (Elliott, 2005: 146). Without this transparency, she wrote, findings cannot be debated or the experiences of individuals understood. This is why narrative was selected as this study's methodology (Elliott, 2005).

Riessman observes that narrative research cannot be objective, as the 'story' has positionality and subjectivity. Participants or narrators can position themselves, for example as victims or powerless (Riessman, 2001). As their teacher, I revealed to participants my personality, attitudes and beliefs through my teaching; this may have been covert or overt. We all make assessments about an individual's identity when we meet them, deciding for

example their sexuality and politics. Many of these assessments are unconscious, so it is difficult for anyone to be completely objective.

Riessman argued that narrative research is from a position of subjectivity (Riessman, 2001). This is a form of bias: it refers to individuals' unique influences that mould their perceptions. However, the 'stories' or the narratives that they tell are not 'the truth' but are the truth from the participant's perspective and the truth from the listener. And the researcher does not treat them as the 'truth', coming from a position that will influence the interpretation. The narratives give an understanding of nurses' experiences and how they navigate health professionals with positive and negative attitudes on sexuality. They show how these enable or constrain their working roles and the development of professional identity. These narratives are the truth from the individuals' involved perspectives, and thus may not tell the true story, as they are stories from the perspective of those individual and may miss or enhance elements of their stories. Using subjectivity may also tell us how nurses make sense of the world around them in undertaking everyday nursing practice.

Polkinghorne highlighted the use of the word 'story' to refer to a narrative, which can imply a falsehood or misrepresent it by saying 'that is only a story' (Polkinghorne, 1995). I am aware that I have used the word 'story' as well as 'narrative' during the analysis. I have adopted the term 'narrative' when describing digital diaries, but 'story' if there is one within that narrative. Labov stated that stories convey 'imperfect truths'; however, others argue that they represent the experiences and realities of the narrator, including unconscious elements, and I would agree with this view (Squire, in Andrews et al., 2013).

Qualitative research was chosen for this project because it would reveal student nurses' voices, and this is why I selected pluralism. Through capturing the subjective experiences of student nurses, we can begin to understand how

they learn and develop non-judgemental practice. Qualitative research generates data that describe real-life situations, and it is concerned with interpretation.

In this research, digital diaries and interviews were collected to obtain the meanings that nurses gave to clinical stories, and these reveal nurses' attitudes (Silverman, 2014). Quantitative researchers' interpretations of their data focus on statistical results and how they achieved them. This type of data produces reliable evidence about a large sample, which gives precise results (Seale & Silverman, 1997); however, it cannot find out why a participant feels how they do or acted in the way they did. By contrast, qualitative interviews, for example, tell a story of the appearance of things to the participant and how they would like them to appear in the world.

The reliability of qualitative data can be problematic, as it relies on the researcher categorising material. This can lack consistency, yet that could also be applied to quantitative research. Qualitative research relies on what a participant tells the researcher, and they may choose not to reveal everything. Seale and Silverman argue that qualitative researchers, rather than addressing the reliability of the material, make claims about their ability to reveal authentic understanding of the practices and experiences of their participants (Seale & Silverman, 1997). They add that observational data, records and transcripts 'can offer a highly reliable record to which researchers can return as they develop new hypotheses' (Seale & Silverman, 1997: 380). Mixed-methods research, which combines qualitative and quantitative methods, might have been used; however, the design and methods of this current study focus on nurses' experiences, lending themselves to qualitative research. This study uses digital diaries and transcripts of online discussions to give the data depth. Interviews with open-ended questions are also used, which is less reliable than structured interviews but a valid route to obtaining participants'

personal accounts (Seale & Silverman, 1997; Corbin & Strauss, 2015). However, it may introduce interviewer bias, where the interviewer puts emphasis or gestures on questions (Delgado-Rodriguez & Llorca, 2004).

By using multiple methods such as interviews, online discussion groups and digital diaries, the triangulation is increased (Bryman, 2012). In this study, the methods and the research strategy are checked against the results of another method (Bryman, 2012). It compares the results of the online discussion group to those of the digital diaries and interviews. Frost argued that accessing data from several levels and of different qualities gives comprehensive triangulation:

> the outcome is a credible integrated reflection of different theoretical backgrounds that have been carefully considered in the methodological planning of the study. (Frost, 2016: 110)

Reflexivity

As I have preconceptions and assumptions, I cannot change my prior knowledge and experience and need to be wary of biasing my work. However, no one is ever actually a blank slate: we all have different experiences, and this study will either confirm or deny my preconceptions. It may be that I have unexpected findings and need to use abduction to explain them (Frost, 2011). This process helps to manage my preconceptions by testing hypotheses against the data and, in doing so, illuminate what my position obscures. Reichertz described two strategies in which abductive reasoning can take place (Reichertz, in Bryant & Charmaz, 2007). The first involves the researcher facing *not knowing* what to make of surprising findings and putting pressure on themselves to find a single meaning. The second is almost the opposite of the first, and allows for the researcher's mind to wander without a goal. These strategies encourage the conscious mind into an 'attitude of preparedness' to abandon old thinking and seek new thinking (Frost, 2011).

As a researcher, I need to be wary of interpreting events in the narratives and interviews and not to bias the interpretations with my personal experience and expertise, as seen in Ayres and Poirier's example of Mrs G (below) or Strauss's interpretation of risk in pregnant women (Ayres & Poirier, in Latimer, 2003; Corbin & Strauss, 2015). The issue of consistency arises in the researcher's choice and selection of material: limited space means not all the data can be revealed to the reader, perhaps influencing their interpretation.

Carl May discussed the problem of the insider and outsider construction of the researcher; along with Oakley, he argued that the participants and the researcher are shaped according to their shared experience (Oakley, 1981; May, in Latimer, 2003). Ayres and Poirier gave the example of meanings being missed if a researcher focuses only on the words of a story (Ayres & Poirier, in Latimer, 2003). They related the case of Ms G and her husband's experiences following brain surgery, when Mr G's behaviour and memory were affected. Ayres and Poirier (2003) found that Ms G had held her husband to blame for his behaviour after surgery. They concluded:

> I learned a great deal from Mrs G's interview, not only about secret and rational solutions, but also about the influence of meaning on caregivers' affective responses. (Ayres & Poirier, in Latimer, 2003: 121)

They commented that Mrs G lacked coherent explanation and, to relate her story to her responses about Mr G's care, made choices about the structure of her story. Ayres and Poirier commented:

> by trying to impose my own story on theirs, I had attempted to make their stories suit the logic of my own plot. Once I recognised that my informants and I were working from different plots, and that my ideas of ending interfered with informants' sense of their own stories, the barriers to a rational solution were overcome. (2003: 124)

They commented that, owing to their clinical experience, they understood the merits of advance planning; however, this was a lower priority for caregivers, for whom it interfered with dealing with the 'here and now'.

Ayres and Poirier's account highlights the unreliability of the researcher's voice in the interpretation of a story, which may bias the research. This can be by the researcher inferring moral values, by being misinformed, or by being unable to understand the events related in the story. As a researcher with clinical experience in sexual health, I need to recognise my position in the research and, like Ayres and Poirier, to recognise its potential influence on participants' stories. For example, I might expect nurses to be unembarrassed by sexuality, as I am not, or to work in a certain way, because I do. This might prevent me from seeing why the participants work and act as they do. Rosenthal advocated that when researchers are discussing the results they include:

> any reference we make to a sequence from the text should show how this sequence reproduces the case structure – or indicates the beginning of its transformation. (Rosenthal, 2018: 87)

To illustrate the emotions within the material, which are difficult to detect if it is dissected, I have chosen to reproduce the whole narratives. This way, my interpretations are verifiable and there is an openness to how I have arrived at them.

Corbin and Strauss argued that researcher biases and assumptions have the greatest impact on research through the meaning that they give to data, the questions that they ask and the comparisons that are made (Corbin & Strauss, 2015). Corbin's role as a nurse meant that she categorised her research on pregnant women by medical definitions of risk rather than by the women's perceptions of risk, which were different. She acknowledged that she had assumed that a woman's definition of risk would be the same as that of the

healthcare team (Corbin & Strauss, 2015). To address this, she argued that researchers need to be reflexive and examine the impact of their position, presence and perspective on their research, and in keeping with pluralism (Frost, 2011). Researchers should keep a methodological log of their research decisions that is open to public scrutiny and evaluate their research process, which this study will do (Frost, 2011; Corbin & Strauss, 2015).

To reduce bias in qualitative research and increase rigour and validity, this is how the account accurately represents the social phenomenon (Silverman, 2014). I have used multiple methods addressing pluralism, using recordings and transcripts to produce accurate data transcriptions and reduce recall bias by either the researcher or participant (Delgado-Rodriguez & Llorca, 2004).

Porter maintained that the values and interests of the researcher are central to the research process (Porter, 1993). He argued that researchers cannot be truly objective and should develop reflexivity, which is an acceptance that they are part of the social situations that they are studying, recognising their effect on their research rather than trying to eliminate or ignore it (Porter, 1993). Rather than 'engaging in futile attempts to eliminate the effects of the researcher, reflexive researchers try to understand them' (Porter, 1993: 141). Reflexivity can be useful in providing information on the problems that researchers face; however, it requires the researcher to examine how their values and interests impinge on the research and how their role colours their choice of research method and assessment. Frost argued that reflexivity makes research more transparent and accountable, so that readers can understand how and why we obtain the results that we have (Frost, 2011). I am aware that, for me, this subject area is extremely important, yet in clinical practice, with plenty of competing issues, health professionals may not agree.

I have argued in the literature review that patients would be happier if their sexual health needs are met. I come from an informed position with skills that

afford me the ability to address this area with confidence, but how do nurses without this knowledge feel? Is it possible for me to understand their position? I hope that by using multiple methods and pluralistic methodology I will be open to understanding.

Theoretical approach of data analysis

The theoretical approach to the data uses the work of Labov (Labov & Waletzky, 1967/1997), Braun and Clarke (Braun & Clarke, 2006) and Balint (Holmes, 2014) to analyse and reveal a more complex and multifaceted picture of sexuality. The data collected include online discussions, digital diaries and interviews. The approaches to data analysis are discussed below.

The digital diaries and interviews were analysed using Labov to provide a broad picture of the data, then Braun and Clarke's work to direct the analysis. Following these methods, Balint's work was used to analyse the digital diaries and interviews, and this is seen in the findings chapters in the researcher's story.

The narrative in this research is a digital diary or interview that participants kept during their clinical placement. This medium allowed participants the freedom to speak and reveal their experiences. By asking the student nurses to tell their own narrative, the complexity of their experience will be revealed rather than reduced to universal understandings and explanations. However, it has been argued that participants will reflect on their narratives and thus change and distort them (Elliott, 2005). These changes and distortions reveal how participants make sense of the clinical area. By asking the students to keep a digital diary, I had indeed hoped to encourage them to reflect on their experiences and feelings. This approach is based on the Balint method to encourage practitioners' reflection on feelings that relate to the emotions of

both patient and practitioner during a psychosexual consultation, using this to move forward with the issue (Wells, 2000; Allan, 2009).

The online discussions were analysed after the digital diaries and the interviews, again using Labov, Braun and Clarke, and Balint.

These methods and their influence on me are outlined below.

Labov

Labov was used first to analyse the narratives. I found it useful to have a framework as I had a large volume of data, and it was overwhelming. Labov described how narrative has two functions: referential and evaluative (Labov & Waletzky, 1997). Referential describes the orientation and grounding of the story in its context and the sequential order of events; evaluative describes the narrator's purpose in telling the story.

I used Labov's categorisation of clauses to analyse the data:

- The abstract – what is the story about, the orientation – who, when, where?
- The complicating action – then what happened?
- The evaluation – what finally happened? (Patterson, 2013: 30)

The abstract summarises the story and is usually at the beginning. The complicating action is often referred to as the 'skeleton plot' or the 'spine of the narrative' and is its structure. The evaluation, Labov believed, was the most essential element, revealing the narrator's perspective of events.

There are three types of evaluation: external, embedded and evaluative. External evaluation is where the narrator overtly stands outside the story and tells how they felt about it at the time of retelling. In embedded evaluation, the narrator stays within the story to recount how they felt at the time. In

evaluative action, the narrator stays within the story and reports the actions that reveal emotions.

Evaluative elements in the narrative text were also identified by Labov, which he categorised as intensifiers, comparators and explicatives. Intensifiers contain expressive phonology, for example 'I shouted'. Comparators are where the narrator compares what did to what might have happened. Explicatives involve the cause and explanation, for example 'I was so upset I burst into tears' (Patterson, 2013).

Labov created an organised and detailed method for analysing narrative, and this structured methodology gives researchers a framework of questions for comparing the narratives of different participants. By these evaluation categories, Labov facilitates the identification and analysis of events. There are problems with the narration of events, as Labov did not make allowance for personal experience's influence on the construction of the nature of the account. As I have professional experience of sexual health, I may have unwittingly influenced the data through this experience.

Labov's categorisation theory helped me to focus on the intent of the story, who the participants were speaking to and why. Labov's model considers the structure of the narrative rather than the narrator. Robichaux, cited in Riessman, commented that Labov's approach can 'reinforce thematic analysis, achieving triangulation' by the formation of structural analysis in the narrative (Riessman, 2008: 91). However, whilst it helped me to organise and facilitate my thinking, I found that using this analysis lost the voice of the nurse – what she was trying to say within the story – so I continued my analysis with Braun and Clarke.

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Braun and Clarke

Following further reading, I chose to use Braun and Clarke to focus my narrative analysis. During my analysis of the diaries and interviews, I considered the following key questions, which are integral to narrative analysis:

- What does the participant say in the story and what are the effects of the story?
- How is the story structured?
- What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?
- How do the narratives constrain or enable the participants' lives?
- How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?
- Who does the story connect the participant to?
- Who is placed on the outside of the story?
- What is the response of the listener to the story?
- What counts in the response from the listener? (Braun & Clarke, 2013)

Superficially, there is an overlap between Labov and Braun and Clarke's methods of analysis: they both ask about the structure of the narrative. However, Labov's categorisation of answers provides a brief summary of the narrative's structure in the form of a sentence, whilst Braun and Clarke's gives a more detailed account. Braun and Clarke's method encouraged me to progress my analysis from Labov, onto Braun and Clarke, onto Balint. I felt that Braun and Clarke did not encourage me to think about the emotions in the diary instalments in enough detail, so I looked at other narrative researchers to evaluate the best possible way to analyse narrative. After reading work by Riessman, Fraser, and Braun and Clarke (Riessman, 2001; Fraser, 2004; Braun & Clarke, 2013), which will be discussed later, I chose to use Balint to analyse

the diaries. This choice evolved. Braun and Clarke's questions – 'What is the response of the listener to the story?' and 'What counts in the response from the listener?' – may become confused with the work by Balint. Their word 'response' could relate to the researcher's feelings, yet it does not look at the countertransference that Balint's analysis theory does, so the two methods of analysis offer different insights. The sequence of analysis, from Labov, through Braun and Clarke and then to Balint, encouraged my interpretation to evolve in a deeper way that seemed a natural progression.

Narratives often involve a negotiation between the speaker and the listener. Paralinguistic utterances ('ohm's), false starts, interruptions and other subtle features of interaction are revealed (Riessman, 2001). Riessman argued that deciding whether these utterances are included or omitted is an interpretive act, and I have chosen to include them as they may indicate the emotion of the speaker, such as her embarrassment. Lanceley and Macleod Clark coded their narrative research (Lanceley & Macleod Clark, 2013) using symbols for short pauses and length of silences. I have chosen not to do this, as I felt that it detracted from the narrative.

Fraser's work on narrative research (Fraser, 2004) asks researchers to consider certain questions, for example: what sense do you get from the narrative? How are emotions experienced during the narrative, and how does each narrative start, unfold and end? How curious does the researcher feel listening to the narratives? How open is the researcher to reflect on the narratives and the insights they reveal in the researcher's experience? Does the researcher have adequate support to engage in this work? (Fraser, 2004). I used Fraser's research questions as a focus in writing up the researcher's narrative of the diary.

Riessman held that there are three levels of inquiry and analysis in narrative research: the story that the research participant tells, which in itself is an

interpretation and reconstruction; the interpretative accounts developed by the researcher ('the narrative of narrative'); and the reader of the narrative reconstruction ('the narrative of narrative of narrative') (Riessman, 2008). Other researchers have referred to these as first-, second- or third-order reconstructions. Riessman discussed four main methodologies that have narrative properties: thematic analysis; structural analysis; dialogic/performance analysis; and visual narrative analysis (Riessman, 2008). She argued that thematic analysis, where the narrative is spoken or written, is like grounded theory but, in this instance, the story is kept intact and thematic meanings are emphasised over language. Structural analysis focuses on how the narrative is organised. This can generate insight that is not simply said in the participants' words. An example would be Labov's categorisation model. Dialogic/performance analysis concerns the performance of the narrative and stories as social artefacts that inform us about society and culture, as well as the person (Riessman, 2008). Finally, visual narrative analysis incorporates images and words, and this current study does not have visual material.

Riessman noted that, when as individuals we 'perform' diaries, we represent our preferred identity, including how we organise material, use grammar and choose our social position (Riessman, 2008; Loots et al., 2013). Social positioning is how the narrator positions themselves relative to the audience, characters and themselves, and also how the listener/reader positions the participant (Loots et al., 2013). It is important that I recognise this process and constructions and my position within this datum.

The participant may speak directly to the researcher or to other people through the narrative. The participants knew the researcher as a teacher who had taught them the topic of sexuality. During the teaching component, I would have revealed my covert and overt views through actions, expressing my passion for the subject area. So, my involvement is entangled in the

research. The participants are often addressing me directly and recognising areas that we have talked about, and this has been acknowledged in the researcher's story. Frost (2011) raised questions about who you are as a researcher, why you are conducting the research and what to do with the awareness of your involvement. I have chosen to include my positionality within this research, as pluralism allows differing aspects to be considered (Frost, 2011); however, I am aware that I will need to keep reviewing and reflecting on it and its influence.

Frost stated that the role of emotions is often neglected when conducting research, yet can, if recognised, be an opportunity to improve it by considering the researcher's emotions and the participants' interactions (Frost, 2016). She argued that the challenging aspect of emotionality is to recognise that:

> it is sometimes easier not to identify unacceptable emotions (perhaps ones that evoke feelings of pleasure at the misfortune of others) and sometimes difficult to name feelings, instead of just knowing that something is not as it should be. (Frost, 2016: 157)

I chose to discuss my emotions as a researcher when analysing the narratives and the participants' emotions that are revealed through the narratives by using countertransference (Holmes, 2014). The advantage of digital diaries is that they reveal the emotion of the participant at the time of talking. Squire stated that spoken diaries have strong cultural currency in this autobiographical age (Squire, in Andrews et al., 2013). This is why the hesitations, silences and rising voices have been included in the transcription of the narratives, as they lend meaning and emotion to the stories told.

Balint

The influence of Michael Balint on this research's theoretical framework has been discussed (please see literature review, Chapter 2). Balint's theory is important because it recognises the emotions, and it is feelings that I wish to

acknowledge in the narratives and discuss. As a nurse working in sexual and reproductive health, I have used Balint's seminar training to understand the psychosexual issues discussed in consultations. This type of seminar training was pioneered by Michael Balint and Tom Main in 1957 and recognised the interaction between the patient and health professional (Montford & Skrine, 1993; Skrine, 1997). It brings a deeper understanding to the unconscious matters within the consultation (Skrine, 1997). My training as a psychodynamic counsellor and experience in using this method have influenced me, but I had not considered it as a method of analysis. However, the emotions within the stories became an important part of supervision; recognising them, I felt, is the value of this research. De Lambert argued that emotions are important in nursing: 'the recognition and valuing of responses and feelings enable nurses to use them for better understanding of interactions and relationships' (De Lambert, 1998).

Balint's consultation model revolves around telling the story of the patient and the consultation, usually within a training group (Montford & Skrine, 1993). The act of telling it encourages nurses to think about what is going on in the consultation, which also serves to create a psychological distance to help reflection on the nurse–patient relationship (Montford & Skrine, 1993). This distance encourages the nurse to think about the feelings that they experience. Skrine outlined how 'the process is one constant change between two positions as the act of pulling back to think can allow more feeling to follow, and as more is felt there is more to think about' (Montford & Skrine, 1993: 223). This is illustrated in Figures 3-1 and 3-2, showing how Balint's work is used in the analysis of the narratives. Figure 3-3 shows a worked example of this analysis.

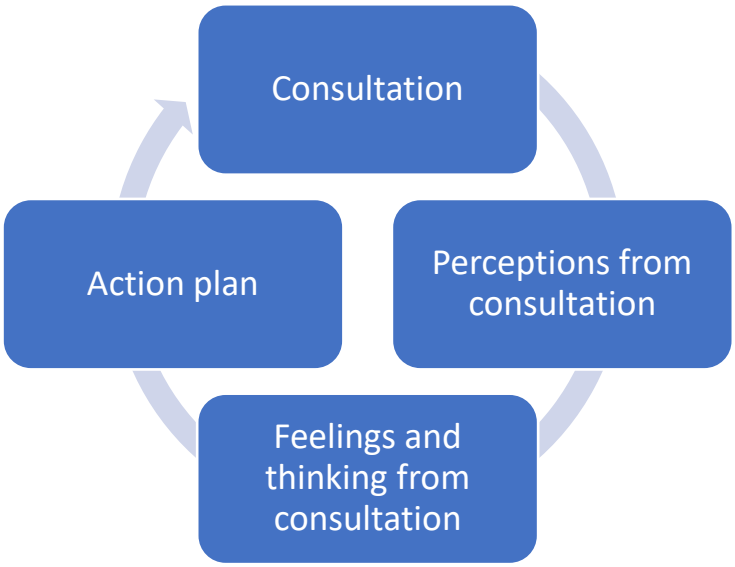

Figure 3-1 Balint's consultation model

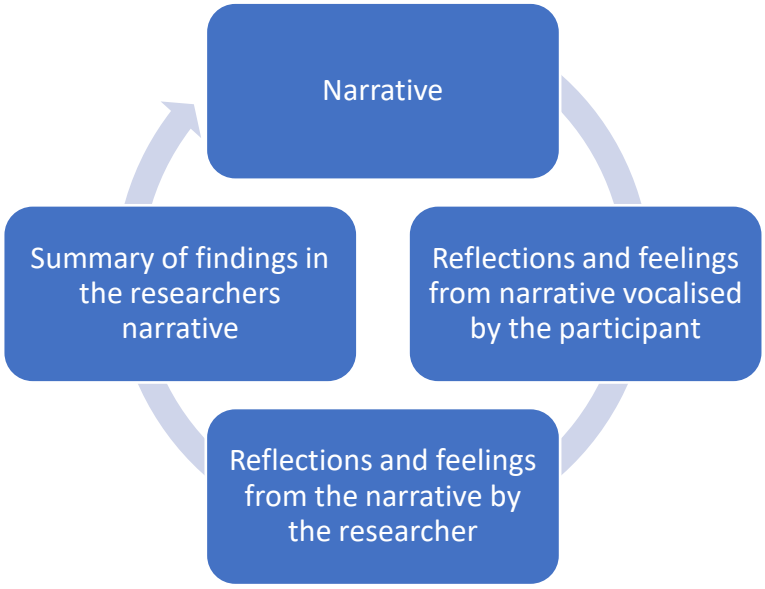

Figure 3-2 Emotional resonance of narratives

The researcher's narrative focuses on Figure 3-2 and the reflections and feelings in the story experienced by the researcher. The emotions may be verbally expressed by the participant, but the strength of feeling may not always be vocalised by either them or the researcher. In Figure 3-3, an invented story illustrates how the feelings and emotions may be recognised. The participant does not vocalise her sadness and anger, yet these emotions are seen in the narrative. This method of analysis encourages the researcher

to reflect on their emotions during the analysis, and these are recognised in the researcher's story, where she vocalises anger and sadness.

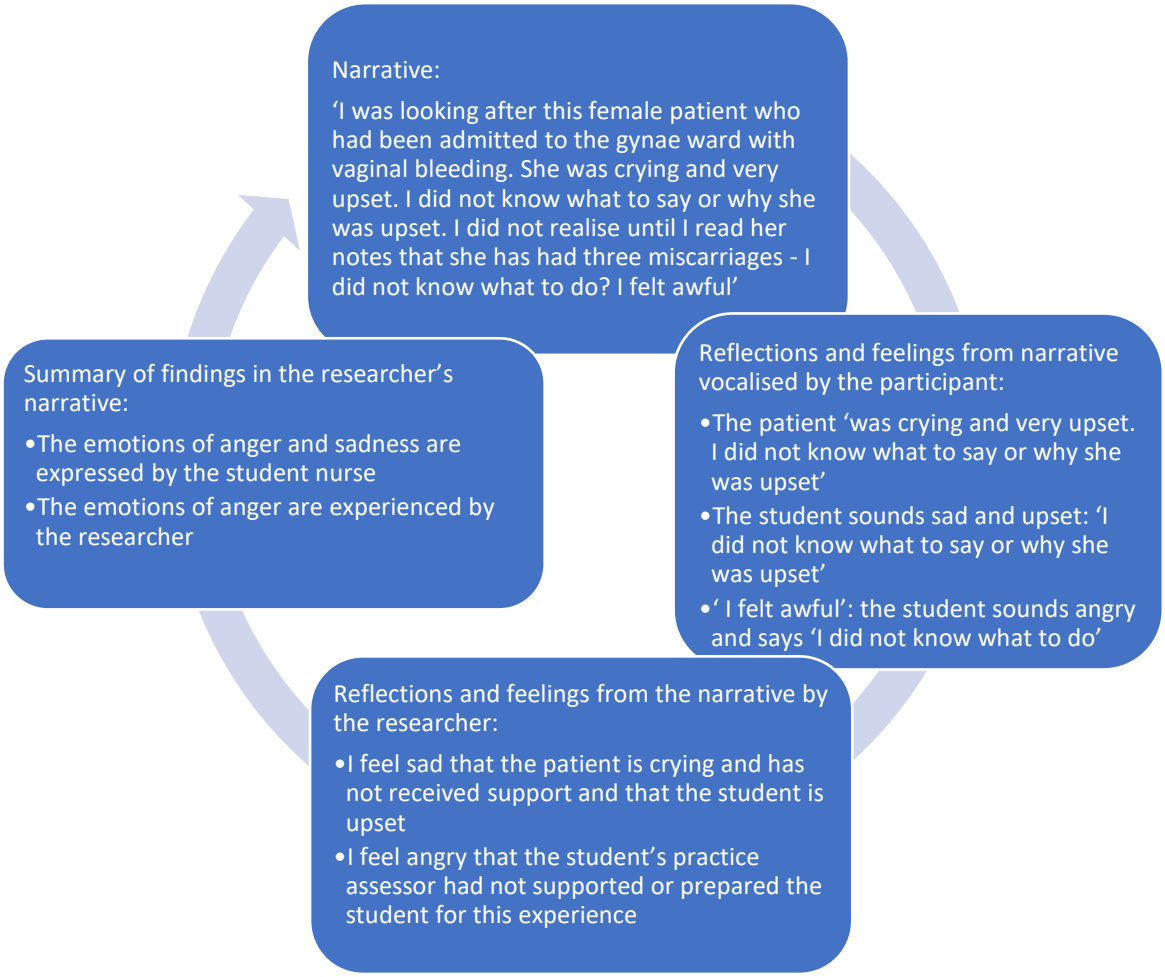

Figure 3-3 Example of emotional resonance of narratives

Summary

In summary, pluralism has been used as a methodology to allow the participants' voices to be heard, giving a layered depth to the data utilising narrative and psychodynamic theories. Narrative methodology has given space for the cultural and social influences to be revealed, giving insight into participants' experiences; this has allowed their stories to be heard. Psychodynamic theory has allowed the emotions to be acknowledged within these narratives from the perspective of the participant and myself. Social

constructionism has framed and influenced my thinking, acknowledging the influences of cultural and society on participants.

This chapter has addressed the following and is linked to Chapter 4:

- Methodology comprises narrative and psychodynamic approaches.
- Methods of data collection comprise digital diaries, online discussions and interviews (Chapter 4).
- Methods of analysis draw on the ideas of Labov, Braun and Clarke and Balint (Chapter 4).

Chapter 4 Methods in Action

This research was designed around a module that was developed, as in Bell and Bray's work (2014), to encourage students to discuss and challenge their attitudes in small groups and, in addition, addressing a wide area of sexuality. Here, the students are asked to discuss scenarios both in pairs and as a group about how their patients may feel and why they may act in the way they do. Encouraging discussion and group discussion in the classroom, I hoped, would foster students' reflection and thoughts on the subject.

During this module participants were recruited to participate in online discussion groups, digitals diaries and interviews. This chapter discusses this process: how this research was designed, implemented and conducted.

Setting

The setting was Middlesex University, based in London, which teaches an undergraduate degree nursing course, where the module 'Sexuality and Health' is on the year-two curriculum.

Ethics

Research approval was obtained from Middlesex University, Health and Education Research Committee (see Appendix C). There were no issues in gaining approval. Participants were given a written explanation of the purpose and benefits of the study (see Appendices D and E). They were given freedom to volunteer or refuse involvement, and were able to withdraw at any point in the study. All data were anonymised. Student nurses were assured that, whether they agreed or refused to participate, their grade or coursework would be unaffected.

This research is of a sensitive nature, as it involves participants' attitudes to sexuality. Lee's definition of sensitive research includes participants' personal

experience, practices where there is social control or where the subject area is sacred to a group of people (Lee & Renzetti, 1990). Non-judgemental attitudes in sexuality can be sensitive, as they involve attitudes, beliefs and practices around sexuality, sexual health and illness. Students may find areas of homosexuality or transgender, abortion or FGM emotionally upsetting. There is a high level of risk to the participant, and it is important that data are kept private and stigma is reduced (Greenhill & Sergeant, 2013). Students who participate may be 'driven by the conscious or unconscious desire to present oneself as socially favourable' (p. 69).

Lee argues that research on sensitive issues is considered ethical if there are benefits to society, it provides knowledge and the risks to participants are minimal (Lee & Renzetti, 1990). This research provides information on students' attitudes and their experiences in clinical practice and whether this area is successfully addressed by the curriculum, and this meets Lee's criteria for ethical research.

The narratives in both the interviews and the digital diaries contain sensitive material. The digital diaries give nurses' accounts of their experiences of sexuality in their clinical placement, and the interviewees were asked about their experiences of sexuality in the clinical area. The interviews were informal, with open-ended questions that focused on their narrative. It was not a formal interview with questions and answers, as the only questions were at the end of the account to clarify details (Brinkmann & Kvale, 2015). Sensitive narratives need to be told with the minimum of interruption to avoid discontinuity and to allow the participants' narrative to be told rather than the researcher's story (Hyden, 2013). Narratives may be incomplete stories and may not contain the expected elements or be stories. There is a danger that researchers can assert interpretations of the narrative to which the participants have no access (Squire, 2013). Nonetheless, as I feel this methodology allows this freedom for

nurses' voices to be told without me as the researcher putting my voice to their story, narrative research has been chosen for this study (Frost, 2016).

The digital diaries and interviews were analysed using narrative methodology. This allows the researcher to focus on the narrative and investigate how the stories are constructed (Bischoping & Gazso, 2016). Elliott reported that:

> by enabling women to tell their own stories and creating a context in which they felt comfortable exploring their feelings and experiences I was able to learn more about their aspects of their lives and crucially affect their chances of success when they return to study. (Elliott, 2005: 23)

An advantage of narrative methodology and the methods chosen was the ability to gain the social and cultural influences that had framed the experiences of the participants.

Recruitment

The year two nursing cohort is divided into practice learning groups and organised by the practice-based placement unit into usually 20 to 25 students. They were taught a 'Sexuality and Health' module in eight groups of 20. In total, 27 students were recruited as participants. Three groups participated in online discussions, eight diaries were completed and three interviews were conducted.

Recruitment of participants

All 160 year-two undergraduate nursing students were taught a two-week module on sexuality and nursing. This comprised two taught days, two weeks apart. Of the eight groups, three groups were due to undertake a clinical placement following the taught module, and these students were asked to participate.

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Prior to day 1 of teaching, Groups 2, 3 and 5 were invited to attend a meeting to discuss the research over the coffee break. Students were provided with beverages and information on the research. They were invited to participate in an online discussion group during the two weeks of online resources (see participant information leaflet in Appendix E. Following the online discussion, the group would meet in the lunch break of the second day to discuss the use of digital diaries in their clinical placement. This is discussed in Chapter 6. Participants who did not take part in the online discussion group were still able to participate and complete digital diaries and interviews.

The online discussion was set up on the virtual learning environment, and only the participants in each group and the researcher could access the discussion. Specific times were chosen by the participants to meet as a group, and students could also post at any time outside of those times. The participants were told that they could discuss anything relating to the sexuality and nursing curriculum, either from the classroom or online resources.

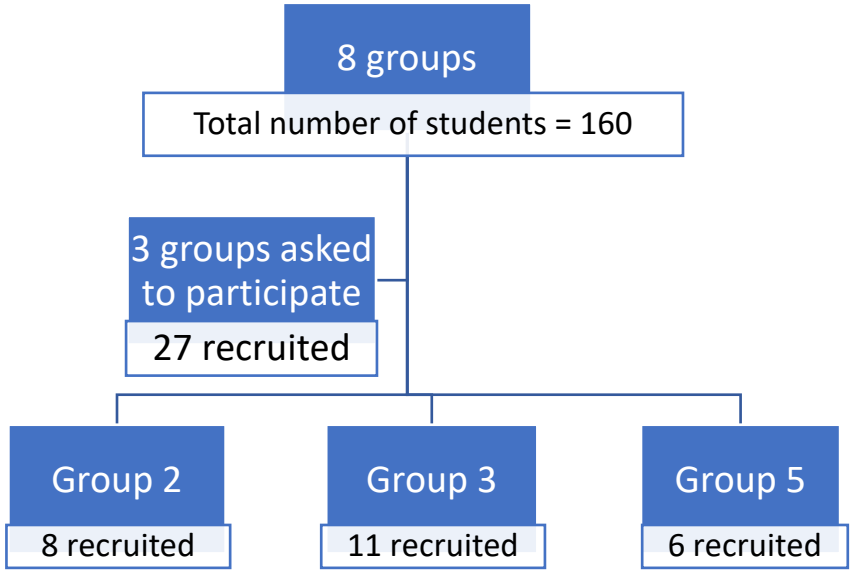

Figure 4-1 Overview of recruitment

Group 2 was the first to participate, and eight participants were recruited. This was my first online discussion group. We initially chose two occasions on which

to meet up. As the researcher, I reminded the participants via their university email account about meeting up. At the first session no participants attended, but at the second there were two. From this first online discussion, I learnt that students did not access their email accounts but preferred text message reminders. Students had organised WhatsApp groups and mainly communicated through these, so when I asked a member to remind the others through this route it proved successful in increasing attendance. Another issue that affected students' ability to attend online at specific times proved to be the Southern Rail strikes. Whilst the students had chosen a convenient time, both the researcher and participants were sometimes delayed, making it difficult to discuss at the designated times. This also highlights some of the difficulties students experience when teaching is taught remotely.

Group 3 was the second to participate, and 11 students were recruited and five participated. This online discussion group's attendance was more successful, because I reminded them via text messages about the online group's times and one of the participants reminded them via their WhatsApp group. The data have been used as an example as they are the most extensive of all the online discussions.

Group 5 was the last opportunity to recruit students. Six students were recruited but, although the same reminders were used via text, none attended. This class had a dominant student in the classroom and, whilst she was not recruited, I did wonder whether her negative attitude to the teaching had influenced her peers' involvement. One student completed a digital diary and two students contacted me, despite not completing a digital diary, and attended an interview. These are detailed in Chapter 6.

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Research design

From October 2016 until October 2017, all second-year undergraduate nurses were asked to participate in a synchronous online discussion group. This provided a space for them to discuss the sensitive subjects covered by the module. The synchronous online discussion was held once a week at an agreed time over a two-week period while the module ran.

Following completion of the module, participants were asked to keep a digital diary during their clinical placement and then return for a one-to-one interview.

Context of research sample

The nursing school sample of Middlesex University is made up of 1,038 students: 19% are postgraduate and 68% undergraduate. The student demography is 85% female and 15% male, similar to the NMC Register proportions of 89% female and 10% male. Some 88% reported no disability. The age range of the students was 23% 16- to 20-year-olds, 15% 21- to 24-year-olds, 14% 25- to 29-year-olds and 48% over-30-year-olds. The breakdown is similar to the NMC Register, once the dissimilar age range parameters are taken account of.

The nursing school's ethnicity is 40% White, 30% Black, 19% Asian, 5% Mixed, 4% Other unknown, 2% Arab and 1% Chinese. The school has a higher proportion of Black and Asian students than the NMC Register. This highlights the importance of a sample that is representative of the nursing population on the NMC Register to give a comparable picture of nursing (see Appendix B).

Purposive sampling

This research used purposive sampling (Cohen et al., 2011), where participants are recruited because they have a specific characteristic. In this instance, the

students were all second-year undergraduates on nursing degree and master's-level nursing programmes. Using purposive sampling would give insights into and understanding of a sample of nursing students representative of the target population of nurses. This means that the samples should have a profile of attributes that match the nursing profile of England and Wales (Cohen, Manion & Morrison, 2011). By choosing year-two students, I include nurses who have undertaken a year of their undergraduate training and thus can cope with the extra demands of the research. The participants who were recruited as a sample reflected the variation of diversity seen on the NMC Register.

Under the Freedom of Information Act, a request was made to the NMC for details of the demography of registered nurses. There were 469,883 (79%) nurses in England, 71,372 (12%) in Scotland, 28,963 (5%) in Wales and 22,079 (4%) in Northern Ireland registered with the NMC on 4 January 2016 (NMC, 2016a). Nurses registered with the NMC defined their ethnicity as shown in Table 4-1 in Appendix B.

Nurses are still predominantly British and, as a result, have similar educational backgrounds. The recent temporary relaxation of the restrictions on recruiting overseas nurses mean that it is now easier to employ a nurse from outside the European Economic Area. The media coverage has tended to show nursing as employing high numbers of overseas nurses, yet this is not reflected in the figures (March & Loudon, 2007; Kirby, 2015).

Methods

There were three methods, and all were optional, meaning that participants could participate in one, two or all three forms of data gathering. The three methods included online discussions, interviews, and digital diaries.

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1. **Online discussion**

Synchronous discussions meant that all the group members were online at the same time, so that individuals' contributions could be responded to by others immediately (Nelson & Staggers, 2014). There are many advantages to conducting research using an online discussion group, as it may allow quieter students to participate. Disadvantages may include a lack of rapport between the researcher and the participants, but this is more likely to occur with asynchronous online discussion groups (when students do not meet at the same time), hence the choice of synchronous discussions (Bryman, 2012). Other problems with online discussion include difficulties with internet access and, particularly in synchronous groups, variations in keyboard skill that may create unequal access for various members of the group (Bryman, 2012; EDUCAUSE, 2013). I chose to keep errors in participants' typing for accuracy, and to illustrate the levels of IT skills that participants had.

2. **Digital diaries**

Participants were asked to use a digital recorder to record weekly instalments of the examples of sexuality that they encountered during their clinical placement. Not all participants completed digital diaries. They were told that they could discuss anything and had the freedom to choose what they covered (see instructions in Appendix D). All diaries were anonymised, but the participants did not any reveal details of patients, staff or locations.

The advantage of the digital diaries for me was the ability to hear the excitement or anger within the narratives. Participants' voices were raised and I chose to illustrate this in the transcribed diaries with ↑. If there were pauses in the diaries, these were indicated by …. The participants spoke their diaries directly to me, whom they knew, so this gave an intimacy, when listening back to the diaries, and facilitated the recognition of feeling and emotions.

3. Interviews

All participants were offered an interview upon completion of their digital diary, but only participants who had been recruited and not completed a diary agreed to attend for an interview.

The interviews were held at the university in a small group office that was quiet and free of interruptions. I chose to not use my academic office as it is open plan and would not give privacy. However, the use of academic offices is not ideal and it is argued that they are 'not conducive to reciprocal interactions between researcher and participant' (Gagnon et al., 2014: 209). I considered visiting the participants' placements, but discounted this as experience shows that there are more interruptions and less privacy. Gagnon et al. (2014) argued that there is an ethical tension in conducting research interviews in hospital environments. My participants were asked to reflect on their clinical experiences; if I had held these interviews in the clinical area, participants might have felt vulnerable and less open to discussing negative events. On reflection, I felt I chose the best location for the interviews; however, the power of the academic and the role of the student make choosing a suitable location problematic.

Interviews were conducted with three participants. These asked open questions and participants were allowed to tell their story in their own words and in their own time, without interruption. I chose to carry out informal interviews where I asked participants to tell their story without questioning to avoid interrogation. I work as a counsellor and use silence within this role and utilised this within the interviews to give participants time to reflect (Brinkmann & Kvale, 2015). By allowing participants to speak, I felt that I was allowing their stories to be told in their own format, keeping within narrative methodology (Frost, 2009). The interviews are shorter than the digital diaries, because I did not interrupt their stories, only asked clarifying questions at the

end of the story. I chose to do this to reduce my influence on the story and how the participants told it. These interviews were recorded and transcribed.

Data collected

Details of the three groups recruited and numbers of participants are shown in Table 4-2.

Table 4-1 Data collected from online discussion groups, diaries and interviews

Participant	Group	Online discussion	Digital diary	Interview
2	5	No	No	Yes
3	3	No	Yes	No
4	5	No	Yes	No
8	2	2	No	No
10	5	No	No	Yes
12	3	3	Yes	No
13	3	3	Yes	No
14	3	3	Yes	No
15	3	3	Yes	No
16	2	2	No	Yes
19	2	No	Yes	No
21	3	3	No	No

These groups were:

- Group 2, from 14.11.16 to 28.11.16
    - Online group: recruited eight participants, and two participated.
    - Digital diaries: recruited nine, and one completed.
    - One interview.
- Group 3, from 9.1.17 to 23.1.17
    - Online group: recruited 11 participants, and five participated.

    - Digital diaries: recruited seven, and five completed.
- Group 5, from 27.3.17 to 10.4.17
    - Online group: recruited six participants. No participants accessed the online discussion group, so none participated.
    - Digital diaries: one completed.
    - Two interviews.

