Enhancing the affective domain in order to reduce fear of death in first-year student nurses

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Kim Goode, November 2015

Abstract - This study seeks to investigate fear of death in first-year student nurses. It considers how this might be ameliorated through teaching and learning interventions that involve addressing emotional and spiritual intelligence within the affective domain. Fear of death, for this study, is defined as fear of death and of caring for dying people and their families. A pragmatic paradigm and a mixed method approach were used to explore the feelings and experiences of newly recruited student nurses in relation to fear of death and the care of the dying person and their families. Quantitative and qualitative methods were used to examine the impact of two different interventions intended to reduce the fear of death.

A questionnaire was used to measure aspects of fear of death. The students were then randomly allocated to three groups. The members of two of the groups experienced an intervention, either a psychological self-help programme called 'Do Something Different', (Fletcher and Pine, 2009) or a weekly group meeting that explored relationships and the use of spiritual strategies based on Family Constellation theory (Hellinger, 2006). The third group acted as a control. After a period of time in clinical practice, the questionnaire was administered again and the results analysed and interpreted. The relationship between the students' fear of death and their age, previous experiences, ethnicity and spiritual beliefs was explored. Findings indicate that the interventions had a positive influence on reducing the students' fear of death.

The qualitative part of the study involved semi-structured interviews with fifteen of the students who had completed both questionnaires. Their experiences of preparation for caring for dying people and of being in an intervention group were discussed. The interviews were analysed using interpretive phenomenological analysis (IPE). Influencing factors from home, such as cultural issues, and from within the clinical context, such as mentorship, were identified.

The thesis contributes to nursing education and practice by showing that early preparation for caring for dying people can be effective in reducing fear of death. Results demonstrate that there is value in using strategies to help the student to develop emotional and spiritual intelligence in order to prepare for aspects of dying, before they experience the death of a patient. This preparation enhances the quality of the therapeutic relationship between student and patient. Another outcome is that students need a particular quality of support, at home and in clinical practice and that there are particular implications for Black, Asian and Minority Ethnic (BAME) students. Mentors of students need to be trained to be sensitive to the students' needs when caring for people who are dying. Greater attention to preparation for death and care of the dying is likely to enhance the provision of end of life care and may also reduce attrition in first-year student nurses.

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Chapter 1 Introduction

The life of the student nurse can be stressful. One of the identified fears affecting stress is the care of people who are dying (Reeve et al, 2012). This study seeks to inquire into fear of death in student nurses and how this might be ameliorated through teaching and learning interventions. Fear of death, for this study, is defined in full as fear of death and of caring for dying people and their families. This care is influenced by two national policies, the End of Life Care Strategy (DoH, 2012), and the National Leadership Alliance for the Care of Dying People (2014).

A mixed methods approach was used to generate knowledge regarding fear of death and possible strategies to reduce these feelings. As a nurse teacher and module leader, the problem before me was founded on evidence that, despite best efforts by the programme team, the experiences of some first-year student nurses can include such difficult challenges that their continuation on the programme becomes untenable for them.

The aims of this research were to:

1. Gain an understanding of the fear of death in a group of first-semester student nurses.

2. Evaluate two strategies designed to reduce fear of death in first-year student nurses by strengthening aspects of the affective domain.

3. Explore the relationship between students' fear of death and gender, age, prior experience, ethnicity and spiritual affiliation.

4. Gain an understanding of factors that affect the feelings of students who are caring for people who are dying and their families in clinical practice.

5. Identify teaching and learning strategies that help to reduce fear of death.

Through my involvement with first-year students, I developed an interest in exploring strategies that might emotionally strengthen these students in terms of supporting them through difficult experiences. This research, therefore, was concerned with the development of the student

nurses' skills within the affective domain, the realm of feelings. Two aspects of this domain are explored.

The first aspect is emotional intelligence (EQ). Mayer et al. (1999:267) defined emotional intelligence as "an ability to recognise the meanings of emotion and their relationships, and to reason and problem-solve based on them". EQ is acknowledged here as a concept that helps me to understand approaches to strengthening the student through the affective domain.

Spiritual intelligence (SQ) is the second aspect of the affective domain to be explored. The definition of spirituality, for the purpose of this research, was taken from the work of Koenig et al. (2012:46). They stated "spirituality is distinguished from other things – humanism, values, morals and mental health – by its connection to the transcendent". They went on to say that spirituality is intimately connected to the supernatural and religion, extending beyond religion, but including a search for the transcendent. Spiritual intelligence applies this concept. Zohar and Marshall (2004:3) defined spiritual intelligence as "the intelligence with which we access our deepest meanings, values, purposes and highest motivations. It is how we use these in our thinking processes, in the decisions that we make and the things we think it is worthwhile to do".

In all nursing interactions, emotional intelligence is necessary in order to deliver compassionate care in appropriate ways. When it comes to caring for dying people and their families, an extra dimension to this intelligence is required because dying people are in a unique transitional state. This is where the skills of spiritual intelligence are relevant. Spiritual intelligence allows nurses to express their capacity to understand the spiritual nature of death across a diverse patient group.

Two strategies addressed the emotional and spiritual aspects of the affective domain. One of the strategies (intervention 1: Do Something Different, DSD) was a self-development programme based on a psychological theory developed by Fletcher (2000). The second one (intervention 2: Family Constellations) was a facilitated weekly group meeting to explore family issues. This intervention was based on theoretical work that suggests spiritual strategies for resolving difficult personal issues (Hellinger, 1998). A third group served as a control and, therefore, received no intervention.

It was hypothesised that by implementing these interventions and thereby strengthening aspects of the affective domain of the learner, the student nurse would experience a reduction in her[1] fear of caring for dying people and their families (Research Aims 1 and 2). This was tested by the use of an established pre and post questionnaire given to the student nurses.

Demographic information collected from the questionnaire provided data that allowed me to start to explore the relationship between students' fear of death and their gender, age, prior experience, ethnicity and spiritual affiliation (Research Aim 3).

The results provided an insight into the efficacy of the two interventions. The impact of the two interventions is probably very complex, and not reducible to one measure or one factor as measured in the questionnaire. Therefore, further exploration was undertaken to gain an understanding of the more qualitative results of the interventions. This included an exploration of the students' experiences of the strategies and of relevant experiences in clinical practice. Interviews with members of the three groups allowed for rich data to be gathered regarding the students' management of fear of issues surrounding death and the effect of the interventions on their feelings in relation to fear of death (Research Aims 1, 2, 3, 4 and 5).

The thesis is structured as follows. The development and context of nurse education are addressed, providing a history and an academic geography to the research. Awareness of attrition and how this shapes the political context of nurses completing their programme is part of this context. This is discussed, leading to an exploration of the stress experienced by student nurses, particularly in relation to caring for people who are dying and their families. I then show how the two chosen strategies are related to nurse education, attrition and stress, and conceptualise the concepts of emotional and spiritual intelligence, which I argue are the key components of the affective domain. The methodology and chosen methods are then discussed, including ethical dimensions. The results are reported and discussed, followed by conclusions and recommendations.

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1. Approximately 90% of student nurses are women (NMC, 2012) and so I will refer to the student as female throughout this dissertation.

Chapter 2 The preparation of the professional nurse

This chapter sets the scene in terms of the particular nature of nursing and the preparation of a nurse. A student will enter her professional preparation with a set of previous experiences and expectations. How these are focussed and honed, so that she becomes a highly competent and compassionate practitioner, is partly the responsibility of those in nurse education, as well as the student herself.

Knowledge, skills and attitudes are developed in the novice to facilitate her transformation to expert (Benner, 1984). There are practical, ethical and psychosocial dimensions to consider. Part of the role is not only to care for people at the end of their life, but also to support the person's family and friends. In this chapter, I discuss the development of the profession of nursing and how the care of dying people has always been a central consideration. At the heart of this, I argue, is spiritual care, so the history and development of spiritual care in nursing will be reviewed. Socialisation and the development of the nursing profession, in terms of the weighting that nurse education gives to the affective domain, will be included. The development of nurse education will be then be explored.

The educational domains (Bloom, 1956) in relation to nurse education will be explored, considering, in particular, the affective or feeling domain. The idea of competence will be examined in terms of the assessment of care and compassion. The chapter will conclude by exploring the development of aspects of the affective domain within the context of the provision of holistic nursing care at the end of life.

2.1 Spiritual care and care of the dying

In order to develop teaching strategies that address feelings of fear of death, an understanding of both the history and the development of the nursing profession, and of spiritual care and care of the dying within this, is important. This will provide a backdrop to the educational context of nursing and where the affective domain plays its part.

Nursing arose out of the work of nuns in the religious orders and the use of the term 'Sister' endures. Nelson (1997) points out that spiritual care in medieval times will have been a significant part of the carer's role. Spiritual issues continue to be central to the provision of

effective care when looking after dying people, despite nurses today working within a secular context (Wright, 2008). The identification of a context of spirituality contributes to my research by sensitising the study to the effects of fear of death on students when they are nursing dying people.

Nurse training, outside the control of the church, was started by Florence Nightingale at St Thomas's Hospital in London in 1860 (Baly, 1977). By 1923, the General Nursing Council (GNC, 1919-1979) had standardised a syllabus that, as Bradshaw (2013) pointed out, changed minimally until 1977. Bradshaw (2013) questioned the type of attributes demonstrated by women in the early days of the emerging profession of nursing. She concluded that the profile of the profession developed throughout the 20th Century, from a public expectation that the nurse would practice Christian virtues towards a more secular, professional image. The nurse historian, Nelson (1997) earlier argued that professionalisation occurred in Ireland some time before Nightingale's work, but was then wholly based within a Roman Catholic framework. She highlights the fact that in the 19th century, many illnesses were highly contagious and anyone entering into the homes of the poor and sick was likely to fall ill themselves. Nursing, therefore, required a "singular trust in providence" (Nelson, 1997: 8).

Caring for people holistically involves the recognition that there is a spiritual dimension to every person. Nelson's thesis is that the professional nurse of today is not separate from, but rather is an extension of, the religious orders of women into a contemporary context of secularisation. She argues that there has been a thread of spirituality, as part of the job, since the beginnings of professional nursing and that this spiritual underpinning of nursing has passed through Catholic and Protestant times and now moves into a secular milieu (Nelson, 1997). This argument, that spiritual care is an essential part of effective holistic nursing care, was reiterated by McSherry & Ross (2010) who considered ways of assessing the spiritual needs of patients.

Burkhardt (1989:70) provided a definition of spirituality in nursing as "that which gives meaning to one's life and draws one to transcend oneself". The former clause ("gives meaning") appears to imply a state of mental health, but the latter is more purely spiritual in terms of transcendence, where transcendence can be internal, external or both. The Oxford Dictionary (2015) defines transcendence as 'existence or experience beyond the normal or physical level'.

Definitions of spirituality appear to involve a connection with something external as well as an internal state. The connection to an external concept might be a religion or nature, or an abstract concept such as love. In this research, the following definition of spirituality will be used in order to avoid contamination with mental health concepts. Koeneg et al. (2012:46) state "spirituality is distinguished from other things – humanism, values, morals and mental health – by its connection to the transcendent". They go on to define spirituality as "intimately connected to the supernatural and religion, and extends beyond religion, but includes a search for the transcendent" (Koeneg et al, 2012:46). Spiritual intelligence applies this concept. Zohar and Marshall (2004:3) defined spiritual intelligence as "the intelligence with which we access our deepest meanings, values, purposes and highest motivations. It is how we use these in our thinking processes, in the decisions that we make and the things we think it is worthwhile to do".

Leininger (2002) argued that effective nursing involves consideration of the human rights, the beliefs and cultural needs of the person being nursed. The Royal College of Nursing (RCN) guide, 'Spirituality in nursing care' (2011), echoes this inclusivity by using the National Health Service (NHS) Education for Scotland (2009: p. 6) definition of spiritual care:

> "That care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self- worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires"

All people have spiritual needs, whatever they might call them (RCN, 2011). Spiritual care remains central to nursing, despite the transition into a secular, multicultural society. Cockell & McSherry (2012), carried out research into the spiritual dimensions of the nurse-patient relationship, and several other leaders in the nursing profession have considered the arena of spirituality in nursing (Burnard, 1987; Narayanasamy, 1991; Ross, 1996; McSherry & Draper, 1997 and Wright, 2008). These researchers concluded that high-quality nursing care involves the recognition of the importance of spiritual care in patient interactions. More recently, Lewinson et al. (2015) argue that education on spirituality for student nurses enables them to understand and apply the concepts and to appreciate that these concepts go beyond religion.

The affective domain embraces a range of feelings, but this research will focus on the feelings associated with fear of death. These feelings are connected to the student's spiritual and cultural values, as she brings with her the feelings and beliefs about death that she has developed since childhood. These feelings might affect her capacity to deliver spiritual care. Cockell & McSherry, (2012: 959), state that "spiritual care is closely bound up with dignity in care, holistic care and the perspective of the patient". Holistic care is regarded as essential to nursing and has been explicated as 'the 6 C's'. These are Care, Compassion, Competence, Communication, Courage and Commitment (DoH, 2012).

The rationale for the delivery of nursing care is provided in the theory part of the programme. However, literature supports the view that clinical experiences play a more significant role in shaping the attitudes of the student than academic experiences (Gibbons et al., 2010; Curtis, Horton & Smith, 2012; Reeve, 2013). In order to explore this, and relate this to the provision of spiritual care, there will be a consideration of how students are socialised into the nursing profession.

2.2 The socialisation of student nurses

Timmons & East (2011) observed that nursing is a profession where there is a well-defined hierarchy, uniforms, shift work and also a specialised language. The hierarchy and specialised language is learned during both the theory and practice components of the three-year undergraduate programme. This socialisation is the way in which the student develops the knowledge, skills and identity that is characteristic of the nursing profession (RCN, 2014).

Melia (1987) explored ways that 40 student nurses experienced their placements and became socialised. Through interviewing these students and using grounded theory for analysis, she found that there were several themes to the three-year experience. One of these themes is that of transience. One of the students used the term "just passing through" (1987:102) which referred to the movement to different clinical locations during their programme. Melia (1987) concluded that this could be both an advantage and disadvantage for the students. She found that students needed to be in placements long enough to learn the unwritten rules and expectations of the permanent staff, to get to know the routines and also the patients.

The length of the time in placements can be seen to be relevant to the student's development of clinical skills. In 2002, the Nursing and Midwifery Council (NMC) replaced the United Kingdom

Central Council (UKCC). This governing body now provides no direction on the length of clinical placements (NMC, 2010). According to Espie (2014) it is usual to arrange a longer placement of ten or twelve weeks in a student's final year at the University of Hertfordshire, but placements in the first and second years are usually only two to six weeks long.

Melia was the first to look at the socialisation of student nurses, and this has stimulated a considerable amount of research regarding the development of professionalism among nurses and other health professionals (Hancock, 2005, McKenna, 2009; Newton, 2009; Curtis, Horton and Smith, 2012; Houghton, Casey, Shaw & Murphy, 2013).

The role of the qualified nurse is different from the role in the 1980s, as is the work of student nurses in placements. However, research on the contemporary socialisation of the students has strong similarities with the findings of Melia's research, so it has been useful to revisit and reconsider this work. Curtis et al. (2012) and Houghton et al. (2013) found that, despite significant changes in the structure of nurse education, some aspects of socialisation, such as the problems of transience and the dissonance felt between theory and practice experiences, continue in the UK. The changes in nurse education that have influenced the students' experiences in clinical practice will be considered in section 2.3 and related to my research.

2.3 Learning and the affective domain: theory

Bloom's (1965) classification of educational objectives included clarification of the three domains of learning. These were the cognitive (thinking), psychomotor (doing) and affective (feelings and attitudes) domains. Thus, nursing competencies have traditionally been categorised under the three domains of cognition, actions and attitudes (NMC, 2004a, 2004b, 2010). Bloom's domains help to develop an understanding of the affective domain for the purposes of this study, as they provide a context for the development of intellectual skills, psychomotor skills and affective skills.

The cognitive domain involves knowledge and the development of intellectual skills (Bloom, 1956). This involves remembering, understanding, applying, analysing, evaluating and creating. Simpson (1972) explained that the psychomotor domain includes physical movement, coordination, and use of the motor-skill areas. Krathwohl, Bloom and Masia's research (1973) found that the affective domain includes the manner in which we deal with things emotionally, such as feelings, values, appreciation, enthusiasms, motivations, and attitudes, including

spiritual attitudes. Beliefs within the domain will influence the feelings of the individual in terms of the provision of spiritual care.

The International Council of Nurses (ICN, 2012:2) code of ethics for nurses states, "in providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected". Enhancing this respect for the beliefs and values of the patient lies within the affective and cognitive domains. Spiritual care is related to the development of aspects of the affective domain. From the above it can be seen that the spiritual care of people is part of holistic nursing; that omission of caring for one aspect of a person's life would result in a diminished quality of nursing care.

Although early nurse theorists, such as Virginia Henderson, were publishing in the 1960s, it was not until the next decade that research-based nurse theorists were emerging (George, 2010). It was to take another ten years for their theories (nursing models) to be included in pre-registration nurse education. Since then, a culture of nurse education has developed that has become constructivist and uses socio-cultural perspectives of learning (Chambers, 2013). These authors argue for the importance of student-centred learning, based on Knowles' (2005) concepts of andragogy, with the recognition that student satisfaction is key to success (Jarvis, 2006).

It was suggested by Benner (1984) that the context and content of the undergraduate nursing programme facilitate professional growth 'from novice to expert'. Benner's research showed that student nurses learn to become expert practitioners by practicing skills repeatedly and also from having the opportunities to relate theory to practical situations.

Benner drew on the Dreyfus model of skill acquisition (1980) to demonstrate that the development of knowledge and skills was incremental and that over a passage of time with the right experiences, a nurse can become extremely skilled in a role that requires a complex range of attributes. Benner describes nursing as an "enabling condition of connection and concern" (Benner & Wrubel, 1989:4), which implies a high level of emotional involvement in the nurse-patient relationship (Benner, 1989). The perspective that Benner brought into the profession was valuable here because her research found that the development of a skilled practitioner rests on the development of all three of the educational domains.

Benner (1982) relates a story from one of her research interviewees to illustrate the development of feelings within the affective domain. A young qualified nurse is stopped in the corridor by a man of roughly her own age who wants to know when his very sick father will die. She replies that there is no way of being sure. He asked if there were other people dying on the ward. She said "yes". There was a pause and then he asked her a barrage of questions. "How can you do this job? How can you sleep at night? How can you do what you do?" She had not been asked these questions before but explained to the young man how she had answered these questions for herself. She spoke for about ten minutes about her views of life, dying and nursing. She had thought she would just work on a medical ward for a short time and then she would move to surgical nursing, but that she had now settled there. She told him that it was difficult, that it was emotionally draining and, yes, there were nights when she couldn't sleep. She explained how there was a deep satisfaction in caring for people during their journey to death and how she could care effectively for the person's family during this time.

The nurse then explained that her reward for this strange work was to feel that she had made a difference, that she had made "the rocky road a little smoother for those who had to travel it" (p. 407). The young man hugged her and turned away with tears in his eyes. Perhaps he had been moved by this moment of intimacy and truth between them? This story illustrates the wealth in nursing that can be difficult for other people to appreciate. The reward of those times of very deep connection with other human beings can be enriching and humbling. There might, however, be a price to pay for these deep experiences.

One aspect of Benner's work has been challenged, that of her concept of intuition playing a part in expertise. English (1993) attempted to make this aspect more scientific and made alternative suggestions for explaining this attribute. His critique of Benner's work came from his own background of cognitive psychology. Derbyshire (1994) then countered this critique and pointed out that the philosophical underpinning of Benner's work was based on interpretivism and Heideggerian phenomenology. The conflict between English and Derbyshire's perspectives suggests that there might be some cultural hegemony. This conflict suggests that cognitive explanations are more acceptable to some in the academic community than experiential, more affective learning.

The critiques by English (1993) and Derbyshire (1994) are interesting in highlighting how two perspectives can be used to explore an issue and then reach different conclusions. This

illustrates that there is a range of opinion with regard to learning through the affective domain. It is important that clarity is sought so that misunderstanding is avoided. This is important because finding teaching strategies that might reduce the fear of death when nursing dying people requires un-ambiguity, otherwise students could get confused. An example of this might be the words that students use for death. Some might use the word 'passed' or 'passed away' or that 'the person has gone'. There could be a range of feelings behind these different terms. A proportion of students has English as their second language and could believe that different terms mean different ways of dying. This must be set in a context where the student is learning how to perform within a new setting, with a background of continually changing theoretical input.

2.4 Nurse education

The implementation of the Project 2000 paper (UKCC, 1986) heralded major changes in nurse education. At this time, the UKCC decreed that the programme would consist of 50% each of practice and theory. Therefore when nurse preparation started to move into Higher Education Institutions (HEIs), shortly after this, there was a shift to teaching significantly more theory than ever before.

Chambers et al. (2012) found that academia, rather than skills, is stressed as being important within the higher education setting. They explored the use of heuristics, scaffolding and spiral curricula in order to make learning more discovery-based. They used Bruner's (1960) findings that cognitive development was based on the student being able to build on prior constructs and knowledge, a concept that Bruner had called discovery learning. This led to the perspective of the teacher as a facilitator, rather than someone who would use didactic strategies. Nurse teachers are encouraged, using this theoretical base, to practice student centred learning and to keep lectures to a minimum. Nurse education in HEIs requires the teacher to be registered as a first level nurse and to retain her connections with clinical practice (NMC, 2010, 2010a). In this way, the students see their lecturers as nurses, as well as teachers.

Psychomotor skills can be developed using simulation in theory settings, and then they are developed and assessed in clinical areas. Schiavenato (2009) suggested that using simulation in a theoretical setting allows the use of theory to provide a rationale for practice. The students have the opportunity, in theoretical settings, to practice the skills that they need to develop in their clinical placements. The assessment of these skills in academic settings, as well as in clinical practice, allows insight into their levels of competence (NMC, 2010).

Affective skills, such as the use of empathy, can be learned through role modelling and reflective strategies, but these mainly take place in the clinical placements. Adams (2014) points out that we cannot take for granted that the qualities needed for being an effective and compassionate nurse are present in nursing students. These attributes need to be developed and assessed. 'Knowledge, skills and attitudes' reflects the three domains that Bloom (1965) set out. It can be seen that they are closely connected with each other and that there is an opportunity to develop and assess skills within each domain in order to develop competence.

2.4.1 Competence in nursing

It is the purpose of pre-registration nursing programmes to develop competent and caring practitioners (NMC, 2010). Competence was defined by the NMC (2010:145) as "the overarching set of knowledge, skills and attitudes required to practice safely and effectively without direct supervision". This definition is similar to the definitions used in other countries, although, as Yanhua and Watson, (2011) point out, a consensus has not yet been achieved. The NMC states that nurses must be prepared to be safe and effective practitioners (NMC, 2001). This Order has been translated into Fitness to Practise guidelines (NMC, 2004) and Standards for Proficiency (NMC, 2004a). These were further refined in 2010 by the NMC when they published the 'Standards for pre-registration nurse education'. This document set out the requirements for programme approval or validation, which were used from September 2011 (NMC, 2010).

These standards are based on core competencies and skills clusters; all of which recognise the credibility of using evidence to support the development of the learner (NMC, 2010). Essential skills clusters were developed from these standards and were specified as: skills for care, compassion and communication; organisational aspects of care; infection prevention and control; nutrition and fluid management; and medicines management (NMC, 2010). These skills clusters have been reconstructed as measurable outcomes so that mentors in clinical practice can assess these skills in terms of competence.

In this section I have considered professional documents in order to identify the central role of competence within nurse education. The use of the identified core competences is central to the planning and delivery of the undergraduate nursing curriculum. The word 'caring' is related to competency throughout these documents and standards. Therefore, successive governments

have recognised that a core element of nursing is competence in caring. The first clause in the nurses Code of Professional Conduct is to prioritise people; "You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern..." (NMC, 2015, p.4). Since all nurses are agreed on this issue, then it is relevant to return to the affective domain and consider the development of these attributes in the student nurse.

2.5 Learning and the affective domain: the student nurse

Development of feelings in the affective domain can enhance care through an awareness of needs and an ability to demonstrate empathy. Lyon et al. (2013) found that attitudinal aspects underpin the students' use of caring skills, which involve the use of empathy and O'Brien (2013) argues that empathy can be seen as a spiritual skill. Doyle et al. (2014) considered the literature on empathy and concluded that the evidence illustrated that professional practice is affected by the nurse's attitude, where attitude is part of the affective domain. They suggest that more work needs to be carried out on the affective domain. One reason for this suggestion was connected to their finding that nurses who are suspended following allegations of misconduct, appear to have behaved in a way that illustrates attitudinal problems (Doyle et al, 2014). In order to develop the quality of nursing care, it is important to explore the efficacy of the strategies used in developing these affective skills and attitudes within the pre-registration programme.

One area of this domain is a response to fear. This is related to the student's ability to feel as if she is safe in the clinical areas. However, the evidence appeared to suggest that the students feel fear and anxiety regarding clinical placements (Sheu, Lin &Hwang, 2002; Kim, 2003, Pitt, Powis, Levett-Jones, & Hunter, 2012; Crossan & Mathew, 2013). If a student does not consider the placement to be a safe place, then it would be more difficult both to reduce their fear of death and also to enhance their ability to cope with people who are dying and their families. It was important then, to explore the affective domain and then consider the experiences of student nurses in clinical placements.

Research by Krathwohl (1964) describes the affective domain as relating to learning objectives that emphasise a feeling tone, an emotion or a degree of acceptance or rejection. Review of research which had focussed on the development of the affective domain found that this can involve tacit learning; primarily from experienced practitioners in practice but also from nurse teachers (Pierre, 2007, Neumann, 2008 and Gray 2012). This learning seemed to be influenced

by role models in practice and theory settings (Neumann, 2008), as well as the student's own reflections on clinical and academic experiences.

However, this domain has been difficult to clarify by nurse teachers within the pre-registration curricula, as there seems to be an assumption that students will learn these skills and attitudes in clinical practice, through the role modelling that takes place there. There seems little evidence for this, as my literature search found almost nothing on university lecturers as role models for student nurses. Following on from this omission, Felstead (2013) found that student nurses do not view the lecturer (who teaches clinical issues at university) as a role model. Chow and Suen (2001) claim that the nurses in clinical practice with the student are seen more clearly in this role.

It appears that the affective domain is under-addressed in nurse education (Gray, 2012). Indeed, there appears to have almost been a collective silence from nurse teachers about assessment of the feelings within the affective domain, which, up to now, has been assessed in clinical practice by the nurse mentors.

The Mid-Staffordshire NHS Trust Foundation Enquiry (Francis, 2013) examined the failure to provide high-quality care to the patients of the Trust. The distress of families who witness poor care of their relatives has resulted in a focus on the need to develop the care and compassion elements of nursing.

The NMC's competencies for entry to the register (adult nursing, Domain 1, 2010, p13) stated "all nurses must use excellent communication and interpersonal skills. Their communications must always be safe, effective, compassionate and respectful". These skills and attitudes reflect the development of these aspects of the affective domain. Structures are now being introduced at the University of Hertfordshire that attempt to assess care and compassion in the clinical sites. Students now have to give examples of experiences that exemplify these attitudes. Mentors assess these reflections when determining whether a student can show that they have passed the essential skills (which reflect their attitudes) at the end of each year of the programme (Practice Assessment Document [PAD], the University of Hertfordshire, 2014a). The mentor's assessment process will provide feedback to the student so that she can be aware of the affective skills and attitudes that require further development.

The aims of this research reflect the proposition that more explicit work on exploring and acknowledging the feelings of the student could facilitate the further development of skills and attitudes that arise from within the affective domain. Gray (2012, p59) found that "transformational learning experiences helped student nurses to reflect on their emotions so that they could see the therapeutic value of emotional labour with the patient and sustain high-quality of care in the health services". Further research is called for by Dwyer & Hunter (2015) who recognise the importance of teaching in the affective domain, but also suggest that there is a need for a research agenda that includes intervention studies. This would support the development of evidence based teaching strategies that prepare students for emotionally demanding experiences. Findings from Dwyer and Hunter's literature review support findings from earlier researchers such as Benner (1994); Morton-Cooper and Palmer (1999); Gray and Smith (2000); Hoover (2002); Ewers et al. (2002) and Gillespie (2002).

2.6 Conclusion

This chapter has provided an exploration of the development of the curricula, the place of the educational domains within the curricula and how the student is socialised into the profession. The focus has been on the provision of spiritual care as part of the role of the nurse. Contagion is not usually such a significant issue these days, but the need for care and compassion endures. These qualities affect the skills of nurses, changing a harsh approach to a more gentle strategy. They have translated from being initially practiced by Roman Catholic nuns, to now being practiced by nurses within a multicultural setting, where they themselves might or might not be aware of a set of spiritual beliefs.

A further exploration into the affective domain has linked with the concept of competence in nursing care. The discussion within this chapter has highlighted two aspects of the affective domain that are useful when addressing fear of death, the emotional and spiritual aspects. The deep-seated concept of fear of death is based on psychological and spiritual constructs within the individual (Neimeyer, 1994). The affective domain addresses the way in which people deal with emotional aspects. This includes exploring feelings such as values, enthusiasm, and motivation. These feelings relate to the person themselves (emotional aspects) whereas other feelings relate to the more transcendental, such as appreciation of beauty and dealing with permanent loss. These are spiritual aspects of the affective domain.

Research by Benner (1984) and Melia (1987), along with later supporting research, suggests that feelings and attitudes play a significant part in the journey to become a qualified nurse. Feelings and attitudes affect the student's ability to care and to be competent. It follows that finding ways to reduce fear of death in student nurses might help the student to become a competent practitioner. Strengthening the emotional and spiritual aspects of the affective domain would help the students to more confidently provide care in emotionally or spiritually difficult situations.

The discussion in this chapter has identified that the dissonance between theory and practice experiences persist (Houghton et al, 2013). This is relevant to my research because it suggests that educators are failing to communicate to students how the theory they are learning is useful to their clinical experiences. My research seeks to reduce the dissonance between theory and practice experience by improving the theory on fear of caring for dying people. The findings of the research on socialisation highlight that students benefit from explicitly relevant sessions that prepare them for clinical practice, rather than information that cannot be related directly (Curtis et al, 2012; Houghton et al,2013). This has influenced the development of more problem-based approaches to education

It is important here to be mindful that the student is experiencing learning within a multitude of nursing contexts and that I am focusing on exploring the student's feelings in relation to death. Feelings of being unable to cope can often lead to students not being able to complete the pre-registration programme (Crombie et al, 2013). Because of this, it is important to explore the aspect of attrition in nurse education and to relate it to the research undertaken. Attrition helps us to see the challenges of the programme from a different perspective and to evaluate the consequences of stressful experiences for the student. As fear of death is one of these challenges, it is necessary to consider if attrition is affected by this particular fear.

Chapter 3 Students who prematurely leave the programme

The UK Higher Education Statistics Agency (2015, online) defines attrition as "non-continuation following year of entry". A significant number of student nurses do not complete the programme and this appears to be partly due to difficulties in clinical practice. As the feeling of fear of caring for dying patients is central to this study, it is relevant to consider if these feelings contribute to the wastage, or attrition, of student nurses. Attrition literature provides insights into the feelings of student nurses and the effects of these feelings on the decision to complete the programme or to leave. These insights demonstrate the effects on the student of fear of caring for dying people and their families.

In this chapter, I will firstly consider the context of attrition within nurse preparation, as distinct from other professions. There are financial implications for both the student and the Higher Education Institution (HEI). These will be explored because these data provide a context to the scale and relevance of the student leaving prematurely. This will lead into the causes of attrition, with a discussion regarding the contribution of attrition research to the understanding of the student's experience of clinical placements. An exploration of the research carried out in this area also gives insights into strategies that might help to strengthen the affective domain.

Leaving the pre-registration programme can sometimes be the best thing for the student nurse and for the profession. A proportion of students will not meet the academic or clinical expectations (Pryjmachuk et al, 2009). Also, some people could realise that the role of the nurse is different from the one envisaged and that this is not the profession for them. However, the opposite can also be true. Students might feel confident to be continuing on the programme and then circumstances dictate that they must discontinue. This could be disappointing for the student, who might have invested financially and emotionally in their preparation to be a first level nurse and see this as a considerable loss. Currie et al. (2014) suggest other losses, in that attrition could imply mistakes in recruitment or lack of support for the individual, and that these might affect the HEI's reputation. There will be a reduction in the number of the local Trust's workforce projections and there will also be the cost of financial penalties to the HEI. An exploration of the factors influencing attrition will help to set the scene for the importance of interventions that strengthen feelings within the affective domain.

3.1 The context of attrition in nurse education

The National Health Service (NHS) Foundation Trusts annually commission HEIs to prepare the number of nurses that will be needed three years later. The money follows the student, with the funding coming ultimately from the Department of Health, rather than the Department for Education (DoH, 2006). The NHS is enduringly money-conscious; there seems to be insufficient resources for all that is required. Attrition costs money; there is a significant wastage when a student does not graduate and go on to work in the NHS. It costs £34,437 to train a degree student (Crombie et al, 2013). The NHS pays for the financial support of the student (bursary) and also the tuition/resource fees, so that when a student leaves the programme, the wastage of these sums is significant.

Traditionally, the group of students that commence a programme at the same time is called a cohort. Waters (2010) found that attrition in England for the cohort that commenced in 2005 had been 28%. This large percentage led to questions being raised regarding recruitment and retention. In 2007, a formula for attrition calculations was implemented which was based on numbers completing the programmes (DoH 2006, DoH 2006a). The cost to the NHS in 2007 was in the order of £108 million (Waters, 2010). It can be seen that this is a significant financial cost to the country. The standardising of the data collection from 2007 has led to financial penalties being levied on HEIs that have higher than agreed levels of attrition, which are usually at around 13% (Deary et al, 2003; Price, 2002). However, it is estimated by Currie et al. (2014) that average attrition in nurse education is between 25% and 30% and has not improved in the last decade.

Although financial and institutional aspects of attrition are important, it is more relevant to my research to think in terms of the human costs. If a student is led to believe that she has the attributes to become a first level nurse, and then clinical practice is too challenging for her to continue, then there is significant disappointment for her and her family. There might also be the loss of the opportunity for her to fulfil her potential for caring for others.

3.2 Influencing factors in attrition

Factors identified in the literature as affecting attrition are age, gender, religion, ethnicity and previous experience. Research by Pryjmachuk et al. (2009) showed that the youngest students, men and those from Black, Asian and Minority Ethnic groups were more likely to leave the

programme prior to qualification. Personal reasons for leaving appear to be an issue in all UK schools of nursing, but 'personal reasons' also appears to be an umbrella term used in international research that encompasses anything that is not covered by the other main categories.

Pryjmachuk et al. (2009) looked at 1259 records and found that these other categories are financial problems, academic failure or ill health and that the official reason was often more complicated than the official categorisation seemed to indicate. Table 3 shows contributing reasons for leaving that were given by students. The researchers did not consider the relative weighting of each of these four reasons. Many contributing reasons can be allocated to more than one of the four reasons. Even the category of academic failure could be seen to potentially include 'personal issues', as students who are not happy might not perform well in assessments, and might even sabotage their own careers. Similarly, the category of ill health could also encompass problems related to the stress of the nursing programme. These could be stress from academic demands, or the concerns associated with clinical practice, such as care of dying people. This demonstrates the interrelated nature of the reasons for attrition.

Table 3. Official and contributing reasons for attrition (Pryjmachuk, 2009).

Official reason given for attrition	Contributing reasons
Personal	Relationship breakdown, childcare, travel problems, housing, time management, dislike of the programme, problems in clinical placement, finance.
Financial	Housing, loans, travel issues, books, childcare.
Academic	Unable to manage coursework, failure to achieve outcomes, time management, learning difficulties.
Health	Reactions to immunisation programme, stress related issues (theory and/or practice), disabilities or accidents.