Analysis

The methodology for this research is pluralistic. The data for the digital diaries and interviews were analysed first, being the most extensive, as I felt that this would give me more of a picture of the themes of the research, whilst the first online discussion, Group 2, produced less data. Whilst the online discussions by each group were completed first, they were downloaded and saved and anonymised; they were set aside and not examined until after the analysis of the digital diaries and interviews.

The digital diaries were recorded and listened to on three occasions. They were then transcribed and listened to again for accuracy and proofreading. The details were anonymised. First, emerging analytical ideas from the digital diaries analysis are seen in Figure 4-2. These revealed attitudes, both negative and positive, about patients and staff, and discrimination: nursing practice showed examples of a lack of training, knowledge, communication and awareness of sexuality. Personal feelings were expressed that revealed anger, embarrassment and sadness. Finally, participants reflected on their journey and increased awareness. The diaries' lengths and word counts were recorded. The data were manually reviewed and re-read, looking at the stories and what these revealed, and through first-level analysis using Labov. This generated an abstract, evaluation and coda of the narrative and enabled me to choose the digital diary with the best examples of the narratives. Following Labov, I used Braun and Clarke to analyse the narratives in greater detail.

Figure 4-2 Emerging analytical ideas from the digital diaries analysis

Each time, I went back to the narrative in its written and recorded forms to listen and review the material. Following completion of the analysis using Braun and Clarke, my supervisors and I discussed the emotions in the narrative, which using Braun and Clarke had failed to address. This led to me considering the use of Balint, which addresses emotions in narrative and psychodynamic theory, as another method of analysis and second-level analysis. One of my supervisors and I had experience of using this method clinically, so we were familiar with it, and this certainly influenced my decision to produce the researcher's stories. Once this process was complete, stronger themes emerged from the data and were considered in the analysis of the interviews.

To ensure accuracy, the interviews were recorded and transcribed immediately afterwards. The details were anonymised following each interview to protect participants' privacy. The interviews were analysed using the same process: first Labov, then Braun and Clarke, and finally Balint were used to create a researcher's narrative (second-level analysis). However, the interviews were analysed in the light of the analysis of the digital diaries. As a

result, I was aware of the themes that I had seen emerge from the diaries, and hence looked for them in the interviews.

Following analysis of the interviews, I returned to the online discussion group and reviewed the discussions. I was limited in my choice of data, as there was less material. Group 5 involved no discussion, so was immediately discounted; Group 2 involved two participants and Group 3 involved five and was the most comprehensive, so I selected this group. The online discussion was analysed using first-level analysis of Labov and Braun and Clarke and second-level analysis of Balint, which is seen in the researcher's story (seen in Chapter 5). The researcher's diary is documented in Section 4 of Chapter 6.

Within the body of the text, any participant comments are written in blue and the narratives as a whole are shown in blue, for clarity.

The analysis of the online discussion groups can be found in Chapter 5. The analysis of the digital diaries is found in Chapter 6, Section 1, whilst the interviews are located in Chapter 6, Section 2.

Chapter 5 Results of Online Discussion

There were three online discussion groups. Group 2 contributed limited discussion, mainly due to the rail strikes that affected participants' ability to join their group at the specified time. Group 5 did not contribute. Group 3 provided the most comprehensive discussion and had five participants.

Online discussion group data

The details of the online discussion group participants are given in Table 5-2. I have chosen to illustrate these data with Group 3's online discussion, as this was the most comprehensive.

Table 5-1 Details of participants in online discussion groups

Online discussion group number	Number of participants involved	Participant ID
Group 2	2	8 and 16
Group 3	5	12, 13, 14, 15 and 21
Group 5	0	–

Group 3 online discussion

Group 3 was an all-female group. I have kept the online discussion as it was originally keyed in and shown when participants entered and left the chat. One participant typed in capitals, and this has been left as in the original. There is also chat with typing anomalies and, again, I have left as it was rather than put my interpretation on it by changing the text.

Group 3's online discussion was analysed using first-level analysis using Labov and Braun and Clarke. Second-level analysis was completed using Balint, followed by third-level analysis seen in the researcher's story.

Suzanne Everett 9834205:

The online discussion was analysed after the digital diaries and interviews had been analysed, so was interpreted with the benefit of that knowledge. However, the data are presented in the order participants undertook them.

Group 3 online discussion, 2.1.2017 to 23.1.2017

Thursday 12 January 2017, 10.00am

Online Discussion 1

Researcher Hi has the study day this week made you think differently about your patients?

Participant 15: has left this chat

Participant 14: has left this chat

10.04 Participant 15 has left this chat

Participant 14: has left this chat

Participant 14: has just entered this chat

Participant 12: has just entered this chat

Participant 13: has just entered this chat

Participant 15: has just entered this chat

Participant 12: Black people who are HIV positive that hide their diagnosis to their family. This interests me so much especially if they are here and born and bred here family should be able to accept their children who are gay.

Participant 15 I feel that they believe that no support is available to them, as well the fear of judgement

Participant 12 I am going to leave for a while to have my appointment with let be back

I would like to ask our lecturer as well about some cases but be back sorry.

Participant 15 has left this chat

Participant 13 Yeah I agree there should definitely be more support available for people who have been diagnosed. Not just in supporting them with their illness but also their family. Because it's an adjustment for both the people who are diagnosed and everyone in their life

Participant 14 PEOPLE JUST NEED TO BE EDUCATED MORE AND AS IT IS NOT THE END OF THE WORLD HAVING STI

Participant 13 I also think education on HIV is also essential especially in terms of the public perception.

Participant 14 HOWEVER THERE IS A GREAT REDUCTION FROM PEOPLE LIVING WITH HIV AS STATED IN YESTERDAY METRO

Participant 13 How reliable is metro ha-ha

Participant 14 I JUST CAN NOT BELIEVE THE FINDINGS FROM THE STONEWALL UNHEALTHY ATTITUDE AND HOW PEOPLE FAIL TO SPEAK UP AND THAT IS A BIG PROBLEM AMONG NURSES, IN EVERYBODY HOSPITAL, THERE JUST SEEMS TO BE THAT NURSE ALWAYS DOING THE WRONG THING AND EVERYONE IS AFRAID TO SPEAK UP

Participant 13 I know right. It is bizarre to me that some healthcare professionals can be so judgemental

Participant 14 NOW METRO IS NOT RELIABLE BUT THEY ARE NOT GOING TO PUT IT TO THE WORLD TO READ IF THERE IS NO EVIDENCE I THINK

Participant 15 has just entered this chat

Participant 13 But I think in some wards it becomes their ward culture in a sense. So, when someone behaves in a judgemental way everyone just looks the other way. It's become normalised in a sense which I think is both sad and frightening

Participant 14 THIS MOSTLY COMMON AMONG THE ONCE WHO HAS BEEN IN THE JOB LONGER, THEY FAIL TO TAKE ADVICE FROM THE YOUNGER ONCE AND THEY BELIEVE, THIS IS HOW IT IS DONE IN THEIR DAYS AND CAN NOT BE CORRECTED

Participant 13 has left this chat

Participant 15 Even if you have been in the job longer. There is no excuse for bad practice and mistreatment of patients.

Participant 14 YES, HOWEVER THE LOT DON'T EVEN VIEW IT IS BAD PRACTICE, THEY JUST TAKE IT AS THIS IS HOW IT DONE

Participant 15 I know where you're coming from. The majority of the blame should be on the manager for accepting these behaviours to continue on the ward.

Participant 13 has just entered this chat

Participant 15 has left this chat

Participant 14 MOST MANAGERS DON'T EVEN KNOW THEIR JOB

Participant 15 has just entered this chat

Participant 13 has left this chat

Participant 15 If the manager doesn't even know what their job description is...they need to look for another job because they are putting patients at risk.

Participant 14 I AGREE BUT HOW MANY PEOPLE WILL CHALLENGE THEIR MANAGER OF DOING SOMETHING WRONG NOT MANY

Participant 15 Action impowers change. If action is not coming from the manager, then the system is corrupt. true. It takes courage to speak up.

Participant 15 has left this chat

Participant 12 I was just reading back all your messages and it is funny that you said some managers don't know their job

Participant 12 Managers who are very open can be approachable and they shouldn't be in that position if they can't accept their mistakes

Participant 14 IT IS FUNNY BUT IT IS DEFINITELY HAPPENING AND MAKES ME QUESTION HOW THEY GOT THE JOB IN THE FIRST PLACE

Participant 12 Metro are unreliable as sources or references as per some of the academic writers are

Participant 14 AND OF COS THERE ARE APPROACHABLE ONES

Participant 14 YES UNRELIABLE, JUST SOMETHING I CAME ACROSS WHY READING THE METRO YESTERDAY

11.17: Participant 21 has entered the chat

There is no more posting.

Online discussion 2

Tuesday, 17 January 2017, 6.31pm

Participant 14 has just entered this chat

Researcher has entered this chat.

Hi Participant 14. I didn't read the Metro article but why do you think this discrimination happened. Do you think this is lack of time, ignorance???

Participant 14 Hi yes, it is definitely lack of ignorance. just watching the video on FGM and this just too sad

Researcher yes, it is

Participant 14 that people had to go through this due to ignorant

Researcher Leyla is amazing to address this

Participant 14 and their belief about this action

Researcher What did you think about Leyla's mum

Participant 14 lack of education I guess

Researcher Yes I think so many women who practice FGM think they are doing it for the best of reasons but never hear about the repercussions

Participant 14 if she was educated maybe she would not have let her children go through this and some believe it was the norm

Researcher Yes you are right I have watched this film several times and I get something out of each time.

Participant 14 Just watching Khadija's story …… very emotional

Researcher Do you think you are going to be able to talk about more sensitive issues?

Participant 14 yes it okay……. people just need to be educated about this thing

Suzanne Everett 9834205:

Researcher What do you think about Khadija's story?

Participant 14 she is a strong woman …. very amazing

Researcher Yes very, will you be able to talk about FGM to patients do you think in the future?

Participant 14 it is very sensitive topic but if I feel a patient is at risk then I will speak up…….and educate people about it …. cos their reasons just does not add up' Âƒ It brings status and respect to the girl. Âƒ It preserves a girlâ€™s virginity/chastity. Âƒ It is part of being a woman. Âƒ It is a rite of passage. Âƒ It gives a girl social acceptance, especially for marriage. Âƒ It upholds the family honour. Âƒ It cleanses and purifies the girl. Âƒ It gives the girl and her family a sense of belonging to the community. Âƒ It fulfils a religious requirement believed to exist. Âƒ It perpetuates a custom/tradition. Âƒ It helps girls and women to be clean and hygienic. Âƒ It is cosmetically desirable. Âƒ It is mistakenly believed to make childbirth safer for the infant'. 'the above just has no meaning' 'â€œI cannot trust her if she is not circumcised'

Researcher I know but unless we talk about this area people won't won't know and we perpetuate that lack of knowledge. It also gives a role to the perpetrator so there have been initiatives to provide another role for these women. I have met men who completely disagree with this practice so it's not all men

Participant 14 yes you are right

Researcher The British Muslim Council have spoken how this practice is not part of Islam. Going to say goodbye and I will see you next week, thanks.

19.01: researcher has left this chat.

There is no more posting.

Analysis of Group 3 online discussion using Labov (level 1)

The online discussion was analysed using Labov initially, followed by Braun and Clarke. The findings of each are discussed after each analysis.

Table 5-2 Analysis of Online Discussion Group 3 using Labov

Narrative component	Group 3
Abstract	'Hi, has the study day this week made you think differently about your patient?'
Orientation	'Black people who are HIV positive that hide their diagnosis to their family. This interests me so much especially if they are here and born and bred here family should be able to accept their children who are gay.'
Complicating action	'But I think in some wards it becomes their ward culture in a sense. So, when someone behaves in a judgemental way everyone just looks the other way. It's become normalised in a sense which I think is both sad and frightening.'
Evaluation	'I agree but how many people will challenge their manager of doing something wrong… not many.'
Result	'It's funny but it is definitely happening and makes me question how they got the job in the first place.'
Coda	'Yes, you are right.'
Findings	Narrative surrounding discrimination within the clinical areas and the public.

Findings from Labov

The participants talk about the judgemental attitude of Black families who find it difficult to accept family members who are gay. They also discuss the ward culture that, by not challenging attitudes, continues to allow people to be judgemental.

As a group, the participants have chosen to avoid addressing their own prejudices and instead to focus on others. Bion described this as scapegoating, and it can be seen in the blame of ward managers and Black families (Bion, 1992). Bion argued that this is a defence against participants dealing with their own 'failings' and is a construct of the group identity (Bion, 1992; De Board, 1978). As a group, the participants have defined what is safe and professional to express and what is not.

Suzanne Everett 9834205:

Analysis of Group 3 online discussion using Braun and Clarke

What do the participants say in the story and what are the effects of the story?

The discussion revolves around Participants 12, 13, 14 and 15 and their disapproval of the homophobia on the wards and within BAME families. Through the discussion there is a strong voice of disapproval of judgemental attitudes, provoked by the pre-module reading of the *Stonewall Report* and participants' experience of ward culture (Somerville, 2015). Did the teaching set up a blaming attitude by giving the student nurses this report to read? The participants put the blame for homophobia in the clinical environment on the ward manager not addressing the situation. The online group shows a cohesive professional voice, with participants respecting and listening to each other.

How is the story structured?

The narrative revolves around Participant 12, who posts about Black men in the United Kingdom hiding their sexuality and HIV diagnosis from their families. This leads the narrative to progress onto the accuracy of the media surrounding HIV, discrimination in the NHS, the culture of the ward and the role of the ward manager in addressing this issue. The discussion is between Participants 12, 13, 14 and 15. At the end of the discussion, Participant 21 enters the discussion yet neither contributes now nor completes a digital diary or interview later. This is an example of lurking, and may be a result of tension between that participant and the rest of the group (Bryman, 2012).

On the evening of the same day, the online session was commenced by Participant 14 and the researcher, and the discussion is on her watching the Leyla Hussein Channel 4 documentary on FGM. This exchange shows the effect of the researcher/teacher and is formal.

Suzanne Everett 9834205:

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

Much of the narrative revolves around the taught curriculum and the online resources provided for the students. For example, the issues surrounding Black HIV-positive gay men was discussed in class, along with the *Stonewall Report* (Somerville, 2015). The rate of HIV infection is highest in gay men, and after this group it is BAME people. There are many elements to this stigma of being gay, and as a group such individuals lack healthcare resources. Coleman and Testa's research on Black and minority groups, discussed in Chapter 2, clearly shows the influences of religion, rather than ethnicity, on sexual beliefs and attitudes (Coleman & Testa, 2008). The online discussion focuses on the stigma surrounding homosexuality in Black British families who originated in countries where being gay is illegal.

This conversation leads to Participant 14 highlighting a report on the reduction in the number of people living with HIV in the *Metro* newspaper, which is dismissed as a poor source of information. This leads to a discussion on the *Stonewall Report* (Somerville, 2015) and how there are stigma and discrimination in the NHS. The conversation continues onto ward managers, who they feel should address this issue: for second-year nursing students, their experience of managers appears surprisingly negative.

In the second instalment, the discussion is shaped around the Leyla Hussein Channel 4 documentary. This is where Leyla asks her mother why she had FGM performed on Leyla and her sister. It is very much a student-and-teacher discussion, and the student sounds shocked and is asking questions.

How do the narratives constrain or enable the participants' lives?

The subjects that the participants have chosen to speak about, FGM and HIV, are sensitive areas and the students may feel that they need to adhere to their professional role in speaking of these. However, the 'gloves are off' when

speaking about ward managers. This is an area that is not addressed in teaching and they may feel that it is safer ground on which to be honest about what they think.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

The participants' poor opinion of ward managers is shared by the whole group; however, I am left wondering why their view is so negative and how they have formulated this in such a short period of time. Students will only spend six to eight weeks in a clinical area. Ward managers have a difficult and complex role. Does this show a lack of knowledge of the role, or is it a direct experience of poor management?

Who does the story connect the participants to?

The participants comprise a cohesive group and they recognise their role as nurses within the profession. Whilst they do not directly discuss patients, they discuss issues that relate to nursing. The participants are connected to Black families and ward managers. The participants identify with those who are oppressed such as gay men from Black families, women who have experienced FGM from perpetrators, and student nurses from ward managers. The online discussion highlights the identification between those who are oppressed and the oppression of others.

Who is placed on the outside of the story?

The university and the registered nurses with whom the participants work are not part of the story. Participant 21 joins the discussion group but does not contribute. She joins after the discussion with Participant 14 on FGM, and she has an Arabic name. It is possible that Participant 21 is a lurker and has direct experience of FGM herself and, as a result, is either reluctant to speak on this issue or just wants to find out what is being said about FGM. In the first part of the discussion, as the researcher, I was a lurker as, because of the group's

size and interaction, I did not feel that I had to respond. In the second online session there was only one participant, so I was part of that discussion.

What is the response of the listener to the story?

I was impressed by the discussion by Group 3, participants' understanding and their respect for each other. The surprising element of the discussion concerns ward managers. The students appear to have little respect for this role, and I found myself wondering why.

What counts in the response from the listener?

The online discussion group shows an understanding of the issues taught and the development of professionalism:

> **Participant 12** I was just reading back all your messages and it is funny that you said some managers don't know their job
>
> **Participant 12** Managers who are very open can be approachable and they shouldn't be in that position if they can't accept their mistakes

I wonder whether we should be developing nurses' knowledge of other health professionals' roles. Why do ward managers receive criticism for discrimination? They are not the only ones who discriminate – it is senior staff and members of healthcare teams, too. Is this an example of scapegoating?

Findings

The participants show knowledge of sexual health, and this is illustrated by their knowledge of HIV, FGM and the *Stonewall Report* (Somerville, 2005), which are all referred to in their discussion. They say that contracting HIV is not the 'end of the world', showing acceptance and knowledge.

The students have formed a cohesive group. They show a non-judgemental attitude by attending to discrimination by others. This is seen in their rebukes for both the families of Black gay men and ward managers for allowing a culture of homophobia. The formation of Group 3's identity has developed

from considering the discrimination of others. Their experiences of oppression by the ward manager have helped them identify with the oppression of others, for example the gay men from Black families and women who have had FGM.

Maio et al. (2019) argued that participants are more likely to use relevant information when they are confident enough to be open-minded and be challenged about the views that they express without their self-concept being threatened. An example of this is Participant 14 and her introduction of an article in the *Metro* newspaper:

> HOWEVER THERE IS A GREAT REDUCTION FROM PEOPLE LIVING WITH HIV AS STATED IN YESTERDAY METRO.

She feels confident to highlight this article and later to add 'NOW METRO IS NOT RELIABLE BUT THEY ARE NOT GOING TO PUT IT TO THE WORLD TO READ IF THERE IS NO EVIDENCE I THINK'. This indicates that she understands that this may not be the most accurate source of information. The confidence to express views enables student nurses to question and challenge nursing practice, and is a key component of professionalism. The NMC is promoting a culture of openness and learning and a move away from blame, encouraging student nurses to express their knowledge. Challenging any poor practice helps to meet this approach (NMC, 2015 updated 2018).

The researcher's story analysis of Group 3 online discussion using Balint (level 2)

The online discussion groups were quite difficult to organise and much more problematic than I had originally considered. So, as a result I was very pleased and proud of Group 3's commitment and effort. However, sadness and anger were expressed through the narrative, which are verbalised by Participant 13:

> **Participant 13** But I think in some wards it becomes their ward culture in a sense. So, when someone behaves in a judgemental

Suzanne Everett 9834205:

> way everyone just looks the other way. It's become normalised in a sense which I think is both sad and frightening

The discussion covered issues surrounding HIV, and this showed insight and compassion and endorsed the teaching. The group sounded like they got on well and were respectful. The participants had been together in a larger group for two years, so this is not surprising, and it illustrates Bryman's offline community (Bryman, 2012). The group members presented themselves as professionals and with a professional nurse's attitude, and this illustrates the changing faces that nurses show to present an acceptable face. The participants presented both an acceptable side and, as seen in their expression of sadness, the reality of qualified nurses' attitudes. There is puzzlement about how qualified nurses juggle the emotional demands of work, seen in their comments about the ward culture and the health professionals' discriminatory practices. Bolton's research shows nurses' ability to present many faces whilst juggling emotional demands (Bolton, 2001). I found myself wondering how much of a true face I am seeing in this online discussion.

The online discussions are unlike the digital diaries, which are discussed in Chapter 6, where the participants elicit more emotion. The emotions in the online discussion show a possible collective defence against anxiety (Allan, 2016). Allan discussed the micro factors that are elicited:

> through patient contact and shape individual and teamwork operate at the individual and team level to subtly shape the organisation and delivery of nursing work. (Allan, 2016: 2)

This means that the social structures influence nurses both as individuals and as a group to work as nurses. I think this is seen through the discussion. It is harder to express conflicting views from the group when the identity of the group is expected to maintain certain professional attitudes. An example of this professional identity is seen below, where all the blame was projected onto the ward manager:

> **Participant 13** I know right. It is bizarre to me that some healthcare professionals can be so judgemental
>
> **Participant 14** NOW METRO IS NOT RELIABLE BUT THEY ARE NOT GOING TO PUT IT TO THE WORLD TO READ IF THERE IS NO EVIDENCE I THINK
>
> **Participant 15** has just entered this chat
>
> **Participant 13** But I think in some wards it becomes their ward culture in a sense. So, when someone behaves in a judgemental way everyone just looks the other way. It's become normalised in a sense which I think is both sad and frightening

So, I do not feel that I know the participants from the discussion to the same degree as I do from the digital diaries and interviews. This corroborates Bolton's research on nurses being emotional jugglers revealing different faces, and what is seen is a professional face of the student nurse (Bolton, 2001).

Bryman discussed the study of groups (see Chapter 3) and said that study of an online group without participation by the researcher will result in the researcher becoming a lurker, as in the first part of the second online discussion (Bryman, 2012). Bryman also discussed that, because of its nature, the group may be hostile to outsiders, which may include the researcher (Bryman, 2012). However, I felt no hostility, and this is seen in the exchange below:

> **Researcher** has entered this chat
>
> Hi Participant 14. I didn't read the metro article but why do you think this discrimination happened. Do you think this is lack of time, ignorance???
>
> **Participant 14** Hi yes, it is definitely lack of ignorance. just watching the video on FGM and this just too sad

However, is Participant 21 an outsider? As seen in the extract '11.17: Participant 21 has entered the chat. There is no more posting', I worried about Participant 21. Why did she not join the chat? Why did the others not address

her directly? Did she leave because they were all leaving, and did she not attend at the beginning of the designated time slot to avoid speaking? Participant 21 did not contribute either a digital diary or interview, although she had been asked and had initially agreed. This may be the result of the group scapegoating Participant 21 and why she lurked in the online discussion (Bion, 1992; De Board, 1978).

Findings using Balint

The online discussion appeared to portray a 'false self', not the nurses' authentic voice. It appears contrived and would support Goffman's work on the 'presentation of self in everyday life' (Seale, 2018). As a researcher, I was proud of this group and their discussion, although this appears contradictory when I detect their fake discussion, but it revealed its professional voice, where the other online groups either avoided discussion or made limited contributions, resulting in no development of this professional voice. The members of this online discussion group appeared to be representing themselves in a way that they thought was acceptable for nurses and displaying their formation of a non-judgemental identity. Goffman would describe this as 'frontstage' identity, showing the official stance of a group and its identity. The 'backstage' identity or 'off-record performance' is where conflicts and contradictions are expressed. Seale's research (2018) uses the example of the frontstage performance of civil servants who show no sign of racism, yet their backstage language frequently uses racist language. Whilst the online discussion group reveals their frontstage performance, participants' backstage language is shown in their digital diaries (see Chapter 6). initially asked two questions of the online discussions in Chapter 3, Table 3-1:

- What influences student nurses' attitudes to sexuality?
- Can nursing institutions facilitate student nurses' understanding of non-judgemental nursing practice?

Suzanne Everett 9834205:

The first question is answered through the knowledge that the participants showed on sexuality and, through their discussion, the formation of a non-judgemental attitude. The participants showed knowledge and understanding of HIV, in that having an STI is not 'the end of the world'.

The second question shows that the pre-course reading and teaching facilitated the recognition of the oppressed and participants' oppression. The facilitation of understanding of non-judgemental nursing practice is also addressed by the way in which the group formed a professional identity, recognising oppression and discrimination.

- How does clinical practice shape or influence student nurses' development of non-judgementality?
- How do student nurses cope with their professional role's expected attitudes?

The formation of the group identity and creation of a frontstage identity show the participants' awareness of professional identity and non-judgemental attitudes. The value of the online group is that it shows us how nurses act as a professional group. This is not the individuals' authentic voice but is the voice of nurses when they express themselves professionally. Pinker argued that non-judgementality is formed through education: 'they are less racist, sexist, xenophobic, homophobic and authoritarian' (Pinker, 2018: 235; Maio et al., 2019). The group expressed attitudes that are liberal and non-judgemental. An example is:

> **Participant 13** Yeah I agree there should definitely be more support available for people who have been diagnosed. Not just in supporting them with their illness but also their family. Because it's an adjustment for both the people who are diagnosed and everyone in their life
>
> **Participant 14** people just need to be educated more and as it is not the end of the world having STI.

The example above shows students' attitudes to HIV and the support and education that they feel the families need, illustrating their knowledge and awareness.

Summary of findings using Labov's, Braun and Clarke's and Balint's methods to analyse online discussion

The online discussion group appears significant in the formation of the student group's professional voice and repertoire, which is a non-judgemental voice. This online discussion shows:

1. How the group's participation was different from how its members participated in their digital diaries.
2. The effect of year-two student nurses' professional experience on their first year of undergraduate nursing training.
3. How student nurses act in a group. The interaction highlights the professional face of the nurse, rather than their individual and personal role.

Chapter 6 Results of Digital Diaries and Interviews

This chapter presents the iterative data analysis of the digital diaries and interviews. The diaries are considered in Section 1 and the interview analysis in Section 2. The analysis of both digital diaries and interviews incorporated three levels of analysis following pluralist methodology (see Chapter 3: Theoretical approach of data analysis).

The digital diaries and interviews were first analysed using a narrative methodology: Labov's categorisation framework and Braun and Clarke's key questions (Figure 6-1, level 1). Following this analysis, the data were analysed using Balint's psychodynamic theory (Figure 6-1, level 2); like Lanceley and Macleod, I believe that 'unconscious feelings are regarded as lying not outside the realm of language but contained with it' (Lanceley & Macleod Clark 2013: 184). I have incorporated these unspoken feelings within the researcher's story; they reveal the emotions within the accounts (Figure 6-1, level 3). The narrative analysis, then the Balint analysis and finally the researcher's story are presented for the digital diaries in Section 1 and for each interview in Section 2.

The analytic approach developed in this thesis was informed by pluralism and developed using Balint's psychodynamic theory to understand the unconscious feelings expressed by the students in the digital diaries and the interviews and experienced by the researcher (me) as I read and analysed the data in the diaries and interviews.

In Section 3 of this chapter, I discuss the synergy and iterative process of this pluralist, analytic approach. As discussed in Chapter 3, Frost (2016) argued for the inclusion of emotions of the research process in any account of the research. This has been achieved in two ways in the thesis: 1) incorporating the researcher's story, which is a reflective account of the researcher's

reactions to the data during data analysis; and 2) including the researcher's diary, which shows the process of analysis and forms a data source itself detailing the iterative process of the data analysis, the multiple readings of the data and the developing analytic narrative of the journey to non-judgementality for student nurses. Frost (2016) argued that a researcher's emotions are also data and therefore the researcher's story and diary are presented as findings in this findings chapter in Section 4. Following Section 4, the chapter is concluded.

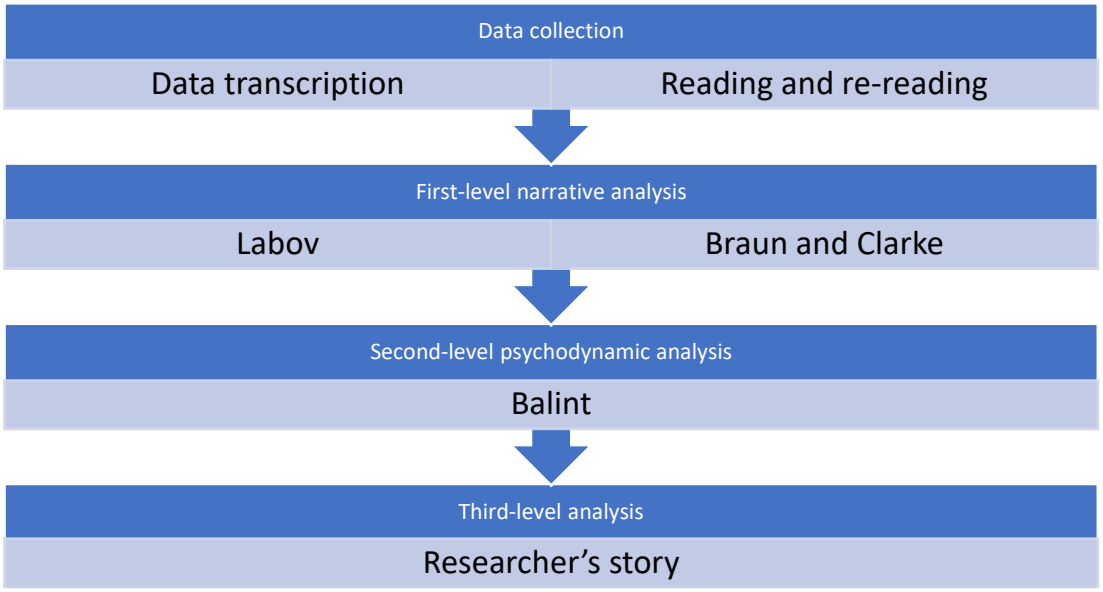

Figure 6-1 The analytical journey

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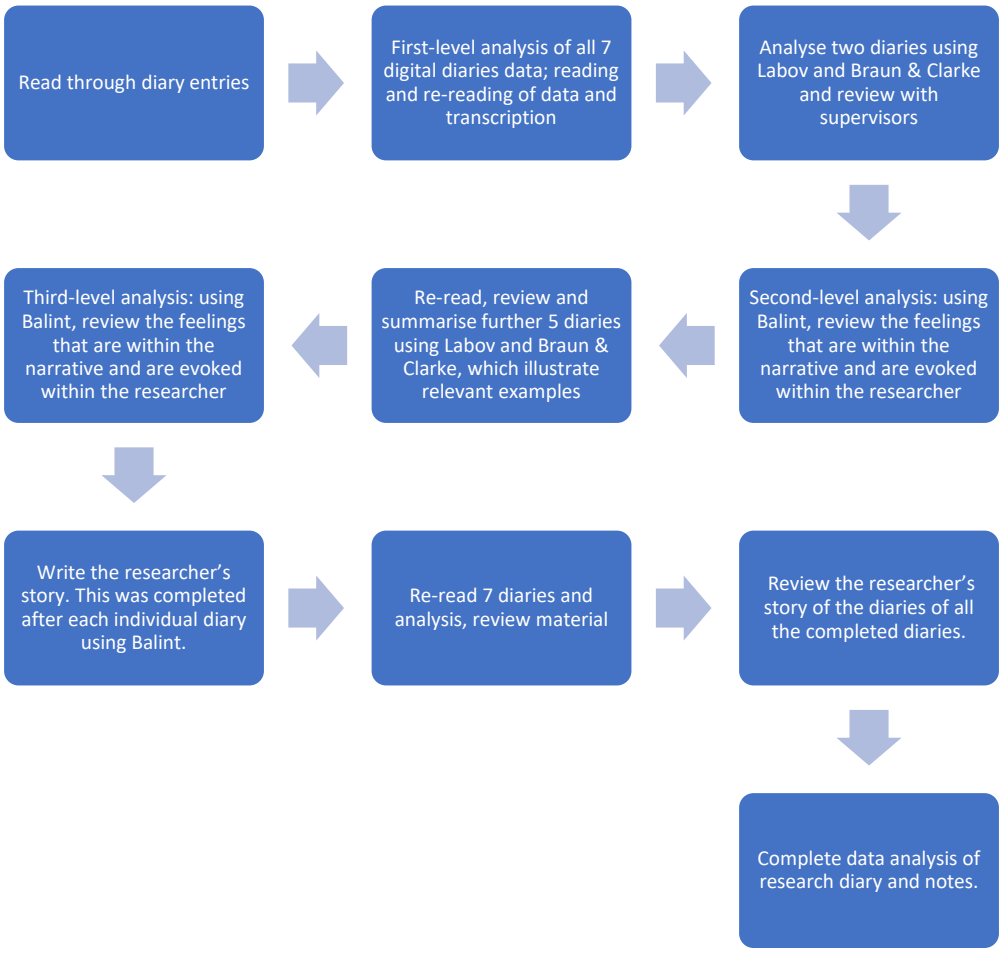

Figure 6-2 The process of analysing the diary entries

In narrative analysis, the data was kept whole rather than fractured so that the story remained intact (Braun and Clarke, 2013). Therefore, in the thesis I have kept the diary entries and interviews as complete events so that the participants' stories remain as they were told. The narratives show how the student nurse participants expressed and articulated their feelings and experiences.

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Section 1: digital diaries

Section 1 contains the presentation of the findings from the digital diaries.

Participant information

Participants were asked to complete diaries and were given the following information on this process. This is discussed in full in the methods chapter but repeated to aid the reader's understanding of the process.

Box 6-1 Participants' information on completing digital diaries

Following your module on sexuality, we are hoping to find out about how you see your clinical area in the light of this knowledge. Please record a diary entry at least once a week. This can be more, but one instalment once a week is needed. Everything you say will be anonymised, so you don't need to worry if you say a name. At the beginning of each session, say the date and time and your participant number, which is on your digital recorder. Try to tell your story, so say the context of the incident you have observed or been involved with in your clinical area. This could be something you have observed between colleagues or with a patient. Please keep your diary entries for the whole of the clinical placement. This exercise will encourage you to reflect on your clinical practice, which is an important skill for registered nurses. If you have any problems, you can contact me on s.everett@mdx.ac.uk.

The data collected from the diaries are shown in Table 6-1: the length of instalments, word counts and numbers of pages.

Table 6-1 Digital diary data collected

Participant number	Number of diary instalments	Word count total	Number of pages
3	1	1214	2
4	1	277	1
12	5	2090	4
13	4	1197	2
14	2	740	2
15	6	1478	3
19	4	1278	2

Analytical process

All the raw data from the seven digital diaries initially received first-level narrative analysis where they were listened to and transcribed verbatim, read and re-read. As these were digital diaries, I wanted to capture the pauses and raised voices in the diaries. I have chosen to portray pauses in speech with ellipses in the sentences, and arrows ↑ indicating a rising voice. I have chosen to keep repeated words and errs as I wanted to keep the narratives as they were spoken.

The diaries were then analysed using Labov. An example of this analysis is seen with Participant 3, followed by Tables 6-2 and 6-3, which shows a summary analysis of all the participants. From this analysis, emerging themes were identified, which illustrated examples of experiences raised by participants and by students in the classroom. The unexpectedly explicit and implicit emotions raised through this first level of analysis highlighted the need to recognise these important elements in the data. Through discussion in supervision, it was recognised that psychodynamic theory, using Balint to analyse the data further, would capture the emotions in the data in a further level of analysis.

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Diaries 3, 4, 12, 13, 14, 15 and 19 were all analysed further, because they illustrated examples of participants being constrained or sustained in their development of non-judgementality.

As discussed, all the diaries were initially transcribed and analysed using Labov. I have shown Participant 3's analysis using Labov in full, followed by Tables 6-2 and 6-3, which show the analysis of the raw data of Participants 3, 4, 12, 13, 14, 15 and 19.

After this process, all seven participants – 3, 4, 12, 13, 14, 15 and 19 – were chosen for presentation and analysed using Braun and Clarke, and the researcher's story was analysed by Balint's psychodynamic theory. Each diary is presented in its entirety and verbatim following Tables 6-2 and 6-3. Following this analysis of each of the selected diaries, the findings are presented with a summary of my analysis of each participant.

An example of Labovian analysis using Participant 3's digital diary (level 1)

Participant 3 is female and completed one digital diary instalment, but did not participate in the online discussion.

Oh I had my practice placement em area was a acute renal ward erm while I was there I did em not much of sexuality issues where um was daily but I remember having um… a patient who had a history of um child abuse actually sexually abusing a child actually I'm very sure his name is on the register or something because it's on his erm history because ever staff seemed to know that this man has a sexual abuse…. em doing handover this was stated regarding him and erm staff were warned to be careful when they dealing with him or taking care of him actually um it was advised that each time care was given to him two staff members of staff should be with him….. um…. I think the first day he was allocated to me where it's was easier said than done to get two staff members to attend to him as they are always short to the ward so um that is most often erm not possible with a wash and erm.. how busy the ward is and I remember when I was err allocated to him I…… I was faced with the situation that I had to attend to him on my own. he's diabetic he's got a renal problem as well and this his on dialysis his got um

diabetes related um amputation as well….in his leg so he uses a sliding board which is quiet it um to larger degrees independent though he can with little assistance help himself with the slide board in and out of bed and to use the toilet as well thou in his words his quiet love darling he refers to staff like that um but I didn't find him I didn't find him um which word am I going to use I didn't find him so much of a threat… as in when they give the handover I was like he's a bit could touch or abuse a staff member em…. while I was looking after him I didn't see that although there's a risk but……. well I was careful it was good that they handed that over that part of him…..but it was wasn't so much of a threat…. to be honest one he was disabled though he used the word love or darling hun he seems to talk a bit too much.. where I just see a patient that needs help.. actually and my problem with it was the way that he should have scene of the staff regarding that patient is a bit different because of that tag that's on him I call it a tag because oh don't go don't look after him on your own because he's he is sexually abusive he is that he is that no it is good for us to have that scene of ..caution when dealing with patients of this nature but I feel there's the perception of this patients because of this……. maybe history was bit I think it was a bit too much actually it's like I can I remember he needing care once and there was he was allocated to someone else this time and they was like I can't go there on my own I can't go there on my own and I say I said to him I said to her I understand.. it was like….. because the ward is busy… if you can't find someone to go with you….the patients of so far because they have to wait.. even though he can be assisted with the help of one person because he has upper hands and don't do his and um diabetic related amputation his upper arms are quite strong so he can actually help with the assistance of one but because there is this whole his sexually abused someone is that that kind of history attached to his attached to him I think he's scared he suffers a bit cos of time and staff members not wanting to help him on their own even in the open bit because there is an open bit ward where we have patients their staff moving up and down we still find staff not wanting to assist him on their own even though he is in an open place that it is most unlikely that he could abuse anyone in that part and concentrate that his on concentrate on his situation probably when the abusive issue occurred he probably was not in that state I don't know because I didn't ask how long ago….him being abusive was in his record I did not know about that I just think it is a little bit… too much and his care did suffer a bit because even though he can be assisted by one person he has to wait until there are two staff available to help him I just found that a bit not right actually I think the nurse should try and assess the situation and assess the environment if it's not it's not maybe a closed environment I can say ok we can wait for one person for two people but it was in an open bit you don't expect him to do anything in an open bit when he is being transferred from a wheel chair to the bed and just leave staff like that…. that don't it's so much of a big deal for me for me I felt that was

much of a big deal one can one staff can assist the environment can help this patient but everyone is like oh no I can't do it on my own I have to wait for someone else has to be here first… the ward is so busy… why you waiting for someone else to be available to help that patient care is suffering but that was one major part of sexuality that I did I did find in that area although we have other a couple of patient about two that I noticed are on there on them erec erectile dysfunction medication kind of with that staff are quiet discreet err cos its mostly most control, control, control medication on that ward that don't put it with the general. With the general medication so it needs to staffed to like erm sign and counter sign before the medication is given so remember when I was dealing with the medication of one of the patient and I saw that medication was I can't quite pronounce the name it is in my head but I can't quite pronounce the name of that medicine I was like I went on google cos I have not seen that medicine before and I was looking of why that medication which was on there and it tells me it is for erectile dysfunction or something and when I ask my mentor she was she used a quiet tune and she say it is a controlled medication I find that quite nice actually cos confidentiality was maintained on that bit it was on the other patient that I wasn't quite comfortable because um I think it was blown out of proportion and it affected the patient care a little bit thank you very much.

Using Labov, Participant 3's digital diary was analysed.

Abstract: the digital diary commences with 'not much of sexuality issues' but continues to discuss the care of a patient who has a history of child sexual abuse. The diary discusses the care of this patient, and a patient receiving medication for erectile dysfunction by nurses on the ward.

Orientation: Participant 3's diary revolves around nurse's judgemental attitudes to 'a patient who had a history of um of child abuse actually sexually abusing a child'. She describes how nurses avoided caring for the patient.

Complicating action: 'it was advised that each time care was given to him two staff members of staff should be with him.' The advice that nurses must look after the patient in pairs results in Participant 3 having to get help when caring for the patient. This results in delaying his care because nurses are busy, or because they do not want to help her care for him.

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Evaluation: Participant 3 identifies in her diary that nurses are avoiding caring for the patient because of his history, and their concerns about their personal safety: 'don't look after him on your own because he's he is sexually abusive he is that he is that no it is good for us'.

Result: Participant recognises that 'his care did suffer a bit because even though he can be assisted by one person he has to wait until there are two staff available to help him'. She recognises that staff are avoiding caring for this patient, and that this is not good nursing practice. However, Participant 3 finishes by highlighting the caring and discreet manner by which nurses gave another patient medication for erectile dysfunction.

Coda: Participant 3 recognises that nurses' attitudes to this patient have 'affected patient care a little bit thank you very much' and identifies that this is wrong.

Findings: Participant 3's digital diary describes discrimination against a sexual abuse patient. The diary illustrates the constraining narrative of the development of non-judgementality. We see through the diary that Participant 3 recognises judgemental practice but is unable to speak up against the poor practice on the ward.

Participant 3's narrative outlines the complex nature of sexual health and outlines the difficulties nurses face, revealing their personal attitudes to sexual abuse, and difficulties navigating this.

All of the diaries were analysed using Labov and this is seen in Tables 6-2 and 6-3 and these are discussed in the next section. Using Labov helped to generate emerging themes in the data, and this first-level analysis of the narratives using Labov revealed nurses' attitudes, for example surrounding sexual abuse (Participants 3 and 13) and HIV (Participant 14). These emerging themes are discussed after Tables 6-2 and 6-3.

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In Tables 6-2 and 6-3, comments in blue text are participant quotes, whilst the black text is the researcher's summary comments.

Table 6-2 Analysis of digital diaries 3, 4 and 12 using Labov (level 1)

Narrative component	Participant 3	Participant 4	Participant 12
Abstract	'Not much of sexuality issues'	'We didn't really have any patients'	'Um this is my first week'
Orientation	'A patient who had a history of um of child abuse actually sexually abusing a child'	'that fell under LGBT'	Experience of nursing home placement and the attitudes of the permanent nursing staff
Complicating action	'it was advised that each time care was given to him two staff members of staff should be with him'	'but we did have staff um, but I didn't really experience anything bad'	'is it wet err is it we now and patients just jump or reacted err cos he hasn't been even like ask if he could touch him'
Evaluation	'don't look after him on your own because he's sexually abusive he is that he is that no it is good for us'	'they were all very open towards each other'	'You made him jump and he said, 'it's ok … he knew me anyway' he said, so I didn't say anything really'
Result	'his care did suffer a bit because even though he can be assisted by one person he has to wait until there are two staff available to help him'	'I had a really pleasant experience'	'so, I just wanted to be away from her that time because I was so upset'
Coda	'It affected patient care a little bit thank you very much'	'I had a really pleasant experience of um that in the workplace'	'err community practice I has was really a good one'
Findings	Discrimination against sexual abuse patient, illustrates constraining narrative of the development of non-judgementality.	Data show positive attitude to LGBT which is an illustration of a sustaining process for non-judgementality: 'they were all open'.	Lack of compassion by nursing staff and participants' difficulties navigating this show constraining influences.

Table 6-3 Analysis of digital diaries 13, 14, 15 and 19 using Labov (level 1)

Narrative component	Participant 13	Participant 14	Participant 15	Participant 19
Abstract	'So, my placement is in a Jewish care home'	'I came across a patient who has HIV'	'Hello, today is the…'	'So, during my first week on placement um I'm based in A&E'
Orientation	'he … displays occasionally around the females err sexually inappropriate gestures and tries to maybe touch someone in a sexual manner'	'I don't know maybe they were trying to protect me because they are from the same country as me…… You need to be careful of that patient has got HIV'	'Anyway, not having enough male staff has caused us… quite a bit of problems' (laughs)	'And the doctors themselves even the one that um did the procedure he um actually commented he was just as embarrassed'
Complicating action	'but some staff were particularly uncomfortable with it which is a shame they've really shown me that they are discriminatory'	'it shouldn't affect my care'	'erm we still provide the care, but it will make the patient uncomfortable'	'She wanted to have sex with God in order to I don't know to reach her fulfilment'
Evaluation	'they don't know how they're just kinda refusing'	Second instalment on female HIV patient and how she contracted it.	'it was probably cos he is a young man and he felt uncomfortable around err cos I was younger than him'	'I have a look downstairs and she said yeah no worries and she realised this patient was in labour'

Result	'There has been some improvement I think people are more … Used to it now but I think the real issue is… is the training'	'Patients should be treated equally no matter their sexuality'	'he was embarrassed or something but yeah, so I respected his decision'	'I was witness too um it's interesting that the fact that … It seems that'
Coda	'We've realised maybe it's not as big an issue as we thought it was'	'You can't catch you can't get infected by HIV just by sharing cutlery with them or by or eating from the same plate or can get it like that so erm I hope this helps'	'Cos he was much more comfortable with her cos he's been with her for a while so yeah that's probably what he probably does this to other students, but I don't know yeah that's it bye'	'um it's just different lots of different ways of doing the same thing so that has really been my four weeks so far on placement s um yeah'
Findings	Narrative surrounds the negative attitudes of nursing staff constraining the development of non-judgementality, in the care of patient with sexually inappropriate behaviour.	Narrative about discrimination from nursing staff over HIV showing the constraining of non-judgementality.	Narrative brief but categorised as shows the sustaining influences of nursing staff.	Narrative addressing the embarrassment and lack of knowledge of nursing and medical staff.

Labovian analysis (level 1)

During the Labov analysis, emerging analytical ideas were noted that surrounded nurses' attitudes, nursing practice, personal feelings, and reflection. At this stage, these analytic ideas had a number of interrelating connections. For example, under the attitudes idea there were negative and positive attitudes, discrimination, and respect for patients and staff. These initial emerging analytical ideas from the Labovian analysis are summarised below in Figure 6-3, and within the researcher's diary section 4.

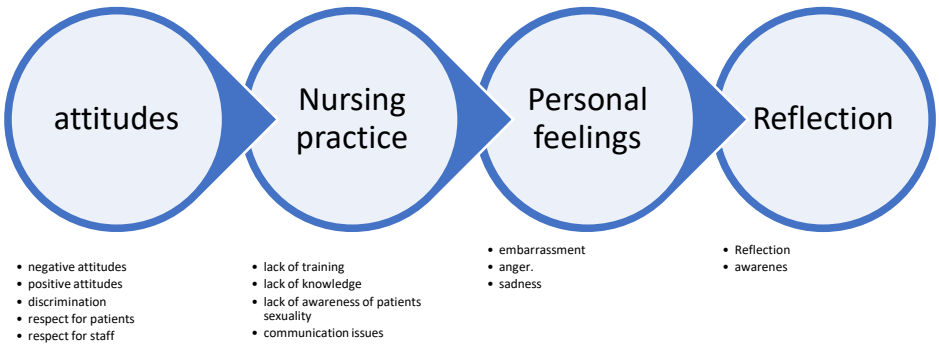

Figure 6-3 Emerging analytical ideas from the digital diaries analysis.

The analysis of the diaries using Labov revealed two developmental journeys:

1. Participant 4 revealed positive attitudes to LGBT, which sustained and developed non-judgementality.
2. Other participants in remaining six diaries show negative attitudes, revealing a lack of compassion; discrimination based on attitudes on HIV and suspected sexual abusers; embarrassment (perhaps from lack of knowledge, or how to behave and manage emotions); and gender-appropriate care (lack of male staff to deliver intimate male care).

The analysis of the diaries using Labov revealed the complexity of sexual health issues found in clinical practice and how staff and students struggle to manage their feelings and deliver good enough care to patients when they encounter sexual health issues. Participant 14's diary shows us that 1) students may be aware of this complexity; 2) students may be aware that staff find sexual health issues difficult and seek to protect students from them; and 3) if this is the case, staff may not role model good care towards students on complex sexual health issues. Participant 14:

> I don't know maybe they were trying to protect me because they are from the same country as me … You need to be careful of that patient has got HIV.

Participant 3:

> one major part of sexuality that I did I did find in that area although we have other a couple of patient about two that I noticed are on there on them erec erectile dysfunction medication kind of with that staff are quiet discreet.

The diaries illustrate examples where participants have navigated discrimination they have encountered in the clinical area. They show the constraining or sustaining influences on participants' development in non-judgementality. Participant 15 describes how she navigated the care of a male patient:

> it was probably cos he is a young man and he felt uncomfortable around err cos I was younger than him.

Participant 3:

> we still find staff not wanting to assist him on their own even though he is in an open place that it is most unlikely that he could abuse anyone in that part.

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The diaries show examples of lack of compassion by nursing staff caused by the staff's embarrassment/disgust etc. when faced with sexual health issues they either do not agree with or find difficult or have not met before. Participant 13 reveals this:

> but some staff were particularly uncomfortable with it which is a shame they've really shown me that they are discriminatory.

Participant 12:

> You made him jump and he said, 'it's ok … he knew me anyway' he said, so I didn't say anything really.

This first level of analysis reveals the attitudes and experiences student nurses navigate in clinical practice.

Braun and Clarke (level 1) and Balint analysis (level 2)

Following the analysis of the data using Labov, further analysis was performed using Braun and Clarke (2013). Whilst Labov helped to identify the emerging analytic ideas, the Braun and Clarke analysis revealed the complexity of emotions within the data. To acknowledge the presence of these emotions in the data, Balint was used to perform second-level analysis on the diaries.

The digital diaries of Participants 3, 4, 12, 13, 14, 15 and 19 are shown in full below. Under each diary, the analysis using Braun and Clarke (2013) is shown with the findings from this analytic procedure. Following this, the Balint analysis is presented together with the findings from the Balint analysis. A presentation of all the findings for each participant is used in the researcher's story, together with its findings, and a summary of all the findings for each participant is presented at the end. A summary of the findings of the seven illustrated participants is given at the end of the chapter.

Participant 3: digital diary data

Participant 3 is female and completed one digital diary instalment, but did not participate in the online discussion.

Oh I had my practice placement em area was a acute renal ward erm while I was there I did em not much of sexuality issues where um was daily but I remember having um… a patient who had a history of um child abuse actually sexually abusing a child actually I'm very sure his name is on the register or something because it's on his erm history because ever staff seemed to know that this man has a sexual abuse…. em doing handover this was stated regarding him and erm staff were warned to be careful when they dealing with him or taking care of him actually um it was advised that each time care was given to him two staff members of staff should be with him….. um…. I think the first day he was allocated to me where it's was easier said that done to get two staff members to attend to him as they are always short to the ward so um that is most often erm not possible with a wash and erm.. how busy the ward is and I remember when I was err allocated to him I…… I was faced with the situation that I had to attend to him on my own. he's diabetic he's got a renal problem as well and this his on dialysis his got um diabetes related um amputation as well….in his leg so he uses a sliding board which is quiet it um to larger degrees independent though he can with little assistance help himself with the slide board in and out of bed and to use the toilet as well thou in his words his quiet 'love darling' he refers to staff like that um but I didn't find him I didn't find him um which word am I going to use I didn't find him so much of a threat… as in when they give the handover I was like he's a bit could touch or abuse a staff member em…. while I was looking after him I didn't see that although there's a risk but……. well I was careful it was good that they handed that over that part of him…..but it was wasn't so much of a threat…. to be honest one he was disabled though he used the word love or darling hun he seems to talk a bit too much.. where I just see a patient that needs help.. actually and my problem with it was the way that he should have scene of the staff regarding that patient is a bit different because of that tag that's on him I call it a tag because oh don't go don't look after him on your own because he's he is sexually abusive he is that he is that no it is good for us to have that scene of ..caution when dealing with patients of this nature but I feel the the perception of this patients because of this……. maybe history was bit I think it was a bit too much actually it's like I can I remember he needing care once and there was he was allocated to someone else this time and they was like I can't go there on my own I can't go there on my own and I say I said to him I said to her I

understand.. it was like….. because the ward is busy… if you can't find someone to go with you….the patients of so far because they have to wait.. even though he can be assisted with the help of one person because he has upper hands and don't do his and um diabetic related amputation his upper arms are quite strong so he can actually help with the assistance of one but because there is this whole his sexually abused someone is that that kind of history attached to his attached to him I think he's scared he suffers a bit cos of time and staff members not wanting to help him on their own even in the open bit because there is an open bit ward where we have patients their staff moving up and down we still find staff not wanting to assist him on their own even though he is in an open place that it is most unlikely that he could abuse anyone in that part and concentrate that his on concentrate on his situation probably when the abusive issue occurred he probably was not in that state I don't know because I didn't ask how long ago….him being abusive was in his record I did not know about that I just think it is a little bit… too much and his care did suffer a bit because even though he can be assisted by one person he has to wait until there are two staff available to help him I just found that a bit not right actually I think the nurse should try and assess the situation and assess the environment if it's not it's not maybe a closed environment I can say ok we can wait for one person for two people but it was in an open bit you don't expect him to do anything in an open bit when he is being transferred from a wheel chair to the bed and just leave staff like that…. that don't it's so much of a big deal for me for me I felt that was much of a big deal one can one staff can assist the environment can help this patient but everyone is like oh no I can't do it on my own I have to wait for someone else has to be here first… the ward is so busy… why you waiting for someone else to be available to help that patient care is suffering but that was one major part of sexuality that I did I did find in that area although we have other a couple of patient about two that I noticed are on there on them erec erectile dysfunction medication kind of with that staff are quiet discreet err cos its mostly most control, control, control medication on that ward that don't put it with the general. With the general medication so it needs to staffed to like erm sign and counter sign before the medication is given so remember when I was dealing with the medication of one of the patient and I saw that medication was I can't quite pronounce the name it is in my head but I can't quite pronounce the name of that medicine I was like I went on google cos I have not seen that medicine before and I was looking of why that medication which was on there and it tells me it is for erectile dysfunction or something and when I ask my mentor she was she used a quiet tune and she say it is a controlled medication I find that quite

nice actually cos confidentiality was maintained on that bit it was on the other patient that I wasn't quite comfortable because um I think it was blown out of proportion and it affected the patient care a little bit thank you very much.

Analysis of Participant 3's diary using Braun and Clarke (level 1)

Using Braun and Clarke, to think about the participant's narrative and story I initially focused on the questions (suggested in Braun & Clarke's analytic model, 2013, discussed in the methodology chapter).

What does the participant say in the story and what are the effects of the story?

Participant 3's story describes caring for a male diabetic amputee patient on renal dialysis who has a history of child sexual abuse. She talks about the difficulties of looking after this patient and how the nurses have been advised to look after him in pairs. She describes the discrimination that the patient receives in his care, both because of this information and the difficulty in providing two nurses to care for him.

She finishes the story by discussing how discreet the staff were about providing patients with erectile dysfunction medication without publicly revealing their diagnosis.

How is the story structured?

The opening sentence of the diary states that there were no sexuality issues. The story revolves around the difficulties in caring for a patient with a history of child abuse and criticism of nurses who avoided caring for him. The story is one of power and discrimination from nursing staff and includes the student's feelings of powerlessness. There is a sense that the student was allocated this patient outside of her normal daily routine in that placement. The story finishes with praise for the nursing staff's professionalism in not publicly disclosing the reason why patients

were on erectile dysfunction medication, almost in an apology for earlier criticism of the nursing staff.

The ending to the narrative is interesting. Participant 3 opened her diary with the statement that there were no issues surrounding sexuality, but by the end of the story she had discussed two complex issues surrounding sexuality: child abuse and erectile dysfunction. This reveals Participant 3's attitudes or her ambivalence to gaining an understanding of 'sexual health'.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

Initially, Participant 3 says that she does not have much experience of sexuality:

> Oh, I had my practice placement em area was an acute renal ward erm while I was there, I did em not much of sexuality issues where um was daily.

This is an interesting initial statement; as the diary entry continues, it reveals a relevant example. It highlights the huge area that sexuality represents and shows how Participant 3 initially did not consider this example so relevant. However, this example highlighted to me denial of the presence of sexuality, and is a good example of the emotions I felt in the analysis. During the teaching, we had discussed grooming and child protection issues; however, we had tended to focus on identifying those at risk rather than addressing caring for perpetrators or discussing the emotions that nurses may feel in giving this care.

How do the narratives constrain or enable the participants' lives?

The story is told directly to the researcher, whom Participant 3 knows as a lecturer, so she speaks in an informed way; even so, she appears constrained in talking of the discrimination against the patient and of

the care that he receives. She is constrained by the need to have two nurses caring for the patient and has mixed views about its necessity; however, she has not voiced her concerns to ward managers and maybe feels that she cannot, as a student nurse, but this is left unsaid. Participant 3 may also feel that I will judge her if she says something discriminating about the patient.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

The narrative of Participant 3, as a student nurse, does not evoke the feeling that she is part of the nursing team. She has not felt able to express her concerns to the registered nurses or ward manager, and no one appears to have considered how she may feel in looking after this patient. The narrative overlooks the position of the managers and hospital in safeguarding their staff by ensuring that they look after him in pairs.

Who does the story connect the participant to?

This story connects Participant 3 to the professionalism of nursing. As a second-year student, she is aware of the complexity of the problem. She discusses the discrimination against the patient by health professionals, understands why this may happen and is aware of the staff shortage.

Who is placed on the outside of the story?

Although Participant 3 discusses the patient, he is not at the centre of the story; the nurses and the participant are. The patients in the ward and in the bay where the patient is located are left unaddressed, and how other health professionals feel about caring for this patient is outside this story.

Suzanne Everett 9834205:

Participant 3 does not express disapproval or any negative feelings about the patient, and this is outside the story. This also shows her growing professionalism as a nurse.

What is the response of the listener to the story?

This story highlighted to me how complex nursing is, how poorly we address these areas within training, how anxious the nurse felt and her vulnerability. As the listener, I was concerned for the participant, who sounded under stress. The story discusses the difficulties of looking after patients in this situation and staffing shortages, but also highlighted how, as nurses, we do not speak of how we feel about these situations. Braun and Clarke's (2013) questions led me to focus on the emotions in the narrative. This encouraged me to reflect on my background working with psychodynamic theory and Balint (see Chapter 2). I wanted to recognise the emotions in the data as I felt they were important, and Balint seemed an ideal theory to support this.

This story reminded me of my first ward, with a patient who had multiple sclerosis and was verbally sexually abusive to nurses, and the lack of support that I and others received and how difficult we found looking after this man. There was no discussion and no support. I felt sad that this story is similar and that we have not really moved forward in our support for nurses. Whilst we address child protection in nurse training, we do not address looking after its perpetrators or the personal and professional issues that it raises among nurses.

What counts in the response from the listener?

As the listener, I think we need to consider addressing issues such as caring for offenders. Batson's research on empathy and attitudes, discussed in the literature review, shows that feelings against a

stigmatised group could be improved if participants have contact with an individual from that group (Batson et al., 1997).

This participant's narrative shows the stress she feels through this incident. This narrative illustrates the pressure that we put on student nurses and health professionals and the lack of discussion and support that they receive, as these are likely to increase both their stress level and attrition. I am also aware that in her narrative the participant may have positioned herself as vulnerable and under stress so that I would be sympathetic.

Findings

Participant 3 reveals the complexity of the problems that nurses face and the emotional resources required of them. We see this in the example of the patient with a history of child abuse: Participant 3 finds the registered nurses' attitude towards the patient and their avoidance of him unacceptable, but is unable to voice these concerns because of her role as a student nurse. Participant 3 has learnt that, as a student, she should not 'rock the boat'. This illustrates the constraints of the clinical area and how she copes in this placement with attitudes that differ from her own.

The diary contains several challenging issues that Participant3 has been confronted with, even though she says 'Oh I had my practice placement em area was a acute renal ward erm while I was there I did em not much of sexuality issues'. Participant 3's diary shows discrimination in the systems within the clinical setting: systems that mean that nurses are not organised to address areas such as safeguarding. There are negative attitudes toward the patient with a history of sexual abuse at the same time as positive attitudes towards the patients with erectile dysfunction. There is evidence of contradictory practice as the patients

with erectile dysfunction are treated with respect and compassion, whilst the patient with a history of sexual abuse is avoided, showing a lack of compassion. This diary reveals a painful and shocking example of poor nursing practice.

The diary reveals emerging themes of negative and positive attitudes and discrimination by nursing staff, which inhibit the journey and development of non-judgementality, and the factors that facilitated its development of the student's journey.

The researcher's story of Participant 3 using Balint (level 2)

Following my analysis using Braun and Clarke's (2013) emerging themes, I reviewed the narratives over a period using the Balint consultation model. The researcher's story is the result of this analysis.

The researcher's story analysis of Participant 3

Participant 3's diary was addressed directly to me and revolves around her placement on a renal ward with a male patient who is a diabetic amputee who has abused children. She sounds angry and disgusted, and my heart leaps at the emotions I hear. I feel worried for Participant 3 from the outset. She describes how, during the handover, she is told that two nurses should always look after this patient, and she sounds ashamed talking about this and his sexual abuse history. Participant 3 talks about the problems encountered when she is allocated the patient: describing how difficult it is to find another member of the nursing team who is willing to help her with him. She sounds angry as she describes these difficulties, as she feels that the patient is so ill that he poses little risk to staff, particularly on a public ward. She mentions how the patient refers to her as 'love' and 'darling', and that he talks a lot, indicating that he may be embarrassed. From Participant 3's diary,

it sounds that she feels that nursing staff are avoiding caring for the patient:

> I think he's scared he suffers a bit cos of time and staff members not wanting to help him on their own even in the open bit because there is an open bit ward where we have patients there staff moving up and down we still find staff not wanting to assist him on their own even though he is in an open place that it is most unlikely that he could abuse anyone in that part.

As a listener, I felt angry at the ward's registered nurses. I thought it was unfair to allocate a patient labelled as a child abuser to a second-year student without support. I felt ashamed of the qualified nurses' avoidance of looking after the patient and their lack of professionalism, but I also suspected that this is down to lack of knowledge and training and that a suppression of negative feelings towards the patient is shaping the decisions and allocation. The identification of feelings in the narrative such as shame and anger, and my reflection from a third position in forming a hypothesis on what may be happening emotionally in the narrative, all are part of the Balint process. Fabricius summarised this third position:

> Because not only the feelings, fears and impulses, but also the defences, are often unconscious or barely conscious, it is only through gradual exploration and increased awareness that they can be understood. With increased awareness, perhaps these feelings can be coped with by sharing them, understanding them and in some part accepting them, so that some of the habitual defences can be relinquished. (Fabricius, 1991: 137)

Whilst Participant 3 sounds ashamed and embarrassed by the reaction of the nursing staff and their discrimination against the patient, she also avoids any continuation of her criticism by discussing positive professionalism. I felt that Participant 3 showed signs of professionalism

in the care of the patient and his discrimination and guilt at speaking out against the ward staff and hence finding a scenario that redeemed them. She then discusses how discreet and professional they are in administering controlled medication for erectile dysfunction to patients, quietly and respectfully speaking about the medication's usage. She shows pride in the nursing staff, possibly because she can see that the qualified nurses can act sensitively, and the story of the amputee is told against this observation. Her feelings tell her that she has been unwillingly forced to be part of unjust or discriminating practice:

> I find that quite nice actually cos confidentiality was maintained on that bit it was on the other patient that I wasn't quite comfortable because um I think it was blown out of proportion and it affected the patient care a little bit thank you very much.

She finishes with her embarrassment at the neglect of the first patient, and this story revolves around him and his neglect. Participant 3 feels that 'it was blown out of proportion' to convey her emotions, and this triggered my feelings, showing transference and countertransference (Dryden, 1990). I felt ashamed and angry at the lack of support and found myself shouting 'Where is the mentor?' as there is no mention of any support. So, this is a story about a student being exposed to value judgements in care decisions, and shows the process by which student nurses learn non-judgementally. Her discomfort is not in relation to caring for a patient who is known as a perpetrator; rather, her discomfort is with the value judgement that brings about discriminatory practice that, in turn, places her in a position of powerlessness. This led me to wonder whether lecturers need to support students in how to respond when they are confronted with care decisions relying on value judgements.

The anger and disappointment within this story are not just my anger and disappointment but the student nurse's feelings of anger and shame, again illustrating transference and countertransference (Dryden, 1990). She is expressing her lack of support from nursing colleagues whilst caring for the patient. This scenario illustrates the complexity of whistle-blowing in patient care. The team-based approach makes it difficult to criticise colleagues. The scenario highlights to me how little we prepare student nurses and registered nurses for these issues and how we avoid, where possible, the 'unpopular patients' described by Stockwell (Stockwell, 1972). This scenario illustrates emerging themes around sexuality, where nurses accept erectile dysfunction but stigmatise particular forms of sexuality such as a history as an abuser. We see through this narrative the participant's development of non-judgementality. Participant 3's diary shows us how difficult this development is, given the strength of the ward nurses' judgemental attitudes to abuse.

Findings about Participant 3 using Balint

The anger and powerlessness of Participant 3 at the discriminatory practice of her nursing colleagues is strong throughout this narrative. The discriminatory practice by the nurses shows that Stockwell's 'unpopular patient' is alive and well and how nurses avoid patients whom they find difficult. Participant 3 has learnt from this exposure to discriminatory practice not to speak up but to stay quiet, but still understands that this is poor nursing practice. Participant 3 shows another emerging theme emotional intelligence through her understanding that she needs to put her personal views of the patient to one side. This shows that Participant 3 is learning to use Fabricius's third position in her personal development of professionalism. She has

weighed up the risks for herself and seen that this is reduced in the open-plan area:

> I think the nurse should try and assess the situation and assess the environment if it's not it's not maybe a closed environment I can say ok we can wait for one person for two people but it was in an open bit you don't expect him to do anything in an open bit when he is being transferred from a wheelchair to the bed.

This example illustrates the development of professionalism. The NMC defines professionalism as:

> characterised by the autonomous evidence-based decision making by members of an occupation who share the same values and education. Professionalism in nursing and midwifery is realised through purposeful relationships and underpinned by environments that facilitate professional practice. Professional nurses and midwives demonstrate and embrace accountability for their actions. (NMC, 2018c: 3)

Participant 3's incident has encouraged her to reflect on the situation and how a student navigates the clinical area and copes with attitudes differing from her own, and helps her on her journey to being non-judgemental.

Summary

The narrative shows the emerging theme of developing non-judgemental practice when confronted with strong examples of judgemental and discriminatory practice. It also shows how nurses avoid patients whom they find difficult, and how the student observes this, and chooses to do otherwise when given the opportunity.

The narrative illustrates how a student navigates the clinical area and copes with attitudes different to her own and helps her development towards being non-judgemental, as seen in the narrative 'we still find

staff not wanting to assist him on their own even though he is in an open place that it is most unlikely that he could abuse anyone in that part'.

The narrative highlights Participant 3's emotional intelligence and understanding: 'I wasn't quite comfortable because um I think it was blown out of proportion and it affected the patient care a little bit.'

Participant 4: digital diary data

Participant 4 is female and completed one digital diary instalment but did not participate in the online discussion.

I was on placement in intensive care and we didn't really have any patients that fell under lesbian, Bisexual Transgender but we did have members of staff um…..but I didn't really experience anything bad they were all very open towards each other so I think I had a really pleasant experience of um that in the workplace

Analysis of Participant 4's narrative using Braun and Clarke (level 1)

Using Braun and Clarke again, I initially focused on the questions to think about the narrative and its story and then revisited this story using Balint (Braun & Clarke, 2013).

What does the participant say in the story and what are the effects of the story?

Participant 4's clinical placement is in the ITU. The diary is brief and she has defined her narrative by saying that there are no LGBT patients but there are LGBT staff, and the placement has been a pleasant experience. We do not know how Participant 4 knows that healthcare staff are LGBT; we might ask ourselves whether they had disclosed this information or whether she has made this judgement about their sexuality. The effect is for the reader to ask: is the centrality of LGBT as a sexual health issue for this student because the participant is not

LGBT? This seems possible given the centrality of LGBT for the student herself when asked about sexual health issues in practice.

How is the story structured?

This is a short story that reveals limited data. It is spoken in the first person to the researcher, but participant appears to be outside the story. This could be an example of lurking, which is discussed further below.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

Participant 4 has defined sexuality around LGBT men and women. By making this definition she appears to distance herself from sexuality: sexuality is related to LGBT patients and healthcare professionals, which distances sexuality from patients and Participant 4. Participant 4 reveals that she has had a pleasant experience even though the staff are LGBT, implying implicit negative attitudes towards LGBT or unacknowledged attitudes to LGBT.

How do the narratives constrain or enable the participants' lives?

Participant 4's narrative shortness means that the story is constrained by her. She has chosen to give a short diary, either consciously or unconsciously resulting in her controlling the narrative. This control of the narrative may be because Participant 4 has chosen to absent herself from the research without having to withdraw formally from the study, and it may also be a way of avoiding discussing LGBT issues that she has difficulties with. By not controlling the narrative, Participant 4 does not discuss the difficulties she may have over LGBT and how they may affect her and her development of non-judgementality.

Suzanne Everett 9834205:

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

Through the diary we see an example of the group dynamics of the clinical area: Participant 4 distances herself from the staff and patients in the placement. This may be the result of the inside group (ward staff) scapegoating Participant 4 and the reason she lurks in the discussion in the digital diary (Bion, 1992; De Board, 1978).

Who does the story connect the participant to?

Participant 4 speaks directly to the researcher but appears unconnected to the patients and healthcare professionals referred to in the narrative.

Who is placed on the outside of the story?

The narrative places Participant 4 on the outside of the story as a lurker, looking in from the outside; this is illustrated by her statement 'they were all very open towards each other so I think I had a very pleasant experience of um that in the workplace' (Bryman, 2012). Bryman discussed the nature of groups and the hostility to outsiders (Bryman, 2012). In the clinical placement, student nurses may feel that they are outsiders and this brief narrative illustrates that Participant 4 may feel this in the way she refers to nursing staff.

What is the response of the listener to the story?

It is difficult to define the story. There is limited information and Participant 4 has kept the researcher on the outside of the story by limiting the narrative. As a result, my response to this diary is to feel like an outsider.

What counts in the response from the listener?

As a listener, you are left wanting more, which puts the listener in an inferior position and the speaker in a position of dominance and power.

Suzanne Everett 9834205:

Findings

Participant 4 has controlled the amount of narrative she reveals and as a result she is powerful. The diary may also be limited because of the sensitive nature of the subject; Participant 4 may have found this subject area more difficult than she expected after consenting and found it difficult to withdraw from the research. She has withdrawn by submitting a brief narrative instead.

The digital diary reveals her lurker and outsider status as a student nurse. We see how she refers to staff and patients in ITU from a distance: she does not appear to feel part of the group. She has had a 'pleasant experience', which almost implies the opposite feelings.

This narrative, whilst brief, illustrates the sustaining narrative of the development of non-judgementality. Participant 4 says 'they were all open' about nursing staff, implying that they were all non-judgemental and illustrating that they acted as role models.

The researcher's story of Participant 4's narrative using Balint (level 2)

It is difficult to gain many emotions from this data because of its brevity; however, it is still a strong statement, as the Braun and Clarke (2013) analysis shows. Participant 4 feels like an outsider in her references to healthcare professionals and, whilst she has described the experience as 'pleasant', these all show signs of unacknowledged anger.

Describing the ITU as pleasant is an unusual description, as it is an intrusive, life-defining clinical area with loss, anger and grief. This is irrespective of sexuality as healthcare professionals intrude on patients' privacy without consent. Sexual health might remain hidden in the ITU, but it is a feature of ITU nursing that there is no consent to any procedures, including those that affect sexual health. All of these issues

highlight Participant 4's passivity. However, we also see Participant 4's power over her control of the digital diary entry and what she reveals.

Findings about Participant 4 using Balint

Participant 4's status as an outsider in this short diary is significant: we see an example of the insider status of the ward staff and the outsider status of student nurses (Bryman, 2012).

Summary of Participant 4's diary findings

Participant 4's diary shows how student nurses can have outsider status: 'but I didn't really experience anything bad they were all very open towards each other so I think I had a really pleasant experience of um that in the workplace'. It invites the hypothesis that, as an outsider, a student may lurk in clinical areas as this student lurks in the digital diary (Bryman, 2012). The implications of lurking for learning are that neither the HEI nor the clinical area is able to pick up visual or auditory cues from the lurker that might denote anxiety or puzzlement in them (Bryman, 2012). The lurker may be at risk of being excluded by the clinical team, and this exclusion may result in the lurker finding it difficult to raise issues of poor practice.

The limited nature of the diary could also be the result of the sensitive material of sexuality, and a way of withdrawing safely from the research. The withdrawal from this research may be a barrier to developing non-judgemental practice as it enables the student to withdraw and effectively not develop or learn.

Participant 13: digital diary data

Participant 13 is female and participated in Online Discussion Group 3 from 2 January 2017 to 23 January 2017, producing four diary entries.

Day 1

Suzanne Everett 9834205:

So, my placement is in a Jewish care home…. and my first week has been ok I mean I haven't got to interact that much with the patients yet because its only my first week and I'm just getting to learn it. There are 40 patients in all like and it's like a mixture of male and female….the bedrooms kinda go around and they've got privacy but if the doors open then they don't. Sometimes.. I ..see.. the carers going in and not shutting the door when there turning the patients which I think is a bit of an issue in terms of like privacy but with everything else they seem good I mean in the care plans they.. always have something filled in under sexuality erm….. I haven't seen any discriminative behaviour or anything like that towards the staff from the staff towards the patients or anything like that. There is erm actually quite a few members of the LGBT community as part of the staff.. you would not know that regularly but I have become friends with some of the staff during…our breaks we were talking about our home lives…and yeah so that's good it's more surprising if anything because it's a… Jewish care home I it's quite I always imagine it to be quite conservative and non-accepting of beliefs from outside but actually…….it's really impressed me the fact that they've got …..members of the LGBT community there's actually a transgender nurse there…who.. you know.. she has worked there for a number of years and she said that they actually deal ……. with everything very well a very like ermm.. tut.. like accommodating and.. accepting of all the views which is what I would hope to see but you don't always see it wherever you go.

Day 2

Two has been very good… um I have noticed that there is……that we ha.. it's a private care home so there is a lot of carers and there is a mixture of male and female and they all interact very well there's I don't I can't really see any issues…. between… the male and the females in terms of sexuality or anything like that but its good em because there is so many staff and such a range of staff if a patient doesn't want to be cared for by a man in terms of like personal care, then they have the ability to actually do something about it and make sure there only cared by women. Same for if a man if a man only wants a man they can do that as well,….. the only issue we've had is that there is a .. patients who……. .is….. who needs the assistance of three (hhh) there is ↑↑ rarely ↓ three male staff carers at once which is a bit of an issue I feel um…….. sad about that because obviously the patients doesn't want a female there.. to be changing him but.. in terms like to enable.. blurr.. laughs.. to be able to.. change him and wash and dress him we need three people so that's a shame but he doesn't mind so much as long as the female only like helps like turn him then it's not so bad but yeah apart from that everything else has been ok. I've actually really enjoyed…. it because I

haven't had any anything that I would call discriminatory it's made me cos I'm doing this it has made me…think a lot more about the way people being treated and it's really good actually.

Day 3

Three we have had a patient in.. who has dementia and the way that its taking form is that he…displays occasionally around the females er sexually inappropriate gestures and tries to… maybe.. touch.. someone.. in.. a.. sexual.. manner, which is not obviously ideal, no one wants that. But it's not his fault; the.. only issue that I've found at this placement is that the staff aren't trained well enough with this so when it was handed over to us.. I thought that, it was pretty normal, you know that does happen sometimes I have been In other care settings where there has been…. like inappropriate behaviour from a patient that's either mentally unwell or has dementia so I thought that was quite normal but it seemed like they hadn't really experienced that very much.. so… . that seemed to be an issue.. for them. The women didn't.. really felt uncomfortable to care for him on his own, which is understandable maybe he needs assistance of two.. but.. some staff members…..Obviously I am not mentioning any names, but some staff members were particularly uncomfortable with it which is a shame.. they've really shown me that they are discriminatory but actually they don't know how to deal with this a patient so instead of finding out how there just kinda refusing… but the way I am handling it, is when I, when he needs to go to the toilet or he needs help is I get someone, normally a male staff member to help me cos he needs assistance of two(tut) and I just.. do it.. with someone with me… but there is there is been an issue with that and you know some people aren't being very professional about it. Which is a shame cos I've had such a good experience but may, yeah so maybe training.. on we have training on dementia patients but maybe we need, they needed more training on dementia patients or mental health patients with this particular issue cos it seemed to make them very uncomfortable which is a shame cos he can't help it the patient.

Day 4

Week 4 and.. it's still been good everyone's still very inclusive I haven't seen any language that I thought was.. Inappropriate towards males females men.. members of the LGBT community or anything like that which I think is good they… there is erm patients there that actually are like married erm and they seem to be able to like embrace that as much as they can you know (tut) hand holding they get to spend time alone together like not in a strange way (amused voice) just in each other's

rooms watching television which I think is nice it means that they get ta even though there in a nursing home they both have MS which is unfortunate even though there in nursing home they still get ta….. be.. as much man and wife as they can be.. without.. erm.. it being inappropriate you know they still get to spend time together cos there living in a.. mixed care home… erm. In reference to the patient I was talking about before who is dipl… displaying sexual inappropriate behaviours there has been san some improvement I think people are more…used to it now but I think the real issue is. .is the training and also that the information wasn't handed over very well so when we got him he came from another care home (kissed teeth) to ours ….the information handed over wasn't complete so they just said sexual inappropriate behaviours displayed towards females which I think …made…… everyone else feel a little bit….on edge when actually we've realised maybe it's not as big of an issue as we thought it was.

Analysis of Participant 13's narrative using Braun and Clarke (level 1)

Using Braun and Clarke again, I initially focused on the questions to think about the narrative and its story and then revisited this story using Balint (Braun & Clarke, 2013).

What does the participant say in the story and what are the effects of the story?

The four diary entries read as a story. Participant 13 is undertaking a clinical placement in a private Jewish nursing home. She discusses working in the nursing home and the supportive nature of the nursing staff. Through the diary entries, she reveals that the staff include members of the LGBT community and expresses surprise that a conservative nursing home would be so accepting. By commenting that staff include LGBT people, Participant 13 may be implying her personal judgemental attitudes unconsciously.

Through the journey of the diary entry, Participant 13 discusses poor nursing care in the form of lack of privacy when turning the patients, but also at the good nursing care in the form of recognition of married couples' right to privacy and intimacy. She highlights the nursing staff's

refusal to look after a patient who exhibits inappropriate sexual behaviour and why they may act in this way, but believes that it is due to a lack of knowledge. Again, we see the development of a third position where Participant 13 is learning professionalism (NMC, 2018).

How is the story structured?

The story surrounds the care in the nursing home. There is criticism and praise of the nursing care. The diary's stories become more shocking. The first instalment embraces LGBT issues, then diary entry 2 discusses the personal care of a male patient by female nurses, whilst the third instalment has the patient with inappropriate sexual behaviour, which is concluded in diary entry 4.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

Early, in day 1 of the diary narrative, Participant 13 says:

> I haven't seen any discriminative behaviour or anything like that towards the staff from the staff towards the patients or anything like that.

This is a statement similar to that of Participant 3, and perhaps indicates that, while initially we do not really see issues around sexuality yet, maybe upon reflection and teaching we do. By the end of day 2, Participant 13 reveals that recording the diary has increased her reflectivity:

> I've actually really enjoyed…. it because I haven't had any anything that I would call discriminatory it's made me cos I'm doing this it has made me… think a lot more about the way people being treated and it's really good actually.

Suzanne Everett 9834205:

The diary has shaped the student nurse's experience and the story that she tells. It has illuminated the clinical area and made her reflect on the nursing care given and the nursing staff's behaviour.

How do the narratives constrain or enable the participants' lives?

Participant 13 obviously finds it hard to criticise the nursing staff. Initially there is praise for the acceptance of LGBT staff, but there is recognition that staff do not always recognise patients' right to privacy. There is recognition of the staffing provision and the difficulties in providing staff of the gender that the patients prefer. In the third instalment, there is more serious criticism of the nursing staff's refusal to care for a patient. Participant 13 feels that this is due to a lack of initial information and nursing staff interpreting this judgementally, and she feels that this is due to a lack of training. Participant 13's narrative is an example of nursing staff constraining her development in non-judgementality.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

Participant 13 reveals paralinguistic utterances, such as 'hhh' and long pauses, and laughs at an inappropriate time, all of which may indicate embarrassment about the content (Riessman, 2001). The difficulty that Participant 13 has in expressing herself is emotionally bound up in sexuality. Her powerlessness over the care of the patient with sexually inappropriate behaviour appears in the story; whilst she has the power to talk to managers, she is not able to use this power. This could be because she is a student and not a permanent member of staff, 'just passing through', or because she does not want to 'rock the boat' and affect the successful completion of her placement. This example illustrates our expectations of students' emotions and how they

struggle to articulate them. This is especially important in this university, as we have a high proportion of student nurses for whom English is not their first language.

Participant 13 also kisses her teeth, making a sucking sound, which denotes disapproval in some countries, showing a cultural patois. This highlights the importance of inclusivity and not neglecting groups with different cultural linguistics.

Who does the story connect the participant to?

The story connects the participant to the nursing profession and her role as a nurse. She reflects on the nursing care and the nurses' refusal to care for a patient with inappropriate sexual behaviour, recognising why this may be happening.

Who is placed on the outside of the story?

The participant does not raise with senior management the issue of breaches of patients' privacy or nurses' refusal to look after the patient with inappropriate sexual behaviour. Participant 13 has difficulty in expressing herself and emotions that are bound up in sexuality. She at no point expresses disgust or disapproval of the patient with inappropriate sexual behaviour.

The patients are not at the centre of the story, but the nurse and nurses are. There is no mention of management. The participant does not relate the unprofessionalism of the other health professionals to their duty of care under the NMC.

What is the response of the listener to the story?

It is encouraging to hear of positive LGBT values being portrayed and the thoughtful care of couples is an example of excellence in nursing care. Participant 13, however, may be revealing her attitudes to LGBT

nurses implicitly through her commentary revealing her struggles with this area:

> members of the LGBT community there's actually a transgender nurse there…who.. you know.. she has worked there for a number of years and she said that they actually deal ……. with everything very well a very like ermm.. tut.. like accommodating and.. accepting of all the views which is what I would hope to see but you don't always see it wherever you go.

There is a lack of communication between staff and students about the patient with sexually inappropriate behaviour. I realised how little we address this area and how poorly we educate and support staff. I felt worried about the care that we may give and nursing's inability to address this area, and felt that this situation could worsen with staff shortages and cuts to education.

I felt pleased that the diary increased the participant's reflective abilities, as if I were personally responsible!

What counts in the response from the listener?

When I set out on this journey, I had not considered that participants would recognise the increase in their reflection and its importance to their nursing practice. I think that it is vital that we create this ability in nurses early in their careers.

Again, I recognise a deficit in professional nurses' ability to address patients with inappropriate behaviour, as in Participant 3's account, and see the need for further training.

Findings

Participant 13 is a similar example to Participant 3, showing how nursing staff avoid 'unpopular patients', in this instance a patient with dementia

who is sexually inappropriate to female nurses. She discusses how she navigates the clinical area and copes with attitudes differing from her own and her development to being non-judgemental.

Participant 13 uses the cultural patois of kissing her teeth, which sounds in this example like disapproval:

> the information wasn't handed over very well so when we got him, he came from another care home (kissed teeth) to ours…. the information handed over wasn't complete.

The Urban Dictionary describes kissing teeth as a sound made by the mouth to denote disapproval (Urban Dictionary, 2019). Without the kissing of teeth action, the diary does not reveal as much disapproval. Allan and Westwood state that a lack of linguistic competence can lead to issues in communication (Allan & Westwood, 2016). This may mean that Participant 3's teeth-kissing disapproval may go unnoticed or be misunderstood by those unfamiliar with this code. This is significant because a written narrative would not have revealed cultural patois and as a result Participant 3's disapproval would not be discussed and documented, which illustrates her development of non-judgementality.