An early part of this doctoral research included a survey that was undertaken with students in their first week of the programme, in order to explore their reasons for entering nursing (Goode, 2009). The results of the self-completion questionnaire showed that around half of the cohort had entered nursing for altruistic reasons and the other half for self-serving reasons. This small-

scale enquiry also explored barriers to progression perceived by student nurses in their induction week. Their position related to known 'at risk' factors was measured, along with their motivation for entering the profession and the perceived barriers. It was found that students considered four main areas to be possible barriers. These were domestic responsibilities; assignment stress; time management and clinical experiences. Although the results of this enquiry cannot be generalised, as the numbers were small (n=279), the findings suggested that students have concerns regarding their progression from the first week in the programme. These findings reflected the findings of published research on attrition (Pryjmachuk, 2009; Eick et al, 2012).

The value of these findings is that they suggest that students experience stress from the beginning of the programme and that one of their concerns is their ability to cope in clinical areas. Strengthening feelings within the affective domain could help to address these concerns and, therefore, have a positive effect on reducing the need to leave the programme prematurely.

The proportion of student nurses leaving programmes in the UK early due to personal issues appears to be approximately half of those who discontinue (Waters, 2010). It is difficult, however, to disentangle what this term 'personal issues' means. Glossop (2002) suggests that these include difficulties related to home and family life. Yorke (2000) mentions changes in personal circumstances being important and Waters (2006) includes difficulties with childcare arrangements. These authors accept that concerns regarding fear of clinical practice affect these difficulties. Thus, the fear of caring for people who are dying could be seen as part of a set of feelings that come under the category of 'personal issues' (Eick et al, 2012).

The reasons for leaving are so complex that the Department of Health (DoH, 2006) has termed this 'a wicked problem'. The word 'wicked' is used to represent the interplay of the issues. The difficulty in collecting data from students who are withdrawing is that there might be a subtle entanglement of several contributing factors in their decision. "The whole point of studying a 'wicked problem' is that it is not possible to predict an effect by looking at any one of the variables in isolation – it is the combination of all the variables which produces the observed overall effect" (DoH, 2006, p.15).

3.3 A review of the literature on attrition and clinical experiences

The databases for literature relating to strategies to reduce attrition were searched, as these would provide insights into strengthening aspects of the affective domain. I was looking for articles that were recent because the context of nursing has changed significantly over the last few years, since the Winterbourne review (DoH, 2012a). It seemed important to find research that reflected the cultural demographic of the students in Hertfordshire, as this would make the findings more useful. The results were examined to find articles relating to students' concerns regarding clinical experiences.

As I am exploring the effect of fear of caring for dying people, the consideration of difficult clinical experiences is relevant here, as these placements are the locations in which people die. Three particular articles focused on clinical experiences. One article relates specifically to the issue of the feelings of the student nurse and related these to attrition (Eick et al, 2012). The second article looks at the culture within the clinical placement (Crombie et al, 2013). These two articles serve to highlight the issues that can make the clinical experience challenging for the student nurse.

The final article examined is one that explores the effect of strategies to reduce attrition (Harris, et al, 2014). These three papers were appraised using the Critical Appraisal Skills Programme (CASP) framework for analysing research (2013). The CASP checklists assist in the evaluation of the efficiency of several methods of research (Appendix A). These three articles are going to be discussed in the following sections.

3.4 The effect of clinical placements on attrition

Eick et al. (2012) carried out a systematic review of studies regarding placement-related attrition. The authors synthesised the information from 18 chosen papers using a narrative summary and produced an ordered narrative description of the evidence. Themes emerged that included reasons for leaving and attributes of the students. The three researchers found that difficult placement experiences contributed significantly to a student's decision to leave the programme. They identify that some students find it difficult to cope emotionally in these clinical placements.

These findings found that mature students (over 25 years old) with clinical experience have more resilience than younger, inexperienced students. Eick et al.'s (2012) analysis found that clinical placements where death is a frequent occurrence could be more difficult for students than being placed in areas where death is unexpected. Their findings led them to suggest that placement experiences and placement related factors are instrumental in a student's decision to leave the programme.

The researchers recommended that more research be carried out in supporting younger, more inexperienced students and to also examine the student journey in more depth. These findings were also reflected in a publication written by a group of American final-year student nurses (Marcial, Brazina, Diaz, Jaramillo, Marentes, & Mazmanian, 2013). The group discussed the findings of a large American study on trained nurses (Burtson & Stichler, 2010), which had concluded that the amount and nature of stress on a nurse might lead to a condition called 'compassion fatigue' which might also lead to 'burnout', or emotional exhaustion. Burtson & Stichler (2010) had suggested that the factors that can lead to this state are many and complex, but can be summarised as stress factors in the work place combining with stress factors at home, making continuation impossible.

This contrasts with the work by Eick et al. (2012) who found that stress factors in clinical placement contributed to attrition. However, Eick et al. had not included home factors in their research. Burtson and Stichler (2010) also found that before the nurse leaves, patient care could be negatively affected. Marcial et al. (2013) voiced their concerns that this might happen to them in the future. They wondered why more emphasis on emotional health was not part of their programme.

Marcial et al.'s (2013) paper is valuable to my research because students here have a voice, which has not been filtered through teachers or researchers. Their concerns reflected what the students were feeling in their college. This perspective is useful, as my research seeks to gain an understanding of factors that affect the feelings of students who are caring for people who are dying and their families in clinical practice (aim 4). This will help in identifying teaching and learning strategies that reduce fear of death (aim 5).

3.5 The culture of clinical placements

Crombie et al. (2013) carried out an ethnographic study in the London region in 2011, following 50 second-year student nurses. They wanted to investigate factors within the context of the provision of care that enhance rates of completion of the undergraduate programme. This article contributes to my research because the context of the care provided will also affect the fear felt by first-year student nurses in caring for people who are dying. The research is also located geographically in a similar region to my research in Hertfordshire.

Results reflected previous research (Timmins and Kaliiszer, 2002) and echoed Melia's seminal research on socialisation (1987) in that the majority of students talked of the stress of placements and the need to comply in order to survive. A set of attitudes was needed in order for the student to feel as if she 'fitted in'. One student described these attitudes as "non-threatening and non-challenging" (Crombie et al, 2013 p.1284). The students felt a need to comply with the permanent work force. This need to 'fit in' and comply means that the socialisation of student nurses in the practice areas has changed little since Melia's research (1987), even if the politics and hierarchical structures have changed significantly in the interim.

Most students found experiences in placements to be difficult in a number of ways that focussed on believing themselves not to be visible and not being respected. Racism was identified as an experience that was endemic. The feelings that arose were a major factor in deciding to leave the programme. These findings provide a context for a student who might then be asked to deal with extremely difficult experiences, such as caring for a dying person and their family. It can be seen that, without other support mechanisms being in place, such as strong family support, the student could consider the experience too difficult and decide not to continue on the programme. Crombie et al. (2013) found that social support mechanisms, including friends and family, were imperative for continuation on the programme. Parents of the students seemed to play a significant part of their support network. The mature students seemed to have more resilience to the stresses of clinical placements.

The research identified the key role of the mentor in the workplace. If this relationship is not successful, this can cause a great deal of stress to the student. Many students became distressed when they related stories of working with unkind mentors. The researchers concluded that although the NMC has standards in place for the preparation of mentors (NMC,

2008), there are mentors that do not demonstrate these standards. Conversely, a clinical culture of kindness seemed to evoke high praise from students.

The factors in table 3.1 can be seen to be key concepts, in terms of the support needed by students in practice. These concepts will be explored in greater depth in the next chapter, as they will influence the way that new students could be prepared for their first clinical experiences.

Table 3.1 Factors that provide a supportive clinical experience (Crombie et al, 2013)

- Resilience
- Social support mechanisms (family and friends)
- Maturity
- Kindness from mentors
- A clinical culture of kindness

The result of Crombie's (2013) research was the finding that the students' experiences in clinical practice have the greatest influence on their ability to complete the programme. There is value in this finding that relates to my research because it implies that preparation for placement experiences will affect the experiences of the student. My research sets out to explore the effect of strengthening the affective domain of the student nurse with regard to caring for dying people and their families. By considering these particular concerns about fear of death prior to their arrival in placements, strategies might be constructed that enhance the experience of the student and result in the perception of a positive placement.

3.6 Strategies to address and reduce attrition

Harris et al. (2014) carried out a three-pronged approach to address and reduce attrition in a mid-west American school of nursing where there was a multicultural population. The presence of a multicultural population is characteristic of many South Eastern English universities (Equality Challenge Unit, 2011) and certainly true of the University of Hertfordshire (Student profile analysis, University of Hertfordshire, 2014).

Harris et al. (2014) were trying to focus on non-traditional students, as the literature suggested that this group is more at risk of attrition (Gilchrist & Rector, 2007). These include the mature

students, those from ethnically diverse backgrounds and those with non-standard entry qualifications.

The researchers used the following strategies: a targeted student success programme, more culturally sensitive teaching and re-evaluating the admissions standards. Through their research, they found that the student success programme was not statistically successful in terms of reducing attrition but was effective for the at-risk students who had been previously identified, in that these students passed the module. The students highly rated the interaction within the support programme and appreciated the culturally sensitive teaching, but felt that there was a lack of time for the extra input of the student success programme in the student day and that to attend extra sessions was stressful. The researchers concluded that the student support programme might have been more effective if delivered before the main programme. The researchers suggested that changes to the admission standards would affect attrition, but that waiting lists of students who met previous criteria meant that it would take time to be able to measure the effects of higher entry requirements.

Harris et al. (2014) recommended that attrition be considered from many angles and that raising entry criteria is the most likely strategy to make a difference. They also suggested that changing teaching to be more culturally sensitive would have a positive effect on reducing attrition. Providing more student support mechanisms can be effective for all students, not just those deemed at risk. However, as Harris et al. found, the timing for these sessions should not put further time pressures on students. The fact that Harris et al. only targeted 'at risk' students, limits the generalisability of their findings. However, these findings are relevant to my research on the affective domain, as they raise important considerations. These are the need for cultural sensitivity with students and for the mindful planning of the student support programmes.

The feelings of the students will reflect their cultural background as well as their previous experiences. The UH student profile analysis (2014) reflects that the students at the University of Hertfordshire reflect a wide diversity of cultures and that 47.4% of the students are from black and minority ethnic families. It is important to recognise and respect the cultural diversity of the population under consideration.

3.7 Conclusions regarding relationships between attrition and clinical experiences.

It has been seen that attrition is a complex issue and that there are many factors that contribute to the decision by a student to leave the undergraduate programme. Attrition is a significant problem to nurse educators and can be expensive in terms of time, money and resources, as well as having ethical implications. Many students have had clinical experiences that contributed to their decision to prematurely leave the programme. Anxiety in the clinical placement also leads to further fear of that anxiety causing the student not to perform well and perhaps harm patients (Marcial et al. 2013).

From a review of the research on the relationship between attrition and placement experiences, it can be concluded that the clinical experiences of the student are a significant influence on whether she stays or leaves the programme. Therefore, clinical experiences are important factors for nurse educators to consider (Eick et al. 2012). Students are involved in a range of affective experiences when they enter the programme. Harris et al. (2014) found that the feelings evoked by these experiences reflect the ' age, gender, culture and previous experiences and that these demographic factors will influence their decision to continue.

It will be helpful to investigate further, from the student perspective, the impact of these factors on fear of death. Research findings from Crombie et al. (2013) and Harris et al. (2014) illustrate the importance of support mechanisms, both in clinical placements and externally. It is hoped that my research will indicate effective strategies for strengthening the affective domain of the student. Although this is only one factor in attrition, this could contribute to the reduction of fear felt in clinical practice and empower some students to stay on the programme. Feelings of fear, anxiety and stress are explored in more depth in the next chapter.

Chapter 4 Feelings of fear, anxiety and stress in student nurses

The incidence of stress in England appears to be a serious phenomenon that affects society at several levels. An individual who is experiencing stress can find that this affects their families, their workplace and their community. The Health and Safety Executive Statistics (HSE, 2013:1) define work-related stress "as a harmful reaction people have to undue pressures and demands placed on them at work". HSE figures (2013) show that in 2011/2012, the number of workers who suffered from work-related stress in England was 383,000. The regions with the highest prevalence appeared to be the North East, Yorkshire and the South West. Those with the least prevalence were the West Midlands, East and London regions. Prevalence has not changed significantly since 2001/02 apart from West Midlands and London, where rates have reduced. The number of working days that were lost due to work-related stress in 2011/12 was 10.4 million days (HSE, 2013), indicating that feelings of stress affect not only individuals but also affect the functioning of our society.

The HSE reported that in England, Wales and Scotland, the occupation with the highest estimated prevalence rate of work-related stress averaged over the last three years (2009/10 - 2011/12) was nursing, with 2,730 cases of work-related stress per 100,000 people working in the last 12 months. The next occupational group was teaching and education professionals with 2,340 cases per 100,000 people. These occupations have statistically significantly higher estimated prevalence rates of work-related stress than across all occupations averaged over 2009/10 - 2011/12 (HSE, 2013). Although no specific data were available for England, these figures demonstrate that nursing is a stressful occupation and that these feelings have an impact both on the individual and the profession.

There is a wealth of literature to suggest that stress is a factor in the experiences of student nurses and that this affects their progression through the profession (Sheu, et al. 2002; Kim, 2003; Pitt et al. 2012; Crossan & Mathew, 2013). Student nurses need to deal with the same challenges in life as other people, but they also have particular issues that are unique to being a student nurse.

Nursing involves helping people who are in pain and those going through difficult life events. That there is stress in many aspects of nursing is indisputable. As Nelson (1997) pointed out,

nurses until the 20th century had the stress of potentially contracting quite horrible, fatal diseases from their patients. When I was nursing in the early nineteen-eighties, caring for people with AIDS led to similar concerns. Ebola virus, SARS, avian flu and other fatal viruses can also provoke contemporary feelings of fear, despite knowledge and understanding of routes of contamination being clear and prescribed precautions being robust.

Causes of feelings of stress for nurses can be diverse, as new people and new situations are being encountered every day. This chapter will explore the terminology of stress and then goes on to consider aspects of stress in nursing. It will be seen that the awareness of a state of stress arises from feelings such as fear and anxiety (Davis et al. 2010). One type of fear that leads to stress is the fear of death, which will be discussed in depth in the following chapter.

4.1 The terminology and incidence of stress

The term 'stress' needs to be explored briefly here, as it is ambiguous and clarity will serve to illuminate the aspect of fear of caring for dying people. Stress is an English term that has been derived from the Latin word 'strictus', meaning tight, strict, narrow (online etymology, 2015). Baltas and Baltas, (1990) state that, in the fourteenth century, the word was defined as 'difficulty, problem or bad luck', and that writers in the seventeenth century defined stress as 'disaster, trouble or sorrow'. In the eighteenth and nineteenth centuries, the definition developed into 'force, pressure and obligation' and later it came to mean enforcements against humans, organs or psychological structure (Baltas and Baltas, 1990).

Selye developed the concept of stress in 1936, whilst exploring the common physiological responses that seemed to be present in all serious illnesses. Selye suggested that stress was the body's defence reaction to excess provocation. Selye (1936:32) used the word stress to describe this "non-specific response to any demand on the body of any kind". Much later, in 1976, Selye, to denote that which provoked the stress response, used the word 'stressor'. The research that ensued explored many aspects of the physiological responses to provocation. Selye's work has provided a foundation of understanding of the nature of stress in that it is a physiological reaction within the body. His work led to others exploring the more psychological and emotional aspects of this reaction.

The concept of stress can be distinguished from the concepts of anxiety and fear. Davis et al. (2010) explain that although the symptoms of fear and anxiety are very similar, considering the

neuro-chemical distributions in the human brain can enable physiologists to differentiate them. Davis et al. (2010) define phasic fear as a state of apprehension that begins rapidly but dissipates once the origin of that feeling is removed. If the origin of the fear is not removed, then sustained fear is experienced. Sustained fear can also be brought about by less specific stressors, or those that are at a more significant physical or psychological distance than that which can trigger phasic fear (Davis et al. 2010). One example might be the sight of a spider. For some, this would trigger phasic fear that would dissipate if someone removed the spider. For some, though, the thought of a spider would be enough to produce sustained fear.

It is not clear from Davis et al.'s (2010) research how long phasic fear can last; although in rodents it appears that the duration is several seconds. When sustained fear lasts minutes, it is known as anxiety (Davis et al. 2010). There seems to be little research on the duration of these stages. Many humans will have experienced anxiety continuing for a significant period of time. Current research into neuro-physiology seeks to clarify this (Vytal et al. 2014). These affective elements of stress are important to recognise because feelings of anxiety regarding caring for dying people could contribute to the student's feelings of stress. Pryjmachuk et al. (2009) found that these feelings can produce physical symptoms of illness, which lead to a premature exit from the undergraduate programme.

Kurebayashi et al. (2012) in their research on stress in student nurses, describe anxiety as an emotion characterised by tension and physically exhausting alertness, where there is a focus on a sensation of imminent and inevitable danger. Stress is "almost always seen as something negative that results in impairment of the individual's global performance" (Kurebayashi, 2012:128). This reflects the findings above that sustained fear leads into anxiety and that stress can be destructive.

To summarise, stressors can produce feelings of fear that might become anxiety. Over time, the individual perceives this as stress. The identification of 'being' stressed can go on to produce further feelings of anxiety (Kurebayashi et al. 2012). Meanings of the terms such as fear, anxiety and stress seem to differ between researchers. After a consideration of the meanings of these terms, in my research the term stress refers to the longer-term feelings of apprehension arising from the specific fears, such as those surrounding death and dying felt by student nurses. A specific fear is where there is a perception of the origin of the fear (Kurebayashi et al. 2012). Examples of a specific fear might be fear of the sight of a dead person, fear of uncontrollable

bodily fluids, fear of families of dying people or a range of other circumstances. These fears will be explored in the next chapter.