The researcher's story of Participant 13's narrative using Balint (level 2)

Participant 13's diary addresses me directly, again, and comprises four diary entries that read as a single, ongoing story of her placement in a private Jewish nursing home. She sounds happy and appears to be enjoying her placement, yet initially sounds a little embarrassed:

> it's really impressed me the fact that they've got…. members of the LGBT community there's actually a transgender nurse there…who.. you know…she has worked there for a number of years and she said that they actually deal ……. with everything very well a very like ermm. tut. like accommodating and... accepting of all the

> views which is what I would hope to see but you don't always see it wherever you go.

Participant 13 discusses the care of patients by staff of the opposite gender, something that she has not reflected upon before. I felt pleased and a proud teacher that she has recognised this:

> it's made me cos I'm doing this it has made me… think a lot more about the way people being treated and it's really good actually.

It is not until the third instalment that Participant 13 is unhappy with her placement. She describes looking after a male patient who makes sexually inappropriate gestures:

> Obviously I am not mentioning any names, but some staff members were particularly uncomfortable with it which is a shame.. they've really shown me that they are discriminatory but actually they don't know how to deal with this a patient so instead of finding out how there just kinda refusing… but the way I am handling it, is when I, when he needs to go to the toilet or he needs help is I get someone, normally a male staff member to help me cos he needs assistance of two (tut) and I just.. do it.. with someone with me… but there is there is been an issue with that and you know some people aren't being very professional about it.

I was surprised at the similarity between Participant 3's and Participant 13's narratives. There are examples of cultural patois, 'tut' signifying disapproval, and the intrusive emotions of caring for the patient and how he is being cared for by others. In this story, however, the student did not evoke anger in me but disappointment. She is supported by some members of staff, not left on her own, like Participant 3. In the final diary entry, Participant 13 talks with pride about nursing staff giving couples time to be together, recognising how caring this is.

However, she ends with the nursing staff's refusal to look after the patient with inappropriate sexual behaviour:

> the information handed over wasn't complete so they just said sexual inappropriate behaviours displayed towards females which I think … made…… everyone else feel a little bit…. on edge when actually we've realised maybe it's not as big of an issue as we thought it was.

Participant 13 talks about the judgements that nursing staff have made about the patient with sexual inappropriate behaviour, highlighting the lack of knowledge and professionalism. Participant 13 is less critical of nursing staff than Participant 3, and not anxious or angry. She appears happier and this may be the result of the increased support that she appears to have experienced. Notably, her diary follows a similar format to that of Participant 3, with fewer problems in the middle of the story and ending with the positive experience of the married patients. However, the very end repeats the central focus of the story. I felt weary that students are experiencing this behaviour and disappointed, and felt that the student is also expressing these feelings.

Findings about Participant 13 using Balint

Participant 13 reveals the complexity of emotions in caring for her patients during her placement. She observes examples of compassion and judgemental attitudes by nursing staff. Her diary reveals disapproval but less anger than Participant 3, and this appears to be because she has had more support from nursing staff. Msiska, Smith, Fawcett and Nyasulu (2014) argued that:

> the learning trajectory demonstrate a gradual change from emotional detachment based on fear to a sense of emotional engagement built on knowledge, experiential insights and the notion of emotion management that led

> to the provision of care driven by compassion as opposed to anxiety. (p. 1246)

As in the online discussion group, Participant 13 presents many faces and juggles emotions (Bolton, 2001). In this diary, we see happiness, sadness and disappointment both reflected by Participant 13 and experienced by me through the listening and reading of the diary. Participant 13 shows her journey to emotional intelligence and the complexity of the emotions that nurses juggle. We see the development of professionalism in the recognition of judgemental and non-judgemental practice.

Summary of Participant 13's diary findings

Participant 13's diary reveals intrusive emotions of caring and the need to develop nurses' emotional intelligence to support this. We see the development of professionalism, an attribute of non-judgementality. This is seen in Participant's 13's recognition of nursing staff discrimination: 'they've really shown me that they are discriminatory but actually they don't know how to deal with this a patient so instead of finding out how there just kinda refusing'. We see examples of positive attitudes in the care of the patient with erectile dysfunction, and a disparity of attitudes towards the patient who is a sexual abuser.

Cultural patois is seen through 'kissing teeth' and 'tuts', which denote disapproval. This shows Participant 13's development of non-judgementality as she portrays disapproval. This narrative shows us the participant's journey to non-judgementality, through discrimination, and the development of professionalism.

Participant 12: digital diary data

Participant 12 is female. She completed five diary instalments and was a member of Online Discussion Group 3.

Day 1

Um……. this is my first week of er placement and during er the handover on my first day of placement er staff said that a patient refused to wear a very tight bra…. er but because she doesn't have any more underwear, err they just put that on to her and she has been complaining about it er they handed it over to the day staff er to check and take it off if she still complains. After handover I went to check the lady in the lounge, but she was sleeping. Then a colleague tried to wake her up for breakfast. When she opened her eyes, she started complaining about what she's wearing, and the staff said to her 'You have your breakfast first and we'll see what to do' after er she was speaking to der er patient er…….. that…. er my colleague errs turned to me and she said, 'don't forget she will forget that later'. For that day I haven't because that was my first day of placement…. I have some orientation and everything is on that day so… er I wasn't able to see her during the day er after that incident in er at breakfast time because I could not see her in the lounge. I think staff had taken her to her room…… so er that's it

Day 2

My second week er I got a lot of things observed but this is the most I had this week. I think because the staffs are used to the patients and they know their patients well er that's why they can just do all types to the patient without any warning or consent…….. er from the handover of one staff after doing the patients personal hygiene care needs she told the other staff that er please check the patients as he is bypassing cos his pad has been er soaked (clears throat) so the other staff er just put his hand on the front area of the patient and saying 'is it wet now er is it wet now' and the patients just jump or reacted er cos he hasn't been even like ask if he could touch him…or……just…even a warning you know dat I am going to check your… you know can I just check er …you, and I was as well like shock you know like I was like pulling back of and I told him you know ….I juss told the other staff that you made him jump and he said 'its ok… he knew me anyway' he said so I didn't say anything…….really

Day 3

Suzanne Everett 9834205:

My week my week 3 and ere we just admitted a patient who got a deformity due to his illness and after asking him everything I need for his care plans my colleague and I took him to the seating lounge with the other residents. We have introduced him and some of the residence welcomed him and er I made him comfortable and settle him and when we are about to leave my colleague notice one of the residents saying something about the deformity er of our new patient, and er when she was about to tell everyone er…you know she was talking to someone… I could er see her because my colleague was.. er.. he just touch me and said 'oh look at her look at her he is saying something about….' and I was looking at her and then when she was about to tell everyone my colleague signs her with the zipping mouth and er she didn't continue what she was about to tell… er… everyone in the sitting room…..err. So after that err we left our new patient; and my colleague and I went to talk to that patient erm who was about to say something about our new patient that it is not acceptable to be snooping or even announcing and as deformity er he should be, he is a new resident and he should be welcomed err anyway she apologise and we thank her

Day 4

Week four we were in the er dining lounge. er I was helping er the other staff prepare the dining lounge for the resident lunch and er one of the resident's daughter just came to the staff and she was pointing at her almost poking her in the eye saying something. I said that er…telling her that last week what you did to my mum was not acceptable and the staff said 'what have I done wrong' den the woman den the resident daughter said 'you put my mum early to bed and when we came to visit her everyone was not happy cos we couldn't talk to her properly' and er the staff said 'er it was your mums choice she said er she said dat she wanted to go to bed early… and, and er…… that's why we, that why I had to ask my colleague to put her in bed and she wasn't really … you know… dat…. herself. She was telling that to the daughter but still the daughter was pointing at her and saying a lot of things and I was really getting annoyed and thinking why can't the staff just say something you know it's just like It's not being you know aggressive but explain to them that these things happen you know but they were not saying anything. They were just quiet, and they were letting her say whatever she can say you know even like I was the one getting annoyed because I cannot really resist what she is telling the staff you know she's juss, really bad on my face so I was just thinking….. I.. I.. I don't know what to say.. I was really annoyed (laugh). And after the resident daughter left, I ask the staff.. Why can't you say something or explain to her… you know dat…. what happen dat day and then the staff said err …… the staff said

'Oh never mind' Everyone know her I mean that resident daughter, even the management cos every time she comes here she complains a lot she even comes around says please close all of the windows as my mum and my dad are will be feeling cold. But some of the resident got their choices so we can't if there in the communal er communal what this communal area you know, we have to you know the choices of the residents we have to see it. But she is really like that and she complains a lot and she see's everything you know so I just keep quiet, I didn't say much, but I was really annoyed, it was really, you know when you see someone pointing or even someone pointing at you, you know it's almost poking your eyes its really..I I was really getting upset I was really annoyed and really upset for da staff and I was really angry with da you know with the how the residents daughter was acting. So I was after the incident I went to talk to one of the senior nurse and I said you know it's not and for me it's my first time to see someone like that you know I can't I couldn't stand you know seeing her like almost poking the eye of the staff er but they explained to me that that is how she is she complains a lot so well at least I jus I have voiced out what I feel inside you know…and er I don't know it's just really I was so it was really upsetting that time and I'd don't you know after that time I think I think my perception you know like the way I see that woman it changed…… I don't know I prefer to be away from that woman than you know than to be……. I think I would prefer not be near her or not to offer her anything because everything what they told me that every time you do something to her it's all wrong so what's the point of going for me what's the point in going to her if she is going to do is she is going to say something you know so I I just wanted to be away from her that time because I was so upset.

Day 5

It's my final week and its regarding a staff providing personal care with the er patient er…she was really saying you know…she …… was er actually discussing it to me when she finished shift but she is a regular staff and erm because I think she was working in pair with an agency but she knows that agency that are really er young and er I think not married and she was looking after a patient er a a male patient and of course when she was cleaning the ……. er cleaning the front part of the male patient er she said that its er it it has erected. So when the you know when the agency came to her she was quite shocked you know she said shock and er… er.. because it was er you know erected and she said er oh maybe this er agency thinks I am doing something to this er to this patient but she's not really doing anything she's just every time she clean him er she clean him er it really you know it will it gets

erected. So she was a smiling at me and said and laughing you know what she said you know what I had you what I have to do really I because I was so embarrassed that you know this agency staff came and she might be thinking that I am doing something to my patient but what I have to do now is like hold it up like you know hold it up and like er I don't know what it is to say hold it up and put it on his skin like he will put it up and then he will just be cleaning you know…… you know the the other er bits of his front side then because I think the agency is er younger and she was really shocked and she said oh please she told her she said I told her that don't you know don't if you're not er feeling comfortable jus you know just turn your yourself back and then. I'll I'll will just finish it I am not doing anything to him I am just cleaning him and er when I am just finished. I will call you because they need to err, I think they they were doing a shower shower on, so he was sitting in a he was sitting in a commode and then showering him, and he said really, I was so embarrassed. Maybe this err staff is err the agency nurse is thinking you know thinking I am doing something to him and I did say you know you know your resident so he shouldn't I don't I don't think she will you know you should have talked to her but at the end she said I spoken to I have spoken to the agency staff that you know usually when we clean him because he is still young the patient was still young but he was having er he was having M M M MS….. yeah Parkinson. So … of Couse he still young you know and if it's a woman a beautiful woman who does himself so I think it's always there always er I was just joking but she did explain to to the agency staff that you know this is how it is you know I I know she she said she was so embarrassed and even the agency staff was embarrassed er to see er the patients er er erected so that's it really you know it's a kind I told them you know its like communication with each other you know you should know…….. the regular staff new the patient really well so if they they been there for like three years so they should know there patient well so that's it really this is all what I I have encountered in this err practice I have had but I enjoyed and I have learned a lot you know er all though prior to my its completely different I think this community…. er community practice I had was really a good one.

Analysis of Participant 12's diary using Braun and Clarke (level 1)

Using Braun and Clarke, to think about the participant's narrative and story I initially focused on the questions (Braun & Clarke, 2013).

Suzanne Everett 9834205:

What does the participant say in the story and what are the effects of the story?

The story discusses the student's experience of the nursing staff's care of the elderly. It shows a lack of compassion and failure to seek consent on the part of healthcare providers in the care of their patients. The student describes a patient's relative who is aggressive to healthcare staff and how threatened she feels over the incident, and how accepting staff are over this aggression and how it makes her want to avoid caring for this patient. The student discusses how the patient and staff and agency nurse interact with each other, the lack of communication and their embarrassment over a male patient getting an erection.

How is the story structured?

The story contains five instalments. There is no introduction to the placement, a community unit for the elderly. The story follows a journey through the placement, and each instalment appears as a separate structure to a greater extent than in the other diaries. The stories also grow more shocking each time, from the first instalment, telling about when the staff refuse to change a patient's bra that is too tight, to the final instalment, about a male patient having an erection.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

The participant's diary entries each revolve around a minor incident, and the examples that she uses focus on her disapproval of others: there is less reflection on her own clinical skills. The first story discusses how a female patient complains about her bra being too tight and the nursing staff's refusal to change the clothing and their dismissiveness. The second instalment discusses a nurse checking to see if a male

patient has been incontinent without telling him what they are doing, resulting in the patient expressing shock:

> saying 'is it wet now er is it wet now' and the patients just jump or reacted er cos he hasn't been even like ask if he could touch him… or…… just… even a warning you know dat I am going to check your… you know can I just check er.

The third story is about a new patient with a deformity and how the patients and nursing staff react to this patient. The fourth is about a female patient's daughter who is aggressive to nursing staff and the participant's feelings about the incident, which she reports to the senior nurse with her concerns. The final instalment revolves around the registered nurse's discussion with the student nurse about an incident with an agency nurse. The registered nurse had been embarrassed that the male patient whom she was washing had an erection, and was concerned that the agency nurse may have thought she had abused the patient.

How do the narratives constrain or enable the participants' lives?

Participant 12's narrative has paralinguistic utterances, such as 'err' and long pauses, showing awkwardness and embarrassment (Riessman, 2001). She appears mature and sometimes more professional than her colleagues. Even though she may actively wish to be perceived in this way by the researcher, her real ability is demonstrated by her ability to question nursing care and to speak to senior nurses about the aggression that she experiences from a patient's daughter. A registered nurse uses her as a confidante, explaining her embarrassment, and the participant shows her compassion. However, she obviously feels helpless at the lack of feedback on nursing care from colleagues and the

senior staff, which shows the constraining influences in her journey to non-judgementality.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

The student's narrative revolves around the healthcare professionals, and the patients appear on the outside of the narrative. Whilst she criticises nurses for touching patients intimately to check that the patient is continent, nurses are very much on the outside of the story, and this is the same for the male patient with an erection.

Who does the story connect the participant to?

The story connects the participant to the nursing profession and her role as a nurse. She reflects on the nursing care and nurses' attitudes to patients and their embarrassment, and she defends them against aggressive behaviour.

Who is placed on the outside of the story?

In diary entry 5, the participant raises the issue of breaches of patients' privacy in the form of examination without consent and the patient's erection. The patients are outside the diary entries and the narrative does not mention how they might feel in such instances.

What is the response of the listener to the story?

There were times during this narrative when I was disappointed by the behaviour of the nursing professionals, such as when checking whether the patient had been incontinent. However, I was not surprised by these actions. I was, however, impressed by the student, who was brave enough to question the healthcare professional's actions in checking whether the patient was continent and spoke to senior staff about a patient's aggressive daughter. I was disappointed at the nursing staff's

response to her and their lack of ability to reflect on these issues or address them.

What counts in the response from the listener?

The issues in the narrative that are important concern professional practice and the lack of consideration for patients. Whilst these need to be addressed, the healthcare professionals' acceptance of aggression and the escalating anger within the stories are important in this practice context of care of the elderly. Whilst these stories focus on sexuality, what unfolds within the narrative is the value judgements and behaviours that the students experience in practice, and these diaries provide insights for nurse education. Nurse education needs to reflect on the way that teaching supports non-discriminatory practice.

The student's reluctance to look after the patient illustrates the development of the 'unpopular patient' and weariness of the staff. The fact that the senior nurse fails to address the anxieties may be due to the lack of compassion and inattentional blindness identified by Paley (2014). Paley (2014) argued that the Mid Staffordshire Hospital incident did not happen as a result of a lack of compassion and care, as purported by the media, but was due to staff being stressed by staff shortages and heavy workloads. This resulted in them being unable to show compassion and care through social cognition and unrealistic expectations being placed upon them. This could be a very worrying early sign within this narrative.

Findings

Participant 12 illustrates the struggles she has to express herself in the paralinguistic utterances when she says 'err' or makes long pauses, showing embarrassment and awkwardness. This diary illustrates the emotional struggle that Participant 12 experiences in expressing her

feelings. Again, emotions are bound up in entries on the escalating anger at the value judgements and behaviours observed in nurses in the clinical area.

We also see the example of an unpopular daughter of a patient, who complains about nursing care. This illustrates the value judgements and behaviours that Participant 12 must negotiate in clinical practice and how she addresses the situation by speaking to the senior nurse.

The researcher's story of Participant 12's diary using Balint (level 2)

Participant 12's diary addresses me, the researcher, directly and is in five diary entries that read as a single ongoing story of her placement in a residential community elderly unit. Participant 12 speaks quickly and, in places, it is difficult to hear the end of her sentences. She initially sounds nervous and embarrassed. In diary entry 1 there are many hesitations that illustrate this. At the beginning, she discusses the nurses' attitude towards a patient who is complaining of wearing a bra that is too tight. The student expresses disapproval of their avoidance of changing the clothing under the assumption that the patient will forget, but the student says that she won't. In the second instalment, Participant 12 describes how a nurse checks whether a patient is incontinent without asking his permission to touch the genital area. Participant 12 is shocked to see this care, and the patient jumps in shock. Participant 12 says:

> I juss told the other staff that you made him jump and he said, 'its ok… he knew me anyway' he said so I didn't say anything……. really.

Participant 12 sounds angry and shocked at the nurse's attitude, and I felt sad but not surprised that she was experiencing this care. I was, however, proud of her ability to speak up and address the incident with

nursing staff. The narrative continues to address the admission of a new patient with a deformity and residents' reactions. She describes how the nurse addresses the residents' reactions. The diary then moves on to focus on a patient's daughter who is aggressive to the healthcare professionals and how frightened she feels. She is again brave enough to speak to a senior nurse. However, I felt frustrated at response of the senior nurse, who accepted this behaviour as normal. I felt angry that they did not address the daughter's behaviour, which was unacceptable, and this shows a lack of recognition and support by the senior nurse. Participant 12 illustrates how patients become Stockwell's (1972) 'unpopular patient': the daughter's complaints have frightened Participant 12 and she wants to avoid looking after her mother:

> would prefer not be near her or not to offer her anything because everything what they told me that every time you do something to her it's all wrong so what's the point of going for me what's the point in going to her if she is going to do is she is going to say something you know so I just wanted to be away from her that time because I was so upset.

Participant 12 shows a mismatch of cultural language through her diary, using patois, for example 'juss'. The difficulty suggests that speakers have access to varying levels of language and endorses Bourdieu's cultural capital theory (Bourdieu, 1972), whereby 'cultural capital contributes to the accumulation and exercise of power and the maintenance of inequality' (Shim, 2010: 2). He showed us that education and class can reproduce inequality. In nursing, the ability to vocalise feelings are not addressed, and this highlights the importance of HEIs teaching nurses to articulate emotion. By doing this we will reduce inequality, increasing the development and progression of student nurses.

Suzanne Everett 9834205:

The final instalment focuses on how a registered nurse copes with a patient who has an erection whilst she and the agency nurse wash him. The student describes the nurse's embarrassment and, in this instalment, Participant 12 appears more mature:

> I was so embarrassed that you know this agency staff came and she might be thinking that I am doing something to my patient.

The instalment highlights the lack of preparation with which we provide health professionals and how concerned they can be about being perceived as abusing patients. Participant 12 sounds surprised at the nurse's embarrassment but enjoys the kinship of being in the registered nurse's confidence. I was proud and pleased at the participant's response: she dealt with it maturely and with sensitivity. As we had addressed in the classroom the issue of patients having erections, this highlights how important the issue is to health professionals, yet it does not consider how the patient may have felt about the incident.

Findings of Balint analysis

This diary contains the most anger, which is directed at the nurses in the clinical placement and the patient's daughter. The student remonstrates with staff about care but soon learns to keep quiet, although she tries again with the senior nurse about the patient's daughter and again is dismissed. The nursing staff's attitude appears to show Festinger's cognitive dissonance (Myers, 1999). They appear to have lost compassion, perhaps due to their lack of emotional well-being and support, which Rose and Glass believed are vital for emotional work in professional practice (Rose & Glass, 2010).

Suzanne Everett 9834205:

Summary of Participant 12's diary findings

Intrusive caring is seen in the anger and embarrassment at the care of the patients. We see these emotions expressed over the poor nursing care and a lack of compassion over the patient whose bra is too tight and with the patient who is checked to see whether he is incontinent without consent.

On two occasions Participant 12 raises her concerns over care, once with healthcare staff in the example above and, second, with the senior nurse over the patient's daughter's behaviour. In both instances, Participant 12 was not taken seriously. For me, this raises concerns over the difficulties student nurses face in whistle-blowing and being taken seriously by healthcare professionals.

Participant 12 struggles to express emotions about patients, and we see her speaking to senior staff about a patient's relative and being rebuffed, illustrating the constraining influences student nurses experience.

We see registered nurses' embarrassment over erections. The incident reveals the insider and outsider status of the student and the agency nurse.

Participant 14: digital diary data

Participant 14 is a female participant who recorded two diary instalments and was a member of group three online discussion group.

Day 1

I came across a patient who had HIV... but in the first place ... how did I know so it as after my placement I realise it wasn't supposed to be put in the handover ever they put it in the handover and during the handover we were told……. that…… (short pause) the patient had HIV

then the sister realise that it was handover and she said oh we not supposed to put in.

However (elongated word and short pause) the way the nurses at my placement treated this patients was just not right because one they like…..well maybe because they were trying to I don't know maybe they were trying to protect me because they are from the same country as me so she's like oh no no no no, come come come and she called me aside and she's like oh you need to be careful of that patients his got HIV Blah blah blah. Which I felt like it was not right because to me it scared me more in the scenes of me knowing that he had HIV. Fair enough I need to be careful in dealing with patients like that however (elongated word) me being told in this manner jus makes me feel some way about the patient (long pause) but it doesn't it shouldn't affect the my care because I still hat to treat the patient just the way I would treat every other person but I just feel like the way the nurses told me it just wasn't right so that was… like However I learned… that…. patients should be treated equally no matter their sexuality their health condition no matter their race Yeah that was my number one experience

Day 2

Another experience of mine which I like to share with everyone is …. during my second placement…. which was in an ???? ward…so this lady.. came in with HIV….and (yawn) it's just the it's just that stereotype behind it like how everyone who has HIV decision is got it from a sexual condition which… I think… it shouldn't be that way because peoples just need to be educated more about this. illness because not everyone that has HIV…. got it from sexual …whatever ... so the (laughs) during the... during the handover so they said to me oh yeah like well they made the handover and then after we were have a discussion basic or and she was telling me how most people from that country they has HIV they live er..they live er..some sort of life style how you can tell she doesn't have a husband or she must have been involved prostitution and all that fair enough she didn't say it to the patient she's discussing it with me but however I just felt like it… it's just not right number 1 yeah you don't know who I am you don't know and am also it was like… it was like my first…experience and me hearing that kind of thing from a nurse… just made me feel ….some kind of way I don't know if you understand what I'm trying to say like it made me feel some kind of way in the sense of would she why would she why does she have that kind of mentality about…about .. HIV patients… I just generally think nurse's patient's families should be educated more about…. about HIV so that um people

don't get really judged and feel like and also like erm based on my personal experience from like ……my… friend…who like…erm ...she has erm HIV ... however well ..well I wouldn't say like... but if..like this was like from my this was like before I started nursing however before I started nursing I never really knew much about …about the condition but I was like...I was just thinking just thinking you can't share cutlery with them you can't ..you can have a proper relationship with them I tried to like distance myself from like her but then by the time I started nursing I made my research and I did my study and I had a lesson about HIV I became more educated and I know like how well you can …. You can't catch you can't get infected by HIV just by sharing cutlery with them…or by …or eating from the same plate or can't get it like that so… erm I hope this helps

Analysis of Participant 14's diary using Braun and Clarke (level 1)

Using Braun and Clarke, to think about the participant's narrative and story I initially focused on the questions (Braun & Clarke, 2013).

What does the participant say in the story and what are the effects of the story?

The story revolves around two patients with HIV and the registered nurses' attitudes to HIV. The narrative concerns the participant's cultural heritage and how a registered nurse from the same country identifies this and tries to protect her. The narrative illustrates the registered nurse's assumptions about an HIV patient and how she had contracted the complaint. Participant 14 describes her knowledge and experiences of HIV.

How is the story structured?

The narrative discusses the issue of HIV and is spoken directly to the researcher. There is a beginning to both instalments, yet the stories in both diary entries focus very much on the student's experience of HIV and her country and the registered nurses' attitudes to HIV.

Suzanne Everett 9834205:

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

The narrative discussed the issue of HIV and two patients, and this subject is the central focus of the story. Participant 14 talks rapidly, with urgency, which illustrates its emotional importance to her.

How do the narratives constrain or enable the participants' lives?

The student is constrained by her role in speaking up about the registered nurse's attitudes to HIV and her discrimination against the patient. She feels that the registered nurse is wrong to single her out by virtue of her cultural identity to disclose that the patient is HIV-positive.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

As the core of the narrative is about HIV, the student's country and her experiences of HIV. This is very much a personal story. The patient is entirely on the outside of the story. She discusses her personal journey with HIV and how her attitudes have changed with increasing knowledge.

Who does the story connect the participant to?

The story connects Participant 14 to the registered nurses and the ward. It also connects Participant 14 to her country and culture and shows the relationship of the registered nurse to this country.

Who is placed on the outside of the story?

The patient is again placed outside the story. There is little written on how the patient may feel and no insight is obtained into their story or experiences.

Suzanne Everett 9834205:

What is the response of the listener to the story?

I felt proud that the student expressed outrage at the nurse's attitudes and knew that she was discriminating against the patient. However, Participant 14 struggles with the formalised linguistic language in which to express herself this is seen in the long pauses. A criticism of narrative methodology is that you only get the participants who have the linguistic skills to articulate their story. In Balint seminar work, you would receive feedback from the group on your story, yet with the digital diaries you receive no such immediate response, leaving the speaker possibly struggling to verbalise their thoughts.

What counts in the response from the listener?

The important part of this narrative is the recognition by the student that the registered nurse's attitudes are wrong, and it shows the importance of addressing this subject area in the curriculum.

Findings

Participant 14 struggles with the words to express herself. She also describes how her cultural identity results in a registered nurse treating her differently, giving her preferential support because of their shared cultural roots. Participant 14 recognises the value judgements and behaviours of the nurse, both in her preferential treatment and her assumptions regarding how a female patient contracted HIV. Participant 14 reflects on her change of knowledge about and attitude to HIV through both direct experience of HIV and the teaching.

The researcher's story of Participant 14's diary using Balint (level 2)

Participant 14's narrative is addressed to the researcher and discusses a patient with HIV. The focus is not the patient but the attitudes of nurses on the ward to HIV. She describes how a nurse from the same

country as her takes her aside and tries to protect her because of her nationality:

> However (elongated word and short pause) the way the nurses at my placement treated this patients was just not right because one they like…..well maybe because they were trying to I don't know maybe they were trying to protect me because they are from the same country as me so she's like oh no no no no, come come come and she called me aside and she's like oh you need to be careful of that patients his got HIV Blah blah blah.

Participant 14 says that this has the effect of making her feel scared, but she recognises how inappropriate this is in the care of the patient. I felt anger that nurses were treating students preferentially. I had been unaware of this and wondered if I did it myself. Subsequently, during teaching I have been told similar stories. All nurses born outside the United Kingdom say that nurses from their country of origin warn them about patients with HIV. I found myself wondering in despair whether we were discriminating against each other and working in silos:

> However I learned… that…. patients should be treated equally no matter their sexuality their health condition no matter their race Yeah that was my number one experience.

The diary continues with another example of a female patient with HIV, and Participant 14 describes a cultural stereotype:

> it's just the it's just that stereotype behind it like how everyone who has HIV decision is got it from a sexual condition which… I think… it shouldn't be that way because peoples just need to be educated more about this. illness because not everyone that has HIV…. got it from sexual… whatever.

Participant 14 highlights how the registered nurse made assumptions about the patient's HIV and how she contracted it. Because the woman

is single, it is assumed that she is HIV-positive owing to sex work. Sex work is frowned upon by many people who do not understand its life cycle and how men and women become involved. This area is addressed in the curriculum; hence, Participant 14 has an increased understanding of the reasons why individuals work in the sex industry. However, this may not be the case for the registered nurse. The registered nurse's attitude is displayed as disapproving and prurient, for instance 'some sort of life style'. This conveys her judgement that this is not an acceptable lifestyle and that a patient who is single and has HIV has contracted it through sex work, implying that sexual intercourse outside marriage is unacceptable. In response, we see Participant 14's anger: 'it's just not right'.

> she was telling me h ow most people from that country they has HIV they live err.. they live err.. some sort of life style how you can tell she doesn't have a husband or she must have been involved prostitution and all that fair enough she didn't say it to the patient she's discussing it with me but however I just felt like it… it's just not right.

Participant 14 discusses her knowledge on HIV and how it has changed. The lesson on HIV that she refers to is in the new curriculum on sexuality, and this covers HIV. Many students in the classroom who were born outside the United Kingdom express the views that Participant 14 expresses here:

> before I started nursing I never really knew much about… about the condition but I was like… I was just thinking just thinking you can't share cutlery with them you can't.. you can have a proper relationship with them I tried to like distance myself from like her but then by the time I started nursing I made my research and I did my study and I had a lesson about HIV I became more educated and I know like how well you can…. You can't catch you can't get infected by HIV just by sharing cutlery with them… or by… or eating

> from the same plate or can't get it like that so… erm I hope this helps.

I felt very proud that Participant 14's attitudes had changed positively through education that I have delivered. I felt that it endorsed my research and teaching and showed how important these are.

Whilst Participant 14 has shown that her knowledge and attitudes had changed, she does not feel able to speak up against the registered nurse's attitudes. She expresses outrage – 'it's just not right' – but there is a resignation whereby she feels that she cannot speak out. This example illustrates the difficulties that student nurses experience in speaking out about poor practice. Whilst initially I felt proud, this changed to sadness. I would have had the same difficulty in speaking up, and I felt sad that, despite all the work on whistle-blowing in health, this was still so difficult.

Participant 14 shows her exposure of the nursing staff who hold discriminatory views on HIV non-judgemental behaviour. She navigates these discriminatory attitudes by not addressing them in the clinical area, yet is clearly angry at the attitudes. Participant 14 reflects on her journey with HIV and her change in knowledge and attitudes, so it is a journey from judgementality to non-judgementality. We only hear this story through her addressing the nurse's discrimination.

Summary of Participant 14's diary

Participant 14 shows the difficulty she has in expressing emotion. This is seen in the example of her disapproval of the colleague from the same culture who gave preferential treatment:

> I don't know maybe they were trying to protect me because they are from the same country as me so she's like oh no no no no, come come come.

Suzanne Everett 9834205:

Value judgements and behaviours are recognised by Participant 14, whose experience and knowledge have increased her non-judgementality:

> she's discussing it with me but however I just felt like it… it's just not right.

This digital diary's findings support my anecdotal evidence, which set me on this research journey, so they are unsurprising to me. However, what surprised me is the participant's recognition of the discrimination, and her development through the curriculum intervention.

Participant 14's narrative shows the journey from judgementality to non-judgementality through attending to discrimination; she has recognised the discrimination of the nursing staff and knows that this is poor nursing practice.

Participant 15: digital diary data

Day 1
Hello, today is the….tenth of February 2017…the time is now……..five thirty…… and the participation number is……. fifteen……..
During my placement I have been working in the district….. Nurse erm within the community I've observed that patients use offensive words and provocative words when talking about female member of staff which can be quite uncomfortable but as nurses…….. we have to……. provide care and be compassionate and understanding and and and adhere to the NMC…….
One patient was very……one male patients was very …… inappropriate he would take off his……..when we come into the room and we try and get his wound done and we get our book out and everything he would just strip…. and its turn around and ask him to can he please put on his clothes if we keep facing him he enjoys it and finds pleasure out of it……..ok that's my log for this week.
Day 2
Today is the sixteenth of February 2017 the time is two o'clock and the participation number is fifteen……. I have realised that in

district nursing in the placement I am I am in right now that we don't have enough male staff…….which is really serious concern and I'm I keep raising it and I'm like 'why don't we have enough male staff' I don't know what the reason is maybe because not much male ……staff apply for the job or…I don't know……. Anyway Not having male staff has caused us……. quite a bit of problems (laugh)…erm…. cos sometimes.. pe, er patients will have sexual preferences on who will provide their personal care for them and if you we haven't got a male staff then we are unable to provide that care…..to suit their needs but if erm we still provide the care but it will make the patient uncomfortable which……. is not a good thing cos having your patients move away from you or can't even look at you next time when you come in all they can remember is what you have done for them… which is very wrong……and……and in the NMC it says make sure you deliver the fundamentals of care efficiently and yeah ok we are providing the care efficiently but we are erm……..we are not adhering to them we are not respecting and upholding their rights to decide who provides care for them……And as a trust we should be able to provide that care and we aren't unable we are unable to we un we are unsuccessful……..and erm…….while we are doing that ……we we are just making the patients very uncomfortable and I was really not happy with it and I was erm ok and like even if it was a bank or someone yeah a bank will do jus a male bank staff just to provide that, just make the and will make the patient feel comfortable and will make the patient not dread the…… psychologically it could be seen as a psychologically erm damaging or emotionally damaging if patients are continuously put in that situation Okay I know we have erm.. a a a male staff member but we can't always make sure he is in every single day that's just impossible and we and he has to have his break and We are… the ……NHS has to make sure…that happens that every everybody has a day off or everybody has annual leave, but if he's not there and the sacral and and what am I talking about and the dressing is due or or or put in erm sacral dressing or erm…..or a dressing erm near erm the upper thigh erm near the groin area erm, and its due then he and he's not here what can we do what can we do….we can't train….the careers or the yeah careers could do the job for us as it's our job to do and we are not even providing it. That's it

Day 3

Today is the twenty third February 2017 and the time is now…….. fifteen minutes to nine ok and the

participation number is 15 today I was talking to a colleague ooh and talking about erm…… jus erm if there was any sexuality or discrimination or something going on…. in the office…or.. that is not talked about or something and we we came across erm that male staffs are paid more.. ok that's under discrimination or not I might be right I might be wrong but that's just not right…..erm yeah……if the male staffs are paid are getting paid more and there's a lack of male staffs I was like proves what I talked about something but or should I have talked about…….then whass going on?..... was going on?……..yeah anyway that's it…….for today Goodnight

Day 4

Today it is the second of March 2017 the time is now…….ten past six and my participation number is fifteen Ok erm …… yeah……today I worked with a male em member of staff for a change which was yeah which was good erm yeah we were doing some new admissions and it was em very……. it was ok but erm……..I found out that the erm male staff find it really uncom I wouldn't say really uncomfortable……..ok I would say that when em asking patients about their sexual history……ok…….. ok it might be because it was like all female patient ok and some male patients but the male patient like easily said it but the female patient just *looked* at him and then *looked* at me and I was just like…….ok why why don't you just go out the room and let me deal with it let me talk to them cos go on go and they will probably most probably talk tell me…talk about it so yeah that's what happened today…….which is good at least I was able to help Ah I would have felt so bad if he was on his own and that happened…yeah and then how would have to deal with it……ok ok I probably no how he would deal with it he would jus say it and if she does not respond then ask the next person at the visits to ask these questions and then and if the next person is probably going to be a woman most likely going to be a woman then…….then they can write it and fill it out on the chart but at least I was able to help which was good that's it for today

Day 5

Today is the……fifth of February I mean fifth of March 2017 the time is…….. 11.25pm and….I just wanted to talk today oh participation number fifteen I I just wanted to talk today about em……..what did I want to talk about.....oh yeah ok here's the thing...we only have in my place we only have one guy and whose like works full time and he is surrounded by by all us girls and then the way we treat him is like one of us girls and we try to include him more in our conversation and we try to engage him more to make him feel much

more comfortable….and more easier to talk to us if you understand what I mean but yeah I find that kinda funny it was in my head so yeah …….and he's sweet and the banter……they have is jus wonderful to see they so included and whenever they talk talk about em…….like a female patient or like catheterisation…..or em…….having groin wounds or having something he yeah he is ready to talk about it and he is engaging which is really good and it's great to see how it allows him to open up and allows him to join the discussion more Ok thanks goodnight

Day 6

Today is the twenty fifth of February em 2017 the time is……. half nine er……. participation number is fifteen yeah today was yeah this week has been good and everything…….. um nothing to complain um yeah something happened…….. ah I had I had ok me and the person I was with went to see a male patient right er yeah he was fine but when it came to we were gonna do a bladder wash out and all that and then it and then he just he jus told me to get out I'm like I don't know what it was but or we were both female but and it's probably cos he is a young man and he felt uncomfortable around me er cos I was….younger than him and he was embarrassed or something but yeah and so I respected his decision ere and and left the room whilst my college dealt with him and cos he was much more comfortable with her cos he's been with her for a while so yeah that's probably what and he probably does…….. this to other students but I don't know yeah……that's it……bye

Analysis of Participant 15's narrative using Braun and Clarke (level 1)

Using Braun and Clarke again, I initially focused on the questions to think about the narrative and its story and then revisited this story using Balint (Braun & Clarke, 2013).

What does the participant say in the story and what are the effects of the story?

The story revolves around Participant 15, who has a placement in the community with district nurses. The narratives focus on male patients and the difficulties female nurses have caring for patients of the opposite gender, and the lack of male nurses in the placement.

Suzanne Everett 9834205:

How is the story structured?

There are six diaries. Participant 15 introduces each diary in an organised format, giving the day and time, and her participant number. The diaries all focus on similar themes and contain pauses where Participant 15 struggles to find words.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

Participant 15 struggles to find the words to vocalise what she wants to say, so there are pauses or she avoids being specific for example; 'one male patients was very …… inappropriate he would take off his…….when we come into the room'. The reader is left to assume that the patient is taking off his clothes and is exposing himself.

How do the narratives constrain or enable the participants' lives?

Participant 15 struggles to find the vocabulary to narrate her story. This is illustrated in the pauses and the word omissions; however, she does not lack vocabulary as she uses terms such as 'sexual preferences' so these omissions and pauses appear to be about personal difficulties describing sexually related issues.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

Participant 15's narrative focuses on the male nurse in the placement. Her stories focus on male patients and the need to have male nurses to care for intimate areas. The stories focus on male patients but they appear on the outside of the story along with the female nurses.

Who does the story connect the participant to?

Participant 15's story centres on the male nurse in the placement, discussing the lack of male nurses and the belief that they are paid more

than female nurses, finally showing how the nursing team ensure he is included.

Who is placed on the outside of the story?

The patients are placed outside the story. We see this in the way Participant 15 refers to them: 'I've observed that patients use offensive words and provocative words when talking about female member of staff which can be quite uncomfortable but as nurses…….. we have to……. provide care and be compassionate and understanding and and and adhere to the NMC…….'

What is the response of the listener to the story?

Throughout this narrative Participant 15 sounds embarrassed and this is seen in her difficulties describing sexually related issues. This could be the embarrassment she feels in the clinical area but could be the embarrassment of having to speak out loud into a digital recorder. Participant 15 has shown that she has the vocabulary to express herself in the words she has used, so this may be an example of embarrassment at speaking into a digital recorder, and a limitation of this research method.

What counts in the response from the listener?

Participant 15's story highlights her vulnerability through the male patient's provocative comments. She also shows awareness of the professional role of the nurse and her duty of care to treat her patients, illustrating non-judgementalism.

Findings

Participant 15's story recognises that nurses need to show compassion and put aside their personal feeling treating all patients equally, illustrating a non-judgemental attitude.

Suzanne Everett 9834205:

We see through the narratives the difficulties nurses have looking after patients of the opposite gender. This is illustrated with the male patient's inappropriate nakedness, and the provocative statements made by male patients. We also see through these diaries the male patient's embarrassment at receiving care by female nurses: 'went to see a male patient right er yeah he was fine but when it came to we were gonna do a bladder wash out and all that and then it and then he just he jus told me to get out I'm like I don't know what it was but or we were both female but and it's probably cos he is a young man and he felt uncomfortable around me er cos I was….younger than him and he was embarrassed or something'.

We also see an example of the male nurse being embarrassed about asking sexual history questions to a female patient: 'I found out that the erm male staff find it really uncom I wouldn't say really uncomfortable……..ok I would say that when em asking patients about their sexual history……ok…….. ok it might be because it was like all female patient ok and some male patients.'

Participant 15, whilst embarrassed, shows how she presents many faces and juggles emotions (Bolton, 2001). She shows her journey to emotional intelligence and the complexity of the emotions that nurses juggle. We see examples of how other nurses juggle their emotions, and their recognition of the embarrassment patients may be experiencing.

The researcher's story of Participant 15's narrative using Balint (level 2)

Participant 15's diary reveals vulnerability and embarrassment over the patient's provocative statements and inappropriate nakedness. She is upset by the provocative statements and is not able to vocalise what has been said. Participant 15 is angry through the diaries about the lack

of male nurses, but also angry that male nurses may be paid more than female nurses. She recognises other people's embarrassment, and we see this in the male nurse's difficulties asking sexual history questions and her desire to rescue him from the situation. Participant 15 recognises that the young male patient is embarrassed to have her present during his procedure, but also reflects that this may be because she is younger than him and female, acknowledging sexuality.

Throughout the diary, Participant 15 struggles to find the words to express herself, illustrating embarrassment. This embarrassment could be about the nature of the material, about verbalising the stories to me, or a mixture of both.

Findings about Participant 15 using Balint

We see through Participant 15 her recognition of the nurses' and patients' embarrassment, along with her own embarrassment. Participant 15 shows through her diary how she and other nurses juggle embarrassment in the clinical area. The diaries reveal the vulnerabilities of nurses looking after patients of the opposite gender, and their difficulties addressing these encounters.

Summary of Participant 15's diary findings

Participant 15 shows the recognition of non-judgementality through value judgements and behaviours. We see this through her recognition of the male nurse's embarrassment about asking a female patient sexual health questions. This is an example reveals how registered nurses juggle their emotions, in this instance embarrassment.