4.2 Stress in student nurses

High stress levels have been reported following studies on nursing students, and in some cases these stress levels are higher than those of students in other health professions (Beck et al. 1997). Student nurses have attributed their stress to academic, financial, work-related, and interpersonal circumstances (Beck et al. 1997; Kendrick, 2000; Suresh et al. 2013; Galbraith et al. 2014). These studies suggest that high stress and anxiety can impede concentration, memory, and problem-solving ability. Kendrick (2000) suggests that this progresses to adversely affecting the student's ability to retain information and can result in impaired academic performances. This outcome could lead to further anxiety and then increased stress levels.

The RCN's (2013) small survey on stress found that student nurses (n=56) had lower levels of perceived wellbeing than trained staff with regard to control over their work, their role and change within the workplace. This survey also found that a higher proportion of students than trained nurses had experienced verbal or physical violence from patients or service users. Also, 33% of the sample had experienced workplace bullying from a colleague, as opposed to 21% of the trained staff. This finding indicates that verbal or physical violence against students is an important issue to be considered in terms of their clinical experiences.

Kurebayashi et al. (2012) tested for both stress and anxiety in a group of student nurses (n=71) and compared their findings with the results from earlier studies with qualified nurses. The levels of both anxiety and stress were higher in the student nurses. This research, located in Brazil, identified that when stress levels rise in student nurses, then their anxiety levels also rise. As suggested in the last section, this appears to imply that although anxiety is influential in causing the perception of stress, anxiety can also be enhanced by the identification by the individual that they are feeling stressed.

4.3 Stress factors in student nurses

It has been seen that experiencing feelings fear and anxiety can lead to a student nurse identifying stress in her life. The incidence of stress and the aspects of pre-registration nursing that can produce fear and anxiety in student nurses are reviewed in this section. Whilst the

student might experience challenging academic and clinical work settings, they also perhaps have a challenging life at home. Demographic factors will also contribute the level of stress experienced by the student.

Jimenez et al. (2010:443) identified three main sources of stress for students from the nursing literature.
These were:

- Academic stressors, such as assignments and workload, exams, the pressure of grades (or fear of failing) and relations with academic staff.

- Clinical stressors such as patient suffering or death, lack of professional knowledge and skills, handling clinical emergencies and relations with clinical staff.

- External stressors such as interference with daily life and financial stressors.

Jimenez et al. (2010) used two well-tested tools to measure the stress related perceptions of Spanish student nurses. They used the Perceived Stress Scale (PSS, Sheu et al, 2002) and also the Biopsychosocial Response Scale, (BPSRS, Jimenez, 2005) to find out that the most significant source of stress in each of the three years of the programme was related to clinical practice. This finding is important for my research as it suggests that nurse teachers need to consider how best to prepare students for the possible challenging experiences in clinical practice.

The findings from Jimenez et al (2010) supported earlier research by Hamill, (1995); Sheu et al. (2002) and Eifried (2003). Physical symptoms appeared to be less significant than psychological symptoms. Jimenez et al. (2010) found that there was a marked response concerning anxiety, cognitive issues and depression. In the next section, I will briefly consider academic stressors then go on to explore the external stressors. This will be followed by a discussion of stressors found in the clinical setting.

4.4 Academic stressors

Students might feel that academic expectations can lead to feelings of stress. The complexity of life for a student nurse means that there can be an overlap between academic stress and stress

experienced in clinical placements. Reeve et al. (2013:420) found that students "perceive that they have little free time due to the demands of studying". Students have significant academic demands placed upon them while they are dealing with the challenges of day-to-day life, including developing presentations, analysing published papers to discuss in small groups and preparing and submitting formative and summative assessments on time. Some of this workload needs to be carried out while the student is in the clinical placement. Misra and McKean (2000) state that junior student nurses experienced more academic stress due to a lack of coping skills, but that these skills do appear to develop during the programme. These demands combine with other stressors in their personal lives and their clinical experiences.

4.5 External stressors

These challenges might include distances to travel, financial issues and struggles with discrimination. The University of Hertfordshire has an extremely diverse student workforce, coming from a very wide geographic area (UH Student Profile Analysis, 2014). Many students live off campus which means that they are commuting from homes that may be close to the university or to their placement, rarely both. Some students, because of family commitments, attend university and placements from as far as Cambridge, Peterborough, Brixton, and Croydon, which are all at least 50 miles from the University campus (Figg, 2014). For many people, this might be unthinkable, as an early shift will commence at 7.30 am in many clinical placements. It can, therefore, be seen that stress in healthcare placements could be highly influenced by such factors.

Many students appear to have chronic financial difficulties. From my observations with first-year students, a significant number of them do not have enough money to get through the first few weeks of the programme, before their first bursary arrives. They appear to rely on borrowing, which could add to their experiences of stress. This is supported by the findings of the RCN review of stress (2013), which found that 48% of their sample of student nurses experienced levels of stress regarding their finances. Of the qualified staff, 24% had similar worries about their financial status.

The RCN (2013) recognised that stress in health care settings might be related to the experiences of living in a multi-cultural society. The ethnic mix can result in challenges for students when confronted by many different people from various areas of the world. These colleagues and patients might have quite different cultural beliefs and perceptions about illness,

disease, religion and sexual orientations. Helman (2007) identified immigration factors, with laws and restrictions that dictate access to health provisions, as another important source of stress to some healthcare workers.

In Hertfordshire both patients and students represent an ethnically diverse population, although the south of the county is far more diverse than in the north, with the majority of people from Black and Asian Minority Ethnic (BAME) groups residing in the Watford area (Herts Direct, 2007). About a quarter of Hertfordshire students are allocated to Watford for clinical placements at any one time. The proportion of households in Hertfordshire, in 2011, containing residents who were from ethnic groups other than white British was 19.18% (Herts LIS, 2015).

The UH Student Profile Analysis (2014) shows that the University of Hertfordshire has an ethnically diverse student population, with 49.8% of undergraduate students identifying as being from a Black, Asian and Minority Ethnic (BAME) background. In adult nursing at the University of Hertfordshire, the percentage of students from BAME groups is 49.5%, with the majority being black African or black British, originating from Africa (Figg, 2014). It can be seen from these statistics that the University student population is more ethnically diverse than the population of the county in which it sits. Scammell and Olumide (2012) suggest that there could be a particular quality of the experience of BAME students that leads to stress in the clinical workplace, including experiences of racism. This is reflected in the work of Crombie et al. (2013) who found experiences of racism to be endemic in their sample of 50 second-year student nurses in London.

4.6 Clinical stressors

Findings from a robust meta-analysis of qualitative research carried out by Thomas et al. (2012) suggest that the student nurses' experience of clinical practice can be negative, as well as positive. These researchers carried out a systematic literature review and found ten pertinent articles relating to the experiences of U.K. universities; seven of these were English. Thomas et al. (2012) concluded that negative experiences in clinical practice do lead to feelings of stress.

Thomas et al. (2012) also observed that some issues in practice that result in stress have changed little in 20 years, despite significant changes in nurse preparation. The particular stressors identified were pre-placement anxiety; the reality of the ward environment (including culture, reality shock, being a student, clinical issues such as body fluids and significant events,

such as death); clinical learning, including the need to be seen to be developing and becoming a nurse in terms of socialisation, such as terminology and shift patterns. They recommend the consideration by nurse educators of ways to enhance 'emotional resilience'. Luthar (2000:544) defines emotional resilience as 'enabling people to put unpleasant and painful episodes to one side, which allows them to move forward with life'. In my research emotional resilience is addressed as emotional intelligence and will be discussed in the next chapter Thomas et al.'s findings were supported by Galbraith et al. (2014), whose quantitative U.K. study found that students believed stress to be high in the nursing profession. They concluded that there might be entrenched attitudes to stress that affect how students seek help during the programme.

Suresh et al. (2013) carried out a small-scale research study in Ireland. They found that newly qualified nurses and student nurses experienced stress through working in the clinical areas. Suresh et al.'s (2013) method involved the use of a reputable questionnaire of closed questions (the nursing stress scale by Gray-Toft and Anderson, 1981) plus one open-ended question. This asked for comments and suggestions regarding stress in clinical practice. The response rates were disappointing at 26% (qualified nurses) and 33% (student nurses), but the results showed no significant difference in stress levels between final year students and newly qualified nurses. Suresh et al. do not discuss the reasons for the low response rate. The identified stressors, in descending order of degrees of stress, were in relation to heavy workloads, death and dying, uncertainty concerning treatment, inadequate preparation, conflict with doctors and other nurses and lack of staff support. Although the response rates were low, these findings reflect Jimenez's (2005) earlier findings that the most significant source of stress in each of the three years of the programme was related to clinical practice. Suresh et al.'s (2013) research contributes to the understanding of stress in nursing and also suggests that interventions for stress management would be helpful in nurse education settings.

4.7 Conclusion

This section has highlighted that researchers often use the words stress, fear and anxiety in an interchangeable way. There has been an effort to clarify the terms and it was concluded that stress is long-term feelings of apprehension arising from specific fears. Recognising that the perception, or awareness, of stress can provoke feelings of additional anxiety, further complicated the terminology. It has been seen that nursing has the highest incidence of stress out of all of the professions and that figures of prevalence appear to be quite steady.

The factors that can affect the development of stress have been explored. These were external stressors, such as the context of the student, including where they have to travel from, their financial status and working within a multi-cultural society, as well as academic stressors. Difficulties experienced by student nurses in clinical practice – clinical stressors - were identified as the most common source of stress within the three years of an undergraduate programme. Relationships; under-confidence; lack of preparation; inadequate support and caring for dying people were among the reasons to feel stressed. These issues will provide a context for the next chapter, which will explore the fear of death in more depth and start to consider strategies that might ameliorate this fear.

Chapter 5 Feelings of fear of death

The World Health Organisation (WHO, 2015) defined palliative care as:

> "…an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".

There are calls from international groups for a worldwide recognition that palliative care is a human right (Schmidlin & Oliver, 2015). End of life care is part of the palliative care journey. The National Council for Palliative Care (2006: p. 3) defined end of life care as care that "provides the last part of the palliative care package, and is provided to the person and their family before, during and after the person's death". For consistency, the term 'end of life' care will be used throughout this research.

It is one of the central assumptions of this research that nursing offers a unique opportunity for nurses to develop their own personal relationship with death. Robinson (2004: 89) found that "nurses are the healthcare providers that are most often with individuals at the end of their lives". There is probably no other secular profession where such relationships develop with people who are in the dying phase of their lives. Counsellors might be involved, but they are unlikely to reach the depth of connection attained by carrying out personal care with the person, perhaps with the help of that person's family. Not all nurses will choose palliative care as their area of speciality but, as Govier (2000) suggested, in all areas of the profession where nurses are in direct contact with the public, the possibility of being part of someone's experience of death cannot be ignored.

The level of closeness reached when caring for a person who is near death is unique to my profession. Doctors and other health professionals do not spend the amount of time with sick people that nurses do, neither do they routinely carry out such intimate procedures as washing, feeding and dressing people who are unknown to them. Caring for those dying might offer more opportunity for intimate relationships than any other aspect of nursing (de Hennezel, 1998) and this can be felt by nurses to be privileged work. Nurses are also trained to facilitate the transformation of a person who has died into a corpse. Only nurses and undertakers have this

professional intimacy with lifeless bodies. How this is addressed emotionally is dependent on past experiences, as well as a number of professional influences.

In this chapter, the conceptual components of fear of death will be explored in order to clarify the complexity of the range of fears to do with death. I start with an overview of the categories of fear of death, which I will then relate to developmental theories. These provide a context for the student's previous experiences with death and dying; these will affect how she views the process of death. Personal factors such as ageing, gender and cultural issues will then be examined and related to the research. Recent research findings on fear of death in student nurses and the particular challenges of communication around those experiences will be explored. These discussions inform the choices for the methodology of this research, as discussed in Chapter 8.

The chapter then goes on to explore the contexts of death and how student nurses feel in terms of looking after people who are dying. Particular fears will be identified, as well as the specific areas of concern for student nurses. The question of how nurses are prepared for this work will be considered. I will conclude by suggesting that strengthening the affective domain in student nurses who are working with dying people might ameliorate these fears.

5.1 Categories of fear of death

Suresh et al. (2013) found that one of nurses' particular fears in clinical practice is fear of death. These feelings can be evoked when caring for dying people and their families. Hoelter (1979:996) defined fear of death as "an emotional reaction involving feelings of unpleasantness and concern based on contemplation or anticipation of any of several facets related to death". This definition is broad and perhaps does not help us to understand the depth of the feeling of fear of death, which has several categories. These categories are the fears that comprise a more overall fear of death, which is the umbrella term in this study. Hoelter (1979) carried out research to determine these different categories, of fear of death. He administered a Likert-type questionnaire to a sample of 375 college students and, after analysis, identified eight categories of the fear of death, which are shown below in Table 5.1. It can be seen that Hoelter's categories are extremely broad. One or two examples are given of each type of fear in Table 5.1.

Table 5.1 Categories of Fear of Death (Hoelter, 1979)

	Fear of death categories.	Examples include:
1	Fear of the dying process.	Fear of painful or violent deaths.
2	Fear of being dead.	Avoidance of the remains of humans and animals.
3	Fear of being destroyed.	Fear of dissection and cremation of the body.
4	Fear for significant others.	The impact of a death of a close friend or relative and the impact of these people dying on the individual.
5	Fear of the unknown.	Anxieties about non-existence.
6	Fear of conscious death.	Anxieties about incorrectly being declared dead.
7	Fear for the body after death.	Fear of decay and isolation of the body.
8	Fear of premature death.	Anxieties about not completing important life goals, fear of missing significant experiences, such as parenting.

Walkey (1982) replicated this research in New Zealand with 256 students and their families. There was an almost perfect reproduction of the results. However, when replicated by Long and Elghanemi (1987) with a sample of men from Saudi Arabia, living in the United States, the results were inconsistent. This led to Long and Elghanemi concluding that some of the categories could primarily apply to people from a western, Christian culture. Categories such as 'fear of the unknown' and 'fear of being destroyed' did not seem to concern Islamic men. However, they also concluded that some categories were shared. These were 'fear of premature death' and 'fear for significant others'. This implies that culture plays a part in one's beliefs about death. My research is based on the findings from a multicultural group and so this is an element that will be explored further. The way that the student interprets the experiences surrounding death reflects the way she has experienced challenges that she has dealt with since childhood. Therefore the next section explores how child-to-adult development is the first influence on how the individual experiences fear of death.

5.2 Issues to do with death and maturity

Eissler (1955) stated that the small child has no ability to conceptualise death and comes to know absence, and then loss, before he or she can understand death. Research by Bowlby et al. (1956), Rutter (1979) and Jarratt (1994) confirmed that children feel a loss as painful, particularly any separation from a parent. Bowlby's (1980) findings indicated that the child could experience separation anxiety, grief and mourning if they lose the love of their mother after the age of 2 months. This is a precursor to experiencing the permanent loss of someone or a loved animal through death.

Hurwitz et al. (2004) found that pre-school children do not usually understand the permanence and finality of death; they often view death as an altered temporary state, such as sleep. Findings cannot be generalised to all children, but Beale et al. (2005) suggested that in western cultures, the irreversible nature of death can only be understood from around the age of 11. Beale et al. (2005) observed that this development of cognition reflects Piagetian developmental theory (1976). This insight will happen before the age of 16, so there is a significant shift between the ages of 11 and 16. Nielson (2012) suggested that the experiences of the child and teenager will consolidate their perceptions of loss and death, until they come to understand that death is an event that will happen to them.

Psychologists have refined developmental theory over the past century. These theories, such as those from Piaget (1976) and Vygotsky (1978), support the proposition that the student nurse will commence the programme with a set of beliefs and constructs that she has acquired through her childhood, affected by her cultural and spiritual influences.

Cox et al. (2013) carried out a systematic review of people's attitudes towards death and dying. They found literature to suggest that as people mature, their ideas and feelings about death are affected by their experiences. For example, they found that ideas of how the individual would like to be cared for at the end of their life were influenced by their previous death-related experiences (Howarth, 1998; Field, 2000; Seymour 2003 and Seymour et al, 2004). One of the studies reviewed (Phillips and Woodward, 1999) noted that while the younger age group in their study wished to be involved in any decision regarding their own end of life, the older group said they would not wish to be consulted, citing fear and risk of distress. This study appears to be out of date, as there are more recent indications that older people would like to be involved in

decision-making (Detering et al, 2010; van Gennip et al, 2013; Heyland et al, 2013). All people, including the elderly, now have more opportunities to discuss their care at the end of life (End of Life Care Strategy, DoH, 2012; National Leadership Alliance, 2014).

Some of the studies examined by Cox et al. (2013) might be too small for generalisation, and they concluded that more research is needed on attitudes to dying and death, as current policy cannot be said to be evidence based. The finding by Cox et al. (2013) that attitudes to death and dying are influenced by maturity and life experiences appears to be valid, and is an important contributing factor in my research.

The research findings from Lyke's (2013) study of students' (n=168) perceptions of meaning of life and death anxiety indicate that the search for a meaning of life, rather than awareness of a presence of a meaning in life, is associated with fear of death. This 'awareness' suggests a state where a person feels confident that they have a sense of the meaning of their own life. This sense of awareness might be based on philosophical or spiritual beliefs. People who do not have this confidence might seek the strength that this feeling can bring. There is a distinction then, between this sense of awareness and the search for a sense of meaning from life.

I would suggest that the transition between the search for, and the awareness of, meaning of life requires personal work. This kind of work is not always easy and requires an inner scrutiny. Without this work, questions regarding a meaning in life could remain unanswered and cause fear. Research by Borglin et al. (2005) had found that older people are more afraid of a meaningless existence than they are of death. Others have researched this perception, with similar results (Routledge and Juhl, 2010; Missler et al, 2012).

A review of research regarding death anxiety (Peters et al, 2013) found that younger nurses consistently reported higher levels of fear of death than more mature students. These findings indicate that as people mature, there can be a change in the way they are orientated towards death. These are important distinctions for nurses to remember, and also have implications for how student nurses are prepared to care for dying people. The student will need to be mindful that their age, and the age of the patient, might play a part in how discussions are managed so that communication is appropriate and effective.

5.3 Gender issues

Thorson and Powell (1988) found that women experienced significantly more fear than men on the specific elements of fear of pain; dread of an operation; what happens to the body after death and body decomposition. They concluded that this perception is more to do with personal suffering and fear of the unknown, rather than fear of loneliness or personal extinction. Dattel and Neimeyer's (1990) research looked at the influence of gender on the various death anxiety measurement tools, as well as a review of the research on gender differences thus far. They concluded that there was evidence to suggest that women have a higher tendency to report more death anxiety than men, especially about their own dying.

Recent work by Missler et al. (2012) suggests that there are different issues in the reporting of anxiety between men and women, with men still reporting less anxiety. Their research, carried out in Holland, found that women showed greater fear for the death of loved ones and for the consequences of their own death on these loved ones, than did men. Gender is relevant to the methods in my research, because differences in attitudes would alert nurse teachers to potentially different needs in terms of preparation for caring for the dying.

5.4 Religion and spirituality

The five major world religions (Christianity, Islam, Hinduism, Judaism and Buddhism) all have a doctrine on the nature of death and the spiritual implications of the end of life (Smith et al, 2009). These doctrines differ in their approaches, but all can help a member of the religion to develop feelings of hope, which can affect the way that they respond to the challenges of death and dying. Adherents of these religions might find comfort from these beliefs at the end of their lives, or can become quite terrified of what might happen after their demise (Smith et al, 2009). Atheists believe that experience of existence ends at death and people who are agnostic keep an open mind regarding what happens when they die (Heflick & Goldenberg 2012).

A student nurse might identify with a particular religion, or might express her spirituality in a different way. Spirituality is culturally influenced and the literature suggests that a student's spirituality affects their perception of their ability to provide spiritual care (van Leeuwen et al, 2008). A person's definition of his or her own spiritual belief might involve the teachings of the religion of their culture, to a greater or lesser extent. Therefore, it is wise to treat every person as unique and to individually assess his or her spirituality and how it affects their day-to-day life.

In my experience, it cannot be assumed that, for instance, a Jewish patient will not eat a prawn sandwich, nor that an Islamic patient's bed needs to be orientated towards Mecca five times a day. How a person expresses their religion is more complex than these assumptions.

The World Health Organization Quality of Life Spirituality, Religion and Personal Beliefs group (WHOQOL SRPB Group, 2006) give eight aspects of spirituality. They are shown in table 5.2.

Table 5.2. Eight aspects of spirituality (WHOQOL, 2006)

	Aspects of Spirituality
1	Connectedness to a spiritual being or force
2	Meaning of life
3	Awe
4	Wholeness and integration
5	Spiritual strength
6	Inner peace/serenity/harmony
7	Hope and optimism
8	Faith

Spiritual care can involve assessing the patients' nursing needs in these eight aspects, and constructing plans to meet the needs that the patients cannot carry out themselves, due to their impaired health status. Nurses then implement and evaluate the care that has been delivered that is associated with these beliefs. The eight aspects can affect dietary requirements, hygiene needs or involving a spiritual leader in the inter-professional care team.

Ross et al. (2013) carried out a large pilot study of 531 European student nurses across four countries, where the majority of the sample (75%) of student nurses and midwives were from first-year cohorts. The results of the questionnaires found that the students perceived themselves to be marginally more competent than not in spiritual care. Ross et al. (2013) state the majority (87%) of students were religious and regularly prayed/attended religious meetings. The researchers suggest that this factor could be related to their perception of competency with delivering spiritual care. It is not known what proportion of students at the University of

Hertfordshire has strong religious or spiritual affiliations, but this aspect will be explored in my research.

5.5 Ethnicity and beliefs about death

As mentioned in Chapter 4, nearly half (49.5%) of the adult nursing undergraduate students at Hertfordshire are from BAME groups (Figg, 2014). Ethnicity is seen as a group of people who have the same cultural background. Culture is how the group shares and expresses their values. This is an essential part of a person's outlook on life, as a person acquires a cultural lens through which they see the world (Helman, 2007). This means that essential ideas about life and death might be culturally determined, or at least influenced by culture. This is partly to do with family beliefs and the religion of one's culture, which can imbue the individual with a set of internal rules (Helman, 2007). For example, cultures that have originated in warmer countries tend to deal with dead bodies faster than those from cooler ones, with burial or cremation sometimes happening the same day, or the next day.

Another example of how people are culturally influenced with regard to death is organ donation. This usually follows death, but could also involve live kidney donation. Morgan et al. (2013) undertook a systematic review of attitudes within communities in North America and the UK towards organ donation. They found that many of the African student nurses who have moved from Africa to become nurses in the UK appear to have a perspective that comes from the Christian influences on their country of origin, yet none of these western religions explains the reluctance to donate organs after death, nor the reluctance to sanction the donation of organs of loved ones. Their analysis found that African-Americans and Black African and Black Caribbean populations in the UK often regard organ donation as a 'white' issue. Morgan et al. (2013) found that the cultural barriers to organ donation, such as concerns with intactness of the body and disfigurement, were also more prevalent among ethnic minorities compared with the majority population.

Gauher et al. (2013) carried out focus groups and interviews with a number of Pakistani and Indian British non-nursing students regarding their view of organ donation. The results indicated that there were different cultural influences on each cultural group. For Pakistani students, Islam was the overriding influence, whereas for the Indian students there were several equal influences. These were religion, awareness of the importance of donation, the impact of medical

education, culture-specific factors, treatment of donors and their organs, and the influence of family (Gauher et al, 2013).

Both groups of students had little awareness of donation and were reluctant to consider organ donation, although those who were studying programmes associated with health care had more willingness to donate. From their findings, Gauher et al. (2013) suggest that further generations of British-born Asians will have an increased appreciation of the relevance and importance of organ donation.

A review by Morgan et al. (2015) found that the British group in most need of kidney organ donation is the BAME group, but that there are fewer organs available. They stated that BAME groups represent 11% of the population but make up 30% of transplant waiting list patients. There is an increased need for kidneys, due to a higher rate of diabetes and hypertension, mainly in Asian people. This is countered by a religious and cultural reluctance to donate kidneys. Work is going on within Asian communities and with Imams in Birmingham to try to open up this issue for discussion (Morgan et al, 2015).

It can be seen that when she enters the nursing profession, the student has a set of beliefs about death and dying which reflect her gender, background and culture, but which are also likely to be mediated individually. Added to this are the particular challenges offered by being in a profession which deals with life and death on a daily basis. The next sections will explore what is known about student nurses' beliefs and perceptions about fear of death in order to gain insights into the experiences of student nurses with people who are dying.

5.6 Experiences of caring for a dying person

Although it is not known if a student has experienced feelings of the grief of bereavement when she commences the programme, it is inevitable that she will meet with an aspect of death at some point during her first year, even if it is just in an academic setting. Anderson et al. (2015) found that a student's first experience with death was a significant event for them and can have a lasting impact.

Over the last 50 years the attention paid to preparing student nurses to care for people who are dying has significantly increased. Quint (1967) found that there was minimal academic input within pre-registration preparation in North American schools of nursing. There is evidence that

a substantial number of pre-registration nursing programmes now offer courses on death and dying, but it is not clear at which point in the programme these courses are delivered. Dickenson et al. (2008) found that 66 courses in the U.K. each provided an average of 45 hours of preparation for caring for people who are dying. Cavaye and Watts (2014) carried out an integrated literature review of death education in pre-registration curricula. They found that there are areas of student nurse preparation that need more attention, particularly communication and attitudes. They acknowledge that communication skills appear key in increasing confidence and reducing anxiety.

The academic preparation also introduces the skills of care after death. Wilson and White (2011; p.2-3), as part of 'The National End of Life Care Programme' provide guidance for staff responsible for care after death. This care covers the following aspects:

- Honouring the spiritual or cultural wishes of the deceased person and their family/carers while ensuring legal obligations are met.

- Preparing the body for transfer to the mortuary or the funeral director's premises.

- Offering family of carers present the opportunity to participate in the process and supporting them to do so.

- Ensuring that the privacy and dignity of the deceased person is maintained.

- Ensuring that the health and safety of everyone who comes into contact with the body is protected.

- Honouring people's wishes for organ and tissue donation.

- Returning the deceased person's personal possessions to their relatives.

Preparing a body for transportation to the morgue or mortuary used to be called 'last offices', or 'laying out' and it appears that many nurses still use these terms. The person that has died is washed, wrapped and transported with care, dignity and respect. Every Health Trust publishes policies and procedures that pertain to this practice. An early theoretical session can help the student to start to raise questions regarding her relationship with death and with caring for people who are dying.

Fear of death might be present in every person, but might be more complex in those who are caring for people who are dying. A student nurse is usually required to actively participate in the care of the dying patient, which requires the development of a therapeutic relationship. A good relationship is one where trust, familiarity, genuineness and friendliness exist (Forchuk et al, 1998). A therapeutic relationship goes further. Travelbee (1971) described this relationship as a mutual human-to-human experience, which is based on the achievement of goals and where there is a benefit for both people. This relationship requires the nurse to engender trust in her from the patient. The patient is welcomed, assessed and cared for by the nurse. In carrying this out with kindness and professionalism, the patient learns to trust in the nurse and a therapeutic relationship is established. However, Morgan (1996) pointed out that the professional therapeutic relationship is unilateral, with the nurse being in a position of power. The relationship is also temporary and will usually be terminated when the goals have been achieved. Despite these aspects, Wright et al. (2010) state that there is widespread agreement that the therapeutic relationship is crucial to therapeutic outcomes.

Experiences with death can happen in community placements, on the wards, or in departments such as Accident and Emergency, or intensive therapy units (ITU), as well as the hospice setting. Eick et al. (2012) found that in a supportive context, caring for dying people would provide valuable learning experiences, but when the learning context is perceived to be hostile, then students can experience significant levels of anxiety.

Niederriter (2009) carried out in-depth interviews with 13 first-year junior students aged 20-42, from an urban mid-west American university. The research question for Niederriter's study was: how do beginning nursing students experience death and dying in the clinical setting? She sought to gain an understanding of nursing students' thoughts and feelings about caring for dying patients and their families. She also set out to examine how student nurses communicate with dying patients and their families.

The students reported that working with dying patients and their families involved communication difficulties and ethical dilemmas. From Niederriter's interview data, eight feelings were identified that students had experienced in relation to caring for dying people. These were compassion, sadness, fear, upset, nervousness, anxiety, awkwardness or frustration. Physical manifestations included a headache, upset stomach, shakiness, neck spasm and itchiness.

Niederriter's (2009) findings indicated that another common feeling when working with dying patients and their families was the feeling of being overwhelmed. Students reported that their primary coping mechanisms were talking feelings through with friends and family or crying.

If the eight categories of fear of death found by Hoelter (1979, as discussed in section 5.1 and summarised in table 5.1) are re-examined, it can be seen that some of these categories will be particularly relevant to the role of the nurse. These are the dying process, significant others, the unknown, conscious death and aspects of the body after death. These categories relate to the process of dying as part of a family and what happens at, and after, death. The student nurse and the nurse will have their personal fears, but also might deal with feelings that are connected to their role. This is because the nurse could feel that she should take responsibility for the quality of the patient's death. The quality of care provided during these times could have a significant impact on the person and their family. Student nurses might have challenging experiences around the requirements of the person and the requirements of their family, and these expectations might not always be harmonious. These might involve caring for patients who are feeling very angry, or dealing with family members who are criticising the care provided.

It can be seen from the list of eight feelings identified from Niederriter's research (2009) that there is a relationship with the eight categories of fear of death proposed by Hoelter (1979). In table 5.3, I have mapped the feelings identified by Niederriter against the eight dimensions of fear of death proposed by Hoelter. This has been carried out by comparing the feelings that Niederriter identified with the categories developed by Hoelter. This attempts to relate the theoretical ideas with the experiences of student nurses Indeed, although the students reported their feelings as individuals, it appeared that they could reflect many of the generic fears of death as proposed by Hoelter. This categorisation has been carried out with the help of the examples from Niederriter's research (2009:113). The two dimensions that have not been reflected by the student nurses in Niederriter's research are fear of being destroyed (3) and fear of premature death (8). It can be seen that there is a relationship between the categories and the expressed feelings of the student nurses.

Table 5.3 Feelings of student nurses in terms of fear of death categories

	Fear of death categories (Hoelter, 1979):	Categories include (Hoelter, 1979):	Feelings of the student nurse, (Niederriter, 2009):
1	Fear of the dying process	Fear of painful or violent deaths	Nervousness, sadness, compassion
2	Fear of being dead	Avoidance of the remains of humans and animals	Nervousness
3	Fear of being destroyed	Fear of dissection and cremation of the body	Not identified
4	Fear for significant others	The impact of a death of a close friend or relative and the impact on the surviving individual	Sadness, upset, awkwardness
5	Fear of the unknown	Non-existence	Frustration, nervousness
6	Fear of conscious death	Anxieties about incorrectly being declared dead	Nervousness and anxiety
7	Fear for the body after death	Fear of decay and isolation of the body	Nervousness and awkwardness
8	Fear of premature death	Anxieties about not completing important life goals, fear of missing significant experiences, such as parenting	Not identified

Niederriter's (2009) findings revealed that students felt they were lacking in education about working with dying patients and their families. They felt they were prepared better for the physiological changes that occur with the dying process, but not prepared emotionally or spiritually. Nor did they feel that they had been provided with the appropriate communication skills needed to work with dying people and their families.

Students also reported that they also felt unprepared for working with a dead body. Niederriter (2009) concluded that there is a need to provide further education and knowledge in the area of death and dying, communication and multicultural diversity in the nursing curriculum. She comments that nurse teachers should continue to teach these issues to student nurses and that specialist support needs to be provided by those who understand the uniqueness of the student's role.

Niederriter's research provides richness to my research because she has considered the feelings of the student nurses who work in end of life care. However, her findings relate to student nurses in North American and may not be generalised to UK students. There is a need to explore these feelings amongst student nurses in the UK, in order to better prepare them for this important work.

5.7 Themes regarding the fear experienced by new student nurses

Cooper and Barnett (2005) carried out a small piece of qualitative research that considered the particular aspects of caring for dying patients that cause anxiety for first-year student nurses in central England. Cooper and Barnett discussed the methodological challenges of their research; such as difficulties in getting access to (and using entries from) the journals that the students were expected to keep for assessment purposes. Thirty-eight out of 62 students submitted reflective journals and eleven students participated in two focus groups. Five of the focus group's students had written of experiences with dying people, although it later emerged that all eleven had had experiences of this kind.

The findings of the research by Cooper and Barnett (2005) suggest that there are several themes regarding the fear experienced by new student nurses when caring for dying people. These fall into six areas and it can be seen that these illustrate all of Hoelter's (1979) eight categories of fear:

1.   Coping with the physical suffering of patients.

It appeared that students felt anxiety from seeing the deterioration of a person. Students felt a desire to ease the person's suffering, especially their physical pain. There were also feelings of inadequacy, as students questioned whether they could have done more for that person. This illustrates the following categories identified by Hoelter: fears of the dying process, for significant others and of conscious death.

2.   The end of the relationship with the patient.

The students had become emotionally attached to particular patients and felt the grief of loss when that patient died. The degree of this seemed related to the extent to which the student had been involved in that person's care. This illustrates the following categories identified by Hoelter: fears of the dying process, for significant others and of premature death.

3. Not knowing what to do or say, feeling helpless.

The students reported being in situations where they had to talk with people who were dying and also recently bereaved people. Students seemed to appreciate the significance of this time in a person's life and were anxious not to say anything inappropriate. This led to feelings of powerlessness. These fears illustrate the following categories identified by Hoelter: fears for significant others and of the unknown.

4. The type of death.

A sudden death or death of a young person is more difficult. The students appreciated being able to give extra special care to people whose death was expected. However, with sudden deaths the students felt robbed of the satisfaction of providing this level of care. Students might, in retrospect, feel anxious about the care that had been provided being good enough. The students also had difficulty with younger dying people and found it anxiety provoking, as it felt more unnatural and they felt that they could identify with the dead person as more like themselves. The students appreciated that the dying process can be unpredictable and that death can happen at any time to any person. These feelings illustrate the following categories identified by Hoelter: fears of the dying process and of the unknown.

5. Cardio-pulmonary resuscitation. Fear of making a mistake and also the issues of not agreeing with 'do not resuscitate' orders.

The first sub-theme that emerged here was the student's fear of not performing correctly in a resuscitation attempt. Much time and training are given to students in order for them to develop the resuscitation techniques that can mean the difference between life and death. When the clinical team is trying to resuscitate a person, there might be self-expectations to perform at the very highest level. Students could also be aware that they are being assessed in these situations. If resuscitation is unsuccessful, this is an unknown dying context, which might feel premature to the student. These feelings illustrate the following categories identified by Hoelter: fear of the dying process, of the unknown, of conscious death and of premature death. The second sub-theme was the anxiety provoked by seeing that some people have a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) label. Students questioned the decision for this and seemed to feel that it represented 'giving up'. This illustrated their inexperience as, in fact, this decision is made with the patient and their family at the centre of the decision-making process. A DNACPR label protects the patient from the trauma and indignity of resuscitation when there

is no hope of recovery. These feelings illustrate the following categories identified by Hoelter: fears of the dying process and of premature death.

6. Care after death. Seeing a dead body and performing difficult procedures.
The first times of contact with a dead body were found to provoke anxiety. However, the students were also fearful of some of the procedures necessary to prepare the body for transportation. These feelings illustrate the following category identified by Hoelter: fear of being dead, (the student might have seen the body treated with disrespect), fear of the unknown and of the body after death.

Cooper and Barnett (2005) conclude by suggesting that more work is needed to explore the experiences of new student nurses, as there is no doubt that fear and anxiety are felt when caring for dying people. Nurse education has changed since this work was carried out, in that students now have trained nurses as mentors (NMC, 2008a). Students are supervised and supported by these mentors and so students should be able to share feelings of anxiety with their mentor. However, this would depend upon the approachability and efficacy of the mentor concerned. This point is supported by Terry and Carroll (2008), who found that 100 of their 184 first-year student nurses had experienced death for the first time in their clinical placements. These student nurses had experienced emotional distress when providing end of life care. Terry and Carroll suggested that care for patients, as well as support for students, needs to be improved in clinical areas.