Participant 15 expresses the belief that male nurses are paid more; this may be an inaccuracy that she has been told or her personal attitude. Participant 15 reveals her attitudes to offensive language and

provocative words; we don't know what the patient has said, as this is not revealed by her:

> I've observed that patients use offensive words and provocative words when talking about female member of staff which can be quite uncomfortable but as nurses…….. we have to……. provide care and be compassionate and understanding and and and adhere to the NMC…….

However, we see that Participant 15 understands that she needs to put these feelings aside to act professionally.

Participant 15's experience and knowledge increased her non-judgementality. We see this in the narrative when she recognises the embarrassment of the male patient:

> it's probably cos he is a young man and he felt uncomfortable around me er cos I was….younger than him and he was embarrassed or something.

The narrative shows a journey from judgementality to non-judgementality through attending to discrimination.

Participant 19: digital diary data

Day 1

So during my first week on my placement um I'm based I'm based in A&E at the **** hospital and in regards to sexual health un this week the only main thing that came up is um that a patient came in on Thursday night with um a tampon stuck inside her er after having intercourse with her partner. She came in to have it removed the doctors had never performed such as procedure before so they were unsure of how to proceed.. but they did their best and got it out…the patients as you would um suspect was quiet embarrassed when she came through um and the doctors themselves even the one that um did the procedure he um actually commented that he was just as embarrassed as her about performing it because it was such an intimate area and that…he had never done such a thing before..um cos he actually even got out the gyne sort of er widener for the vagina so he

could you know…have a better look un put whatever he need to put up there..(laugh) and he was standing in the in the minors section and he was opening and closing this thing and he was like (huff) I don't know what to do now with this so um so really for my first week that was the main sort of thing that has arisen due to sexual health ok

Day 2

On my second week of placement there was nothing really to do with sexual health… um things besides having to be a chaperone for a few um exams and…. er....that's really about it but on my third week it was….again it wasn't there wasn't much to do with sexuality or gender um….I mean I don't know how relevant it is but we had on Friday night last week a mental health patients that came in and her things was that…um she believed she had died that morning and had ascended into heaven un she wanted to have sex with God in order to I don't know to reach her fulfilment and so she was looking for god to ss quench her thirst to have this child that she wanted..the mental health nurse and.. the.. psychiatrist who interview well the psychiatrist interviewed her and I was there because she had er I don't want to say jumped but a sort of sexually sexually…… charged as such to… attack men in order to have this child that believed that she needed um and the both mental health and psychiatrist when we finished they was just astounded as to how…..I don't know how not with the well she was she was the worst that either of them had seen in quite a number of years um she was pretty psychotic um because she brought her med just weren't working for her um so that was that on Friday um….. there's not really much else I means to do with that we did a few catheters and stuff but it wasn't really relevant so um that was last week anyway so maybe something else will turn up this week.

Day 3

Nothing to report

Day 4

Am let's see so…..so in my fourth week… at..um placement we had er unexpected pregnancy come through the doors..it was…it was my first time of seeing actual labour um so it was quite an eye opener for me er the little the girl or the woman that walked through she um…she…I don't I don't wanna she came through full term and the nurse that saw her um saw her in triage and asked her um what's wrong with you and she said she had really sore abdominal pains at the moment and so she the nurse felt her and she said went err it doesn't feel right can…… I

have a look downstairs and she said yeah no worries and she realised this patient was in labour so she got rushed through to A&E's um resuscitation room whereupon the emergency er call went out for the gynaecological team to come down and set everything up to help this mother and her baby…um it was a really..um.. Interesting sort of thing because the the girl herself was an interesting case because she um was a young a young mother I would say and er she…….. she didn't want she sort of was in denial for the whole of her pregnancy that she was pregnant um until probably this last week and she never had seen a doctor really about her pregnancy and she had never been to any midwifery sort of sessions either so that was one thing but the baby came and it was full term it was healthy it cried….um I think what took most people aback initially was that the woman she was asked if she wanted to see her baby once it was born and she said no and I think that sort of threw people quite a bit cos you would think that you would want to see your child but she didn't she did after a few minutes she did want to see her baby but um another thing that was quite impressive was I never seen placenta before and that was a real….. Interesting thing just because if its size and the…I don't want to say texture but you know the consistency of a placenta was really interesting and what its actual role was cos you only ever I only really ever hear of what a of placenta I've never seen it in the flesh so it was really interesting to see um…….so that was last week um I assisted with a few um….catheters as well both male and female we I watched a male man get catheterised but he was…um he had he was having a……bradycardia um attack well I would not say attack but he was suffering from severe bradycardia so they so he was being….um……..how do we put this he was on his heart was being um monitored by the pacemaker so it was controlling his heart rhythm which was interesting cos the body was um sort of flexing with to the beat of his heart rhythm but um….we were told in class you know that when you do a male catheterisation you have to hold the penis for five minutes and then you can put the catheter in whereas in this time the nurse he just put the lub lubricant straight into the male urethra and then put the catheter straight in so that was…so that was interesting in that respects and but then afterwards the man himself he was..when he actually did come round again and kept constantly trying to er remove the catheter cos he felt that it was really uncomfortable on him as you would expect but but we had to keep telling him to keep his hands by his sides and not too remove it…the….and then the other two female catheterisations that I was witness too um it's just interesting that the fact that.. it.. seems.. that.. the..older you get the harder it is to catheterise cos things start to move and there not supposed to be where they are supposed to be in the

books un you know it's and then sometimes you've wet the bed or and then you're trying to catheterise someone and there is not residual urine left so that also um an interesting factor but….um..it's just different lots of different ways of doing the same thing so that has really been my four weeks so far on placement so um yeah

Analysis of Participant 19's narrative using Braun and Clarke (level 1)

Using Braun and Clarke again, I initially focused on the questions to think about the narrative and its story and then revisited this story using Balint (Braun & Clarke, 2013).

What does the participant say in the story and what are the effects of the story?

Participant 19's diaries surround her placement in A&E. They cover issues around the removal of a retained tampon, catheterisation, the delivery of a baby, and a psychotic patient who believed she had sex with God. The story shows the lack of experience of healthcare staff in certain situations, for example the doctor removing a tampon and the two female nurses catheterising a male patient.

How is the story structured?

There are four diary entries, although one diary has nothing to report. The stories focus on an event. Each event is treated as an individual entity. Diary entry 1 describes a doctor removing a retained tampon, diary entry 2 describes caring for a mental health patient, and the final diary entry discusses a young woman delivering a baby she has concealed and the catheterisation of a male patient.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

Participant 19 her shows embarrassment through laughter: 'he had never done such a thing before..um cos he actually even got out the gyne sort of er widener for the vagina so he could you know…have a

Suzanne Everett 9834205:

better look un put whatever he need to put up there..(laugh) and he was standing in the in the minors section and he was opening and closing this thing and he was like (huff) I don't know what to do now with this'. This story highlights the doctor's embarrassment and inexperience. The patient is outside the story, and there is acknowledgement that the patient is embarrassed by the incident but she is outside the story.

Diary entry 2 discusses a female patient who is psychotic and believes she has had sex with God; the psychiatrists have not seen such an ill patient. Again, the patient is outside the story, with the story focusing on the psychiatrists.

The final diary entry, number 4, focuses on the delivery of a baby: 'the girl herself was an interesting case because she um was a young a young mother'. We do not get an age for the young woman but as she has been referred to as a girl or young woman it is likely that she is under the age of 18. This must have been a traumatic incident for the young woman, but there no sense of this in the narrative. Finally, in the last diary entry Participant 19 discusses the catheterisation of an unconscious male patient, and his attempts to remove it as he wakes up. Again, the male patient is outside the story, and the narrative focuses on the procedure.

How do the narratives constrain or enable the participants' lives?

Participant 19's narrative is descriptive and the telling of the narrative shows embarrassment. The narratives appear to have constrained Participant 19 from reflecting on the incidents.

Suzanne Everett 9834205:

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

Participant 19's stories are descriptive and told from a distance; this may be her unconscious defence to cope with the embarrassment and complex nature of the incidents.

Who does the story connect the participant to?

Participant 19 speaks directly to the researcher and feels connected to the researcher.

Who is placed on the outside of the story?

The patients and other nurses are placed outside the story. Participant 19 describes the story but does not reflect on the implications of the event on the patient. The stories feel voyeuristic in nature as Participant 19 is looking in on the incidents but not involved.

What is the response of the listener to the story?

Participant 19 appears to sit outside the narrative. This narrative illustrates how student nurses can feel unconnected within the clinical team, experiencing outsider status. Outsider status may make it harder for student nurses to feel connected and reflect on the incidents.

What counts in the response from the listener?

Participant 19 has described the incidents but the diaries lack reflection. This may be a defence against embarrassment. Bion argued through his work on groups that defences are used to stop participants dealing with their own 'failings' and is a construct of the group identity (Bion, 1992; De Board, 1978). Participant 19 may have used her descriptive narrative as a defence mechanism to avoid her looking at healthcare professionals and her involvement. For example, the doctor who had no experience of using a vaginal speculum should have sought help, as he

lacked the clinical skills. Participant 19 and other healthcare staff are complicit in his actions by not suggesting he seeks support, and Participant 19 appears to express embarrassment through laughter. This may be as a result of the sensitive nature of the incident or a lack of experience of how to do deal with someone else's lack of clinical competence.

Findings

The narratives are descriptive and focus on incidents**;** the patients sit outside the story. The diaries feel voyeuristic, with the student an outsider looking in.

There is a lack of reflection in the diaries and this may be a defence by Participant 19 to avoid interacting with emotions of the incidents.

The researcher's story analysis of Participant 19's narrative using Balint (level 2)

The effect of the diaries being told from an outsider perspective has revealed less emotion. Embarrassment is seen through the diary in laughter, but Participant 19 has used clinical description to distance herself from the incidents as a possible defence.

Findings about Participant 19 using Balint

Participant 19 shows her embarrassment through the diary with laughter over the doctor's lack of experience and knowledge about removing the tampon. This may be embarrassment about the situation but also may be embarrassment over the retelling of the incident.

There is a lack of emotion in the diaries and this may be a defence mechanism to protect the student nurse from the complex nature of the incidents. This may also be the result of using a digital diary;

Suzanne Everett 9834205:

Participant 19 may find using the digital diary does not encourage reflection.

Summary of Participant 19's diary findings

Participant 19's diary reveals a lack of emotion, she does show embarrassment about the doctor's lack of knowledge and clinical skills. However, there is an immaturity to this narrative: Participant 19 does not relate the doctor's lack of competency to patient care, and the patients appear outside this narrative.

Participant 19 shows a lack of compassion, or possibly immaturity, by assuming that the woman who has just delivered her baby unexpectedly in A&E would want to see her baby: she was asked if she 'wanted to see her baby once it was born and she said no and I think that sort of threw people quite a bit, cos you would think that you would want to see your child but she didn't, she did after a few minutes'. Participant 19's narrative may reveal outsider status, which may make it difficult for her to connect and express emotions about patients.

Summarising the findings of the diaries from analysis using Braun and Clarke (level 1) and Balint (level 2)

Participants struggle to express themselves, showing increased difficulties in expressing emotions. This is seen in the prolonged pauses and dots, errhs and grammatical lapses throughout the diaries.

Participant 3:

> Oh, I had my practice placement em area was an acute renal ward erm while I was there, I did em not much of sexuality issues where um was daily.

These illustrate participants struggles to express themselves. Cultural patois is illustrated by participants expressing disapproval through 'kissing teeth' and 'tuts'.

Suzanne Everett 9834205:

Participant 13:

> the information wasn't handed over very well so when we got him, he came from another care home (kissed teeth) to ours…. the information handed over wasn't complete.

The digital diaries have illuminated cultural patois, which written narratives would not have shown.

The diaries reveal a lack of emotion, seen with Participant 19, who shows a lack of compassion, or possibly immaturity, but may also reveal outsider status, which may make it difficult to express emotions. On the other hand, Participant 12's narrative reveals how registered nurses juggle their emotions in the instance of embarrassment. Participant 12's diary illustrates intrusive caring, which is seen in the anger and embarrassment at the poor care of the patients.

We see the development of the third position of professionalism, where participants need to set their feelings aside to act professionally, as seen with Participants 15 and 14. Participant 3's narrative shows the development of emotional intelligence and understanding: 'I wasn't quite comfortable because um I think it was blown out of proportion and it affected the patient care a little bit'.

The narratives show the journeys participants have travelled from judgementality to non-judgementality through attending to discrimination.

The findings from the diaries show two possible journeys to the development of non-judgementality for students: one that sustains the development of non-judgementality and one that inhibits or slows the development of non-judgementality. Other factors appear to influence how constraining these developmental journeys may seem for students:

the value judgements registered nurses show in front of them; the degree to which the student observes registered nurses delivering intrusive caring in a sexual health context; and the emotions the student feels around sexual health issues and those she observes and feels are expressed by registered nurses in practice.

Value judgements and behaviours are recognised by participants in their journey to non-judgementality. The diaries illustrate how the student navigates the clinical area and copes with attitudes differing from their own and their development to being non-judgemental. This is seen in the diaries over nurses' attitudes to HIV and how patients contracted the illness.

Participants' intrusive caring for patients is portrayed in the diaries through anger and embarrassment. An example of this is seen in nurses' avoidance of caring for a male patient who was a perpetrator of sexual abuse, and the participant's anger over this.

Participants show the difficulties that they have in navigating these emotions. These difficulties show that participants can identify judgemental and non-judgemental practice.

Emerging themes

The emerging themes from the digital diaries revealed:

Intrusive caring: value judgements and behaviours are recognised by participants in their journey to non-judgementality. The diaries illustrate how students navigate the clinical area and cope with attitudes differing from their own and their development to being non-judgemental. This is seen in the diaries over nurses' attitudes to HIV and how patients contracted the illness.

Emotions bound up in sexuality: Participants show the difficulties that they had in navigating these emotions. These difficulties show that participants can identify judgemental and non-judgemental practice.

Section 2: interviews

Three interviews are discussed in this section, and were the only interviews undertaken: Participants 2, 10 and 16. All three had originally agreed to record digital diaries, yet failed to do so. The researcher offered to conduct interviews with all participants following completion of their digital diary and any who had failed to keep a digital diary. None of the participants who kept a digital diary wanted to have an interview.

Participant 16 had had her placement deferred due to illness; Participants 2 and 10 failed to complete diaries and gave no reason but offered to do an interview. There may have been many reasons for this choice, as interviews may be perceived as more personal, or they may be seen as involving less commitment and work by the participants.

I allowed 40 minutes for interviews but Participant 2's interview was shorter, at 20 minutes, and came to a natural end. All the interviews were informal, with open-ended questions to support the participants' own stories being revealed. Participants 10 and 16 were the longest interviews, at 30 minutes.

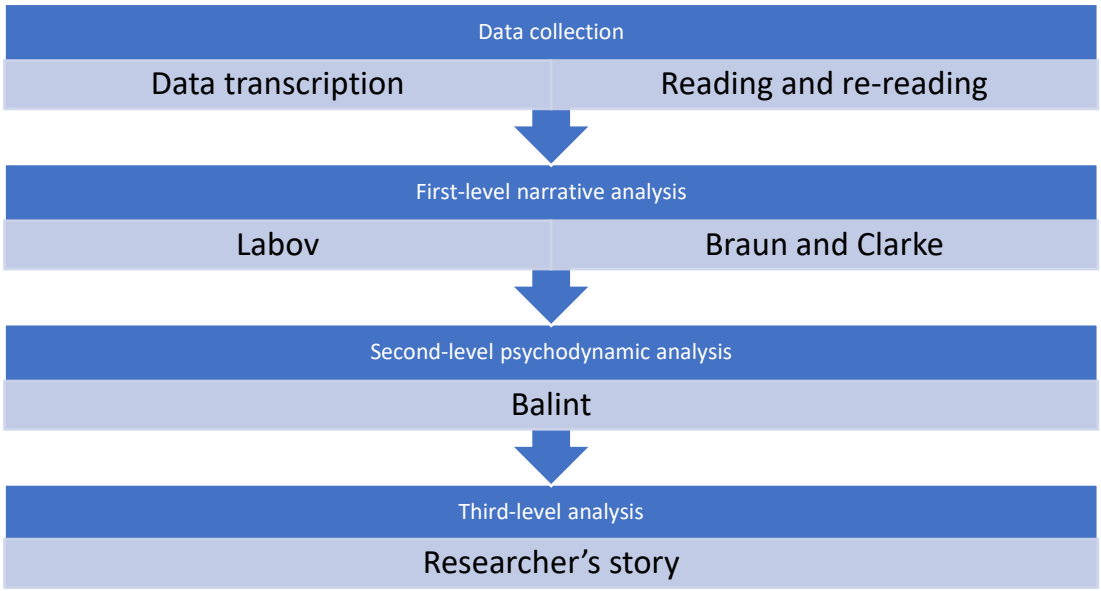
Table 6-4 Data collected from interviews

Participant number	
2	Interview
10	Interview
16	Interview

Interview analysis

All the interviews were recorded and transcribed verbatim, and had first-level analysis where they were read, re-read, and analysed using Labov. Figure 6-4 below highlights the process of analysis for the interviews. As discussed at the beginning of this chapter, the interviews were analysed as part of a pluralist approach to data analysis using the iterative analysis that started with Labov, then Braun and Clarke, and finished with Balint analysis. The themes that emerged during the first level of analysis using Labov and Braun and Clarke were then further explored in the second-level analysis stage using Balint. The interviews were analysed in the knowledge of the analysis of the digital diaries. The emerging themes are detailed at the end of Section 1 and influenced the interview analysis; the third level of analysis reveals the researcher's story using Balint. This is discussed further later in Section 4, where I present data from my diary.

Figure 6-4 The final analytical journey



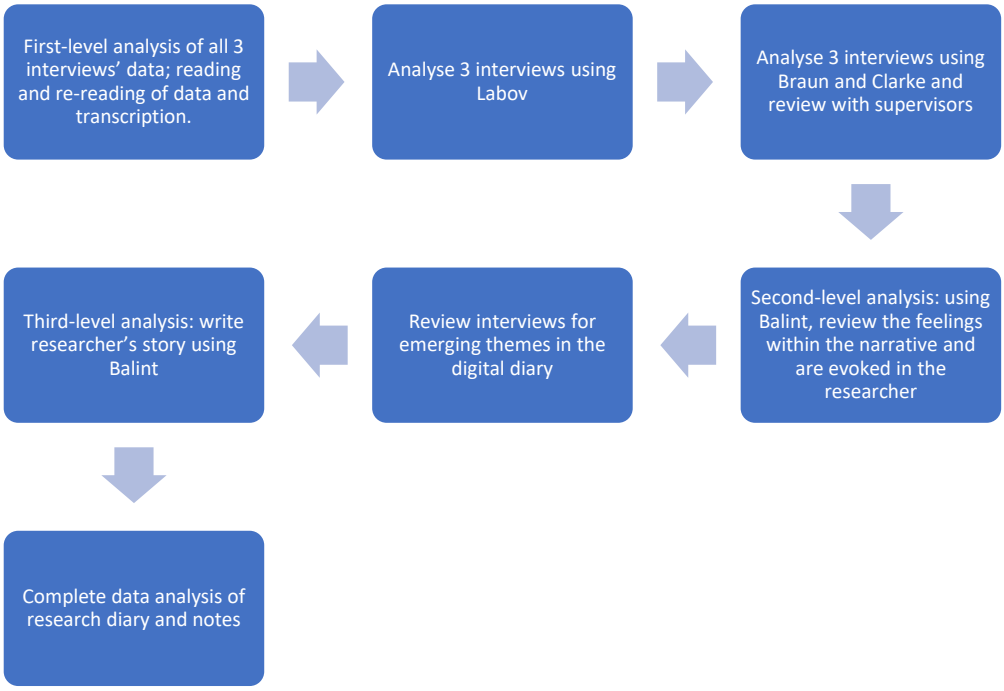


Figure 6-5 Process to analyse the interviews

Labovian analysis of interviews first level

All of the interviews were first analysed using Labov. A summary of these is seen in Table 6.5. The entire interview transcripts are shown after this paragraph. Following Table 6.5, the interviews are shown with Braun and Clarke and Balint analyses.

Participant 2: interview

Participant 2 is female; she failed to complete a digital diary but offered to do an interview.

Participant 2: I was working in the Emergency department when a patient who had HIV attended. They had not been taking their medication and were very ill. The nurse asked the health care assistant (HCA) to take some blood from the patient and mouthed to her that the patient had HIV. The HCA said that she did not want to take blood from the patient to the staff nurse, who asked why, what was the problem. The HCA agreed to take the blood but then proceeded to put on two pairs of gloves to take the blood. The patient was unaware of this, as she did do it discreetly.

Researcher: How did you feel about this.

Participant 2: I felt really awkward about this incident I did not feel as a student nurse I could say anything, I did not want to come across as a stuck up or know it all student.

Researcher: What would you do if you were qualified?

Participant 2: I think I would be able to address the issue as a staff nurse and discuss with the HCA her actions.

Participant 10: interview

Participant 10 is a female student nurse who did not complete a digital diary but completed an interview.

Participant 10: I was working on a respiratory ward. I didn't really see much which is why I didn't do the diary. But there was this episode where a patient was found watching porn, and staff did not really do anything.

Researcher: Was the patient male or female?

Participant 10: They were male.

Researcher: Why do you think staff did not really address this? Do you think this was cultural or religious, embarrassed?

Participant 10: No, I think they just did not know what to do, how to deal with it.

Researcher: How do you think you would deal with it?

Participant 10: I think it would be easier if I was not a student and was staff then I could feel I could talk to him without having to ask permission. He had been caught before watching porn and is paralysed from the neck down but can use his hands.

Researcher: That's difficult I have not come across this issue, but I suspect we will see this more.

Participant 10: It wasn't so bad as he had a side room.

Researcher: Yes, it would be difficult with bays especially if you had under eighteens in the room because of safeguarding.

Participant 10: I think staff felt that because he was paralysed, he couldn't do anything.

Researcher: Did anyone ask?

Participant 10: No, I think they just assumed he could not have sex, they did not ask him.

Researcher: Did they offer help in any way?

Participant 10: No nothing.

Researcher: I have known patients being given support through sex workers. It may also that talking to him may have helped him, listening to how he felt. Did you notice anything else?

Participant 10: I noticed that some staff did not ask about washing the genital area, they would ask about washing but did not say what they were doing or seek permission when they went to the genital area or talk to patients, I am thinking with tracheostomy patients who can communicate. I think people would like to know what's happening. Some staff did ask though and talk about what they were doing through washing.

I did feel that some of the young men got off on having a young woman wash them; they would lie back with their arms over their head. I had to be careful about the boundaries and if they could wash their genital area would get them to wash this.

Researcher: How did you feel about this?

Participant 10: I felt ok because I was in control of the situation, and my mentor was there.

Researcher: Did they ask you how you felt afterwards?

Participant 10: No but they could see I was ok.

Researcher: What do you think about doing the module now?

Participant 10: I think it's made me more aware of sexuality.

Researcher: Do you want to add anything else?

Participant 10: [Shakes head.]

Participant 16: interview

Participant 16 is a female student who took part in Online Discussion Group 2. Due to ill health, she was unable to keep a digital diary and so completed an interview after her clinical placement had finished.

Participant 16: I was working on in the Emergency department. I noticed some good and not so good things. There were two male gay patients where we had to do rapid HIV tests and two members of staff refused to do the tests.

Researcher: How did you feel about this?

Participant 16: I felt that it was wrong its part of their role.

Researcher: Did you say anything?

Participant 16: Yes, but it's difficult being a student and you get in trouble for saying stuff, but I've done it before. So, I said that it was part of their role, but they said what did I know, I was only a student.

Researcher: What were the other things you saw?

Participant 16: I saw a woman with FGM she was really ill and old we had to catheterise her.

Researcher: Did you talk to her about the FGM?

Participant 16: She did not want us to talk about it when her daughter was around, but we talked to her afterwards. She understood it was illegal in this country. The nurse tried to catheterise her, and it was difficult to find where to insert the catheter, so I had tried and was able to insert the catheter. We knew we had to do and as the Doctors were all male and there no female doctor.

Researcher: Did the nurse know about mandatory reporting?

Participant 16: Yes, she did and we datexed it.

Researcher: Did you feel you were more able or less able to deal with situation following the teaching?

Participant 16: Yes, I think doing the drawings had helped me realise how things could be.

Researcher: Anything else?

Participant 16: Yes, there was this woman I who was having an abortion miscarriage who I chaperoned. The doctor was looking for a chaperone and I was the only student and they just shoved me in, and I just wasn't expecting it. I didn't feel prepared. I didn't know what to say to the patient. I would have liked some warning before I went in.

Researcher: Was this a medical abortion or a pregnancy with a miscarriage.

Participant 16: It was her seventh pregnancy; the last two pregnancies were miscarriages. I went in and was soon covered in blood as I tried to open packs for him, and you could see the baby in the sac and everything it was fourteen weeks.

Researcher: How did you feel about this?

Participant 16: I was ok, but I would have liked to be prepared?

Researcher: Do you want to add anything else?

Participant 16: No.

Table 6-5 Analysis of interviews using Labov level 1

Narrative component	Participant 2	Participant 10	Participant 16
Abstract	'I was working in the emergency department when a patient who has HIV attended'	'I was working on a respiratory ward'	'I was working on in the ED department'
Orientation	'The Health care assistant said that she did not want to take blood from the patient'	'There was this episode where a patient was found watching porn'	'There were two male gay patients where we had to do rapid HIV tests and two members of staff refused to do the tests'
Complicating action	The staff nurse questions this and the HCA and double gloves.	'and staff did not really do anything'	'I felt it was wrong its part of their role'
Evaluation	'I felt awkward about this incident I did not feel as a student nurse I could say anything'	'No, I think they just did not know what to do, how to deal with it'	'The doctor was looking for a chaperone and I was the only student and they just shoved me in'
Result	'I did not want to come across as a stuck up or know it all student'	'I think staff felt that because he was paralysed, he couldn't do anything'	'I didn't feel prepared. I didn't know what to say to the patient. I would have liked some warning before I went in'
Coda	'I think I would be able to address the issue as a staff nurse and discuss with the HCA'	'I think it's made me more aware of sexuality'	'I was ok, but I would have liked to be prepared?'
Findings	Narrative about discrimination against patients with HIV, and how these constrain the participant.	Narrative shows constraining influences of nursing staff lack of response.	Narrative constrains the participant and shows the emotional dissonance of staff.

Suzanne Everett 9834205:

Labovian analysis (level 1)

The interviews reveal complex issues surrounding sexuality. Participant 2 reveals discrimination against patients with HIV from other healthcare professionals. In the interview with Participant 10, she outlines qualified nurses' lack of preparedness in dealing with patients watching porn, and their lack of response so this situation. In the interview with Participant 16 we see the complex nature of the emotional issues the student nurse faces and the lack of awareness by healthcare staff of this; this perhaps illustrates the emotional dissonance of nursing staff (Hochschild, 2003). Hochschild (2003) argued that emotional dissonance may be used by nurses to help distance themselves from the emotions of the incident.

The analysis of the interviews using Labov revealed the powerlessness felt by the students and their perception that the nursing staff constrained participants' actions in some way. This is seen with Participants 2, 10 and 16:

Participant 2:

> I felt really awkward about this incident I did not feel as a student nurse I could say anything, I did not want to come across as a stuck up or know it all student.

Participant 10:

> I noticed that some staff did not ask about washing the genital area, they would ask about washing but did not say what they were doing or seek permission when they went to the genital area or talk to patients, I am thinking with tracheostomy patients who can communicate. I think people would like to know what's happening. Some staff did ask though and talk about what they were doing through washing.

Participant 16:

> I was working on in the Emergency department. I noticed some good and not so good things. There were two male gay patients

> where we had to do rapid HIV tests and two members of staff refused to do the tests…….. Yes, but it's difficult being a student and you get in trouble for saying stuff, but I've done it before. So, I said that it was part of their role, but they said what did I know, I was only a student.'

We see in this analysis how the participants recognise discrimination and poor nursing care. The data show us how the participants had difficulty navigating these situations. The data show how constrained and disempowered the students feel by the attitudes they witness. This is seen in the participants' difficulties in speaking up against this care; however, if they did speak up, as in the example of Participant 16, they were silenced.

Braun and Clarke (level 1) and Balint (level 2) analysis

Following the analysis of the data using Labov, further first-level analysis was performed using Braun and Clarke (2013). This was followed by analysis using Balint in a second-level analysis to identify the emotions in the interviews.

The interviews of Participants 2, 10 and 16 are shown in full below. Under each diary, the analysis using Braun and Clarke (2013) is shown with the findings from this analytic procedure. Following this, the Balint analysis is presented together with the findings from the Balint analysis. A presentation of all the findings for each participant is used in the researcher's story (level 3), together with its findings and a summary of all the findings for each participant is presented at the end. A summary of the findings of the three participants is given at the end of the chapter.

Participant 2: interview

Participant 2 is female; she failed to complete a digital diary but offered to do an interview.

Participant 2: I was working in the Emergency department when a patient who had HIV attended. They had not been taking their medication and were very ill. The nurse asked the health care assistant (HCA) to take some blood from

the patient and mouthed to her that the patient had HIV. The HCA said that she did not want to take blood from the patient to the staff nurse, who asked why, what was the problem. The HCA agreed to take the blood but then proceeded to put on two pairs of gloves to take the blood. The patient was unaware of this, as she did do it discreetly.

Researcher: How did you feel about this.

Participant 2: I felt really awkward about this incident I did not feel as a student nurse I could say anything, I did not want to come across as a stuck up or know it all student.

Researcher: What would you do if you were qualified?

Participant 2: I think I would be able to address the issue as a staff nurse and discuss with the HCA her actions.

Analysis of Participant 2 interview using Braun and Clarke

Using Braun and Clarke, I reviewed the interview.

What does the participant say in the story and what are the effects of the story?

Participant 2 discusses how a staff nurse and an HCA reacted to a patient with HIV and how this affected the care that they gave the patient. The effects of the discrimination against the patient and the student nurse's inability to voice her concerns in the story show how disempowered student nurses may feel when they disagree with nursing care.

How is the story structured?

The student nurse appears as an observer of the story. She discusses the interaction between the staff nurse and HCA. The story revolves around how the staff nurse mouths to the HCA that the patient has HIV and how the HCA refuses to do the blood, and when challenged puts on two pairs of gloves to conduct venepuncture:

> **Participant 2:** I was working in the Emergency department when a patient who had HIV attended. They had not been taking their medication and were very ill. The nurse asked the health care assistant (HCA) to take some blood from the patient and

> mouthed to her that the patient had HIV. The HCA said that she did not want to take blood from the patient to the staff nurse, who asked why, what was the problem. The HCA agreed to take the blood but then proceeded to put on two pairs of gloves to take the blood. The patient was unaware of this, as she did do it discreetly.

The student feels awkward and does not feel, as a student nurse, that she can speak out about this interaction but feels that she will be able to when qualified. The narratives finishes after this comment as Participant 2 'clams up'; this may be due to the nature of the material or because it is harder to speak in person to the researcher.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

This is a short narrative, yet it illustrates how problematic the role of the student nurse can be. This is verbalised by Participant 2 stating that she does not feel that she could say anything: 'I did not want to come across as a stuck up or know it all student'. This is Participant 2's final comment and where the interview ends.

How do the narratives constrain or enable the participants' lives?

Participant 2 feels constrained by her role as a student nurse and unable to verbalise and address the situation between the HCA and staff nurse. She appears powerless, and this story is a good example of the value judgements and behaviours seen earlier in Section 1. The final statement in the narrative has also resulted in paralysing me, the researcher, making me powerless to ask further questions.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

Participant 2 demonstrates the verbal struggles she has to describe her situations. However, although she describes the situation and she thinks in this

way, she does not reflect on the unprofessional nursing care or the discrimination that she alludes to, or how it makes her feel. She says she felt she did not want to appear stuck up; it is unclear whether this is based on her knowledge of HIV or nursing procedures. It is difficult to know the meaning Participant 2 gives to her feeling 'awkward'.

Who does the story connect the participant to?

The story connects the student nurse to the nursing profession, the staff nurse and the HCA, who is not a qualified member of the nursing team. The story connects Participant 2 to the HCA, her powerlessness as a student nurse, her looking forward to being a qualified nurse and her role in any future nursing team.

Who is placed on the outside of the story?

The patient is outside the story, and it is difficult to imagine that they do not realise the discrimination around them. In many ways, Participant 2 also appears on the outside of this story. The staff nurse and the HCA do not address the situation with Participant 2 afterwards.

What is the response of the listener to the story?

The listener is embarrassed and feels awkward and powerless, yet she feels that when qualified she will have the power to address the situation and speak to the HCA. This appears to be an unrealistic view of qualifying: it is not easy to address this situation, and the staff nurse has shown this.

What counts in the response from the listener?

This story was no surprise to me; unfortunately, I had been told similar stories before. I found it shocking and was angry that healthcare professionals can act in this way and that they appear unconcerned for the patient.

Suzanne Everett 9834205:

Findings

This interview describes discrimination by healthcare staff against a patient with HIV and how Participant 2 navigates the experience. We see the difficulties that Participant 2 has in addressing the issue. She feels that she cannot speak out as this would adversely affect her clinical placement assessment.

The researcher's story analysis of Participant 2 using Balint

Participant 2's story discusses discrimination against patients with HIV. I found it shocking yet not surprising, because I had heard similar stories by health professionals double-gloving whilst caring for patients with HIV. What I found most disturbing about this narrative is that it was going on with the patient present, whom the student feels was unaware. I think it is very unlikely that the patient was unaware of the judgemental attitudes and behaviour of the healthcare professionals and feel that Participant 2 did not want to address this behaviour, which I suspect happens a great deal in healthcare. In reading through this scenario, I felt very angry, yet I do not remember feeling angry at the time of the interview.

The student highlights the difficulties of the role of the student nurse and how hard it is to speak up. I felt sad and disappointed that she felt that she cannot, and that she was more worried about appearing 'stuck up' or 'know it all'. I expect that many qualified nurses would also find it difficult to speak up. I was at a loss to know why the staff nurse needed to alert the HCA about the patient with HIV. Care for a patient who is HIV-positive should be no different from that of a patient who is HIV-negative, when performing venepuncture. I found it frustrating that there was still poor knowledge among healthcare professionals, and this supports the need for education and training in this area. This highlights the effect of a lack of training among HCAs and the importance of addressing attitudes. The devolution of nursing practices to

unqualified staff means that there is increasing risk of discriminatory attitudes and behaviours being perpetuated and unchallenged as unqualified staff take on further nurse roles. HCAs do not have a recordable qualification or code of conduct and are considerably cheaper to employ, so there is a risk that we lose sight of the importance of knowledge and professional attitudes.

Participant 2 shows limited reflection on the situation, which is disappointing, but has the linguistic skills to describe the story fluently. There are no pauses or 'errs', and so on, that would indicate someone trying to explain the situation and feeling awkward. She describes the situation as awkward, which appears to understate its awfulness. Participant 2 is from the United Kingdom, so this could be a cultural patois from this country, where we tend to downplay and restrain our emotions.

Findings

Participant 2's narrative is fluent and reflective but concise. The interviews are noticeably shorter than the digital diaries. The participants who were interviewed were given as much time as they needed; in contrast to the diaries, this has resulted in shorter interviews. It is possible that the nature of the material is harder to articulate in person, whilst the digital diaries, which can be recorded in private, have acted like a confessional.

Participant 2 has focused on not wanting to feel stuck up, and more knowledgeable, which she is. However, this may also be about 'run-ins' with HCAs in the past and knowing her 'position'.

Participant 2 is angry and frustrated about her experience and feels 'silenced' in her role as a student nurse. Her description of the discrimination illustrates her journey to non-judgementality through exposure to it.

Suzanne Everett 9834205:

Summary

Value judgements and the behaviours of nursing staff are seen in the narrative and how the student navigates these through silence.

This interview illustrates the student's journey and her exposure to judgemental attitudes and the failure of the registered nurse to address them.

Participant 10: interview

Participant 10 is a female student nurse who did not complete a digital diary but completed an interview.

Participant 10: I was working on a respiratory ward. I didn't really see much which is why I didn't do the diary. But there was this episode where a patient was found watching porn, and staff did not really do anything.

Researcher: Was the patient male or female?

Participant 10: They were male.

Researcher: Why do you think staff did not really address this? Do you think this was cultural or religious, embarrassed?

Participant 10: No, I think they just did not know what to do, how to deal with it.

Researcher: How do you think you would deal with it?

Participant 10: I think it would be easier if I was not a student and was staff then I could feel I could talk to him without having to ask permission. He had been caught before watching porn and is paralysed from the neck down but can use his hands.

Researcher: That's difficult I have not come across this issue, but I suspect we will see this more.

Participant 10: It wasn't so bad as he had a side room.

Researcher: Yes, it would be difficult with bays especially if you had under eighteens in the room because of safeguarding.

Participant 10: I think staff felt that because he was paralysed, he couldn't do anything.

Researcher: Did anyone ask?

Participant 10: No, I think they just assumed he could not have sex, they did not ask him.

Researcher: Did they offer help in any way?

Participant 10: No nothing.

Researcher: I have known patients being given support through sex workers. It may also that talking to him may have helped him, listening to how he felt. Did you notice anything else?

Participant 10: I noticed that some staff did not ask about washing the genital area, they would ask about washing but did not say what they were doing or seek permission when they went to the genital area or talk to patients, I am thinking with tracheostomy patients who can communicate. I think people would like to know what's happening. Some staff did ask though and talk about what they were doing through washing.

I did feel that some of the young men got off on having a young woman wash them; they would lie back with their arms over their head. I had to be careful about the boundaries and if they could wash their genital area would get them to wash this.

Researcher: How did you feel about this?

Participant 10: I felt ok because I was in control of the situation, and my mentor was there.

Researcher: Did they ask you how you felt afterwards?

Participant 10: No but they could see I was ok.

Researcher: What do you think about doing the module now?

Participant 10: I think it's made me more aware of sexuality.

Researcher: Do you want to add anything else?

Participant 10: [Shakes head.]

Analysis of Participant 10 interview using Braun and Clarke

Using Braun and Clarke, I reviewed the interview.

Suzanne Everett 9834205:

What does the participant say in the story and what are the effects of the story?
Participant 10 discusses a story about a paralysed male patient watching porn and the registered nurse's inability to address the situation. The story progresses to talk about healthcare professionals not asking permission to wash patients' genitals, and the student's embarrassment over some young male patients' attitudes to being washed by a young woman.

The story highlights how vulnerable a young female nurse may feel when washing young men, and how this is not addressed within nursing. There is a lack of communication between the registered nurse and the student nurse. They do not address the patient's porn or the male patient's attitude to the nurse washing him. Participant 10 says her mentor did not ask if she was all right – 'No they could see I was ok' – but how did they know without talking to her? The impact of mentors not asking students how they feel may result in students internalising their feelings, learning to cope on their own, and learning to not 'speak up'.

How is the story structured?
Initially, Participant 10 says that the reason she did not complete a digital diary was because she did not see much; however, she progresses to talking about relevant and important issues surrounding sexuality. The story develops to talk about a male patient watching porn and washing a male patient's genitals, revealing the vulnerabilities of nurses washing patients.

At the end, Participant 10 shakes her head, ending the interview, also possibly revealing embarrassment through the discussion of sexual health in an interview.

Suzanne Everett 9834205:

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

Participant 10 is able to vocalise and express her feelings and there is no cultural patois. She is articulate and has clearly reflected on her experiences, but she feels powerless to address the situations in which she has been in by nurses, and does not want to 'rock the boat'.

How do the narratives constrain or enable the participants' lives?

The narrative shows how constrained nurses can be in washing a patient's genital area, and there are many emotions bound up in this area. It feels very difficult for the student nurse:

> **Participant 10:** I did feel that some of the young men got off on having a young woman wash them; they would lie back with their arms over their head. I had to be careful about the boundaries and if they could wash their genital area would get them to wash this.

As I read back this interview, I was aware that in the same clinical situation, with a man who puts his arms over his head and lies back in perceived enjoyment, I would give that patient the flannel to wash his own genital area himself. I was left wondering why the mentor did not intercede and suggest this, as the mentor's role is both to care for the patient and to protect the student.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

Participant 10's story reveals her vulnerability, both as a female and as a student nurse, to being sexually abused. Her story brought to the forefront the duty of care the hospital trust and the university have in safeguarding students. The story highlights the need to listen to our students and hear from them when they feel personally unsafe in their work.

Suzanne Everett 9834205:

Who does the story connect the participant to?

Participant 10 is connected to the patients, but she is very isolated and she does not feel connected to the healthcare professionals on the ward. She feels unsupported and vulnerable to the male patients.

Who is placed on the outside of the story?

The registered nurses and permanent healthcare staff appear outside this story and their lack of responsibility for the student nurse appears throughout the story.

What is the response of the listener to the story?

Throughout this story I feel frustrated and angry with the registered nurse's failure to intervene on Participant 10's behalf. There is a lack of support and knowledge and an acceptance of the use of porn and the man appearing to enjoy himself whilst being washed.

What counts in the response from the listener?

This interview highlights the importance of educating students and nurses about these situations. But, more importantly, to enable them to cope with these stressful encounters, this education needs to revolve around discussion on how nurses feel about these situations.

Findings

Participant 10 discusses the value judgements and behaviours of the healthcare staff and their lack of knowledge and silence in dealing with the issue of pornography and genital washing on the ward. In these experiences, she reveals the emotions bound up in sexuality and the isolation that these bring.

The researcher's story analysis of Participant 10 using Balint

Participant 10's story revolves around two incidents: washing a male patient's genitals and a male patient, who is paralysed, watching porn:

> **Participant 10:** I was working on a respiratory ward. I didn't really see much which is why I didn't do the diary. But there was this episode where a patient was found watching porn, and staff did not really do anything.
>
> **Researcher:** Was the patient male or female?
>
> **Participant 10:** They were male.
>
> **Researcher:** Why do you think staff did not really address this? Do you think this was cultural or religious, embarrassed?
>
> **Participant 10:** No, I think they just did not know what to do, how to deal with it.
>
> **Researcher:** How do you think you would deal with it?
>
> **Participant 10:** I think it would be easier if I was not a student and was staff then I could feel I could talk to him without having to ask permission. He had been caught before watching porn and is paralysed from the neck down but can use his hands.