A high quality of care for the dying person and their family would involve the implementation of effective communication skills by all members of the inter-professional team. The student has an opportunity to learn these skills through their own experiences and also through the role modelling of their mentors. This is part of developing learning through the affective domain.

There are limitations of this research, in that Cooper and Barnett's sample came from one HEI. However, their choice of using student diaries, along with two focus groups, enhanced the validity of the results. Although they used a small convenience sample, the data were rich and meaningful. The data were analysed in a rigorous way, using Collaizzi's (1978) method of content data analysis, which involves seven stages to reach the appropriate level of depth. Ethical issues had been carefully considered and the relationship between researcher and students had been taken into account. The fears of death identified in this research are relevant

to all student nurses, who will deal with death throughout their careers (Cox et al, 2013). However, each student will have a set of different experiences and will respond to these in their own unique way.

Cooper and Barnett's (2005) findings illuminate the feelings of inadequacy felt by new students within the context of end of life care. This kind of nursing is intimate and students perhaps have high expectations of how they should be acting and feeling with people who are dying and their families. Both the experiences of a person's sudden death and participating in care after death present unique challenges, where students will need to feel that they are doing the best for that person. However, managing well in these challenging situations takes experience and an awareness of where the individual is in their relationship with death. By developing skills with people who are dying and their families, the student prepares for her own death. Indeed, Neimeyer (1994) suggests that Maslow et al.'s (1970) self-actualising person has a greater acceptance of themselves that includes lower anxiety and a lower fear of death.

5.8 Conclusions

This chapter has illuminated the complexity of fear of death. It has become clear that there are several influencing factors on fear of death. Eight categories of fear of death have been presented here and linked to the contributory factors of development, gender, spirituality and ethnicity. Developmental influences will influence how an individual approaches issues of death and dying. Fear of death appears to change over the lifespan, whereas attitudes related to aspects of gender, ethnicity and culture might be more enduring.

The research findings explored here have suggested that there are particular and unique challenges for student nurses in clinical practice. Niederriter (2009) found that students experienced a range of feelings surrounding the care of dying people. These feelings affect how they communicate with patients, families and colleagues. Cooper and Barnett (2005) and Niederriter (2009) both concluded that students needed more emotional preparation, as well as preparation to communicate with families.

The literature that has been considered supports the proposition that appropriate preparation for student nurses might reduce the fear felt in clinical practice. The affective domain was discussed in Chapter 2, where it was seen to be one of Bloom's (1965) three domains of learning. That chapter concluded that the affective domain includes the manner in which we

deal with things emotionally, such as feelings, values, appreciation, enthusiasms, motivations, and attitudes, including spiritual attitudes. Emotional intelligence (EQ) is a concept that helps me to understand approaches to strengthening the student, through the affective domain.

The affective domain also includes the feelings of the individual in terms of the provision of spiritual care. The skills of developing and managing these feelings and attitudes can be developed during the nurse undergraduate programme through theory, clinical practice and through personal experiences. Strengthening the emotional and spiritual aspects of the affective domain would be instrumental in helping students to successfully traverse difficult situations when caring for dying people and their families. The concept of spiritual intelligence (SQ) is discussed in Chapter 8.

Cooper and Barnett's (2005) and Niederriter's (2009) findings from research with student nurses show that the students feel a range of specific fears of death. My research considers fear of death in student nurses in southern England. The next chapter will consider the strategies that are found by student nurses to cope with fear of death. It will also explore how nurse education might enhance this journey through the use of particular strategies.

Chapter 6 Strategies to ameliorate fear of death: (1) Do Something Different

From an examination of the literature pertaining to student nurses and end of life care, it is clear that students feel anxiety and fear in some situations. The literature suggests that there are specific fears related to caring for dying people and their families (Niederriter, 2009). Because the affective domain is concerned with learning through feelings and attitudes, any strengthening of this domain might be addressed through appropriate psychological and spiritual strategies that help to develop emotional and spiritual aspects. I needed to look for interventions that were designed and tested to address the skills within this domain, and to provide tools for managing a challenging undergraduate programme. My Master's degree in medical anthropology meant that I would be able to build on this in order to consider cultural issues within psychological and spiritual interventions.

This chapter is the first of two chapters that explain the reasons for selecting the two specific strategies tested in this study and puts them into context. I identify the sources of help that are already available to the student nurse. There is a discussion on the evolution, strengths and limitations of the chosen psychological intervention, called Do Something Different (DSD), which developed from earlier research. This had been called FIT (Framework for Internal Transformation or Flexible, Innovative, Trainable (Fletcher, 2003: 560). The chapter continues with an exploration of the ways in which DSD has been empirically tested and a discussion regarding its applications.

I conclude by hypothesising this will be an effective tool for use with student nurses to strengthen feelings within the affective domain and ameliorate their fear in terms of death, and caring for dying people.

6.1 Available support - university and clinical practice

There is usually a range of choices for students who seek support in times of trouble. The University of Hertfordshire has a website that lists the help available (www.herts.ac.uk/university-life/student-support). For stress and anxiety issues, there is a free anonymous help-line and a free confidential counselling service. The chaplaincy team offer a range of spiritual services that cover the major world religions. The chaplaincy team also offer spiritual care for those with no religious affiliation. For holistic help from a nursing perspective,

each student has a named personal and programme tutor (Say, 2013). During the first modules, there are lectures on stress and its management. Students spend time in seminars discussing their stress management strategies. However, there are no specific stress management programmes implemented for student nurses.

Gibbons (2010) had found in his research with final year students that they were more likely to succeed if they have a positive attitude towards their studies. However, adequate support was very important in this. When a University of Hertfordshire student nurse is working in clinical practice, she has a named link lecturer, who visits her at least once during the placement. This link lecturer is accessible to the student by phone and email and knows the placement staff. This lecturer will liaise between student and staff, if necessary, and will support the student as best they can. The student is allocated two named mentors who are staff nurses or nursing sisters.

It is also part of the link lecturer role to support all the mentors so that the mentor can provide the best learning environment for the student. Further support is also available to the student nurse from the Practice Education Facilitators (PEFs) on each hospital site. These arrangements are in line with guidance from the NMC (2008) and so are standardised across England.

6.2 A Framework for Internal Transformation – FIT

I wondered how fear of death could be ameliorated through the use of a psychological strategy. Kurebayashi et al. (2012) found that the identification of 'being' stressed can go on to produce feelings of fear and anxiety. Gibbons (2011) had suggested that initiatives that look to bolster student self-efficacy, control and support would help to reduce stress in student nurses. I searched for stress management initiatives that would be evidence-based and easily accessible to the students. The programme needed to be self-managed, as I considered this might be a factor in the success of the intervention. Mindfulness programmes were already available to students within the university but on an individual basis.

Conveniently, or serendipitously, I had come across a programme that had recently had success with University of Hertfordshire students, as well as many other groups of people. This is a psychological programme called FIT. This acronym stands for Framework for Internal Transformation or Flexible, Innovative, Trainable (Fletcher, 2003: 560). Essentially a personal

development tool, FIT considers the qualities that determine success and wellbeing. FIT does not refer to a physical state; rather it refers to a mental or psychological state. Fletcher and Stead (2000) wanted to identify which behavioural dimensions would result in a person having a behavioural richness that underpinned a broad personality.

Fletcher's earlier research (1988, 1993, 1999) had thrown light on the ways in which people perceived the world and how they interacted, using those perceptions. Further work on occupational stress showed that improvement to the experience of the worker might be brought about by changing the nature of the job, or by changing the culture of the organisation, but that neither of these changes would be as effective as enhancing the 'FITness' of the individual (Fletcher, 2003:557). It seems that the important concept in considering the harmful effects of stress is not the stress itself, but how the individual perceives that stress (as discussed in Chapter 4).

FIT theory postulated that aspects of the self could be measured and, if changed, could enable the person to view the world in a fundamentally different way. The corollary would be that the person would shift towards being empowered to change the way they think, and how they behave. This development sits within the affective domain, as it addresses attitudes, feelings, motivation and enthusiasm that are developed within that domain (Krathwohl et al, 1973). Enhancing more positive attitudes towards stress, death and dying would involve strengthening feelings within the affective domain.

6.3 The FIT Profiler

Fletcher and Stead (1999) had developed the concept of flexibility allowing the person to be so adaptable that any issues in the work environment would not be perceived as stressful. Fletcher (2003) went on to describe the FIT profiler as a tool that measures behavioural flexibility (i.e. the breadth of the repertoire of behaviours they are able to call on). Individuals indicate the possible range of their behaviour in various circumstances across 15 scales to indicate outer FITness:

- Unassertive …………… Assertive
- Trusting of others……....Cautious of others
- Calm/relaxed …………..Energetic/driven
- Reactive …………………Proactive
- Definite………………......Flexible

- Risky ……………………Cautious
- Behave as expected …....Behave as wish
- Spontaneous …………...Systematic
- Single-minded …………Open minded
- Introverted ………………Extroverted
- Conventional…………....Unconventional
- Individually-centred ……Group-centred
- Predictable ………………Unpredictable
- Gentle ……………………Firm
- Lively……………………...Not lively   (Fletcher, 2003:560-1)

By allowing people to plot a point, or several points, on each continuum between these poles, a score is obtained. This is the overall Behavioural Flexibility score. An extremely flexible person would be able to display the entire range of behaviours on each continuum if the context required it of them. Fletcher (2003) also suggested that having a wide repertoire of behaviours was not enough to be able to tell whether the person would be able to implement them appropriately. Fletcher suggested that being able to use these behaviours in the appropriate context would prevent stress developing. Therefore, the FIT Profiler was developed, which measured the level of the five psychological dimensions that are responsible for performance, behaviour and individual integration (Fletcher, 2003). These are known as Constancies and, as the name suggests, should not change according to the situation, but would deeply influence the behaviour. If an individual has high levels of the Constancies, they are more able to implement a wide repertoire of behaviours (i.e. behavioural flexibility).

The FIT Constancies (Fletcher, 2003) are:

- Awareness: this refers to the degree to which the individual picks up signals and interacts with their internal and external worlds.

- Fearlessness: facing challenges of the unknown with the same courage as the familiar.

- Self-responsibility: the individual's perception of their own level of personal accountability for their experiences.

- Morality and ethics: the individual's ability to discern the difference between good and bad; their ability to do the right thing, conscience.

- Balance: keeping different aspects of life in harmony. Paying attention to the important aspects that need care. The person puts sufficient levels of effort into these aspects of their life in order to feel satisfied.

Psychometric testing has been used to support the concept of these five Constancies and of Behavioural Flexibility, as well as the validity and reliability of them (Page and Fletcher, 2006). Psychometric testing is usually used in recruitment and selection processes where a person's capabilities, work styles or values are assessed (British Psychological Society, 2014).

Individuals can assess themselves on the Constancies, or another person can use the tool to assess them. A numerical value is awarded for each of the five Constancies and then totalled to give a 'FIT Integrity' score. This indicates a level of inner FITness. This is then combined with the 'Behavioural Flexibility' (outer FITness) score to give an overall FITness indicator. Page and Fletcher (2006) found that the ability of an individual to deal efficiently with stress is influenced by their personal levels of the five constancies.

Further work by Page and Fletcher (2006) found that low levels in one or more of the five Constancies would result in a perception of higher levels of stress. High levels of the five Constancies are generally very good assets. People with high levels base their behaviours and decisions on these, and have a wide repertoire of behaviours so that they can cope with a variety of situations. Those with low levels of the Constancies might be affected by a challenging environment because they are not aware of the implications, or are fearful, or not able to take personal responsibility, or are not sure of the right strategy, or put inappropriate amounts of energy in the wrong places (Page and Fletcher, 2006). Using the FIT theory, unFIT people experience chronic stress because they repeatedly cannot deal effectively with a recurrent situation. The unFIT do not learn from their experiences and do not adapt to develop new behaviours. Fletcher and Stead (2000) proposed that if a person's behavioural repertoire is developed over time then the Constancies are likely to also change.

6.4 Research and development of FIT

FIT science makes three assumptions (Fletcher, 2003). The assumptions are that:

- Those who score high on the FIT profiler will be able to perform better in their lives. They are flexible and effective problem solvers.
- There is a correlation between the Constancies and depression and anxiety. People with higher levels of the Constancies will report lower levels of depression and anxiety because they are more able to take responsibility and have higher levels of self-awareness. They might respond more positively to the demands of difficult situations due to being less fearful.
- Personal strengths in the cognitive and behavioural dimensions of FIT science can be trained through developing behavioural flexibility with Fletcher and Pine's (2012) Do Something Different (DSD) change techniques. This is achieved through disrupting people's daily habits and enhancing the thinking and behaviour that facilitate enhanced flexibility. FIT science proposes that changing the behaviour of individuals could lead to enhancing the Constancies. These Constancies guide behaviour and can lead to a better ability to cope with life's events.

These assumptions have been tested by Fletcher (2003, 2007a, 2007b, 2007c) and were also tested by Sharma (2012) in her doctoral research. Findings from these empirical studies were that people with a higher score in FIT variables, especially the Constancies, report less stress in their lives and in their occupations.

Taking action is a much more powerful tool of change than trying to change thinking or cognitions through therapy, knowledge or information (Pine and Fletcher, 2014). FIT theory served to underpin the work that went on to further develop the concepts into the DSD programme. The knowledge gained through testing the FIT concepts was used to develop DSD, in order to enhance a person's ability to address stress in their life.

The DSD programme was tested with a small sample of people who had identified themselves as stressed in the workplace (Fletcher, 2007c). The participants carried out instructions to change one thing that they did every day. This was to expand their repertoire of behaviour (outer FITness), which in turn can affect the level of the Constancies (inner FITness). If these

are enhanced then the individual is more able to manage challenging situations and the result might be reduced perceptions of stress. The study showed significant decreases in levels of anxiety and an improved experience of life (Fletcher, 2007c). The results further support the relationship between the FIT variables and personal stress. The findings also support the third assumption (see above), in that strengths in the cognitive and behavioural dimensions are trainable.

The DSD programme was further tested with a group of mainly white-collar and professional staff (Fletcher, 2012). Here it was called the Do programme. After an assessment of their stress levels, the members of the group carried out the programme over a one-month period. Statistically significant statistical results indicated a reduction in stress, anxiety and depression levels. There was an increase in the behavioural flexibility of the participants. The DSD techniques are now being used to improve health and wellbeing in a range of different communities, most notably in community settings in the UK and The Netherlands, as well as to bring about targeted changes in important corporate strategies around the globe (Fletcher, 2014).

Further research has been undertaken using the FIT strategy and has been shown to affect people's perceptions of their lives. Hanson (2008) found that individuals with greater levels of inner, cognitive FITness had lower levels of anxiety and perceived their work in a more positive light. Individuals with a greater outer, behavioural FITness experienced higher levels of physical well-being. The second part of her study explored why these people would demonstrate a lower Body Mass Index (BMI). Her results showed that this was linked to habitual behaviour, which could be trained. This would result in enhanced outer FITness.

Hanson (2008) found that the greater the increase in outer FITness, the greater the decrease in BMI. Based upon these findings, a more accessible DSD tool was developed by Fletcher et al. (2010). Fletcher et al. (2010) further tested this tool with a group of overweight people and the findings were that there was a positive relationship between greater FIT behavioural flexibility and BMI reductions. Qualitative methods revealed that people changed their behaviour through using the tool and that this helped them to develop more effective shopping, eating and exercise strategies (Fletcher et al, 2010).

Sharma (2010) tested the DSD intervention in her research, focussing upon the experiences of mothers of children with Autistic Spectrum Conditions (ASC). Sharma's discussion with parents had shown that a degree of routine in life had needed to be developed to help to reduce the anxiety experienced by their child. There was evidence to suggest that there were significant levels of stress in parents. The research sought to examine whether scores on FIT variables explained differences in perceptions of family functioning and outcomes, such as individual stress levels (Sharma, 2010). Findings from Sharma's research included that the DSD intervention (targeting FIT variables) can be effective in improving perceptions of family life and one's own levels of stress, as a parent and as an individual. Mothers reported a sense of calm and increased self-care from using the intervention. They were also more self-aware of feelings of stress. This resulted in the management of their stress and a resulting reduction in symptoms of depression. Sharma (2010) also found that romantic relationships between parents were improved and that the parent felt an increased sense of self-responsibility.

Sharma's research is valuable in identifying that the intervention can be used in extremely challenging situations, such as with parents of a child with a disability. This suggests that deep-seated perceptions, such as one's ability to parent, can be affected by this strategy. It follows, therefore, that other core perceptions, such as fear of death issues, might be positively influenced by the use of the DSD intervention to bring about changes to important FIT variables. It can be seen that DSD can also change other behavioural factors, in addition to the FIT variables.

At the time of writing, there is research being implemented with people with Mild Cognitive Impairment to consider the use of a multi-modal strategy (including the DSD) to prevent the progression of dementia in older people (Dannhauser et al, 2014). This research project has completed the pilot study in Essex and the main trial (RCT) is now in progress. The pilot study produced positive results that led to optimism that this tool will help to provide more information on the progression of memory impairments. These positive results provide further evidence for the validity of the DSD tool.

6.5 DSD and student nurses

The FIT intervention has been shown to have a positive effect on cognition and behaviour in many settings, including with undergraduate university students (Fletcher, 2003). However, nursing students are quite different from most university students, due to the two separate

parallel working lives that they lead in education and practice. Challenging experiences for the student nurse can occur in the HEI or in clinical practice, or both. The huge variety of experiences offered to the student nurse in any clinical setting is not really going to change, but the context in which she works does vary from placement to placement. It seemed then, that having a focus on developing the emotional aspect of the student's emotional intelligence (EQ) was one route to strengthening that domain and developing the flexibility that could help her to deal with stressors in any environment, at any time during the programme. Because nursing is such distinctive work, the nature of this tool allowed real flexibility, with the student choosing how and when the DSD would be implemented.