It had been assumed by the healthcare professionals that the patient cannot have sexual intercourse, but it is possible that he may still get an erection. Disappointingly, the nursing staff do not address his use of porn or whether he has concerns or unresolved sexual needs that he might want to discuss. The nurses assume that as he is paralysed he is no sexual danger to other patients, showing their lack of knowledge, as well as value judgements and behaviours. There is a lack of compassion for the patient. No one identifies that he may be distressed or upset by his situation. The narrative describes embarrassment, shame and sexual frustration.

I felt angry at the lack of communication with the patient and worried that this man has no one to talk to about his sexual needs because the nurses are too embarrassed or have no resources to address this area. This part of the story highlights the emotions bound up with sexuality, the disapproval that people may have of pornography or embarrassment at using it. There is an increase in the use of pornography among men, and the denial of this issue in the clinical

area is worrying (Papadopoulos, 2010). Increased use of pornography has been shown to adversely affect how women are treated and could put female nurses and patients at risk (Papadopoulos, 2010).

Participant 10 continues to discuss how difficult it is to wash the genital area of the young men on the ward:

> **Participant 10:** I did feel that some of the young men got off on having a young woman wash them; they would lie back with their arms over their head. I had to be careful about the boundaries and if they could wash their genital area would get them to wash this.

I felt angry that something I experienced as a student nurse was still unaddressed. The student sounds embarrassed and vulnerable. I found myself wanting to shout out at the mentor and student about the incident with the man with his arms above his head, 'Give him the cloth to wash his genital area'. The description of the male patient conveys an image of personal enjoyment. Why are we still making nurses feel this way? This feels like abuse, like we are prostituting our young nurses out for patients' gratification. Participant 10 feels very isolated and there seems to be a lack of support from nursing staff. The fact that the mentor does not suggest to the patient, who can move his arms, that he washes his own genital area gives the impression of a mentor who has become conditioned to this situation. When I asked whether her mentor had asked afterwards how she felt, she replied, 'No they could see I was ok'. I want to shout, 'How? How can they see how you are feeling, and why are they not talking and asking you?'

To me, this narrative highlights the lack of communication between nurses, and between nurses and patients. The story shows how important it is to talk about these situations with nurses. The student feels vulnerable and we have put her in a stressful situation that will increase cognitive dissonance (see Chapter 2) (Myers, 1999; Crisp & Turner, 2014; French et al., 2015). If we do

not communicate with student nurses and listen to their feelings, we will increase attrition.

Findings

The vulnerability of Participant 10 and the emotions bound up in this placement are experienced through the patient's use of pornography and Participant 10's embarrassment at washing the male patient. There is a lack of compassion by healthcare staff towards the student nurse, and this is seen in their silence and lack of communication.

Summary

The behaviour of healthcare staff over the male patient's use of pornography shows their lack of knowledge. The ward nurses' response shows value judgements and their behaviour shows a lack of care towards other patients and the participant.

Emotions are bound up in sexuality; these are seen in the intimate care of male patients, and the participant's feelings that he is experiencing sexual gratification from the care she gives. Possibly this narrative reveals the judgemental attitude of the student; he may not be experiencing sexual gratification but may be embarrassed and trying to show he is relaxed.

Participant 16: interview

Participant 16 is a female student who took part in Online Discussion Group 2. Due to ill health, she was unable to keep a digital diary and so completed an interview after her clinical placement had finished.

Participant 16: I was working on in the Emergency department. I noticed some good and not so good things. There were two male gay patients where we had to do rapid HIV tests and two members of staff refused to do the tests.

Researcher: How did you feel about this?

Participant 16: I felt that it was wrong its part of their role.

Researcher: Did you say anything?

Participant 16: Yes, but it's difficult being a student and you get in trouble for saying stuff, but I've done it before. So, I said that it was part of their role, but they said what did I know, I was only a student.

Researcher: What were the other things you saw?

Participant 16: I saw a woman with FGM she was really ill and old we had to catheterise her.

Researcher: Did you talk to her about the FGM?

Participant 16: She did not want us to talk about it when her daughter was around, but we talked to her afterwards. She understood it was illegal in this country. The nurse tried to catheterise her, and it was difficult to find where to insert the catheter, so I had tried and was able to insert the catheter. We knew we had to do and as the Doctors were all male and there no female doctor.

Researcher: Did the nurse know about mandatory reporting?

Participant 16: Yes, she did and we datexed it.

Researcher: Did you feel you were more able or less able to deal with situation following the teaching?

Participant 16: Yes, I think doing the drawings had helped me realise how things could be.

Researcher: Anything else?

Participant 16: Yes, there was this woman I who was having an abortion miscarriage who I chaperoned. The doctor was looking for a chaperone and I was the only student and they just shoved me in, and I just wasn't expecting it. I didn't feel prepared. I didn't know what to say to the patient. I would have liked some warning before I went in.

Researcher: Was this a medical abortion or a pregnancy with a miscarriage.

Participant 16: It was her seventh pregnancy; the last two pregnancies were miscarriages. I went in and was soon covered in blood as I tried to open packs for him, and you could see the baby in the sac and everything it was fourteen weeks.

Researcher: How did you feel about this?

Participant 16: I was ok, but I would have liked to be prepared?

Researcher: Do you want to add anything else?

Participant 16: No.

Analysis of Participant 16 interview using Braun and Clarke

Using Braun and Clarke, I reviewed the interview.

What does the participant say in the story and what are the effects of the story?

This is a story that starts off shocking and becomes worse, which the participant does not appear to process. There is a lack of support and preparation of the student.

How is the story structured?

The interview starts with Participant 16 saying that she has seen some good and some not so good things, and this is how the story progresses: from shocking to very shocking. She describes how two members of staff refused to perform a rapid HIV test. This progresses to her catheterising a woman who has had FGM, as there was no female doctor to do this. The last part of the story revolves around Participant 10 chaperoning a woman having a miscarriage. Again this interview is short, and this may be the result of discussing sensitive material in an interview; participants may feel more restricted in this format.

What are the narrative resources that shape the student nurse participants' experiences and the stories they tell?

The student is an articulate and confident speaker. There is no sign of cultural patois, and she has the resources to describe and vocalise the situations. She appears also to have the cultural capital to speak up and address the member of staff who did not perform a rapid HIV test, which takes confidence and assertiveness.

How do the narratives constrain or enable the participants' lives?

Participant 16 described how constrained she is, as a student:

Suzanne Everett 9834205:

> Yes, but it's difficult being a student and you get in trouble for saying stuff, but I've done it before. So, I said that it was part of their role, but they said what did I know, I was only a student.

This incident shows the disregard that some health professionals have for students, and how difficult it is to address poor and discriminatory practice. The incident is like that of Participant 2, who felt she could not speak up. Participant 16 does speak up, but is treated with contempt.

How are student nurses' lives defined by the narratives they overlook as well as the stories they tell?

Participant 16 does not reflect on how she really feels about the woman with FGM or about chaperoning the woman having a miscarriage:

> She did not want us to talk about it when her daughter was around, but we talked to her afterwards. She understood it was illegal in this country. The nurse tried to catheterise her, and it was difficult to find where to insert the catheter, so I had tried and was able to insert the catheter. We knew we had to do and as the Doctors were all male and there no female doctor.

She feels more prepared about the FGM. This may be because this topic is addressed in the curriculum, but she may be saying this because she is aware that I have been involved in its teaching.

Who does the story connect the participant to?

Participant 16 is connected to the nurses, but really appears on her own and isolated from the story's actors.

Who is placed on the outside of the story?

The patients and the healthcare professionals all appear outside of the story. This is illustrated through her addressing the staff's failure to perform a rapid HIV test and in the way that she is shoved into chaperoning the woman having a miscarriage.

Suzanne Everett 9834205:

What is the response of the listener to the story?

I initially felt proud of the student and her ability to speak up but, as the story progressed, I felt very angry and upset. However, at the time of the interview I did not feel those emotions, which highlights how nurses control their emotions professionally.

What counts in the response from the listener?

There was a lack of care and support by the healthcare professionals for the student nurse. I find it difficult to accept that they put the student in these situations yet did not prepare her beforehand or check up on her afterwards.

Findings

This is an articulate narrative that highlights the value judgements and behaviour that is seen in the example of the HIV test. Participant 16 reveals her non-judgementality through her narrative of the discrimination practised by other healthcare staff. We also see how she navigates the instance and speaks up yet is dismissed by the healthcare staff.

The researcher's story analysis of Participant 16 using Balint

Participant 16's story made me feel initially proud that she could speak up about the unprofessional care of the two men by the members of staff, but this changed to anger at the healthcare professionals' response: 'but they said what did I know, I was only a student'. This lack of respect and dismissiveness of a student nurse made me feel angry, and it only encourages student nurses not to speak up, as seen with Participant 2.

The narrative goes on to discuss caring for a woman with FGM and the difficulty in catheterising her, which Participant 16 was able to achieve. I felt slightly worried reading about this, because I thought that the student had been put in a difficult position; if she had not been successful, what would have

happened to the patient? Participant 16 felt more prepared for the situation because of the teaching, so I feel pleased that we have given her these skills.

The final part of the narrative addresses the difficulties in chaperoning, and also healthcare professionals' lack of preparation and regard for both the patient and the student:

> **Participant 16:** It was her seventh pregnancy; the last two pregnancies were miscarriages. I went in and was soon covered in blood as I tried to open packs for him, and you could see the baby in the sac and everything it was fourteen weeks.
>
> **Researcher:** How did you feel about this?
>
> **Participant 16:** I was ok, but I would have liked to be prepared.

This lack of preparation shows how little the healthcare professionals had thought of the upsetting situation and its effect on the patient and the student. I felt so disappointed, sad and frustrated at the effects of this incident. There is a lack of respect for the woman; it does not matter who they shove in the room, as long as the doctor has a chaperone. This is her baby, and an awful and sad part of her life. The student may have had no experience. This is a distressing and stressful situation for anyone, so why does the registered nurse not take a few minutes to discuss it? Is this an example of Paley's inattentional blindness (Paley, 2014)? Paley (2014) argued that the Mid Staffordshire Hospital incident did not arise as a result of a lack of compassion and care, as purported by the media, but through staff being stressed through staff shortages and heavy workloads. This resulted in nurses being unable to show compassion and care through social cognition, and unrealistic expectations being placed upon them. Working in an emergency department is a busy and stressful environment, and it may be that the nurses had put Participant 16 in this situation because they were stressed and unable to show compassion. As discussed with Participant 10, this is an example of a stressful situation that could increase cognitive dissonance and lead to student nurses leaving the

profession (see Chapter 2) (Myers, 1999; Crisp & Turner, 2014; French et al., 2015).

I found this last instalment upsetting and, whilst the student does not appear to be as upset, I would argue that the emotions that I am feeling are hers and also those of the patients. As a woman who has lost a baby in a similar situation, I was horrified at the lack of compassion that the nurses had for the patient and the student.

Findings

We see the emotions bound up in sexuality. The dismissiveness of the student's knowledge by healthcare professionals produces anger. The lack of compassion by healthcare staff towards the student nurse who chaperones a miscarriage highlights that the healthcare staff have lost sight of the emotions experienced within the work (Hochschild, 1983; Smith, 2012; Mazzotta, 2016). Mazzotta argued that the challenges of emotional labour are to allow:

> nurses to manage their own emotions as well as those of their patients, but more important, to assess the manner in which nurses handle difficult elements of client care. (Mazzotta, 2016: 31)

This lack of compassion towards Participant 16 shows the effects of the increased demands on healthcare staff and signs of burnout. Burnout occurs when healthcare staff are overloaded and suffer the effects of vicarious traumatisation and become inauthentic (Mazzotta, 2016). The fact that they do not brief Participant 16 or debrief her afterwards indicates that they have become accustomed to detaching themselves from these feelings.

Summary

Value judgements and behaviour are seen in the example of qualified nurses' reluctance to carry out the HIV test. This illustrates lack of knowledge about how HIV is contracted and value judgements are seen in the assumption that

a gay man will have HIV. We see value judgements and behaviour in the example of the miscarriage, where there is a lack of compassion for the patient and student nurse about the upsetting nature of the incident. The patient's privacy is not recognised, nor is the impact of a new healthcare professional at this moment.

Emotions bound up in sexuality are seen in the lack of compassion by ward staff over the woman having a miscarriage.

Summary of the findings of interviews 2, 10 and 16

The analysis suggests that students navigate the judgemental behaviour of nursing staff through silence or through addressing it, for example Participant 10's silent navigation of male patient and intimate care and the other male patient watching pornography or Participant 16's navigation of the discrimination of nursing staff refusing to perform HIV tests:

> **Participant 16:** I was working on in the Emergency department. I noticed some good and not so good things. There were two male gay patients where we had to do rapid HIV tests and two members of staff refused to do the tests.
>
> **Researcher:** How did you feel about this?
>
> **Participant 16:** I felt that it was wrong its part of their role.
>
> **Researcher:** Did you say anything?
>
> **Participant 16:** Yes, but it's difficult being a student and you get in trouble for saying stuff, but I've done it before. So, I said that it was part of their role, but they said what did I know, I was only a student.

Emotions are bound up in sexuality, illustrating that participants recognised judgemental care. Anger is expressed over the care patients receive; this is seen in Participant's 16 example of the gay men and staff refusing to take blood, illustrated above.

The development of the third position appears to assist some students in developing professionalism. It is seen with participants learning to not 'speak up'. This is seen with Participant 2, who recognised discrimination but wanted to avoid 'rocking the boat':

> **Participant 2:** I felt really awkward about this incident I did not feel as a student nurse I could say anything, I did not want to come across as a stuck up or know it all student.
>
> **Researcher:** What would you do if you were qualified?
>
> **Participant 2:** I think I would be able to address the issue as a staff nurse and discuss with the HCA her actions.

Participant 10 felt that it would have been easier to address situations such as the male patient watching pornography if she had been qualified. However, since qualified nurses appeared to be unable to address this issue in this narrative, possibly Participant 10 shows an idealised or unrealistic view of registered nurses:

> I think it would be easier if I was not a student and was staff then I could feel I could talk to him without having to ask permission. He had been caught before watching porn and is paralysed from the neck down but can use his hands.

The interviews show the complexity of clinical practice, the issues participants face and the emotions these create. This seen in Participant 16's interview, where the narrative becomes more shocking with complex emotional events, finishing with the example below:

> **Participant 16:** It was her seventh pregnancy; the last two pregnancies were miscarriages. I went in and was soon covered in blood as I tried to open packs for him, and you could see the baby in the sac and everything it was fourteen weeks.
>
> **Researcher:** How did you feel about this?
>
> **Participant 16:** I was ok, but I would have liked to be prepared.

Section 3: findings from the diaries and interview

At the beginning of the research, I formulated questions that I felt the interviews and digital diaries would address. These are shown in Figure 3-1 of Chapter 3 and are detailed below:

- What influences nurses' attitudes to sexuality?
- Can nursing institutions teach undergraduate nurses to be non-judgemental?
- How do student nurses navigate judgemental and non-judgemental clinical practice?
- How do nurses cope with their professional role's expected attitudes differing from their personal attitudes?

The digital diaries show the effect of the student nurses' struggle to find the 'words' to express themselves. Examples are seen with Participants 12 and 14, where they described situations where they were unable to express themselves. However, Participants 2 and 16's interviews illustrated advanced abilities to vocalise emotions and less struggle to verbalise how they felt and their emotions. It is perhaps notable that both spoke English as a first language. Although this was important, the diaries and the interviews showed the students' struggles and ability to speak up against discrimination. This is seen with Participant 12:

> I juss told the other staff that you made him jump and he said, 'its ok… he knew me anyway' he said so I didn't say anything……. really.

And Participant 16:

> Yes, but it's difficult being a student and you get in trouble for saying stuff, but I've done it before. So, I said that it was part of their role, but they said what did I know, I was only a student.

These are illustrations of where students were basically told to be quiet and not speak up. Cultural patois is seen with Participant 13, illustrating the struggles students have to express the right words, and the importance of comprehending the meaning behind the patois so that we can understand nurses and their experiences. It was notable that the cultural patois expressed suggested disapproval, and this was an advantage of the using digital diaries to reveal these inflections, as a method of collecting the data.

The digital diaries revealed emotions of sadness, anger, embarrassment and disapproval. In comparison, the participants who were interviewed revealed less emotional material and these were shorter in length. The digital diaries format appears to have acted for the participants like a confessional, whilst in comparison, in the interviews, participants struggled to express themselves, possibly because they felt inhibited about discussing sexual health face to face with the researcher. While all three participants who were interviewed were unable to complete a digital diary, it is possible that this was an unconscious way of avoiding the digital diary format. Participant 4's digital diary was brief, and this may also be an unconscious way of absenting herself from the diary and controlling the situation.

The diaries and interviews highlight student nurses' difficulties in coping with health professionals who hold discriminating attitudes and how hard it is to speak out against poor practice and judgemental attitudes. We see examples of Menzies Lyth's 'detachment and denial of feelings' and 'splitting of the nurse–patient relationship and depersonalisation', as discussed in Chapter 2 (Menzies Lyth, 1960). Student nurses are left to cope with difficult situations without the support of healthcare staff, who, I would argue, have depersonalised the situation and no longer see its emotional impact.

The diaries reveal the emotional complexity required of student nurses and how they learn to cope and compartmentalise these emotions in order to

practice clinically. This supports Smith's work on the emotional labour of nursing and findings that student nurses:

> felt comparatively high levels of anxiety and stress associated with feelings they were not generally expected either to feel or express. (Smith, 2012: 164)

This is illustrated in the interview with Participant 16, when she talks about chaperoning the patient who was miscarrying. There are many examples throughout the diaries where anger is expressed and, as in Participant 16's account, there appears to be a lack of acknowledgement by healthcare professionals of the upsetting nature of some situations. Is this an example of cognitive dissonance? Smith's work supports these findings, stating:

> students frequently found themselves in emotionally charged situations which went beyond the medical and technical definitions of their training and back to nursing as 'people work' in which they engaged in emotional labour. Often, they experienced anxiety and stress because the emotional labour went largely unrecognised and undervalued as part of 'real' nursing. (Smith, 2012: 192)

The participants encountered a lack of knowledge in healthcare professionals about sexuality and its effect on patient care. An example is Participant 10's account of the denial of the dangers of pornography and nurses' personal safety. Knowledge and education on sexuality have increased reflection and awareness of sexuality in the participants. At times, they appear more prepared than the qualified health professionals. The importance of teaching alongside an immersive experience of encounters with patients in the development of non-judgementality illustrates Guile and Longhurst's recontextualisation theory (see Chapter 2, (Guile & Longhurst, 2010; Evans et al., 2010).

Throughout the diaries and the interviews, there are the strong authentic voices of the participants. Unlike the online discussion groups, which portrayed

a professional identity, these diaries reveal the individuals' voices. At times, this is a moral voice, where participants 'chide' or remonstrate against the attitudes of healthcare professionals or reveal personal attitudinal changes on HIV (Participant 14). Gilligan discusses the development of moral judgement through understanding and women's struggle to resolve moral problems in such a way that no one is hurt (Gilligan, 1977). In many ways, this describes the diaries' accounts, where participants have struggled with healthcare professionals' behaviour and attitudes; by the end of the instalment, they have tried to show an example of good care in an attempt not to hurt the nurses.

I compared the digital diaries and interviews with the online discussions. The online discussion groups had formed a professional voice, as illustrated by their non-judgemental attitude towards homosexuality and judgemental attitude towards ward managers, for example, whilst the digital diaries expressed participants' dismay at and disapproval of other nurses. This is seen in the accounts by Participants 3 and 12, where their disapproval was aimed at the nurses they worked with:

> I think he's scared he suffers a bit cos of time and staff members not wanting to help him on their own even in the open bit because there is an open bit ward where we have patients there staff moving up and down we still find staff not wanting to assist him on their own even though he is in an open place that it is most unlikely that he could abuse anyone in that part.

Another example is Participant 12:

> saying 'is it wet now er is it wet now' and the patients just jump or reacted er cos he hasn't been even like ask if he could touch him…or……just…even a warning you know dat I am going to check your… you know can I just check er.

In the online discussion, the disapproval was aimed at a group. In this example, it was the ward manager:

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> **Participant 12** I was just reading back all your messages and it is funny that you said some managers don't know their job
>
> **Participant 12** Managers who are very open can be approachable and they shouldn't be in that position if they can't accept their mistakes

In the online group, it appeared professionally acceptable to show disapproval of a group of people who are higher up the nursing hierarchy.

Summary

The digital diaries and interviews are significant in how the nurses' personal identities and authentic voices are revealed. Whilst I use the term 'authentic', I am aware that participants are still presenting themselves to an audience, which is me. They show:

1. The challenges of diverse students' emotional meanings and how student nurses learn to work with trained healthcare professionals' value judgements.
2. How student nurses navigate nursing care and the emotional struggles required of them. Participants have navigated discriminatory nursing practice, and they have expressed emotions in the diaries and interviews that reveal how difficult they have found these because they have recognised judgemental nursing practice.
3. The ability of knowledge and the diaries to support participants learning and development of non-judgementality.

This chapter is continued in Section 4 with the researcher's diary, which contributed to the Balint analysis of the diaries and interviews, and is presented in the researcher's story above. Following this diary, email evidence is documented that illustrates the ongoing discussion between me and my supervisors. Section 4's contribution is summarised and, finally, Chapter 6 is concluded.

Section 4: research diary

As discussed in Chapter 3, Frost (2016) argued for the inclusion of emotions of the research process in any account of the research. This has been achieved in two ways in the thesis: 1) incorporating the researcher's story, which is a reflective account of the researcher's reactions to the data during data analysis, and 2) including the researcher's diary, which shows the process of analysis and forms a data source in itself that details the iterative process of the data analysis, the multiple readings of the data and the developing analytic narrative of the journey to non-judgementality for student nurses.

My research diary uses eight examples of supervision based on structured face-to-face sessions and email feedback. Work was sent to supervisors a couple of weeks in advance of the face-to-face sessions. Following these hourly sessions, email exchanges captured further reflections and discussion, which formed part of the Balint analysis, submitted in this thesis. These emails, in their entirety, are found in the appendix. Following this, Section 4 is summarised and finally the chapter's conclusions are outlined.

Research diary supervision 25.9.18

After completing an analysis of P3 and P13 using Labov, Braun and Clarke), the following illustrates the supervision process using a Balint approach to data analysis as discussed in Chapter 3.

Summary of Participant 3's digital diary

The story revolved around the difficulties the student has or the staff had caring for a patient with a history of child abuse and the student's criticism of nurses avoiding caring for the patient. The story finished with praise for nursing staff over their professionalism at not revealing the reason patients were on erectile dysfunction medication; it appeared to me that Participant 3

apologised for criticising nursing staff earlier. Participant 3's original digital diary can be found on page 163.

In the supervision, it appeared to us (me (SE), Helen Allan (HA) and Margaret Volante (MV)) that Participant 3 started her recording with the statement that there was nothing about sexuality in the placement area. However, her digital diary then continued to describe complex issues surrounding sexuality. MV commented during supervision that this is an important observation. It is in the opening sequence that much of the meaning from the orientation of the student resides. MV gets the sense that allocating P3 to this patient was outside of P3's normal daily routine in that placement. So possibly the story is one of power and discrimination including the student's feelings of powerlessness and discrimination.

During supervision I commented how I felt as a researcher: how ashamed I was of nursing staff for not supporting P3. P3 commented that the nurses' practice was due to lack of training, illustrating her development and recognition of the nursing professional role. HA suggested that Balint would suggest suppression of negative feelings towards the patient, and it is seen in the shape of the decision that it is lack of training. On reflection, I can now see this might also be part of the idealisation of the nurse–patient relationship. I concluded that I needed to ask myself questions like these to make my analysis more complete.

P3 talked of her pride in staff being confidential about erectile medication. MV commented during a supervision that the student saw that the qualified nurses can act sensitively and the story of the amputee patient is told against this observation, where she has been unwillingly forced to be part of unjust or discriminating practice and exposed to value judgements in care decisions. So this seemed to be a story about the student recognising contradictory values and practices; that practice is not always ideal. Her discomfort was not in relation to caring for a patient who is known as a perpetrator; rather, her

discomfort was with the value judgement that brought about discriminatory practice that in turn places the student in a position of powerlessness. After I reflected on this, I wondered whether lecturers needed to support students in how to respond when they are confronted with care decisions made on poor value judgements.

During supervision we felt that P3 illustrated the cultural mores of staff and what they thought about a patient who had been convicted of sexual abuse.

Reflecting after the supervision, which is part of the continuing Balint process, I reflected that lots of participants had commented at the beginning of the diary that there wasn't 'anything about sexuality' – I needed to think about this. Participant 3 did not seem to be aware of sexuality, despite the module on sexuality; it appeared to her that sexuality is hidden and not obvious.

Participant 13

Following supervision I analysed Participant 13's digital diary using Balint. Participant 13's digital diary can be found on page 179.

A summary of Participant 13's digital diary showed poor nursing care with examples of lack of privacy when turning patients, but also good nursing care in the form of the recognition of married couples' right to privacy and intimacy.

Thematic analysis of the data

Data extract	**My comments**	**Supervisor comments**	**Emerging themes**
P3: 'isn't anything about sexuality'. P13: 'I don't I can't really see any issues…. between… the male and the females in terms of sexuality.'	Why do participants think that some of the issues they describe not about sexuality? Sexuality appears hidden despite the module.	MV commented that this is important observation. It is in the opening sequence that much of the meaning from the orientation of the student resides.	Attitude – possibly of participant to sexuality and what this means.

P3: 'him I think he's scared he suffers a bit cos of time and staff members not wanting to help him on their own even in the open bit'. P13: 'I haven't seen any discriminative behaviour or anything like that towards the staff from the staff towards the patients or anything like that.'	Recognition of discrimination by participants in complex situations in clinical practice.	Story one of power and discrimination.	Attitudes; discrimination Attitudes; discrimination.
P3: 'I think the nurse should try and assess the situation and assess the environment if it's not it's not maybe a closed environment I can say ok we can wait for one person for two people but it was in an open bit you don't expect him to do anything in an open bit when he is being transferred from a wheelchair to the bed and just leave staff like that.'	Anger over patient care and lack of support for student nurses all evoke anger in me. P3 appears angry. It had not occurred to me that student nurses might face these issues.	Telling the story shows reflexivity, the decision to keep their heads down and not rock the boat. Hesitancy shows anger. Emotions within story appear to be located in Balint tradition.	Nursing practice: lack of training. Personal feelings: anger. Attitudes; participant respect for patients; discrimination.
P3: 'I wasn't quite comfortable because um I think it was blown out of proportion and it affected the patient care a little bit thank you very much.'	Does this show participant's developing professionalism? Because they recognise the patient's poor care.	Students learning through judgemental care about non-judgementality.	Enlightenment: reflection and awareness.

Analytic notes

- I need to think about what participants are not saying and how they articulate their own beliefs – the hidden story.
- Who are the participants speaking to? Is it me or someone else? I need to articulate this. Hermeneutic suspicions: who is being talked to?
- How did participants present themselves?
- Look at Felicity Stockwell – unpopular patient.

Suzanne Everett 9834205:

- Look at Heather Fraser 'Doing Narrative Research – Analysing Personal Stories Line by Line'.

For next supervision

Analyse two further diaries.

Write researcher's story about what the participants are saying, what is behind it and the interpretation of the story.

Research diary supervision 21.11.18

I have completed the researcher's diary for P3, P13, P12 and P14.

Participant 14

Participant 14's digital diary is found on page 202. The digital diary narrative revolved around two patients with HIV and the registered nurse's attitudes to HIV.

During supervision we talked about the emotions of P14's diary and the feelings evoked by this through the Balint process, which were 'sadness'.

Participant 12

Participant 12's digital diary is found on page 191. Participant 12's digital diary story discussed the student's experience of nursing staff care of the elderly; it showed a lack of compassion and consent by healthcare providers in the care of their patients.

During supervision, MV commented about the aggression in this story and how it is constituted in this practice context of care of the elderly. MV felt that the narratives of sexuality were interesting because they were about value judgements and behaviour. By focusing on sexuality for the research, I am beginning to develop insights into value judgements and behaviour that students experience in practice. This, we felt, gave me a foundation for

thinking about nurse education interventions in relation to supporting non-discriminatory practice.

HA commented in supervision: what is the point of P12's stories? She felt that it seemed significant that each story became more shocking. In supervision we discussed the language and the difficulties that participants had in the narratives with vocalising their story when angry. We considered the example of the agency nurse in the diary and reflected that this showed them being an insider and outsider.

General comments

The diaries need to have an introduction at the beginning. We discussed in supervision how the researcher's story should include the story: how it made me feel, then and now. The researcher's story should recognise the difficulties I had trying to be objective but not emotionality: I am not a counsellor! The researcher's diary should recognise the process of analysis, field notes, and how Balint recognises feelings.

Thematic analysis of the data

Data extract	**My comments**	**Supervisor comments**	**Emerging themes**
P12: 'so the other staff er just put his hand on the front area of the patient and saying 'is it wet now err is it wet now' and the patients just jump or reacted err cos he hasn't been even like ask if he could touch him…or……just…even a warning you know dat I am going to check your… you know can I just check err …you, and I was as well like shock you know like I was like pulling back of and I told him you know ….I juss told the other staff that you made	Anger over the nursing care. P12 shows disapproval but learns to keep quiet. Is this why people don't whistle-blow: they learn to not speak up?	HA wonders what the point of P12's stories is. It seems significant how each one becomes more shocking. All this together with transference of feeling is very powerful.	Nursing practice: lack of awareness of patient's sexuality. Personal feelings; anger. Attitudes; participant respects for patients; discrimination.

him jump and he said ' its ok… he knew me anyway' he said so I didn't say anything…….really.'			
P14: 'However (elongated word and short pause) the way the nurses at my placement treated this patients was just not right because one they like…..well maybe because they were trying to I don't know maybe they were trying to protect me because they are from the same country as me so she's like oh no no no, come come and she called me aside and she's like oh you need to be careful of that patients his got HIV Blah blah blah. Which I felt like it was not right because to me it scared me more in the scenes of me knowing that he had HIV.'	We see again participants recognising discrimination and judgemental attitudes. Is it significant that participant is looked after by a nurse from the same country who tries to protect her? I am shocked. Angry by this, will this encourage alienation of other student nurses who do not come from same country? P14 recognises this is wrong.	I am beginning to gain insight into the value judgements and behaviours that students experience.	Personal feelings; anger. Attitudes; discrimination; nurse's negative attitude; participant positive attitudes. Enlightenment; reflection.
P12: 'Maybe this err staff is err the agency nurse is thinking you know thinking I am doing something to him and I did say you know you know your resident so he shouldn't I don't I don't think she will you know you should have talked to her but at the end she said I spoken to I have spoken to the agency staff.'	P12's embarrassment over erection with nurses and patient. P12 does not appear embarrassed; is this because we have talked about this in class discussions? But qualified nurses appear less equipped, embarrassed.	Does the example of the agency nurse in the diary show them being insider and outsiders?	Nursing practice: lack of awareness of patient's sexuality. Attitudes; discrimination Enlightenment; awareness.

Analytic notes

- The data extracted was polyvocal. I need to look at Walkendean and 'Growing up girl'.
- Meaningful in the encounters: look at Doreen Wells.

  I need to think about whether I should write a shorter story of the defended story.

Suzanne Everett 9834205:

For next supervision

- To write up and review narratives analysis for next supervision. To read through online discussion groups – could I use Balint here too?
- Analyse two further diaries.

Research diary supervision 11.2.19

During supervision we discussed the themes of the diaries, how the digital diaries informed the interviews. Should they be a separate chapter or the same one but separate sections?

During supervision HA commented that the thesis seemed to be asking what nurses' emotional reactions were to the complexities of sexuality, and student nurses' development to cope with these. HA felt that the thesis showed the factors that enabled or constrained nurses' ability to be non-judgemental and tolerant of diversity in sexuality.

Following the supervision, HA commented that Balint was taking shape for her and she felt was the most successful of the three analytic treatments. She felt that the analysis is at the level of the single case and recalled a conversation in which the Balint questions were set out and I had used these to articulate the emotion work of the accounts. The findings about the emotion work in relation to student constructions of sexuality have taken the form of a researcher story. She felt it may well be possible to also undertake a thematic synthesis of the researcher stories and present this as a single story of the emotion work encountered by students when in working with sexuality in practice settings.

Thematic analysis of the data

Data extract	**My comments**	**Supervisor comments**	**Emerging themes**
P12: '"don't forget she will forget that later". For that day I haven't because that was my	So much anger, frustration, sadness within the participants' diaries.	I recall a conversation in which the Balint questions were set out and Su has used these to articulate the	Nursing practice: lack of awareness of

first day of placement….' P13: '…. it because I haven't had any anything that I would call discriminatory it's made me cos I'm doing this it has made me…think a lot more about the way people being treated and it's really good actually.' P14: 'Patients should be treated equally no matter their sexuality.'	The emotions within the narratives are important. Students show knowledge, they also show increasing awareness of their professional role.	emotion work of the accounts. The findings about the emotion work in relation to student constructions of sexuality take the form of a researcher story. It may well be possible to also undertake a thematic synthesis of the researcher stories and present this as a single story of the emotion work encountered by students when in working with sexuality in practice settings.	patient's sexuality. Attitudes; discrimination Enlightenment; awareness and reflection.
P13: 'sexually inappropriate gestures and tries to… maybe.. touch.. someone.. in.. a.. sexual.. manner, which is not obviously ideal, no one wants that. But it's not his fault; the.. only issue that I've found at this placement is that the staff aren't trained well enough with this.'	Complex nature of the material, far bigger than I expected, more shocking. There are narratives of two sexual abusers, it had not occurred to me that nurses would meet this issue or to address it in teaching.	HA: thesis seems to be asking what nurses' emotional reactions to the complexities of sexuality are and how do they develop to cope with these, and what factors enables or constrains nurses' ability to be non-judgemental and tolerant of diversity in sexuality.	Nursing practice: lack of training, knowledge. Enlightenment; awareness and reflection.

Analytic notes

- There is methodological argument that methods impact on nursing, for example narrative, and Balint encourages reflection, and therefore does it improve nursing care?
- The explicit findings showed the challenges of diverse student emotional meaning and how students learn to work with trained staff's value judgements. The diaries showed how student nurses navigate care.
- We discussed my abstract for RCN international research conference.

Suzanne Everett 9834205:

For next supervision

To write up and review narratives analysis, complete analysis of interviews and analyse online discussion group for next supervision.

Research diary supervision 25.3.19

During supervision we discussed the purpose of the online discussion group. We asked what the online discussion gave to the data, what is different from the digital diaries and interviews, and how they were conceptually linked. The online discussion appeared 'fake' and superficial, whereas the diaries were narrative stories. We discussed how Goffman's 'presentation of self' might be helpful here in understanding the formation of the non-judgemental identity. We discussed De Board's work on how we act in groups.

During supervision, HA commented that were so many comings and goings in the online discussion groups. How do we interpret this? Can the other data help us understand these patterns? Was this because the subject of FGM was painful? The emotion was obvious in the online discussion, where P14 talked about FGM, which she touched on rather clumsily but didn't really develop. HA wondered whether there could be some analysis of the interplay of different forms of data and analysis in relation to Balint. We also discussed the data collection, which appeared more like a group interview where the interviewer controlled the talk, as opposed to the digital diaries, which were more participant-led.

Thematic analysis of the data

Data extract	**My comments**	**Supervisor comments**	**Emerging themes**
P14: 'Hi yes, it is definitely lack of ignorance. just watching the video on FGM and this just too sad.'	This is a participant who may have direct experience of FGM within her country of origin.	The emotion is obvious in the talk, which she touches on rather clumsily but doesn't really develop.	Personal feelings of sadness.

P14: 'I JUST CAN NOT BELIEVE THE FINDINGS FROM THE STONEWALL UNHEALTHY ATTITUDE AND HOW PEOPLE FAIL TO SPEAK UP AND THAT IS A BIG PROBLEM AMONG NURSES, IN EVERYBODY HOSPITAL, THERE JUST SEEMS TO BE THAT NURSE ALWAYS DOING THE WRONG THING AND EVERYONE IS AFRAID TO SPEAK UP.' P13: 'I know right. It is bizarre to me that some healthcare professionals can be so judgemental.'	The online group discussion appears fake. It is different from digital diaries; feels superficial. Groups shows a professional identity. They represent an acceptable view of nursing.	Group shows professional identity formation in comparison to individual digital diaries, which are personal.	Personal feelings of anger. Attitudes; discrimination. Enlightenment; reflection and awareness.
Participant 21 has entered the chat.	Lurker in the discussion; are they an outsider? P21 was a Muslim student; she is checking before speaking.	Group dynamics: is she watching and viewing what is being said?	? attitudes

Analytic notes

During supervision we reflected that the online discussion group showed how groups participated and acted in a group. The online discussion group highlighted the professional role of the nurse rather than the personal role and individual role, which were seen in the digital diaries. The online discussion and digital diaries showed how student nurses acted in different groups and how they revealed and protected themselves. The online discussion group showed the influence of year one: they had attitudes about ward managers.

We talked about Goffman's presentation of self, unconscious, subconscious, and conscious presentation of self. We play a role, e.g. abortion; we may not agree but present differently consciously.

Suzanne Everett 9834205:

For next supervision

- To analyse and write up a table of Labov thematic analysis of all the digital diaries.
- To write up in more depth the themes at the end of the digital diaries.
- To write an analytic chapter on four analytic treatments to go before online discussion and digital diaries. This discussed my analytic treatment of the data and ontological perspective using Jennifer Mason.

Research diary supervision 7.5.19

During supervision we discussed how the nurse's identity appears passive. The diaries showed identity development; this is seen through the participants attending to discrimination, which showed the development of non-judgemental attitude and professional identity. Participants acted differently in the online discussion group, showing their professional identity, from the individual diaries. The data showed that student nurses learnt from exposure to clinical practice and HEI. We saw participants' journey of learning to become non-judgemental. This was seen through their disposition and reflexivity, showing how nurses become non-judgemental. We saw this in the example of the participants' view of the ward manager in the online discussion group.

We discussed in supervision the participants' mature thoughts in the online discussion group and their professionalism. The online discussion group showed us how the participants distanced themselves from judgemental practice: participants have learnt to present a professional face. I needed to think about the culture of nursing, and how it supports and develops this culture. I needed to think about what is talked about and what is avoided.

Following supervision, HA reflected that I needed to address the overall defence of the approach of thesis and what might be argued to support my additional work on analysis and data. She felt that, whilst the overall data set

might seem smaller and 'thinner' than other qualitative research approaches ('you've explained elsewhere why this is the case – but I think could be referenced to in I) i.e. your contribution to knowledge'), narrative researchers do not think this necessarily matters if the analytic methods are robust. She believed that my engagement with these two aspects of the research (data quality and analysis) showed that I had produced doctoral work worthy of a PhD.

I believe that I have produced a novel and important piece of work that recognises student nurses' professional journeys and acknowledges their experiences towards this.

Thematic analysis of the data

Data extract	**My comments**	**Supervisor comments**	**Emerging themes**
P13: 'But I think in some wards it becomes their ward culture in a sense. So, when someone behaves in a judgemental way everyone just looks the other way. It's become normalised in a sense which I think is both sad and frightening.'	Online group discussions; we are seeing participants' journey of learning to become non-judgemental, through disposition, reflexivity; how nurses become non-judgemental.	The overall data set might seem smaller and 'thinner' than other qualitative research approaches (you've explained elsewhere why this is the case – but I think could be referenced to in I) i.e. your contribution to knowledge).	Attitudes; discrimination. Enlightenment; reflection, awareness. Personal feelings; sadness.
P15: 'Even if you have been in the job longer. There is no excuse for bad practice and mistreatment of patients.'	We see professionalism, mature thoughts in online discussion. Distancing face from judgemental practice; participants learnt to present professional face.	Online discussion shows the culture of nursing. The participant's view of ward managers shows what student nurses have learnt through first year from clinical practice.	Attitudes; discrimination. Enlightenment; reflection, awareness. Personal feelings; anger.

Suzanne Everett 9834205:

Analytic notes

- Participants learn from exposure to clinical practice and HEI.

Research diary supervision 24.6.19

In supervision we discussed the analytical treatment of the diaries, which are about the participants' identities. We discussed the relationship of the data and how they speak to each other. We discussed the scapegoating of groups and the work of Bion. We discussed the repertoires, e.g. not taking part and not talking about emotions or sexuality so online discussion group talked about managers. We noted that the patient voice is not present in the online discussion.

We discussed what makes one nurse non-judgemental and another judgemental when nurses receive the same training. Are nurses who are perceived as non-judgemental better at hiding judgements?

Following supervision, MV commented that she felt the focus was interesting, as it is about learning, not judgementality itself. She felt that the focus of the study sat at the interface of student learning and the curriculum. The findings have informed the nursing curriculum in the development of nurses who are non-judgemental and tolerant of diversity. The study used a pluralistic methodology to investigate the student experience of learning about sexuality as a way to illuminate the problem of how the education of student nurses develops a nursing practice that is non-judgemental. The study was more about how the student made sense of their curricular (university and practice setting) experience to become a nurse with an analytic focus on the development of non-judgemental practices through working with diversity. MV felt that the focus was not an evaluation of a teaching intervention or an evaluation of the curriculum per se. Rather, by happenstance, the teaching intervention around sexuality had created a situation that lent itself to investigating the development of non-judgemental nurses. In essence,

because of the narrative approach, it was a study of student identity formation.

MV felt that the discussion chapter would be about student learning experiences, dispositions, and identity formation in the development of non-judgemental nursing practice (and from there to explore and make recommendations for how the preparatory nurse curriculum might recognise and work with and through student dispositions to support the development of a non-judgemental professional identity).

Thematic analysis of the data

Data extract	**My comments**	**Supervisor comments**	**Emerging themes**
P14: 'I JUST CAN NOT BELIEVE THE FINDINGS FROM THE STONEWALL UNHEALTHY ATTITUDE AND HOW PEOPLE FAIL TO SPEAK UP AND THAT IS A BIG PROBLEM AMONG NURSES, IN EVERYBODY HOSPITAL, THERE JUST SEEMS TO BE THAT NURSE ALWAYS DOING THE WRONG THING AND EVERYONE IS AFRAID TO SPEAK UP.' P13: 'I know right. It is bizarre to me that some healthcare professionals can be so judgemental.'	The online discussion group repertoires, e.g. not taking part, not talking about emotions or sexuality, so online discussion group talked about managers. Patient voice is not present in the online discussion. What makes one nurses non-judgemental and another judgemental when nurses receive the same training? Are nurses who are perceived as non-judgemental better at hiding judgements?	My expectation is that the discussion chapter will be about student learning experiences, dispositions, and identity formation, in the development of non-judgemental nursing practice.	Attitudes; discrimination, negative attitudes of staff. Enlightenment; reflection, awareness. Attitudes; discrimination, negative attitudes of staff. Enlightenment; reflection, awareness.