6.6 Choosing the DSD strategy for fear of death

The fear of caring for people who are dying and their families is a particular stressor in clinical practice (Niederriter, 2009). The literature reviewed earlier has shown that students could start to be aware of this fear before their placement and throughout the experience (Cooper and Barnett, 2005). This reiterated the need to focus on the way that the student responded to her own perceptions. There were other interventions that could have made a difference, such as teaching meditative or mindfulness practices. These strategies were considered, but they felt less user-friendly for the student nurses. The students are so busy when on placement that the strategy needed to be quick and easy for them. Meditation and mindfulness also blurred the concept of a psychological strategy, as they are connected to the Buddhist tradition. I was seeking to ameliorate the fear experienced when student nurses are caring for dying people and their families. I hypothesised that increasing the student's inner and outer FITness using the DSD would reduce her fear of death.

I was in a position to have easy accessibility to the DSD programme, through the University of Hertfordshire. I also had the potential help of the authors of the DSD programme, which was invaluable. I currently teach stress management strategies, which include enhancing self-awareness and time-management issues. However, the students might have used these before arriving at the University of Hertfordshire. The novelty of a new strategy was attractive and it was highly unlikely that any of the students would have met with the DSD programme prior to commencement on the programme.

FIT theory had been very well tested in a range of environments and it had been shown to be effective with a variety of stressors. The end of life care experience had not been explored

before, but it seemed reasonable to expect that a movement towards flexibility would affect this particular set of fears. The findings of Sharma's (2010) research illustrated the efficacy of this strategy with deep-seated perceptions.

Bonk and Kim (1998) recommend socio-culturally based teaching techniques that include "pushing student exploration and application of their problem-solving skills and fostering student reflection and self-awareness" (p.72). This programme appeared to offer just that. The fears of death and dying (Hoelter, 1979) were reviewed, and they were seen to span a range of attitudes regarding death. Although it is appreciated that the perception of the individual towards these aspects could be deep-seated, and could also be culturally influenced, this strategy offered a way in which these particular specific fears, such as fear of the dying process and fear for the body after death, might be perceived as being non-threatening.

The DSD strategy offered a development of the Constancies, one of which is fearlessness. The other four constancies, if strengthened, would also offer the student increased resilience in challenging situations, helping them to be more aware of the experience, and feel more in control. This might ultimately lead to a deepened appreciation of their new experiences. By the time I came to consider the strategies, a journal type book: Do Something Different – The Journal, had also been produced. This made the suggestions for brief, daily, behavioural changes accessible for the individual (Fletcher and Pine, 2009).

6.7 Conclusion

The genesis and development of the FIT theory have been discussed. It has been shown that this theory developed into the DSD strategy, which has now been empirically tested in a number of contexts. It has been seen that this intervention can lower levels of anxiety and that individuals can perceive their work in a more positive light (Hanson, 2008). Research findings by Sharma (2010) indicated that participants became more self-aware of feelings of stress. They were able to manage their stress, with a resulting reduction in symptoms of depression. Deep-seated perceptions, such as the ability to parent a child with a disability, were addressed. Changes led to increased feelings of responsibility and improved perceptions of family life.

The deep-seated concept of fear of death is based on psychological and spiritual constructs within the individual (Neimeyer, 1994). By addressing the cognitive aspects of responses to stressors, the individual will be more flexible with regard to their fear of aspects of death and

dying. This strategy offered a specific route to expanding the individual's flexibility and was considered worthy of trial. The following chapter will consider a more spiritual approach to ameliorating fear of death in student nurses.

Chapter 7 A spiritual support strategy - family constellations

This chapter considers a second strategy that would help the students to develop the emotional and spiritual strength needed to meet the particular challenges of nursing dying people and their families. Culliford (2012) considers that emotions are entwined with spirituality and can provide a gateway to the spiritual dimension. He suggests that calm, joy and contentment are among the emotions that typify a mature spirituality in a person.

The relationship between spirituality and emotional intelligence (EQ) will be explored in this chapter. As noted in Chapter 5, the definition of EQ used within this research is from Mayer et al. (1999:267) who defined emotional intelligence as "an ability to recognise the meanings of emotion and their relationships, and to reason and problem-solve based on them". Emotional responses to death and dying are connected to spiritual beliefs. Zohar and Marshall (2001) discussed the relationship between emotion and spirituality. They suggest that as well as a person's level of cognitive intelligence, as indicated by an intelligence quota (IQ), and EQ, there is a third intelligence called spiritual intelligence (SQ). They argue that all human intelligences can be variations on one of these three.

I discuss in this chapter issues in choosing a strategy that might develop EQ and SQ to ameliorate fear of death in student nurses. The strategy of family constellations is then described and the underpinning evidence explored. A discussion of the choice and use of the family constellations strategy with student nurses is considered and conclusions drawn.

7.1 Spiritual and emotional intelligence

In Chapter 2 a definition of spirituality was discussed. The definition of spirituality, for the purpose of this research, was taken from the work of Koenig et al. (2012:46). They stated "spirituality is distinguished from other things – humanism, values, morals and mental health – by its connection to the transcendent". They went on to say that spirituality is intimately connected to the supernatural and religion; extending beyond religion, but including a search for the transcendent.

Zohar and Marshall (2004:3) defined spiritual intelligence (SQ) as "the intelligence with which we access our deepest meanings, values, purposes and highest motivations. It is how we use

these in our thinking processes, in the decisions that we make and the things we think it is worthwhile to do". They suggest that SQ involves asking the bigger questions such as 'why are we here?' and 'what happens after death?' They also propose that SQ allows humans to be able to question rules and to know where emotional responses are appropriate; "we use SQ to wrestle with questions of good and evil and to envision unrealised possibilities" (2001:5). Wigglesworth (2012:8) defines SQ as the ability to behave with wisdom and compassion while maintaining inner and outer peace, regardless of the situation. She believes that everyone is born spiritual, but can choose to develop their spiritual intelligence. Her definition, however, implies that those without the gift of inner and outer peace, due to mental or physical health problems, cannot experience spiritual intelligence. For this reason, I will be using the definition from Zohar and Marshall (2004).

One barrier to inner peace is stress at work. The stressful nature of nursing was discussed in Chapters 4 to 6. It was concluded that nursing dying people is one of the most stressful aspects of nursing (Niederriter, 2009; Eick at al., 2010). Dealing with this stress is important for the student's emotional, spiritual and physical health. Cooper and Barnett's (2005) examination of journals, along with data from focus groups, indicated that the students had suffered an emotional impact when they reflected on their experiences after getting home from their clinical placement.

Rankin (2013) reported a study where EQ and performance were correlated in a sample of 307 student nurses. He found that there was a correlation between EQ, academic and clinical performance and retention. EQ was seen to be an asset for nurses who are dealing with challenging situations (Rankin, 2013). This implies that the students with enhanced EQ manage the programme and do not reach the point where they need to leave. Aradilla-Herrero (2014) points out that many authors argue that having high levels of EQ is an asset for nursing professionals who care for patients and their families in a challenging context (Smith et al, 2009; Hurley, 2008; Rochester et al, 2005; Freshwater and Stickley, 2004; Epstein and Hundert, 2002).

Research carried out by Cooper and Barnett (2005) found that students agreed that the best strategy for coping was to share their experiences with their peers. They came forward with ideas for improving their programme and suggested more input on emotional issues during the course. However, the research undertaken by Peterson et al. (2010a) found that the more

experience a nurse has, the easier it is to postpone feelings of distress. This can lead to nurses failing to express any emotions during working hours. Peterson et al. found that these nurses eventually provide only physical care to the person that is dying. This could impede the therapeutic relationship, which we know to be effective in the recovery or comfortable death of patients (Wright et al, 2010).

Cooper and Barnett's research (2005) highlighted the benefit of connection with peers. This connectedness is a feature of nursing within clinical placements where there is an emphasis on teamwork. This connection with humans (and also with the natural world) is an aspect of spirituality. With regard to spiritual intelligence, Zohar and Marshall (2001) suggest that SQ allows us to put feelings and events into a wider context, enabling us to see helpful relationships and patterns. They claim that SQ has a transformative power that EQ does not have. Research findings from Niederriter (2009); Cooper and Barnett (2005), Peterson et al. (2010a) and Rankin (2013) pointed towards the need for an enhanced input into the undergraduate curriculum in terms of developing both EQ and SQ.

Burkhardt (1989:70) considers spirituality to be bigger than religion, and religion is seen as an expression of ones spirituality. She explains that expressions of spirituality "include prayer, meditation, interactions with others or nature, and relationship with God or a higher power." In her later work Burkhardt (1994) went on to talk about spirituality as described by women. These women said that spirituality was illustrated by a connectedness to both a higher power and also to other people and to nature. They also spoke of spirituality being concerned with growing self-knowledge and maturity, which was connected to an awareness of past and future. Thus the definitions of spirituality point towards this notion of connection, of not feeling individual and isolated.

A biologist, David Hay (2006), has built on the work of William James (1902) and Sir Alistair Hardy (1979). Both James and Hardy played an important part in developing a theoretical understanding of spiritual experiences through empirical investigation (Woods, 2007). In Hay's work, he observed that there is a shift of the western population away from religion and he argues that there is a secular awareness of spirituality. Hay (2006: 49) defines spirituality as "a built-in, biologically structured dimension of the lives of all members of the human species" and sees this as the precursor for religious and secular experiences. There is an implicit meaning here, that because this dimension is in the lives of all human beings, there is the capacity for

overlap and sharing of this experience. Hay rejects individualism and sees a spirituality that is individualistic as self-contradictory (Hay, 2006). This relates to the concept of what Jung (1936) and then Rogers (1966) called the collective unconsciousness, where there is an internal knowing experienced by all the members of a group.

This work is useful when put in the context of nurses working closely with others, usually in a team. Hay's discussions are focused on people, and how they behave in communities and groups. His research explored the perceptions of spirituality amongst British people who did not attend church (Hay and Hunt, 2000) and found that 76% of the British population is likely to admit to having a spiritual or religious experience. Findings from this research culminated in Hay and Hunt's (2000) observation:

> "We know from literally hundreds of conversations with adults about their spirituality, that the typical result of being directly aware of one's immersion in the physical and social matrix is the experience of a shortening of the psychological distance between oneself and one's surroundings. When a person realises this, it matters much more to them when some aspect of reality is damaged, whether it is another person or a part of the environment, for they are much more likely to experience it as a shared damage; the feeling is 'I too am damaged by what has happened to the other."
> (Hay and Hunt 2000: p.7.4.5)

It appears that EQ is relevant to nurses in all areas of their work with people who are suffering from health disturbances. However, in the context of end of life care, it might be that development of SQ through the affective domain can ameliorate specific fears of caring for dying people and their families.

Spirituality is seen by Burkhardt (1989) and Hay and Hunt (2000) as a connection, both to others and to ones surroundings. It is a way of avoiding isolation and does not need to be seen within the context of religion. This sense of connection is fundamental in family constellation work and so this particular spiritual strategy was considered as a means of strengthening feelings within the affective domain and, therefore, ameliorating the student nurses' fear of death.

7.2 Family constellations

DSD, the first strategy, had been tried and tested, and was based on strong psychological evidence. A spiritual strategy will bring additional insights that the psychological strategy could not. This section will describe and discuss the origins and structure of the family constellations strategy. The efficacy of this strategy lies entirely within the affective domain, which explains its choice for this research. The next sections will provide the theoretical underpinnings and the empirical evidence for this work.

Research findings from Liu et al. (2011) suggest that experiential teaching strategies can be effective in developing feelings within the affective domain; therefore teachers should consider the value of role play and simulation strategies. Cavaye & Watts (2014) identified that one effective strategy used to teach effective care of dying people and their families was simulation. Family constellations provide a similar strategy for addressing specific challenges with communication and for dealing with emotional and spiritual difficulties.

Family constellations allow a problem, or issue, to be explored in three dimensions, with people other than those involved in the problem representing those who are involved. Where stellar constellations provide a map of a group of stars, family constellations provide a map of family members and significant others. Two years of training provides the theory and experience for a person to facilitate this work. These people are called facilitators or constellators. It could be argued that every family constellation is a small heuristic inquiry, as the phases of engagement, immersion, incubation and illumination (Kenny, 2012) are reflected in the constellation process. To fully understand this strategy it must be experienced. It is learnt through participating in the work.

In a family constellation, a group of (usually) adults is seated in a circle. The facilitator prepares the group for how the work is constructed and seeks a sense of containment for the group. That is, as this is spiritual work, the facilitator is clear with the group that there is a need to create a safe, sacred space. This is done through a short period of silence and by identifying that the circle is symbolic of a sacred space. The need for confidentiality is stressed. There is also a request to avoid discussing the work immediately after the constellation, particularly with the issue holder (the person that is seeking help with their life issue). The issue holder needs some quiet time to digest their experiences. The group is asked to support the work by keeping silent

unless asked to speak. It is part of the facilitators training to observe the group and pick up signs that a representative might wish to speak.

The issue holder presents a problem from some area of their life. This can be family, health or career, or any other relationship problem. The facilitator is not interested in detail, only the bare bones of the problem, such as "I hate my mother". This statement will be enough for the facilitator to know that there is a problem in the issue holder's female line; her mother, grandmother and possibly further back. Sometimes issue holders cannot explain clearly, so the facilitator will ask 'what is your heart's desire?' Some say things like 'I want more love in my life' or 'I need more peace'. The facilitator might need a little more information but will discourage the issue holder from sharing their opinions.

The facilitator asks the issue holder to choose people from the group to represent the issue holder and members of their family of origin, such as parents. If the representative agrees, the issue holder uses their intuitive feelings to position this individual within the circle. The representatives will then start to check if they have feelings towards the others and also how they feel in themselves, their mood and demeanour. Preiss (2012: 20) says, "constellations provide an instantaneously accessible image of underlying problems". This means that the trained facilitator can see relationships as being functioning or in difficulty, according to whether the individuals are in visual contact or show any interest in other people in the constellation. Distances between people, stance, demeanour and expression are all very important information to the facilitator.

Once the representatives have been positioned, they will each in turn be asked by the facilitator to describe feelings rather than thoughts. This can be in the form of their position, the interest felt towards other representatives, or by their somatic sensations. Their feelings are coming from the 'knowing field', an energetic source of information that will be discussed in the next sections. Sometimes a representative will not be able to lift their gaze from the floor. The extensive training enables the facilitator to inquire of the issue holder regarding deaths in the family. This downward gaze can indicate that a deceased member of the family needs to be acknowledged.

In constellation work, a representative might also be asked by the facilitator to represent a non-human being, such as a country or a feeling. On one occasion, with an issue holder from

Columbia, it was necessary for me to find a representative of her country in the constellation. Work I have done with Jewish issue holders has often required me to bring in the Jewish nation to be represented during the constellation. I believe that this is because of the trauma that is held in their collective unconscious. In other constellations a representative might be asked by the facilitator, if appropriate, to represent 'the secret', 'the being of death', 'cocaine' or other relevant symbols.

That this is spiritual work is evident in the way that information becomes available. In my experience, an issue holder will always be astonished that the person, say, representing their father, might express features of his general morphology, such as a stiff leg, although the representative will not have met the man, indeed the man could have died long ago. Synchronicity in this work is also not uncommon, where the person that is being represented has profound aspects of life in common with the representative (Manne, 2009). The facilitator is trained to understand the information given by the representatives and the process that occurs. She or he is then able to consider how the individuals can be rearranged to allow love to flow in the most healthy way to restore balance.

At an appropriate point in the constellation, the facilitator will decide to ask the issue holder to take the place of their own representative. The re-balancing that is then arranged will allow the issue holder to gain new insights into the problem that they are seeking to address. The facilitator might suggest some sentences to the issue holder to assist this process. Examples of sentences are "you are the father for me", or "the burden is too heavy for me, I return it to you with love". The issue holder, who will have an awareness of the truth of these sentences, speaks the sentences. If they do not feel authentic, then the facilitator will suggest another sentence, until a sense of truth is achieved.

Re-positioning at the end of the constellation aims to provide the issue holder with a clear feeling of a shift in the issue or problem. This should enable them to feel lighter and to perhaps feel a sense of satisfaction with the status quo. My training has taught me to be able to understand the process during the constellation, the somatic changes within the participants, and to be able to recognise the moment when all those taking part are collectively releasing tension within their bodies when a sense of ease is apparent. The moment when the issue holder and others in the constellation breathe out deeply is usually a sign that there have been useful insights, and that the work is complete. The facilitator would check this with the issue

holder and perhaps continue for a while if the issue holder feels incomplete, although this is rare. If the issue is very complex, such as rape across several generations, then a series of constellations might be needed. These would need to be spaced a few months apart to allow the issue holder to reflect on the influence of each constellation.

The primary aim of this work is to provide the individual with a shift of perception regarding an issue that has troubled them. Constellation work can also be carried out in various locations in order to improve a situation in the school, workplace or in nature.

7.3 Historical aspects of constellation work

Constellation work was developed in the 1970s by the German psychotherapist, Bert Hellinger, The work is offered in many western Europe countries, and there are facilitators in the US and Australia (Cohen, 2006). It can be defined as "a trans-generational, phenomenological, therapeutic intervention with roots in family systems therapy, existential-phenomenology, and the ancestor reverence of the South African Zulus" (Cohen 2006:226). This definition means that the work can involve many generations of the issue-holder's family. It is phenomenological because the issue holder and those present experience the constellation as a phenomenon that is explored.

The aim is to provide therapeutic insights into the situation and rituals from several cultures influence this work. The concept of involving all members of the family in resolving a problem of one of the members of the family comes from the work of family systems therapy (Bowen, 1966). Existential phenomenology refers to the work of Heidegger (1962), where the experience and actions of the individual, in terms of their values, purpose and relationships, is seen as central (Jun, 2008).