Research diary supervision 16.9.19

During supervision we reviewed the methodology chapter to reflect findings. We discussed Crotty, narrative, and psychodynamic methodologies.

Suzanne Everett 9834205:

We discussed a psychodynamic approach to learning, using emotions in data analysis. I needed to think about Jan Savage and Nollaig Frost. I needed to address in more detail social constructionism and how this addressed the research perspective, then, following this, pluralism methodology and multiple research perspectives, and my narrative. We discussed how narrative theory led to me using psychodynamic theory and this needed to be explicit.

We discussed Michael Crotty: how we get to where we get! Crotty argued that there are two types of phenomenology: original and new phenomenology. Crotty asked us to critique our conscious experiences and be open to new meanings. He argued that phenomenology was a first-person experience and believed that symbolic interactionism and humanism have key roles – 'we are born into a world of meaning' – and this means that the participants are born into a world of meaning; they are not blank slates.

During supervision, MV felt that the study was substantively about how student nurses develop non-judgemental practice within their undergrad programmes using pluralistic methodology in order to inform their practice.

We discussed that I needed to situate the problem in the literature, i.e. why I chose pluralism and narrative/Balint. I needed to discuss how they are related and analysed. For example, the observation that there were so many comings and goings in the discussion groups. How did interpret this? Could the other data help us understand these patterns?

We discussed in supervision the emotion that is obvious in the digital diaries and in the online discussion when P14 talks about FGM, which she touched on rather clumsily but didn't really develop. We discussed whether there could be some analysis of the interplay of different forms of data and analysis in relation to Balint?

Thematic analysis of the data.

Suzanne Everett 9834205:

Data extract	My comments	Supervisor comments	Emerging themes
Participant 16: 'I was working on in the Emergency department. I noticed some good and not so good things. There were two male gay patients where we had to do rapid HIV tests and two members of staff refused to do the tests.'	The reasons for setting out on PhD were to consider the anecdotal comments about this issue. There are so many examples of discrimination against HIV men and women in this data. So distressing. Huge educational gap.	My take is that the study is substantively about how student nurses develop non-judgemental practice within their undergrad programmes using pluralistic methodology.	Attitudes; discrimination, negative attitudes of staff. Enlightenment; reflection, awareness.

For next supervision

- To address issues raised in feedback and tidy up methodology chapter.
- Read through methodology, results, aims and research questions to ensure consistent.

Research diary supervision 29.10.19

We discussed in supervision emotional labour and the difficulties between psychodynamic and emotional labour. We discussed how Hochschild dissected the tensions between sociology, psychodynamic and biological: do they support my stance?

Thematic analysis of the data

Data extract	My comments	Supervisor comments	Emerging themes
P16: 'Yes, there was this woman I who was having an abortion miscarriage who I chaperoned. The doctor was looking for a chaperone and I was the only student and they just shoved me in, and I just wasn't expecting it. I didn't	This is a distressing and stressful situation for anyone, so why does the registered nurse not recognise this for the student? Is this the registered nurses' way of coping with the emotional demands?	Is this an example of cognitive dissonance? The lack of compassion by healthcare staff towards the student nurse who chaperones a miscarriage highlights that the healthcare staff have lost sight of the emotions	Nursing practice; communication, lack of awareness of patient's sexuality. Attitudes; discrimination, negative

feel prepared. I didn't know what to say to the patient. I would have liked some warning before I went in.'		experienced within the work.	attitudes of staff. Personal feelings; embarrassment.
P10: 'I did feel that some of the young men got off on having a young woman wash them; they would lie back with their arms over their head. I had to be careful about the boundaries and if they could wash their genital area would get them to wash this.'	This feels like abuse; it feels like the participant is being taken advantage of. I feel really uneasy about this; feels like a safeguarding issue.	Emotions are bound up in sexuality.	Nursing practice; lack of awareness of patient's sexuality. Personal feelings; embarrassment.

For next supervision

- Discussed tightening up of methodology, and analysis. Writing summaries; reordering of sections to aid clarity.
- To write up a fictitious Balint reflection and title.

Research diary supervision 29.11.19

We discussed in supervision emotional labour and I need to think and read more about this area. We discussed how this might evolve. I need to think about what would have happened if we had not had the curriculum and reflect on this intervention. The curriculum opportunity has raised awareness.

Thematic analysis of the data

Data extract	**My comments**	**Supervisor comments**	**Emerging themes**
P12: 'Black people who are HIV-positive that hide their diagnosis to their family. This interests me so much especially if they are here and born and bred here family should be able to	I need to think about what would have happened If we had not had the curriculum, so reflect on the intervention to the forefront. This is seen with P12 in the online discussion group	The students have formed a cohesive group. They show a non-judgemental attitude by attending to discrimination by others.	Attitudes; discrimination, negative attitudes of staff. Enlightenment; reflection, awareness,

accept their children who are gay.' P14: 'I JUST CAN NOT BELIEVE THE FINDINGS FROM THE STONEWALL UNHEALTHY ATTITUDE AND HOW PEOPLE FAIL TO SPEAK UP AND THAT IS A BIG PROBLEM AMONG NURSES, IN EVERYBODY HOSPITAL, THERE JUST SEEMS TO BE THAT NURSE ALWAYS DOING THE WRONG THING AND EVERYONE IS AFRAID TO SPEAK UP.' P13: 'I know right. It is bizarre to me that some healthcare professionals can be so judgemental.'	where participants talked about BAME and HIV, and Stonewall's *Unhealthy Attitudes*; all were discussed in the curriculum of the module.		Attitudes; discrimination, negative attitudes of staff. Enlightenment; reflection, awareness.

For next supervision

- To write first draft of discussion, addressing themes of psychodynamic, emotional labour, critical resilience and social constructionism and Bourdieu.

Appendix: supervisors' emails

The email discussion that contributed to the researcher's diary is outlined below, following this the researcher's diary is summarised. Finally, at the end of this section, I conclude the chapter.

From: Margaret Volante <M.Volante@mdx.ac.uk>

Sent: 03 October 2018 09:50

To: Helen Allan <H.Allan@mdx.ac.uk>; Suzanne Everett <S.Everett@mdx.ac.uk>

Subject: Re:

Suzanne Everett 9834205:

I have been reflecting on what might be of further help Su.

It might just be timely to return to the book Doing Narrative Research edited by Molly Andrews, Corrine Squire and Maria Tamboukou (2013) 2nd edition published by Sage. Each of the chapters offer a range of ways for how narrative can be treated analytically. In Jennifer Mason's words to articulate your own ontological and epistemological position about narratives research in the societal historical context of nursing and nurse education in respect of the topic being investigated. Also what about putting Balint narratives in the mix- would be relevant to the discussion board data (emergence of group story)?

Corrine Squire's chapter 2 moves from experience centred to socio-culturally oriented approaches and Anne Phoenix chapter looks at analysing narrative contexts. Have a go now at reading Chapter 5- practising a rhizomatic perspective in narrative research. These readings can help you question the assumptions of Braun and Clarke's method in relation to different ways of approaching narrative research (and also with the Fraser paper).

This should help to clarify and set out an analytic framework for narrative analysis that has fit with the research question(s) and in turn to identify the specific methods in relation to the data sets. The methods you end up using to analyse the narratives do say something about how the research is constructing student nurse identities (the point Nollaig was making about using narrative data).

It is worth making and taking the time to work through your approach to narrative analysis.

Margaret

Suzanne Everett 9834205:

From: Helen Allan

Sent: 03 October 2018 08:37

To: Suzanne Everett; Margaret Volante

Subject: RE:

Dear Suzanne

While this is fine as a summary, I am concerned that you haven't mentioned the main issues regarding narrative analysis we discussed, namely, different types of narrative analysis. I think we agreed that you would read around these typologies and 'experiment' with them to produce one you felt comfortable with? We spoke about you using a mixture drawing on Reismann, Braun & Clarke. Margaret has sent you through some reading to help with this thinking.

Could you add these notes? Amended if you prefer of course.

Best wishes

Helen

Professor Helen T Allan

Possibilities for diary transcript analysis.
A way in (in keeping with pluralism) would be to reconstruct the story using Labov (however need to be mindful the diary is not an 'f2f' narrative telling). First step draw up a three-column analysis table with the various aspects of Labov's narrative structure:

1. Abstract – How does it begin? Su's data extract

2. Orientation – Who/what does it involve, and when/where? Su's data extract

3. Complicating Action – Then what happened? Su's data extract

4. Resolution – What finally happened? Su's data extract

Suzanne Everett 9834205:

5. Evaluation – So what? Su's data extract

6. Coda – What does it all mean? Su's data extract

Then she can write up the narrative a story starting with the coda of 'what it means' on a case-by-case basis prior to comparing across the case stories as reconstructed by the researcher.

A sort of global sense making. Would help with uncovering the orientation of the student when telling the story. This would sensitise Su to the possibilities of meaning across the cases. What these diaries are stories of. Then the transcript could be subjected to an analysis of **how the story is told: the telling of the story** - picking up on your point about language.

This second approach to the analysis needs to provide a short 'biography' of what is known factually about the participant : student in second year of adult nursing programme in placement -what is it we know the area- following curriculum input on sexuality,.age, west African heritage,.? Worked where before coming a student nurse.

Then to ask the question: How would a student who has a lived life like this tell a story of clinical practice experience of working with sexuality as a way of understanding how they are learning and developing a non-judgemental attitude.

Could tell a story of why I need to put up with this s...from so called professional nurses in my clinical placement: a story of the racism and discrimination of trained nurses to both students and patients. Because the student has a goal is to register as a nurse there will be an absence of challenge or direct questioning in the story. The telling does show reflexivity with a decision to keep their head down and not rocking the boat, letting the waves was over because this too will pass. The acquiescent student identity. Talks

about being abandoned to deal with situations as they arise using their own resources. The telling would be full of hesitance because of an underlying anger which needs to be careful about expressing because tutor listening to transcript. The telling would be of multiple starting point which tail off because of what cannot be said.

Alternatively - Could tell a story of support and empowerment where trained staff openly address the daily challenges of sexuality and strategies supportive of patients and staff. The story is told with few hesitancies and many emphases since the student felt safe and supported. The telling addresses the exploration of an incident when the student had inappropriately reacted to a patient.

Then you would go in an interrogate the narrative data in terms of how the story is told - not what is said (this is where Su is stuck I think). The above analysis of the how the story is told does seem to be located within the Balint tradition?? The identity of the student resides within how the story is told.

Another alternative - Could take a slightly different approach possibly more in line with Fraser and ask what is the story of learning in clinical practice about non judgementality being told here?

All my very best

Helen

Professor Helen T Allan

Email Feedback 31.1.19

Dear Suzanne

Suzanne Everett 9834205:

Very well done on this first go at the analysis of the digital diaries and immersing yourself in the emotions of the data. This can be quite exhausting and possibly might explain the tailing off of engagement that can be seen over the four selected participant accounts. Narrative analysis is intense and can wear you out; because of this it takes time.

Just wonder if you are selling yourself short. Lovely to see how you have used your reading around narrative analysis to create your own analytic framework informed by Balint and incorporating the nuts and bolts of Labov, Reismann, Fraser and Clarke and Braun in terms of the analytic questions. Labov does seem to fade into the background in terms of asking what the intent of this story is; why it is being told to me, what is the point of this story. Beginnings and end evaluations also tell us something of the meaning (to the student) residing in the data. All this together with working with transference of feeling is very powerful as you clearly demonstrate in the analysis of the data from participant 3. How you used your feelings to reflect on ' what is going on here' for this student shows how feelings are such a useful analytic device in narrative analysis and in the reconstruction of the story. Looking forward to a stimulating conversation next week.

Best wishes

Helen and Margaret

From: Helen Allan

Sent: 08 January 2020 07:09

to: Suzanne Everett <S.Everett@mdx.ac.uk>; Margaret Volante <M.Volante@mdx.ac.uk>

Subject: RE:

Suzanne Everett 9834205:

Dear Suzanne

Thanks for this. I have made extensive comments on your chapter which I attach and we can discuss next week.

The key to a good thesis is clear and well-expressed thinking, the development of an argument. Towards the end of the chapter, under summary you say the findings are:

1. Student's own backgrounds, which are diverse, shape how they meet/deal with the challenge;
2. Students observe/ witness judgemental practices in their mentors and other nurses towards sexuality, which challenges them developing non-judgmentally;
3. These experiences raise emotional challenges which are processed through emotional labour.

This is clear and well expressed and needs to be used as the basis of this chapter. I think you have the beginnings of your argument but it's not there yet.

You also need to make sure that these summarising points are clearly demonstrated throughout each of the findings chapters through the presentation of data.

See you next week.

Best wishes

Helen

Summary of the research diary

The researcher's diary documents my feelings and those of my supervisors in response to the data and the ongoing commentary and reflection on the data and those feelings during supervision, illustrating Fabricius's third position (Fabricius, 1991). The process of supervision, through face-to-face and email discussion, acted as a Balint seminar session, revealing the emotions of the participant and those of the researcher. The supervision sessions between Helen Allan, Margaret Volante and me revolved around the emotions elicited through the diaries, and the transference and countertransference of these through the research diaries (see the discussion in Chapter 2 (Dryden, 1990)).

The researcher's diary has been an integral component of the data of this research, which is why it is recognised within the findings. The researcher's diary has helped me to reflect on the data, supervision helped to illuminate emotions, and often after these sessions we have continued discussing these findings.

The emotions experienced by the participants and me are important as they show the burden placed on nurses in the clinical area, and illustrate the complex nature of nursing.

Conclusions

We see in the diaries and the interviews the journey student nurses experience in their development to non-judgementality. We see how participants learn to navigate discrimination, and how these constrain and sustain their journey through complex sexual health issues.

Chapter 7 Discussion

This research commenced with the aim of exploring, through an analysis of the teaching and learning experience of sexuality within preparatory adult nurse education, the ways in which student nurses develop non-judgementality.

I chose to use a pluralist methodology to give a description of student nurses' experiences from narrative and psychodynamic perspectives. Narrative methodology gives us a narrative or story of what is important to the participant, and this gives us the student nurses' view of what it is like to be them. Psychodynamic theory has allowed student nurses' feelings to be recognised and then interpreted and made sense of in the larger picture of teaching and learning. As a qualified nurse, I cannot understand what it is like to be a student nurse today, only what it was like to be a student nurse in the 1980s. These stories tell us about the relationships that the participants have as student nurses in the clinical area today. The act of recording the diary has given the participants distance and time to reflect on the experiences that threaten them and that, in itself, can give a 'recuperative role' (Frank, 2000: 355).

The verbal feedback that I received from participants returning the digital diaries was that the 'process was useful and increased reflection'. Narrative methodology has given space for cultural and social influences to be revealed, giving important insight into how these affect student nurses. Psychodynamic theory has contributed by revealing the emotions within the nursing culture, and the complexities of the role of a student nurse.

This chapter discusses my findings from Chapters 5 and 6, which are summarised below, and these are developed individually in this chapter.

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Summary of research findings

1. Participants' backgrounds, which are diverse, shape how they deal with the challenges of sexuality that they encounter in the clinical area; an example of this is seen with Participant 14 and her previous experience of HIV.
2. Participants witness in their mentors and in other nurses judgemental practices towards sexuality. These experiences challenge participants in their journey towards developing non-judgementality. Participants 10, 12 and 13 experienced healthcare professionals' lack of consent when carrying out intimate care. Participants 16 and 2 experienced staff refusing to take blood for HIV.
3. These experiences raise emotional challenges for the student nurse and their development towards non-judgementality. This is seen with Participant 2 and her experience with nurses' refusal to care for a patient convicted previously of sexual abuse, with Participant 16's experience of the miscarriage and with Participant 10's vulnerability over the male patient's enjoyment of being washed and the patient watching pornography.

1. Students' own backgrounds, which are diverse, shape how they meet/deal with the challenge in clinical practice

The findings in the digital diaries, interviews and online discussion groups reveal the personal identities and the voices of the participants, which are shaped by their social and cultural worlds. The findings illustrate the impact of the social and cultural worlds of the participants and how participants deal with the challenges they meet in the clinical area. These challenges include discriminatory attitudes surrounding sexuality, poor nursing care, as seen in the lack of knowledge and awareness of sexuality, and finally the difficulties faced in raising the issue of discriminatory practice with nurses. The findings showed reports of discriminatory attitudes through the assumptions of

registered nurses over how patients had contracted HIV. Participants identified poor nursing care by healthcare professionals in not gaining patients' consent when patients needed intimate care and in avoiding caring for patients who were known sexual abusers. Throughout the findings, the participants found it hard to speak up about any discriminatory practice that they identified because they felt that this would adversely affect their practice placement, or, if they did raise the issue, it was not addressed. These findings are important for clinical areas and universities, as they give us a picture of what it is like to be a student nurse from their perspective, how to develop teaching and learning and reinforce the duty of care we have to them.

A student nurse is not a *tabula rasa* (blank slate): they enter nursing with experiences that are influenced by their cultural and social backgrounds. This has been illustrated by the findings and by participants' cultural experiences of HIV/AIDS. To recognise these cultural and social experiences, in this research I have been influenced by Bourdieu and social constructionism, which has provided a framework for my work. Social constructionism and, within that approach, Bourdieu's theory on cultural capital and habitus acknowledge cultural and social backgrounds. These recognise the inequalities perpetuated in access to education and knowledge. Bourdieu's work highlights the reproduction of inequality through education and class (Bourdieu, 1972; Sullivan, 2002; Shim, 2010). One of Bourdieu's key concepts is 'fields', which are networks, structures or set of relationships in which individuals experience power differently in different fields (Bourdieu, 1972). This is illustrated by the findings where participants lacked the power to raise issues of poor practice because they felt that this would affect their placement outcome or, when they did raise concerns, these were not addressed. It is difficult to know whether these findings were because of participants' position as student nurses or because of their linguistic competence and BAME positions, and this

is a failing of this research. Future research should record and address ethnicity to gain an accurate picture.

Bourdieu recognised biases, beliefs and assumptions and believed that reflection helped to disclose the sources of power and explain inequalities in society (Bourdieu, 1972). Bourdieu believed that our encounters are shaped by social experience, habitus and education; he believed that these gave the holders increased ability to gain access to resources, whilst their lack disadvantaged individuals and created inequality. This is encapsulated in the findings, showing the power and social capital of the trained staff in relation to student nurses. These differences are played out in the clinical area, revealing its culture. The findings have shown the powerlessness of participants when raising concerns over poor nursing care, which are dismissed by the ward staff, who have cultural capital. This supports the argument that, to create equality in nursing, we need to address the area of culture. This is encapsulated by Navarro:

> All forms of power require legitimacy and culture is the battleground where this conformity is disputed and eventually materialises amongst agents, thus creating social differences and unequal structures. (Navarro, 2006: 19)

Navarro described the inequalities in power that can be created by culture, as a lack of power can result in individuals feeling that they are not heard. Gramsci described the voiceless in cultural hegemony, where people are without a voice, which power and culture support (Reed, 2012). The findings show that the backgrounds of the student do have a bearing on how the curriculum intervention is facilitated. Participants who were born in Africa had different experiences of AIDS and were able to access this experience and bring it to the clinical context, and the curriculum had encouraged them to reflect on and review their experiences. An advantage of this research was the use of digital diaries, as this allowed their voices to be heard. However, these

narratives have shown many examples of participants' voices not being heard by registered nurses, illustrating the lack of power that student nurses may experience, which I will address in later sections in more detail.

Another area of unequal structure is diversity. Nursing in the United Kingdom has a predominantly White population, and because of this the values of nursing are those of Whiteness and the modality of nursing is one of White privilege (see Appendix B). This privilege is an example of Bourdieu's cultural capital, and could result in BAME nurses being voiceless and lacking power, as in Navarro's and Gramsci's theories (Bourdieu, 1972; Navarro, 2006; Reed, 2012). What the findings show us is participants' hinterland (the area beyond what is visible) and ways of viewing the world through their experiences. Because the nursing context is predominantly White, what the findings confront us with is the hidden context of diversity, revealing that we need to know the diversity of others so that we can care for the diverse nature of patients and healthcare workers. If the profession wishes to embrace cultural capital by attracting nurses from various cultural backgrounds, nursing needs to address diversity and value it in both the curriculum and the practice area. Wilson et al. argue that the key to addressing diversity is to create a learning space for cultural inclusion that celebrates our own uniqueness within a larger cultural group and allows us to learn from and appreciate each other (Wilson et al., 2009).

In 2019, the Equality and Human Rights Commission stated that one in 20 students had left their university studies due to racial harassment, emphasising the need to address discrimination and stereotypes to reduce attrition (Equality and Human Rights Commission, 2019). The nursing school used in this research had an ethnic population of 40% White, 30% Black, 19% Asian, 5% mixed, 4% other unknown, 2% Arab and 1% Chinese (see Appendix B,). The population of the nursing school shows a higher proportion of Black

and Asian students than is found on the NMC Register (see Appendix B). The population in the United Kingdom is changing, with its ethnic population increasing, and so understanding our student nurses' cultural differences will help us to understand our patients' differences and create cultural equality. In these findings, examples such as Participant 14 show the diverse backgrounds participants have come from; hers also shows the cultural judgements made by nurses from her country. This example shows how the participants have developed non-judgementality as professionals amidst a workforce that is itself diverse and prejudiced. By addressing cultural differences in relation to the values played out in nursing practice and how values are addressed within nurse education, student nurses learn about themselves and about the patients for whom they care:

> To deliver effective care, healthcare professionals need to understand about the cultural attachments of our patients, to friends, family and other members of the wider community that share both ethnicity and culture. (Brathwaite, 2020: 9)

Coleman and Testa (2008) highlighted cultural differences surrounding sexuality, and this has been seen in the findings on participants' experiences of HIV and AIDS. Some participants have had relatives die of AIDS in their countries, whilst participants from the United Kingdom have had no such experience. Aggleton et al. (2015) have argued that sexuality is socially constructed, and this shapes an individual's experiences and interpretations. They argue that much research in this area is Western-based and does not address all cultural settings (Aggleton et al., 2015). For example, in some countries homosexuality is illegal and can result in death or imprisonment, in contrast to the United Kingdom, where marriage between gay or lesbian couples is legal. Nurses may hold cultural beliefs on FGM from their country of origin, whilst it is illegal in the United Kingdom. Culture is multi-layered, and

what may be seen on the surface may be quite different underneath (Seale, 2018).

Cultural heterogeneity refers to the differences in cultural identity, such as class or ethnicity, whilst cultural homogenisation is a unified organic community (Conversi, 2010). The participants in this research have shown an internal cultural homogenisation in that their cultures have influenced their view of sexuality. Culture influences identities and the meanings that individuals ascribe to them. This means that any data collected surrounding culture are multi-layered, and so I have had to be careful about the conclusions I draw. It is important to remember that understanding the cultural norms of a given group is not predictive of that cultural group. A weakness in this research is that the ethnicity of its participants was not recorded, and this may be something to consider in future research.

What is seen in the findings is an awareness that participants recognise discriminatory practice in qualified nurses even if they are from the same cultural group. Through the introduction of the curriculum, the participants have developed an understanding of sexuality that differs from their previous cultural experience. This highlights the need to address this area, as it could perpetuate the discrimination of other nurses and also encourage health professionals to work in silos, not as a team, which could put patients at risk. Ensuring that the nursing curriculum addresses cultural difference will help to reduce the stigma and prejudice against health professionals and patients, as highlighted by Somerville (Herek, 1999, 2007; Somerville, 2015). This is supported by Korhonen et al.'s research (2012), which showed that Finnish undergraduate students from stricter religious backgrounds had a stricter attitude to sexual behaviour, homosexuality, HIV and AIDS. Pickles et al.'s research (2012) with Australian year-two undergraduate nurses found that students with citizenship from China, Asia and the Middle East expressed

significantly more negative attitudes surrounding HIV and AIDS than other citizenships. Korhonen et al. (2012) and Pickles et al. (2012) illustrate the discriminatory attitudes surrounding sexuality and the influence of culture on judgementality, supporting curriculum development to address this area.

Dyson argued that nurses from high social capital communities are more likely to identify with that community when they are working in clinical practice (Dyson, 2018). This may mean that we give preferential treatment to patients with a higher social capital, for instance wealthier and educated patients, and discriminate against patients from less educated and poorer backgrounds. This research shows that the teaching of sensitive subjects such as sexuality, women undergoing abortion, male and female sex workers, and HIV transmission and management supports the learning journey of student nurses toward non-judgementality. By increasing awareness through discussion, we were able to address hearsay about HIV transmission and management and address stereotypes, such as 'all gay men are promiscuous', and, by showing that no one can be categorised, we hoped greater openness and understanding would be gained.

The participants found that staff lacked knowledge and showed embarrassment over incidents or judgemental attitudes. Participants' journeys to non-judgementality involved reflecting on personal and cultural attitudes through the acquisition of knowledge. The registered nurses had not experienced this knowledge, and therefore had not reflected, and this appears to have hindered their journey to non-judgementality. However, this should be taught by positive role models with expertise in this area, and the NMC should advocate this in its framework for nursing programmes.

This research has shown that the participants have clearly benefited from participation in this research; however, what it does not show us is why participants dropped out or did not take part. There are many reasons, but

one may be the sensitive nature of the subject and a wish to remain silent. By taking part, they may reveal secrets, and by not participating and remaining silent they do not. Frost argued that:

> Silence can be an important part of identity or survival for participants such as those who choose to remain silent about their sexuality. (Frost, 2016: 81)

Individuals may have internalised stigma, which is part of their personal acceptance of sexual stigma and part of their value system (Herek, 2007). By staying silent, individuals do not reveal these, which may conflict with the attributes of nursing.

One of the issues that has arisen through this research is the struggles participants have had to express themselves, resulting in the use of local vernacular in difficult situations. This supports Bourdieu's work on social and cultural capital creating inequalities in education and class (Bourdieu, 1972; Sullivan, 2002; Shim, 2010). Participants reported that the diaries had increased their reflection and encouraged them to think and express themselves. However, when faced with difficult or emotionally provoking situations, some reverted to speaking their mother tongues. Whilst I did not collect data on whether English was their second language, the diaries illustrate that for many participants that this was the case. Having a second language lends a different type of social and cultural capital, and showing an ability to speak and express oneself in it is a positive attribute (Coffey, 2018). It can be advantageous in nursing practice, if a patient is from the same cultural background, yet speaking it in professional conversations can be inappropriate. This research has illustrated the cultural patois seen in the 'tuts' and 'kissed teeth', which denotes disapproval. Cultural patois can result in communication problems and misunderstandings between healthcare professionals and patients. This shows the need to give student nurses support to develop linguistically, supporting Allan and Westwood's research that

having the verbal ability to express oneself and having cultural competency are vital to the integration of student nurses (Allan & Westwood, 2016). Giving student nurses the linguistic skills to express themselves will inevitably give them social capital and professional agency.

Traynor put forward an answer to the inequalities in nursing, such as power and cultural capital, in the form of critical resilience: 'Critical resilience is about understanding ourselves and our experiences in relation to our society' (Traynor, 2017: 29). He believed that by addressing critical resilience in nursing we free ourselves of the culture of blaming individuals. It encourages us to reflect on and understand why we act in the way we do, encouraging us to see explanations and insight (Traynor, 2017). Critical resilience is achieved through high levels of knowledge and analytical abilities that enable the individual to debate issues.

The curriculum intervention has supported critical resilience by giving participants the ability to recognise poor nursing practice and decide that they do not want to practise in the same way. In doing this, participants appear to have used the context of their cultural background to reflect on and identify discriminatory practice. This can only happen if student nurses develop reflexivity, which can only happen if they re-examine themselves and choose to change. The findings show examples where participants recognised discriminatory attitudes to HIV and misconceptions from their own country or in the preferential treatment by a registered nurse from their country. These examples show how knowledge has been generated in one context (the participants' cultural experience) and transferred to another (clinical practice) by recontextualisation (Evans et al., 2010; White et al., 2013). Recontextualisation takes place through engagement with new contexts and knowledge, which changes concepts and practices. The curriculum intervention in the research enabled this process. This has encouraged student

nurses to recognise discriminatory attitudes and poor practice through recontextualisation and, I believe, given them social capital.

Nurses need to reflect, but they also need to be able to articulate reflections. As educators, we need to prepare and support student nurses to verbalise their feelings and experiences, supporting critical resilience and raising concerns. Benner's research shows us that to develop novice nurses to become expert nurses with deeper understanding we need to have explicit theory to support reflection: 'It is the clinical dialogue with theory that makes refinements accessible or possible for the experienced nurse' (Benner, 1984: 36). The findings relating to diverse backgrounds reveal the cultural struggles of student nurses. The curriculum intervention enables student nurses to understand their position and that of others, helping them to recognise discrimination.

2. Students observe/witness judgemental practices in their mentors and other nurses towards sexuality, which challenge their development of non-judgementality

I have discussed how culture impacts on students' journeys to non-judgementality, and this is intertwined with the participants' observations of clinical practice. This research has shown that participants can recognise inaccurate information and discriminatory behaviour, supporting Batson's research (Batson & Thompson, 2001): it has shown how nurses' negative feelings could be changed by increased knowledge. There are examples in the data that show an incremental transformative learning experience, which Mezirow described as small shifts in perspective (Mezirow, 1978). Dyson argued that the transformation of learning experience occurs through the process of critical reflection becoming a reality (Dyson, 2018). The findings capture the journey that participants experienced, which involved knowledge from the curriculum, the diaries and interviews, and show the development of reflection.

The intervention of the nursing curriculum has raised awareness in participants. Sung et al. argued that education alone is not enough, and that the advantage of a curriculum intervention is the discussion with an experienced teacher (Sung et al., 2015). To develop nurses who can identify judgemental attitudes and practice, they need to have experienced knowledge, discussion and reflection with positive role models (Evans, 2011, 2013; Kit Fong Kong et al., 2009). Purkerson Hammer discussed how nurses can be negatively and positively socialised by teachers, and this highlights the importance of having appropriately qualified staff to facilitate nurses in teaching (Purkerson Hammer, 2000).

The findings show a key theme of discriminatory nursing care, where the student nurses recognise poor practice yet 'keep quiet', expressing their need not to make problems regarding their placement. This supports research that shows that student nurses find it difficult to challenge poor practice and instead conform by rationalising poor care, which reduces the need to report and challenge it (Duffy et al., 2012; Price et al., 2015). Bourdieu argued that social capital gives individuals the resources to be able to speak up and be socially cooperative (Bourdieu, 1972). As part of the NMC requirements, educators and practice placements need to support student nurses to raise areas of concerns (NMC, 2015, updated 2018). The NMC Code of Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates states that we should:

> raise and, if necessary, escalate any concerns may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices. (NMC, 2015, updated 2018: 14)

The findings, however, show how nurses have learnt to keep quiet and not raise issues about discrimination. Their combined voice says that raising the

issue of poor practice affects their practice placement and they are perceived as troublesome. Milligan et al. (2016) conclude that raising concerns over poor practice is difficult, yet some students in this study had felt morally compelled to report it, despite knowing its implications for their practice placement. This highlights the plight of student nurses, who fear reprisals that will affect their clinical placement and assessment. If they speak up, it appears from the digital diaries that they are not taken seriously, illustrating their powerlessness. This supports Elcock (2013), who argued that student nurses have learnt to keep quiet and to give feedback only through evaluation at the end of a placement to avoid affecting the placement's outcome. This also illustrates Gramsci's cultural hegemony, showing that the culture of student nurses is to stay quiet, highlighting their powerlessness, and that not speaking up is seen as normal behaviour for this group (Reed, 2012).

Groothuizen et al.'s research found through their longitudinal study of student and midwifery nurses that they gain confidence and accountability over their nurse training, yet find it difficult to raise issues about clinical practice (Groothuizen et al., 2019). If student nurses find it hard to raise concerns or if, when they do, these are not taken seriously, this may not facilitate raising areas of concern when they become registered nurses. This highlights an ongoing issue about the difficulties that nurses have in raising issues about poor practice. Milligan et al. (2016) argued that there is a lack of clarity on how and to whom student nurses should report concerns. They feel that universities have a role in clarifying procedures, monitoring their experiences and highlighting gaps.

Discrimination can be seen in other areas of nursing. It would appear from the digital diaries that nursing staff are unaware of the facts about HIV transmission and, as a result, are avoiding caring for patients who they wrongly perceive pose a risk of infection. Rodger et al.'s research (2019) suggests that

‘the risk of HIV transmission in gay couples through condomless sex when HIV viral load is suppressed is effectively zero’ (Rodger et al., 2019: 1). Examples in the findings of discriminatory care highlight the need to address these areas in nursing to reduce the discrimination against these groups of patients and to support staff.

The participants have stated that the teaching has increased their knowledge, and this has helped them to review and recontextualise their cultural experiences and to identify judgemental practice and non-judgemental practice. By role modelling non-judgemental attitudes in the curriculum, students have learnt to discriminate between the two.

Throughout this research there has been evidence of Stockwell’s ‘unpopular patient’ (Stockwell, 1972). Stockwell’s research found that nurses least liked looking after patients who they felt should not be on their ward or in hospital and those who grumbled or complained, thus requiring more of their time (Stockwell, 1972). The digital diaries and interviews have described registered nurses’ avoidance of patients whom they find difficult. There were two examples in the digital diaries in which HCAs and nursing staff refused care, involving patients who had a history of perpetrating sexual abuse and patients with HIV. These examples highlight a lack of education and training, and also the cultural and social experiences of registered nurses and healthcare workers over sensitive areas of caring for patients with HIV and patients who are sexual abusers. This needs to be addressed. These examples show that we are still seeing discriminatory practice over the care of patients with HIV. I would expect nursing staff to show clinical practice that was evidence-based. The examples show that there are other types of unpopular patient whom nurses avoid: the patient who is a sexual abuser and the patient with HIV. This may be because nurses are concerned about contracting HIV or being

assaulted by sexual abusers, or because they hold discriminatory views against homosexual men or perpetrators of sexual abuse.

Stockwell found that nurses avoided and ignored unpopular patients, forgetting their names, using sarcasm and imposing rules, and the findings from this research show that nurses copied some of these behaviours by ignoring and avoiding the patients with HIV and sexual abusers (Stockwell, 1972). The subject of sexual abuse is only ever tackled in nursing from the perspective of identifying the victim and following safeguarding protocols. This research identifies the need to tackle this area from different perspectives to reduce discriminatory care. By educating nurses about people who sexually abuse, they would be in an informed position to care for these patients. This research reveals the need to educate and safeguard nursing staff and student nurses in clinical practice when dealing with patients who put them at risk.

Participants acted differently in the digital diaries and interviews from the online discussion group. The digital diaries and interviews presented an individual and personal view, whilst the online discussion group showed the professional face of nursing. The online discussion group findings were significant in their formation of the student group's professional voice, and its repertoire illustrates a non-judgemental voice (Chapter 5). The online groups combine to criticise ward managers and Black families for the perpetuation of homophobia seen in the *Stonewall Report* (Somerville, 2015). Traynor argued that,

> faced with an everyday experience that is strongly at odds with the idealized vision, nurses look to external constraints for an explanation. They do this because this provokes less anxiety than profoundly questioning a fundamental ideology of autonomous caring in nursing. (Traynor, 2017: 32)

This supports the findings of how we act in different groups and how nurses reveal and protect themselves, illustrating the protection against the emotions

of nursing highlighted by Hochschild (Hochschild, 2003). The online group chose to avoid addressing its own prejudices and instead focused on others and their prejudices – in this example, the ward manager and the families of young gay Black men. Research on groups by Bion and De Board shows how they develop an identity and function, and my research shows this in the example of the development of a professional identity (Bion, 1992; De Board, 1978). Bion and De Board have shown how groups protect themselves by using scapegoats; my research shows scapegoating of ward managers (Bion, 1992; De Board, 1978). The online discussion group defined what is safe and professional to express and what is not. This example shows the effect of clinical experience in the first year of nurse training and how this had influenced their view of ward managers, resulting in their being scapegoated. The formation of the online discussion group shows the defences that the student nurse participants use to protect themselves from the emotions of nursing by blaming others.

Dyson argued that 'social capital can be a force binding people together in ways which can exclusionary and ultimately damaging' (Dyson, 2018: 111). She argued that the norms and values of nursing are conveyed to student nurses through education and clinical practice. These values and norms can be positive, for example treating patients holistically. Others are negative, in that they encourage team action that may oppose the individual action of speaking up. The findings show that the group of student nurses understand that speaking up is ultimately damaging to themselves, and that registered nurses do not appear to allow student nurses the ability to recognise unprofessional behaviour, illustrating that they may exclude student nurses because of their lack of social capital. The findings show how we act in different groups, and how nurses reveal and protect themselves against the emotions of nursing. In this example, the registered nurses may be protecting their role against the student nurses' perceived criticism and emotions.

The findings show that student nurses observe judgemental behaviour, seen in the examples of the unpopular patients and discriminatory nursing practice, in their development to non-judgementality. This takes place through the creation of a professional identity, social capital and awareness of and ability to identify non-judgementality. This happens through students' acquisition of knowledge and recontextualisation of clinical practice experience to identify judgemental practice.

3. These experiences raise emotional challenges for the student nurse and their development towards non-judgementality

This research shows the feelings revealed by a sample of student nurses in carrying out certain aspects of nursing. The findings illuminate their unconscious emotions of anger, sadness and frustration through the use of Balint and psychodynamic theory. By using pluralism as my methodology, I have data that acknowledge the tensions between sociology, psychodynamic and biological theories. The use of psychodynamic theory and Balint as a method of analysis has allowed the emotions of the diaries to be revealed and given us important insights into how student nurses navigate nursing care and the emotions experienced by of them. Psychodynamic theory involves Freud's transference and countertransference, recognising the unconscious transmission of emotions from one person to another, and the projection of my emotions, as the researcher, helping me to understand the participants' experiences (Dryden, 1990). How we define emotion is important, and sociologists argue that our culture influences what we feel and how we name it (Bourdieu, 1972; Hochschild, 1983), supporting recognition of cultural influence in the nursing curriculum. However, this also means that my labelling of emotions has been subject to my cultural influences. It is important to realise that psychodynamic theory considers neither the context of a situation nor its cultural and societal influences. Pluralism and narrative were chosen first as the methodologies. Psychodynamic theory was added to give greater

depth to my data; used on its own, it would have given a narrow and incomplete picture of the data.

Menzies Lyth's theories are founded in psychodynamic theory. She highlighted the defensive techniques to avoid anxiety that are used in nursing (Menzies Lyth, 1960). Two of these are illustrated in the digital diaries: detachment and denial of feelings, and collusive social redistribution of responsibility and irresponsibility (Menzies Lyth, 1960: 439–62). Examples of emotional detachment and poor care by healthcare professionals are cited by participants. The findings from the digital diaries support Bolton's research, which showed nurses' ability to present many faces whilst juggling emotional demands (Bolton, 2001). Whilst participants questioned the behaviour of nursing staff, the responses that they received showed both a lack of emotional care for patients and burnout. The online discussion group laid the blame for discrimination firmly at the feet of the ward manager (see Chapter 5) Nurses use defences to protect themselves from these emotions of the work. Earlier, I discussed the use of group dynamics and defence techniques to avoid the need to address emotions (Bion, 1992; De Board, 1978). Hochschild identified three ways to cope with this distress, and the first risks burnout of healthcare workers (Hochschild, 2003).

The findings draw attention to student nurses' awareness of poor nursing care and discrimination. Smith summarised this process succinctly in her research:

> students frequently found themselves in emotionally charged situations which went beyond the medical and *technical* definitions of their training and back to nursing as 'people work' in which they engaged in emotional labour. Often they experienced anxiety and stress because their emotional labour went largely unrecognised and undervalued as part of 'real' nursing. (Smith, 2012: 192)

Through their experiences, participants recognised what is poor nursing care and what is discriminatory nursing practice. They learnt through these emotionally charged situations to 'park' their emotions at the time of the incident, but the diaries and the interviews allowed these to be expressed. Their digital diaries, interviews, online discussion group and introduction to the curriculum of sexuality module all increased their self-awareness by bringing sexuality to the forefront of their minds, when prompted to do so, and encouraged participants to reflect and express themselves.

Festinger argued that attitudes do not necessarily predict behaviour. He first derived the term 'cognitive dissonance' in 1964 to describe the feelings evoked when we carry out actions that are inconsistent with our attitudes, creating an internal dissonance or imbalance (French et al., 2015; Crisp et al., 2014). He maintained that individuals will try to resolve this dissonance. However, this will only happen if their attitude is strong; if not, then dissonance will not occur. There are three factors in cognitive dissonance: justification, choice and investment. Justification is where individuals behave in a way that is counter to their attitudes and need to justify this behaviour yet do not change their attitude (Crisp et al., 2014). An example could be where nurses care for a woman having an abortion against their religious beliefs, but understand that they have a duty of care to her. If we have no choice about our action and it contravenes our attitudes, then we can explain away our action and it will cause no dissonance. Finally, the importance of the attitude to our self-concept is that, if this is integral to us as individuals and our behaviour contradicts this, dissonance will occur (Crisp & Turner, 2014). An example is where, due to poor staffing levels, nurses are unable to provide good nursing care – which, for many, is the essence of nursing.

Hochschild's work seeks to make visible the underlying role of emotion and the work of managing emotions in job roles that demand this, which is known

as emotional labour (Hochschild, 1983). Two components of her theory are deep and surface acting. Surface acting is where we display the emotions expected of our work role without changing how we feel. It involves no reflection. Deep acting is where we use effort to change our internal feelings to meet professional expectations, and it does involve reflection (Hochschild, 1983). In the digital diaries, the participants were able to express themselves. The digital diaries and interviews illustrate and show reflection on the stress and burnout that student nurses inadvertently observe in the healthcare professionals whom they work with. The digital diaries and interviews are an example of deep acting. Hochschild's theory of 'emotional dissonance' shows the healthy estrangement and clear separation of emotions that have helped participants to cope with the distress of their emotions (Hochschild, 2003).

At times through this research I have been shocked and horrified at the narratives. One participant discusses in her interview a patient watching pornography on an open ward bay. Her diary illustrates her embarrassment and anger, as well as the registered nurse's possible embarrassment and lack of training to address the situation. The findings highlight the emotions bound up with sexuality, the disapproval people may have of pornography and the embarrassment they may have in using it. Current research shows that the use of pornography is a growing problem (Papadopoulos, 2010). The use of pornography has been shown to adversely affect how women are treated and could put female nurses and patients at risk (Papadopoulos, 2010). This is a subject that we need to discuss both in the curriculum and in the clinical area, and it also identifies the need to safeguard student nurses.

The findings discuss genital washing and healthcare staff not seeking patients' consent. Similar examples of discriminatory practice are seen in the digital diaries. This corroborates McCabe and Holmes's ethnographic research, where nurses were observed to medicalise intimate care and sexuality (McCabe &

Holmes, 2013). White's research suggests that this may be because knowledge is context-dependent, not straightforwardly transferred to other contexts (White et al., 2013; Guile & Evans, 2010). The introduction of sexuality into the curriculum has helped participants to transfer knowledge to a different context, and the ward nurses had not had this intervention so were less able to transfer knowledge. The findings show the ability of knowledge and the digital diaries to support reflection and development.

As a researcher, I found one diary entry to be the most disturbing: a participant's experience of washing young men and her feeling of vulnerability, which gives the impression of sexual abuse (Chapter 6). What is interesting about this instance is how much it upset me and reminded me about how I myself had felt at washing a male patient who was paralysed, who had used sexualised verbal language to me; when I complained to the nursing staff, they dismissed it. My example is from 1981, and it is shocking that we had failed to address this area by 2020. Since completing this research, I have presented it at conferences and repeatedly been approached by nurses with similar upsetting stories. The vulnerable position in which we place student nurses and the lack of support and acceptance from nursing staff are evident in these stories. This illustrates the nurses' expectation that these experiences form part of the nursing role, and thus they are self-fulfilling prophecies. This may be why these concerns are not raised. However, with increasing recognition of sexual abuse and the advent of the 'Me Too' movement, clinical areas and education need to recognise that they have a duty of care to protect and support nurses (Burke, 2018).

The findings show reports of disregard by registered nurses for the emotional impact on patients and student nurses of the upsetting nature of some incidents. There seemed to be a lack of thought over the emotional impact, for example the miscarriage and a chaperone whom the patient had not met

being ‘shoved into the room’. This is quite apart from the lack of preparation and support for the student nurse, possibly illustrating burnout in the registered nurse who acted in this way. The reports show that nursing staff did not consider the emotional implications to themselves or student nurses. There is a lack of recognition of the duty of care that we owe to student nurses. Hochschild explained how we cope with this emotion:

> The sense of emotional numbness reduces stress by reducing access to the feelings through which stress introduces itself. It provides an exit for overwhelming distress that allows a person to remain physically present on the job. (Hochschild, 1983: 188)

The findings show how nurses reveal and protect themselves, showing the protection against the emotional work of nursing highlighted by Hochschild (Hochschild, 2003). As I write, a letter sent in by a student nurse has been published in *The Guardian*. Its narrative reveals the emotion of anger at the pressure of her placement in the emergency department (‘The harsh reality’, 2020). For me, this letter is similar to some participants’ narratives. If student nurses are feeling the pressure, we need to look at the pressure that the permanent members of the nursing team are experiencing.

It could be argued that the diaries portray only what participants want us to see and do not convey their authentic voice. This may be true, to a certain extent; we all present an unconscious picture of what we think is correct. However, I would argue that this is a defence mechanism used by the profession to avoid addressing student nurses’ experiences. As a profession, we ask nurses to park their feelings to work as professionals. It could be argued that we are not seeing an authentic picture of participants experiences; they are presenting an image of what they want me to see. However, these experiences give us a picture of what student nurses experience from their standpoint. This is supported by: ‘I would not open windows into men’s souls’ (Spedding, 1862: 98) (attributed to Elizabeth I, drafted in a letter by Francis

Bacon). This statement implies that, to understand them, we do not need to see into an individual's soul; it is enough if they 'park' their beliefs and develop a professional attitude. However, by encouraging nurses to do so we increase their stress and risk of burnout, so we need to address this to reduce attrition and improve patient care.

Finally, the findings have revealed the journey that student nurses travel to become non-judgemental. The students identify discriminatory clinical practice through their parking of personal feelings and beliefs, their acquisition of knowledge and their recontextualisation of clinical practice. The emotional impact of student nurses' clinical work shows the need to scaffold and support them through their nursing training as part of higher education and clinical practices' duty of care.

Methodological contribution and reflection

I now wish to return to the beginning and revisit the contribution of the methodology, my reflections and the student nurses' evaluations of the curriculum to consider how these have affected this piece of research.

The aim of this research was to:

> Explore the ways in which the student nurses experience non-judgementality through an analysis of the teaching and learning of sexuality within preparatory adult nurse education.

The research objectives were:

1. To explore student nurses' understanding of non-judgementality using sexuality as an exemplar.
2. To investigate the factors that enable or constrain student nurses' ability to be non-judgemental and tolerant of the diversity in sexuality and nursing.

3. To explore how nurse education might facilitate the development of non-judgemental practice by nurses to achieve the NMC standards at the point of entry to the Register.

These objectives have been addressed in this discussion, and this research has clearly explored nurses' understanding of non-judgementality and investigated the factors that enable or constrain student nurses. I have explored how nurse education might facilitate the development of non-judgemental practice and, in Chapter 8, I make recommendations on these. The verbal and written evaluations of the module have shown that all students found it valuable, and this has created increased interest in this area.

I have chosen methodologies that addressed the social and cultural elements of nursing and realised that student nurses' socialisation into nursing is important. How nurses present themselves and their social interaction with other nurses in the digital diaries, interviews and online discussion group shows that they are socialised to an image of the student nurse (Miell & Dallos, 1996). The participants do not express homophobic or racist views, and the discriminatory views that they convey are related to the image of the registered nurse. Goffman's 1959 theory on impression management discusses individuals' attempts to present an acceptable image to those around them, which these findings illustrate (Miell & Dallos, 1996). He believed that we view ourselves as others view us, from the outside looking inwards. Goffman also believed that individuals present an acceptable image by concealing information that conflicts with that image. Participants have presented an image that is acceptable to nursing and chosen to show images that may unconsciously have supported this image, avoiding revealing an unacceptable image of nursing. Sociologists argue:

> that individuals cannot be the starting point for the analysis of society, since all individuals are shaped, influenced and

> constrained by the social order in which they live. (Hughes et al., 2003: 10)

The socialisation of nursing as a profession involves explicit formal teaching and implicit internalised values and beliefs (Traynor, in Allan et al., 2016). The digital diaries have shown examples of stigma related to sexuality, such as pornography, sexual abuse and HIV. These have been labelled by society with negative connotations and are treated unequally, as seen in the findings. The research findings have stressed the importance of both explicit formal teaching through the example of the curriculum intervention and implicit values and beliefs through role modelling by the researcher. Their combined effect shows the importance of addressing sexuality in the curriculum to help participants to socialise to nursing. However, Goffman's presentation of acceptable images means that it is difficult to see a true image of student nurses and nurses. Addressing sexuality can ensure that student nurses are given knowledge and role modelling that support a positive image of nursing, creating expertise, and this needs to be an integral part of the curriculum.

The findings of this research have shown the importance of nurse education to student nurses' experiences of non-judgementality. Nursing education needs to learn from HEIs' quality and the standards of other university education courses. Curriculum knowledge and the understanding of non-judgementality need to be rethought using pedagogic resources. Universities have an important role in healthcare to produce nurses that meet the NMC's standards. The Department of Health (2013) presented a mandate to Health Education England (HEE) about creating the right healthcare professionals following the *Francis Report*:

> Effective and high-quality education and training must ensure that NHS staff are available in the right numbers with the right skills, values and competencies to deliver both excellent clinical outcomes together with patient centred care. … There is the responsibility on healthcare providers to deliver high quality

> education and training not just for students, but for all their staff in order to ensure high quality and safe patient care. (Department of Health, 2013: 3)

Increasingly, because of staff shortages and cost savings, there is now pressure to teach online and reduce face-to-face teaching, combined with hospital trusts providing educational training. The disadvantage of this type of pedagogy is the lack of scaffolding and role modelling. Like Vygotsky, I believe that learning happens through the scaffolding by teachers, which helps to develop expertise, and this takes place by giving learners conceptual tools and knowledge (Matheson, 2015). These include relating knowledge to patients care in the clinical area, for example addressing HIV patients' daily living requirements.

Carper's theory (1978) has four fundamental patterns of knowing in nursing. She held that the fourth was ethics, the aspect of moral knowledge in nursing that is an important component of knowing what is right and wrong. Carper held that this included: 'all voluntary actions that are deliberate and subject to the judgement of right and wrong – including judgements, and traits of character' (Carper, 1978: 29). Carper's theory shows the importance of moral knowledge within nursing education, and the findings have shown that this knowledge is vital to the recognition of discriminatory care. As discussed earlier, there is evidence that, morally, some students feel compelled to raise concerns over poor practice. This supports the need to address moral knowledge in education (Milligan et al., 2016). Deeper learning happens if we relate theory to practice, increasing understanding and reflection. This encourages students to think about and question practice, which creates emotionally resilient clinicians. Benner (1984) discussed this complexity of pedagogy and the processes that create expert knowledge, which is encoded in highly complex forms. This incorporates rules on conduct and character. Finally, participants have discussed the influence of poor and good role models

in their online discussion group, digital diaries and interviews, and the emotional pressures this creates is seen in the findings. O'Callaghan's work on role modelling with junior doctors has shown that:

> it is not only explicit teaching but also the behaviours and attitudes of teachers that are noted by students, with subliminal messages having the capacity to powerfully influence student behaviour. (O'Callaghan, 2013: 309)

The findings show that delivering the curriculum with teachers who are authentic was important. If the teacher holds negative views on HIV or abortion, then if the participants' cultural norms had discriminatory views they might have difficulty in recognising these behaviours in the clinical area. The curriculum intervention and the use of the example of sexuality have offered a way to understand diversity and enabled participants to understand their position and that of others on sexuality. Participants have multiple contexts: what they see in the classroom, what they see in practice, and recognition of discrimination in others. All these have enabled participants to recontextualise their experiences on their learning journey to non-judgementality and professionalism.

Reflecting on this research journey, I feel that the participants' development to non-judgementality is complex. The issues that student nurses face are varied and difficult. The reflections participants have expressed show exposure to experiences in practice and from teaching that bring about change, showing increased reflection and openness and appearing non-judgemental. It is almost impossible to say that everyone is non-judgemental because of the defences that an individual will use to hide their attitudes, especially as these might fall outside of the acceptable image of the nurse. What I now believe is that it is possible, with appropriate and relevant teaching and facilitation, to ensure that nurses are open and reflective to enable them to identify judgemental practice. This process facilitates nurses'

recontextualisation of judgemental practice experience in the development of their own non-judgementality.

Summary

This chapter has discussed findings in relation to students' own backgrounds, which are diverse, shape how they meet/deal with the challenge in clinical practice and the influence of cultural and social backgrounds, and the work of Bourdieu (1972). I have discussed students' observation of judgemental practices in their mentors and other nurses towards sexuality, which challenges their development of non-judgementality, and the difficulties participants have had raising concerns. Finally, I have discussed participants' experiences, which raise emotional challenges for them and their development towards non-judgementality. We have seen the complex emotional challenges that student nurses are faced with, and the emotional juggling they portray.

This chapter has finished with a methodological review: my reflections on my choice of methodologies and experiences as a researcher. I have reflected on the benefits of recognising the emotional content in the data, and its importance within the findings.

Chapter 8 Conclusions

This chapter discusses the research findings and their implications, my reflections on the research and the curriculum intervention it was based on; contributions to knowledge, the recommendations for practice and research, and final conclusions.

This research has aimed to explore, through an analysis of the teaching and learning experience of sexuality within preparatory adult nurse education, the ways in which student nurses develop non-judgementality. This research has found that student nurses encounter complex emotional experiences related to sexual health practices in the clinical settings. These experiences and their emotional responses to the challenges of these experiences contribute to their development of non-judgementality.

Student nurses develop non-judgementally through a number of ways: through their diverse backgrounds, which shape how they deal with the challenges of sexuality, and through witnessing healthcare professionals' judgemental practices towards sexuality. These experiences raised emotional challenges for the student nurses and their developmental journey towards non-judgementality.

Findings and their implications

The findings of this research have implications for the approach of the regulator, the NMC, to the topic of non-judgementality and to the education of student nurses regarding their approach to issues of sexuality and non-judgementality in general. This includes both how these topics are framed and taught within the curriculum and how nurse educators and mentors might support students who encounter judgemental attitudes among the qualified nurses and others with whom they work during placements. Final assessment of placements by student nurses is incorporated into clinical placement

educational audits. However, as discussed in Chapter 7, the findings of this research show that the participants understood that speaking up was ultimately damaging to themselves. As a result, students' assessments of their placements are unlikely to be an honest portrayal of their experiences. The findings have shown that registered nurses have a lack of experience with issues surrounding sexuality. There is no professional development or support for teachers/mentors to address their attitudes about sexuality and their professional non-judgementality. We send healthcare professionals on diversity courses; however, these do not discuss personal feelings in relation to sexuality. The digital diaries encouraged reflection, and allowing time to reflect is important for professional development for both registered and student nurses.

The role of the NMC in addressing non-judgementality is a vital one. As a professional organisation, it sets the standards for the nursing curriculum and endorses programmes. It can influence how the curriculum is taught. An example is the introduction of service user input throughout the teaching programmes that it endorses. The NMC has a prescriptive and standardised framework, in which the acquisition of skills is heavily promoted and to which nursing programmes must adhere, yet this framework does not address the moral and personal commitment required of nurses (Dyson, 2018; NMC, 2018b). These additions would require a confidential support service and clear safeguarding protocols to be agreed between universities and commissioning practice placement bodies. The 2018 NMC Standards Framework for Nursing and Midwifery Education (2018b) clearly states that the safety of patients, staff and student is central; however, this is not considered in relation to sexuality, and, if addressed, that would ensure that the support and safeguarding of patients and nurses were successful.

By addressing these areas, universities and practice areas would honour their duty of care and value the emotional welfare of their student nurses.

Reflections on curriculum intervention

This research was founded on a change in the nursing curriculum. This intervention was important to the research as it gave participants the tools to recognise discriminatory practice. The introduction of sexuality to the curriculum has helped to address the student nurses' moral and personal commitment through education, discussion and role modelling. The focus of the teaching undertaken by the researcher that formed the backdrop for this research was to raise awareness. No questions were off limits, and a 'safe' area was created where anything surrounding sexuality could be discussed. This made learning amusing and horrifying at times, yet memorable. Many of our students had received no education on sexual health at school because their parents had opted out of this education on religious grounds, so some participants had learnt from the media or hearsay. As discussed in Chapter 7, Vygotsky (Matheson, 2015) described the concept of scaffolding, by which teachers help develop learner's expertise by giving conceptual tools and knowledge. The importance of scaffolding students through this research journey cannot be underestimated. The curriculum was delivered by the researcher and another senior lecturer, who are both passionate and experienced in this area and were able to offer support and refer students to appropriate confidential services if needed. Both hold liberal views and, whilst these were not overtly expressed, they would have been experienced by the student nurses, highlighting the positive influence of the hidden curriculum. The evaluation of this teaching was unanimously positive, and free text feedback showed that the student nurses realised that they had to put their personal opinions to one side and work as professional nurses, with a duty of care to each patient.

Purkerson Hammer (2000) discussed how students can be both negatively and positively socialised. The role of teachers with non-discriminatory views on such topics as HIV, abortion, transgender and homosexuality is an important component of this teaching and its evaluation. The evaluations noted the teachers' clinical and teaching experience, and the students commented that the teaching reflected the lecturer's clinical currency. Both teachers hold honorary contracts in clinical areas either in sexual health or related to it. The importance of this role modelling cannot be underestimated, as it counteracted the discriminatory practice seen in some nurses in the clinical area.

Reflection on research

Reflecting on my research journey, I found that pluralism has given a depth to the research findings that I believe a single methodology could not. The use of Balint in the analysis of the data has revealed student nurses' feelings and emotions, allowing their voices to be heard. A strength of this research has been its choice of methodology, which has allowed the feelings of student nurses to be heard. Carl Rogers's work (Rogers, 1983) shows what the digital diaries, interviews and online discussion groups give to the nursing profession. Earlier, in the literature review, I quoted Rogers: 'At last someone understands how it feels and seems to be me without wanting to analyse me or judge me' (Rogers, 1983: 25). This summarises the contribution of this research to knowledge: the diaries, interviews and online discussion illuminate the student experience of sexuality and their journeys to non-judgementality. In my experience, the digital diaries were an excellent tool to elicit the participants' emotions in clinical practice, and helped me to understand how their emotions shaped their learning. They help us to understand what it feels like to be a student nurse today without being judged by the nursing profession, and we need to listen to these voices.

Suzanne Everett 9834205:

At the outset of the teaching, my aim had been to raise awareness and reduce discrimination relating to sexual health. I had not considered that by doing this I might support student nurses' journey to professionalism as well as non-judgementality. The challenges that nurses meet in the clinical area are expanding and, as a profession, we need to look after nurses and equip them to deal with these. Our society is changing quickly, and we need to be proactive and address these changes within nursing. Heise argued that, to change social norms,

> programmes should cultivate role models, identify and exemplify those who deviate from the norm in a positive way … frequently it is easier to promote a new positive norm than to dismantle a negative one. (Heise et al., 2019: 3)

This research has shown that using sexuality as a focus appears to offer nurse education a way to address student learning more explicitly in the development of non-judgementality. The findings show that positive role models in clinical practice and in the university setting facilitate student nurses' recognition of judgemental practice in difficult situations, such as patients known to be sexual abusers or HIV-positive. To move forward, we need to address the judgemental attitudes within nursing that have been illustrated by participants. The NMC could address this by advocating that the revalidation of all nurses includes participatory education on some of the issues that are discussed in this research, such as consent and pornography. This would equip nurses to look after patients, and participatory education would give the freedom to discuss anxieties, to increase critical resilience and compassion and to reduce stress.

The research findings show the complexity of sexual health-related issues student nurses meet in the clinical area and the difficulties they have navigating these. While many of the student nurses have witnessed discrimination against HIV patients, which endorsed my personal experiences,

Suzanne Everett 9834205:

I had not realised the complex nature of the issues that student nurses were witnessing. I have been upset by participant's experiences and the lack of support they have received. I feel these findings are important as they endorse the need for nursing to raise awareness of sexuality through education, and the requirement by HEIs and hospital trusts to provide support to nurses in the clinical area.

Research findings contribution to knowledge

As discussed in Chapters 3 and 6, I have argued, along with Frost (2016), that the inclusion of emotions is an integral component of research process and the findings. This recognition of emotions in this research has been achieved in two ways: first, by incorporating the researcher's story, which is a reflective account of the researcher's reactions to the data during data analysis, and, second, by including the researcher's diary, which shows the process of analysis and forms a data source itself. All of these sources of emotions show the developing analytic narrative of the journey to non-judgementality for student nurses.

This research provides nursing and HEIs with knowledge on student nurses' experiences related to sexual health practices in the clinical area. The findings emphasise the importance of addressing sexual health in the curriculum, which helps to support student nurses' identification of discrimination. The findings tell nursing, HEIs and clinical areas about the need to safeguard student nurses. This is observed through the complex sexual health encounters and emotions expressed by them. These findings show that registered nurses often struggle with these complex sexual health encounters, and would benefit from education and support. These research findings would, if addressed, help to reduce stress in nurses and support nursing professionalism.

Recommendations for practice and research

This research has revealed areas within nursing practice and education that I feel need to be addressed:

1. The methodologies of pluralism, narrative and psychodynamic have enabled student nurses' voice to be heard. Further research needs to be carried out to understand their journey and development towards non-judgementality. There is limited research using these methodologies in nursing and healthcare, and a programme of research utilising these would benefit the education of healthcare professionals.

   This research has found complex practice related to sexuality and future research needs to be deepened around our understanding of both learning and practice around sexuality.

2. Teaching sexuality within the curriculum with a positive role model appears to enable participants to recognise discriminatory practice.

   A strength of the curriculum that was introduced was the expertise and authenticity of the teachers, which supported nurses' journey to non-judgementality. Teachers who are able to talk about aspects of sexuality with clinical experience are in a minority. However, the evaluation of the teaching showed that students and participants valued their knowledge and experience. All the students said they felt better equipped to address issues on sexuality and FGM with their patients. This feeds into the requirement to increase realistic portrayals of nursing that is advocated by the Royal College of Nursing (Clayton-Hathway et al., 2020).

   The introduction of sexuality into the nursing programme helps to address the NMC standards of care and develop a workforce that is accepting of

diversity and reduce homophobia. It is important that this is continued and supported to raise awareness and reduce discrimination.

3. This research has highlighted the need to address sexuality with qualified nurses as part of mandatory training, and as part of continuous professional development. The findings show poor clinical practice related to sexual health over issues such as pornography and patients with a history of sexual abuse offending. The findings show not only poor practice by trained nurses but a lack of understanding, practice and knowledge related to sexual health.

   Whilst addressing sexuality with qualified nurses is important, there have also been accounts in this research involving HCAs that reveal that they have poor knowledge of HIV. Maben, Cornwell and Sweeney's research shows that:

   > in interviews and evidence (Dawoud and Maben, 2008; Maben and Griffiths, 2008) over and over again a wide range of nurses suggested that the essence of nursing, being with patients, performing essential but intimate care, where relationships are forged and built has been passed over to health care assistants. The broad consensus seems to hold: compassion once seen as the essence of caring and therefore the essence of nursing is no longer always the central focus of nursing practice. (Maben, Cornwell & Sweeney, 2009: 9)

   I would, as a result, recommend that all nursing staff who have direct contact with patients receive education and training on sexuality to improve their care and reduce discrimination. This training could involve a day to raise issues, with discussion on these areas, incorporated into compulsory training that is facilitated by a suitably qualified nurse.

   Whilst raising this issue, I was informed by educationalists that the NMC's framework has just been changed, implying that the issues raised within this research cannot be addressed. This emphasises the need to publish

and present the findings of the research to raise awareness. Denial by educationalists and the NMC fuels poor nursing practice, as failing to address this area is not an option: we do it at our peril.

4. This research has highlighted the need by clinical areas and HEIs to safeguard student nurses.

   The findings of this study show the need to safeguard student nurses in the clinical area, and this should be extended to all nurses. Whilst the safeguarding of university students focuses on important issues relevant to university-based students, there appears to be a gap in the safeguarding of nurses in clinical work with patients. The findings show that universities and hospital trusts have a duty of care to the nurses who work for them, as they have for their patients.

   There have been times within this research that I have felt that there are parallels with the 'Me Too' movement on sexual harassment. When I have presented this research, many qualified nurses have told me stories of times when they had felt abused. Safeguarding is aimed at patients, but the stories have revealed that nurses also have been put in vulnerable situations, and the findings support them. As a result, it is important that universities reach out to safeguard student nurses in the clinical area. I suspect that this has not been addressed because registered nurses feel that this is one of the pitfalls of their role in looking after patients and that its acceptance is deeply entrenched in nursing. Allan (2016) argued that by failing to recognise the implicit anxiety in the work of nursing, which these findings show, we reinforce the devaluation of nursing. It is unacceptable that this situation continues. Student nurses need to be able to raise their concerns and be treated with respect. Smith argued that nursing leaders need to give nurses:

> an emotionally caring tone and promote an organizational and educational system sensitive to the complex and financially driven world of the twenty first century. (Smith, 2012: 203)

To address these safeguarding concerns, universities need to work with hospital trusts to formulate safeguarding procedures to protect student nurses. Academic assessors, practice supervisors and assessors all have a duty of care to the student nurse and need to listen and advise on poor practice from an informed position. This needs to be supported by leadership that has positive role-modelling qualities, upholds nursing values and believes in its duty of care to its nursing staff.

5. The findings highlight the difficulties that student nurses have in raising concerns and the need to address this area.

   Participants found it difficult to raise the issue of discriminatory practice, as they felt that it would affect their practice placement assessment. Those who did raise it were not taken seriously by registered nurses, and this highlights the need to address this with clinical areas. Student nurses can raise concerns over poor practice with academic assessors and programme leaders, but this is often only at evaluation. Milligan et al. (2016) argued that universities have a role in highlighting gaps and monitoring student nurses' experiences, and this study's findings will be fed back to this institute's practice-based learning unit. However, registered nurses need to be more open to listening to and accepting feedback from student nurses and considering their concerns. Raising concerns in the NHS applies to anyone who works in the NHS, including students, yet these findings show that student nurses' concerns were not accepted (NHS Improvement, 2016). By accepting student nurses' concerns, we help to perpetuate the culture of whistle-blowing in the healthcare system and thus reduce poor care.

6. Addressing and embracing cultural differences is important to understand patients and reduce discrimination and support the development of nurses from different cultural groups.

   The NMC and universities need to address the effects of student nurses' diverse backgrounds on their knowledge about and attitudes to sexuality. For example, the findings show that participants' backgrounds have influenced their knowledge and experiences of HIV and AIDS. The findings show that some participants have found it difficult to talk about sexuality given their backgrounds and education. If universities recognise the possibility that students may have diverse backgrounds that have addressed sexuality differently, the curriculum could then be developed to address these diverse educational experiences

   By doing this they will increase social capital and this, in turn, will increase compassion and critical resilience. With students coming from different religious and cultural backgrounds, there is a lack of knowledge. As discussed, many students in this study had not covered sexual health at school and so had major deficits in knowledge. By addressing these areas, we help to reduce stereotypes and discrimination. The digital diaries highlighted differences vocalising and expressing emotions and use of cultural patois, all of which reduce cultural capital and equality. Addressing these in nurse training would enable the progression of BAME groups and hopefully facilitate recruitment.

   As discussed, the research has shown that students from different cultural backgrounds are disadvantaged. Rafferty et al. discussed the 'increasing complexities of and demand for care' (Rafferty, 2019: 21). Combined with this complexity is the impact of healthcare workers from different cultural backgrounds and the need to address educational needs. Participants from different cultural groups displayed a struggle to verbalise their feelings in

the diaries, and this may result in them struggling more with their emotions in the clinical area. Encouraging all nurses to develop and reflect would support the emotional demands on them.

International students have expressed feeling unwelcome, isolated and vulnerable in universities (Equality and Human Rights Commission, 2019). Encouraging all students to understand and appreciate cultural difference would reduce discrimination, both in HEIs and in healthcare. This research represents this university, which has a diverse population, so it should be replicated in another institution with a dissimilar population to help to understand cultural influences.

7. The ability to verbally express concerns is important in the raising of poor practice and development of professionalism.

   This research has shown the difficulties that participants face in raising concerns over poor practice. The findings show that, if you do not have the resources to verbally express and vocalise your concerns, it is harder to raise this issue. Participants appeared less confident vocally in their narratives, illustrated by the use of cultural patois. It is important that education supports student nurses by giving them the verbal resources to raise concerns. The identification of poor practice needs to be woven through the curriculum, alongside the verbal resources to support students to report it. By supporting our student nurses, we create future registered nurses who are more able to raise these concerns.

Final conclusions

The main message of this research is that student nurses encounter complex emotional experiences related to sexual health practices in clinical settings. These experiences and their emotional responses to the challenges of these experiences contribute to their development of non-judgementality. Sexual

health education has an important role in supporting this journey and raising awareness of discrimination.

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Appendix A: Influences on the research journey – ethnomethodology

The online discussion group data were originally to be analysed using ethnomethodology, but narrative methodology was then used. This was decided following discussion at the transfer panel, yet I have enclosed ethnomethodology to show why this method was considered and its usefulness within narrative methodology.

Ethnomethodology is a research approach developed by Harold Garfinkel in 1967. It examines how individuals, through interaction, make sense of the social world and give meaning to it (Garfinkel, 1967). Garfinkel believed that social interaction is guided by implicit rules, and only if challenged do we give an account. He believed that it is only when rules are broken and individuals do the unexpected that we become aware of the 'taken for granted' (Miell & Dallos, 1996). By saying that social interaction is implicitly rule-based, it is argued that our actions are unconscious, without us having to think about our actions. Whilst there are general rules, how these are applied and employed is down to the individual.

Ethnomethodology involves keeping comprehensive detailed accounts of social interaction. These accounts describe how individuals decide what is going on, what has happened and how they behaved (Gilbert & Stoneman, 2016). Garfinkel's research focused on how individuals reacted when their personal space was invaded. Typically, this type of research shows what happens when the pre-reflective is interrupted (Sapsford, 1996). Garfinkel argued that action is both deep and superficial, based on the 'pre-reflective and life world' (Sapsford, 1996: 35). The deep is defined as the thoughts and anxieties of reason, which we fail to notice in their pervasiveness in our lives. Superficial is defined as what we see, hear and feel, which is pervasive and ever-present in our lives. Ethnomethodology is not concerned with factual truth but what the individual says in their account and the stories that they

tell. These stories, Gilbert argued, are not 'created in a social vacuum but are moulded by a social context and interactions between the storyteller and audience(s)' (Gilbert & Stoneman, 2016: 462). Ethnomethodology is concerned with how social order is accomplished through talk and order and gives theoretical foundation to conversation analysis. Conversation analysis is the naturally occurring discussion that occurs in situations. By recording and transcribing this discussion, the interaction and underlying structures of the discussion are analysed by looking at participants' interaction with each other through their turn-taking. Conversation analysis follows assumptions: first that speaking is structured in patterns that we are implicitly aware of; second, the context of the conversation to be understood; and, third, that there is a social order to the characteristics of the conversation.

Through the online discussion groups, the participants' interactions with each other and the researcher were recorded on the sexuality and nursing teaching material. This gave participants the opportunity to vocalise views that maybe they had not had the opportunity to do in the classroom. Participants were able to express personal, religious, ethnic, class-based and emerging professional views. Sprecher and McKinney discussed how attitudes to sexuality influence what we think about an individual, and these attitudes help us to formulate a picture about someone. These constructs and interactions may be seen through discussion (Sprecher & McKinney, 1993). Online discussion groups may encourage increased debate, but some participants may lurk or avoid joining. This may be because some have been victims of assault, abuse or FGM and may feel that they are reliving their experience, or may feel disempowered to speak about their experiences or feel they cannot express views if they are different from the majority (in this instance, their classmates). This may be seen in the online discussion group, where participants might have felt disempowered to contribute to the conversation. An example may be participants who join the online discussion group but do

not contribute, known as 'lurking' (Bryman, 2012). Lurking can create tension within online groups, with active online participants censoring their discussion. Bryman noted that active participants can usually identify what lurkers are doing; however, he also raised the issue of the researcher, who often 'lurks' in an online discussion group (Bryman, 2012). Bryman identified four types of online interaction study, and the type may influence how the group is studied:

1. The study of the online group without any participation by the researcher will result in the researcher becoming a lurker. This may have to happen because of the nature of the group, and they may have hostility to outsiders, and this may include the researcher. In this research, the participants were aware of the researcher's involvement.
2. The study of the online group with some participation by the researcher. Bryan highlighted that the researcher may have to intervene covertly or overtly, but I did not have to intervene covertly. If there was one participant online, I commented on their posts.
3. The study of the online discussion and offline interviews. The nature of the online community is that individuals may have an offline existence, as these participants did.
4. The study of the online interaction as well as offline research, and this research falls within this category as the researcher teaches the participants and will be interviewing or listening to digital diaries. (Bryman, 2012).

Conversation analysis recognises that discussions have certain features. These include turn-taking, adjacency pairs, preference organisation, accounts and repair mechanisms. Turn-taking occurs in everyday conversation and illustrates shared codes. If such shared codes did not exist, there would be no smooth conversation, as these codes indicate the end of utterances. Adjacency pairs illustrate the activity of two linked phases of questions and answers

(Bryman, 2012). If you ask a question, there will be an answer or response to that question. This answer may be anticipated, but if an acceptance is given to an invitation this will not be qualified, whilst refusal will be given with a reason, which is an example of preference organisation. The accounts feature illustrates the format of the reply to declining an invitation that has a factual nature. Repair mechanisms are where turn-taking is not followed. For example, when someone starts to speak before someone has not finished, the first speaker will stop or, when someone does not respond to a question, the questioner will repeat it. 'Repair mechanisms allows the rules of turn taking to be maintained in spite of the fact that they have been breached' (Bryman, 2012: 527). There are taboo topics that we as individuals respect; for example, an individual's previous sexual partners are usually avoided (Duck, 1998). For some participants, subject areas like FGM may be taboo, especially if they come from an area where this is practised; for others, this may not be a taboo subject. There is the area of self-disclosure, which can help to establish a relationship, and students may self-disclose within the research.

Traynor discussed how healthcare professionals represent themselves through discourse analysis (Traynor, in Latimer, 2003). He compared community nurses to senior managers to describe a discourse in moral agency. Traynor found that nurses tended to use a self-sacrificing moral agent, in contrast to their description of managers, who were financially oriented and detached from the emotional involvement of patient care (Traynor, in Latimer, 2003). He said:

> this self-sacrifice is pictured as exploitation. This avoids a presentation of moral reluctance, which would be problematic because it would undercut a moral stance. The position of self-sacrifice could also augment injustice of what they described as their exploitation because their moral orientation and sensitivity rendered them highly vulnerable to abuse. (Traynor, in Latimer, 2003: 144)

Traynor argued that nurses had constructed a moral high ground, which enabled them to diminish the importance of the financial considerations associated with the senior managers. He warned that these ideological self-presentations are constructed by groups to define and strengthen their position at times of conflict (Traynor, in Latimer, 2003). Traynor's work is important to this research as he highlighted professional identity.. The participants in this research might have constructed an identity that is opposed to the identity of registered nurses, and this may be seen in the discussion group. This might give me insight into how participants cope with the patients whom they see as undergraduate nurses. It might have been that the participants constructed other group identities, which may be unintentional but could be seen as the exclusion of other members in the group or scapegoating. Bion discussed the influence of the group on the individual, of which participants may be unaware. This may have resulted in scapegoating or exclusion and may be the reason why some individuals 'lurked' in the online discussion groups (Bion, 1992; De Board, 1978).

Critics of the constructionism model have argued that researchers focus on the conversation skills of the participants rather than the content, which creates narrowness in the data analysis. The argument against this is that conversation analysis reveals what participants are doing in their speech, through hesitations and inflections in the interview content. It does not infer meaning from what is said and therefore reduces the influence of the researcher's interpretative role. There is a risk of reporting bias where participants collaborate with the researcher by giving the answers that they perceive as warranted (Delgado-Rodriguez & Llorca, 2004).

Appendix B: NMC – registered nurses' ethnicity

Table 4-1 – Registered nurses' ethnicity with the NMC (courtesy of the Freedom of Information Act request) (NMC 5.1.16b)

Ethnicity	Total (%)
White	
British	67.06
Irish	3.89
Any other White background	6.99
Black	
Caribbean	1.69
African	5.72
Any other Black background	0.50
Asian or Asian British	
Indian	2.87
Pakistani	0.62
Bangladeshi	0.34
Any other Asian background	
Chinese	0.86
Any other Chinese background	0.86
Mixed group	
White and Black Caribbean	0.59
White and Black African	0.46
White and Asian	0.54
Any other mixed background	0.62
Other	1.50
Prefer not to say	1.77

There were 66,500 nurses who had trained overseas and in 2016 were registered with the NMC. The countries that had trained more than a thousand nurses who worked in the United Kingdom were: the Philippines, with 23,251 nurses; 17,045 from India; 6,037 from Romania; 4,909 from Portugal; 3,719

from Jamaica; 3,080 from Nigeria; 2,776 from Poland; 2,331 from Zimbabwe; 2,164 from Eire; 1,437 from Ghana; and 1,561 from Australia (NMC 5.1.16c).

Table 4.2 illustrates the personal characteristics of nurses registered with the NMC in 2016. This shows a predominantly female workforce of 380,219 (89.63%), compared to 43,957 (10.36%) male nurses. The largest ethnic group was White British, at 67.06%. Some 367,441 nurses defined themselves as heterosexual and 279,599 nurses Christian. The number of nurses in all the age ranges was similar, with a slight increase for nurses aged 40 to 49. There are significant groups of overseas nurses from countries with strong religious links, such as India and the Philippines.

Table 4-2 Age, gender, disability and sexual orientation of nurses registered with the NMC (courtesy of the Freedom of Information Act request) (NMC.5.1.16b)

Age	**Total (%)**
19 to 29 years	22.59
30 to 39 years	22.90
40 to 49 years	28.63
50 to 59 years	20.41
60 years and over	5.47
Gender	
Male	10.36
Female	89.63
Unknown	0.0%
Disability	
Yes	24.64
No	71.27
Prefer not to say	4.09
Sexual orientation	
Bisexual	1.93
Gay or lesbian	1.72

Heterosexual	85.36
Prefer not to say	10.99
Religion or belief	
Buddhist	1.06
Christian	65.82
Hindu	1.22
Jewish	3.51
Muslim	1.50
Sikh	0.42
Other religion	3.89
No religion	19.54

Appendix C: Ethics Approval

Middlesex University London

School of Health & Education
The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 020 8411 5000

13th October 2016

HEESC APPLICATION NUMBER: NO89 Suzanne Everett

Dear Suzanne

Re your application titled: "Sexuality and Nursing: Exploring the potential of the nursing curriculum to develop nurses who are non-judgemental and tolerant of differences and diversity"

Thank you for submitting your revised application. I can confirm that your application has been given approval from the date of this letter. This approval is valid until 30th October 2017. If you require an extension to this end date please complete Form E which can be found at http://ethics.middlesex.wikispaces.net/Health+Studies

Please ensure that you contact the ethics committee via Leeann Bradley HEethicsSubC@mdx.ac.uk if there are any changes to the study to consider possible implications for ethics approval. Please quote the application number in any correspondence.

The committee would be pleased to receive a copy of the summary of your research study when completed.

Good luck with your research.

Yours sincerely

Gordon

Dr Gordon Weller
Chair of Health and Social Care Ethics Sub-Committee

Suzanne Everett 9834205:

Appendix D Participant information on keeping a digital diary

Participants Digital Diaries

Following your module on sexuality we are hoping to find out about how you see your clinical area in the light of this knowledge.

Please record a diary entry at least once a week, this can be more but one instalment once a week is needed. Everything you say will be anonymised so you don't need to worry if you say a name.

At the beginning of each session say the date and time and your participant number which is on your digital recorder. Try to tell your story so say the context of the incident you have observed or been involved with in your clinical area. This could be something you have observed between colleagues or with a patient. Please keep your diary entries for the whole of the clinical placement. This exercise will encourage you to reflect on your clinical practice which is an important skill for registered nurses.

If you have any problems you can contact me on s.everett@mdx.ac.uk.

Thank you Su

Appendix E: Participant Information Sheet (PIS)

MIDDLESEX UNIVERSITY
SCHOOL OF HEALTH AND EDUCATION

HEALTH AND EDUCATION ETHICS SUB-COMMITTEE

PARTICIPANT INFORMATION SHEET (PIS)

Study title

Sexuality and Nursing: Exploring the potential of the nursing curriculum to develop nurses, who are non-judgemental and tolerant of differences and diversity.

Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this

What is the purpose of the study?

The purpose of this research is to understand whether we working towards the Nursing and Midwifery Councils (NMC) standards for professional practice in the nursing curriculum (NMC, 2015). The NMC guidelines set out the expectations of the behaviour and practice of professional nurses. I wish to understand this area and how nursing institutions ensure that undergraduate nurses meet these NMC standards. Research shows that nurses have to address issues around sexuality, which they may not have had to address before or had training and I would like to understand their experiences

The aim of this project is to conduct a study using participant involvement in an online discussion group whilst undertaking a module on sexuality and nursing. Following completion of the module nurses will be invited to continue in the study and keep an oral digital diary whilst undertaking their clinical placement. Following completion of the diary a small proportion of participants will be invited for a one to one interview.

Why have I been chosen?

You have been chosen because you are a second year student nurse who is undertaking a module on sexuality and nursing.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you decide not to participate or withdraw this will not affect the outcome of this module.

Suzanne Everett 9834205:

What will happen to me if I take part?

If you decide to take part in this study, you will be involved weekly for up to 3 weeks for the online discussion group, and you will be asked to keep a weekly a digital diary over an 8 week clinical placements. Finally you may be asked to undertake an interview of one hour.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated audit or member of the audit team.

What do I have to do?

You will be asked to allow the researcher to observe you as you interact with your peers in the online discussion group whilst undertaking a module on sexuality and nursing. You will be given a digital recorder to record your experiences in your clinical placement. I (the researcher) will listen and transcribe your digital diary and you are welcome to read and comment on this. You may be invited for a formal interview asking you about your experiences within the digital diary lasting approx. 60-90 minutes. I will send you the transcribed interview so that you may read it and send me any feedback on your reactions to my observations and interpretations of our conversations. There is no obligation at all for you to continue and you may withdraw until amalgamation of the data, and this will not impact the progress or outcome of the course. If you withdraw before undertaking the digital diary after the online discussion group you will be invited to take part in an interview, there is no obligation for you to agree to this.

What are the possible benefits of taking part?

I hope that the results of this project will be disseminated and contribute to increasing awareness of diversity and discrimination, if found, and to contribute to the way we teach nursing. You will gain an insight into the research process.

What are the possible disadvantages and risks of taking part?

I am a senior lecturer in nursing at Middlesex University and you are a nursing student. Your participation will be anonymous and will not affect the outcome of the module on sexuality and nursing.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

Any identifying details will be stored separately from the researchers by a third party. All data will be stored, analysed and reported in compliance with the Data Protection Legislation.

What will happen to the results of the research study?

The data will be analysed and form the research project of my post graduate study. I plan to present this to the nursing faculty, at conferences and for publication.

Who has reviewed the study?

The Middlesex University, School of Health and Education, Health and Education Ethics Sub-committee

Contact for further information

Su Everett	Helen Allan
Senior Lecturer	Professor.
The Williams Building	The Williams Building
School of Health and Education	School of Health and Education
Middlesex University	Middlesex University
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Hendon	Hendon
London	London
NW4 4BT	NW4 4BT
020 8411 2631	
s.everett@mdx.ac.uk	h.allan@mdx.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.