Hellinger also claims that there are influences from shamanic and Kabbalistic traditions (Preiss, 2012). These influences often come to play where there is a need for a ritual exchange at the end of a constellation. For example, the issue holder might want to symbolically give a burden back to his (dead) father, with whom it belongs. The use of symbolic ritual can be useful in many circumstances, such as the issue holder bowing down to the person representing his father.

Family constellation work is not a form of psychotherapy because in psychotherapy the relationship between the therapist and the client is central and grows over time. The

development of a therapeutic relationship is central to the degree of efficacy of psychotherapy. In constellation work, the therapist/client relationship does not influence the outcome and the work is usually completed within one hour. Constellation work can be seen as a brief or solution-focused therapy (De Shazer, 1985). However, constellations do stimulate profound change in human beings (Manne, 2006). In this way, it can access feelings associated with death and dying, which might be influenced by inter-generational belief systems. This is particularly relevant to this research.

One of the central features of family constellation work is the transmission of information from individuals or beings that are not in the constellation, to those who are involved. Facilitators call this arena 'the knowing field'. Facilitators see this field as "an assumed storage medium extending beyond the individual" (Dragaset, 2014:28). The knowing field is based on the concept of the interconnectedness of all things.

Hellinger (2006) developed his perspective of the interconnectedness of all things from the writings of Jung (1927), who suggested that there was an individual consciousness, in that the person is aware that they are separate from others, and also a collective unconsciousness. Jung's (1936:99) thesis is that the collective unconscious is "a second psychic system of a collective, universal, and impersonal nature which is identical in all individuals. This collective unconscious does not develop individually but is inherited". Jung talks of archetypal beings and, in Hellinger's work, past and present members of the person's family and friends represent these beings.

Hellinger (2006) suggests that collective unconsciousness is concerned with the welfare of the group or the system. He goes on to suggest that this consciousness serves the survival of the group as a whole, as it can be seen as a drive to restore completeness and lies beyond judgments of good and evil. Hellinger (2012) suggests that a person's personal consciousness seeks a feeling of belonging, a sense of balance within the family system and a sense of order within the family system. These feelings influence what Hellinger called 'the orders of love' and these are developed through the affective domain. The orders of love are the unconscious rules between family members and between other people in relationships. These orders are, in essence, a guide for addressing entanglements and for finding the proper place for each person (and the associated trauma) in the system. An entanglement follows rules where a person in a later generation unconsciously carries trauma or pain on behalf of the ancestor, then attempts to

expiate painful feelings in the present day. Children might also choose, unconsciously, to take on the trauma or pain of their parents (Hellinger, 2006).

One of Hellinger's most useful insights is that individual consciousness is concerned with the belonging that is inherent to the collective consciousness. This need to belong appears to influence behaviours that seek to make reparation for some earlier exclusion in the family system. Hellinger et al.'s (1998) hypothesis is that if a person has been excluded from a family, or an imbalance perpetrated, then there will be repercussions in following generations, as the collective unconsciousness determines that a later individual within the family will represent the excluded relative from the past. This concurs with Bowen's (1974) ideas of family homeostasis in family therapy, which will be discussed later in this chapter. Experiences of violence, unusual death, war, addictions, missing adults, loss of children, miscarriage, termination of pregnancies, adoption and previous relationships can all leave an enduring effect on a family. Members of successive generations might not have any awareness of the root of their own emotional and spiritual disturbances.

The unique contribution of family constellation work is two-fold. The first is that it incorporates the proposition that current human emotional disturbances can be caused by trans-generational entanglements. That means that personal traumas experienced through relationships can reverberate upon collective unconsciousness and have an impact on later generations. The second contribution is the proposition that these problems can be resolved using the appropriate techniques. These techniques are based on 'orders of love' (Hellinger, 2006), as mentioned above, which reflect the needs of the personal consciousness. The resolution also follows the rules, or order, where the need for recognition, belonging and rebalancing is facilitated. To clarify then, these orders of love are: the need to belong and be loved; that there is a balance between giving and taking within a system; that there is respect for those who came earlier; and that there will be a loyalty in later members to represent those who have previously been excluded (Hellinger, 2006). The facilitator will use the orders of love to restore balance to the system within a constellation.

In my experience as a facilitator with people who find it difficult to have satisfying relationships, they might have felt that their childhood was less than ideal. By experimenting with family constellations, it is possible for understandings to be reached through the information that is provided from the representatives, from the knowing field. Sometimes by recognising the

difficulties their parents had had themselves as children, or particular challenges that had come into their lives, their adult child can release feelings of judgment. In ceasing to judge their parents harshly, the balance moves towards restoration. In my experience, there is always some movement, however small, towards understanding the parent. Forgiveness is a complex concept in family constellations and is not always appropriate or feasible. In circumstances where abuse is unforgivable by the issue holder, it is possible to find another, perhaps earlier, member of the family from whom the individual can draw courage and strength for the future (Manne, 2006).

7.4 Theoretical underpinning and empirical evidence

This section explores the theoretical underpinning of family constellations and empirical evidence relating to it. Constellation therapy is deeply connected to systemic family theory (which underpins family systems therapy) through shared understanding of the centrality of family, belonging and health. Family systems therapy is an established therapeutic approach, underpinned by empirical evidence (Carr, 2009). The research that supports family systems therapy can be extrapolated, to some extent, to support the use of family constellations.

I believe that it is a feature of most humans that close relationships are deemed to be important. This is supported by the work with the satisfaction with life scale (TSWLS) (Pavot and Diener, 2013). Our sense of 'who we are' seems closely bound up with the quality of our relationships. When relationships deteriorate, our perception can be that the world becomes more challenging. This can affect many aspects of our perceptions, including self-esteem and levels of self-confidence. When relationships are harmed, then a person can perhaps feel that their overall wellbeing or safety has been compromised. This section will consider the empirical evidence supporting family systems therapy and then will go on to explore the empirical evidence for family constellation work

7.4.1 Systemic Family Therapy

This concept of homeostasis within the family comes from the work of Murray Bowen (1974), a psychiatrist, who firmly believed that considering issues in one's family of origin was more fruitful than looking at current relationships. Homeostasis refers to the idea that families resist change in order to maintain a steady state (Bowmar, 2004). This state need not always be healthy and one member of the family might be stuck in a role that maintains this homeostasis,

at a cost to themselves. Systemic family therapy denies that there is value in seeing the individual as distinct from their family, or their closest significant others (Bowen, 1966). If one member is excluded or becomes unavailable, then the other members of the family are affected.

Systemic family therapy suggests that only by working with a person as part of the group can that person be 'fully seen', in the sense that they are valued and appreciated for who they are (Carr, 2014). That is not to say that the whole family is involved; that would not be possible and might be dangerous (in abusive families), but the presence and influence of the family is acknowledged, and might be explored. Stratton (2011: 5) defines the purpose of systemic family therapy as "to help people to mobilise the strengths of their relationships, so as to make disturbing symptoms unnecessary or less problematic". Strengthening the affective domain, through improving relationships, therefore has a positive effect on an individual's health, whether it is psychological, physical, social or spiritual health.

After a thorough systematic review of the evidence for systemic family therapy Carr (2009) concluded that this approach was effective for a wide range of common adult mental health and relationship problems. He updated this work in 2014 and looked at the research to support the use of systemic family therapies with children and adults. The evidence was conclusive that these approaches are extremely effective. Systemic family therapy has been recognised by the UK National Institute for Clinical Excellence (NICE, 2014) for a range of conditions, including psychosis and schizophrenia. Understanding the importance of family and relationships helps to explain the relevance of systemic family therapy to family constellations. It has been seen here that the research on systemic family therapy provides evidence to support the effect of positive family relationships on strengthening feelings within the affective domain.

7.4.2 Family constellation therapy

Up until 2008 there had only been small research projects whose outcomes tentatively demonstrated the value of family constellations. One of these by Hoppner (2001) was a small quasi-experimental controlled trial with non-clinical participants. He found that four months after the family constellation there was an increase in physical and psychological health, improved perceptions of self-esteem and a decrease in psychopathological symptoms. Wolynn, (2005) used the strategy with people who were self-harming. He documented three cases, using a case study approach. In each case there was a marked improvement in perceptions of self-worth. Results were immediate and sustained, although there is no information on longer-term

sustained change and using three cases is limited. Sparrer and Varga von Kibed (2008) argue that there are ample case studies to indicate the value of family constellations, but that there needs to be more empirical research undertaken.

Cohen used constellation work with prison inmates for his doctoral research (Cohen, 2008). Several sources of data were used, including those from thirteen sets of constellation meetings with nine prisoners. Most of the prisoners were serving life sentences and all had committed violent crimes, such as rape or murder. Cohen (2008) used content analysis to develop themes from not only the meetings, but also the contexts surrounding the meetings, such as Islamic prisoners withdrawing on religious grounds, although they tended to return and did participate. This is a typical quote from one of the nine prisoners, after his experience with his family within a constellation setting:

> "I was carrying all this weight. I hated my father for abandoning me, my stepfather for the beatings, my brother for disappearing, and myself for all the harm I have done, especially being involved in a murder. Because of the constellations I have been able to feel like I am *somebody*, be openhearted, be patient, be forgiven. Now I walk a spiritual path, with wisdom, compassion, and truth in my life" ('James' in Cohen, 2008: p.103)

Self-reporting by the prisoners indicated that the constellations helped them to resolve difficult emotions and estrangements from those they loved. The constellations helped them to confront the faces of their victims and to also come to terms with the death of their loved ones (Cohen, 2008). The results support the use of family constellations with perpetrators and victims of violent crimes and their descendants.

There has been a small-scale pilot study carried out by members of the Nowhere Foundation (2012) on the use of the principles of constellation work with 16 Wiltshire primary schools. This has been part-funded by the Department for Education and Skills (DfES). A 'feelings thermometer' was used. This is graduated, colourful and hangs from the ceiling, so that children can clip on their own named peg every morning. This lets people know how they feel. A mobile hangs in the centre of the classroom with each child represented by a small hanging picture. "Being in balance helps us learn," explained nine-year-old Ben. "If someone's causing trouble or being noisy, Miss puts a peg on the mobile and it goes out of balance. We know that's not

helping us get on so we all have to decide what to do to get it back in balance" (Montague, 2006:31).

Interventions also included the use of individualised painted pebbles for each child. During circle time at the beginning of the day, each child was asked to place their pebble near the centre of the circle to represent how included they felt. A pebble placed close to the centre indicated the child feeling fully included. A constellation was represented enabling teachers to easily see which children were not feeling part of the group. Teachers and assistants could then take steps to help the child to feel included. A study of schools involved in the initial phase of the project found that, almost without exception, children were more relaxed, and there were fewer tantrums and there was less aggression and rudeness. The results suggested that, after the interventions, children were calmer and performed better in standard assessment tests (SATs). (Nowhere Foundation, 2014).

A group of German psychotherapists carried out a randomised controlled trial on family constellation work (Weinhold et al, 2013). They recruited 208 adults from the general public who were randomly allocated either to a constellation group or a waiting list control group (who received the same treatment 4 months later). To avoid harm, participants were excluded from the intervention if they showed (a) acute suicidal tendencies, (b) an acute psychotic episode, or (c) an acute drug or alcohol intoxication. Most had done constellation work before, which is an important point, as it tells the reader that most of the participants were familiar with this strategy. A three-day workshop was carried out with a package of three psychological functioning tests administered both before and after the workshop. Results showed that there was a statistical difference between the groups at 2 weeks and 4 months, after the workshop. There was a significant increase in psychological functioning in the intervention group with a corresponding decrease in psychological distress and motivational incongruence. It was found that including those people who had previously experienced the role of a representative would enhance the pace at which new people would settle into the process. The authors point to the efficacy of this intervention in people who are mentally well.

Weinhold et al.'s (2013) research appears to have been managed well. It is particularly interesting that those who were observers or representatives in the workshop had similarly good outcomes to those who were the issue holders (Weinhold et al, 2013). This points to positive experiences for all those involved. The limitations of this research were that the results are not

generalisable because of the self-selecting sample. Weinhold et al. (2013) also suggest that using a control group treatment, rather than a waiting list control group, might have enhanced the results.

The evidence underpinning the use of family constellations is in its early days. There is evidence from small-scale case studies and Booth Cohen's larger study, but only Weinhold et al. (2013) have published findings that use quantitative research. However, the findings do support its use in developing EQ and SQ through the affective domain, particularly in areas of trauma, such as fear of death.

7.5 Underpinning theoretical constructs

This section discusses the theorisation within family constellation work, as opposed to the external theories that have informed it, which were the subject of the previous section. The knowing field falls into that realm where physicists and psychologists find it difficult to explain phenomena that ordinary people experience, such as consciousness, emotions and belief systems. Although we are aware that these aspects of consciousness are real, in terms of shared experiences, they appear to be outside physical measurements and are often labelled 'spiritual'.

Quantum theory starts to help to explain how this knowing field might operate. Quantum theory was developed early in the 20th century to explain the mechanics underlying the behaviour of atomic particles (Rosenblum and Kuttner, 2006). The word quantum relates to the discrete energy of these particles; that is the energy that can be quantified. Quantum physics has so far provided explanations for radioactivity and antimatter (McKee, 2006). Eminent physicists such as Max Planck, Albert Einstein and Niels Bohr were involved in the early work of developing quantum physics. The emergence of quantum physics attempted to address questions that saw beyond the possibility of quantifying all aspects of our environment. Veneziano (1968) was the first physicist to model the energy of atomic particles as strings. The force of the atomic particles makes sense to physicists if they consider the particles as tiny vibrating strings. The String theory developed, became multidimensional and was then re-named M theory, although what the M stands for is intentionally mysterious (Greene, 2012).

One of the theories of quantum physics is that matter can exist in two states or places at the same. This is called duality. An explanation for duality might be entanglement. This is where

objects have interacted with each other, then have moved far apart, but have become interdependent. These objects are entangled, as changing one of the objects will lead to a change in the other, even if they are separated by thousands of miles (McKee, 2006). Einstein called this 'spooky action at a distance' (Brooks, 2004). Experiments continue regarding applications of this idea, with physicists now being able to explore entanglement in more macro systems (Vedral, 2008).

A number of physicists have gone on to explore the more spiritual aspects of quantum theory. Initially, it was seen by physicists that the model of Cartesian duality was no longer helpful and that the division of the human being, into mind and body, was missing an important connecting influence. If an electron could be recognised as a particle, and at the same time, a field, then a pre-quantum view of reality was called into question (Rosenblum and Kuttner, 2014). Some of the physicists involved in this work went on to question the nature of reality. One of these was the highly respected physicist David Bohm (1917-1992).

Einstein was interested in Bohm's work, particularly the philosophical dimension, although he continued to have reservations about the quantum physics proposal that an object is real only because it is perceived. Einstein wanted physics to more clearly represent reality in time and space (Rosenblum and Kuttner, 2006). Time and space are not constant in quantum physics, nor in our perception of reality. We now understand more about time being a human construct and that space changes according to perception (Friedman, 2014). Up to his death, Bohm continued with his questions regarding the nature of reality. He argued that there are levels of mind that communicate with other levels of mind. His understanding from quantum physics, that reality was constructed by the human mind, led him to suggest:

> "If [man] thinks of the totality as constituted of independent fragments, then that is how his mind will tend to operate, but if he can include everything coherently and harmoniously in an overall whole that is undivided, unbroken, and without a border then his mind will tend to move in a similar way, and from this will flow an orderly action within the whole." (Bohm, 2012: p. xi)

Thus, each area and level of the mind takes part in the perception of awareness. All levels are said to be interconnected and, in the human body, there is wholeness, with mental and physical processes participating together. Bohm (2012) further suggests that intellect, emotion, and the

whole state of the body are in a similar flux of fundamental participation. Bohm (1990) mentions a 'collective mind'. There can be no way to separate the mind from the body, as this interconnectedness is systemic. This resonates with the earlier work by Jung (1936) and with the psychologists who continue to research the collective unconsciousness. Contemporary psychologists are using Jung's ideas to develop research into unconscious emotions (Hunt, 2012; Woodside et al, 2012; Jacobi, 2013 and Carminati et al, 2013).

Rupert Sheldrake, a biologist, has espoused the quantum theory ideas of interconnectivity in the form of what he calls a 'morphogenic field' (Sheldrake, 1996). This field, like the magnetic field, is always there, but is significantly more difficult to demonstrate than the magnetic field. Referring back to the earlier discussion of quantum physics, it suggests a version of the concept of entanglement, but on a macro (non-testable) scale. Sheldrake (2013) further suggests that these ideas might also involve the concept of time, in that if time were eradicated, then my knowing what is happening now would seem, to the being of myself yesterday, to be inexplicably all-knowing.

Sheldrake (2013) argues that the way that science has been viewed as a materialistic, mechanistic field is now outdated. He proposes that twenty-first-century science will embrace a more holistic, multi-professional approach to science that will look beyond materialism. The work by Hay and Hunt (2000), Bohm (2012), Tremblay (2013) and Sheldrake et al. (2013) has gone some way to explore this idea that there is a unifying field that connects human beings. It is supported by the work of contemporary psychologists who are developing the ideas of Jung (Hunt, 2012; Woodside et al, 2012; Jacobi, 2013, Carminati et al, 2013, and Chang et al, 2013). It would follow that this field might be able to provide information to those who can access this energy. This information could even be used as a therapeutic tool, as is the knowing field in family constellations.

7.6 Uses of family constellations

Due to its ability to explore and potentially resolve relationships, constellation work is used in business, organisations, health, community and education settings. A German professor of psychology, Franz Ruppert (2008), is using family constellations with people with mental health issues, such as schizophrenia and bipolar disorder. He has developed the work in the particular context of trauma. The work is also being used with children as part of their therapy, along with sand tray work (Salters, 2013). As mentioned earlier, a project called 'enhancing children's

learning' (ecl) is continuing in Wiltshire with 16 primary schools. In these schools, the interventions between teacher and children are based on family constellation work (Nowhere Foundation, 2014).

Shi, a neuro-psychologist at the Chinese Academy of Science, Beijing, is teaching family constellation work to psychology undergraduates as a technique for helping people (Schenk, 2014). Therefore, it can be shown that constellation work has been used in a number of contexts. However, as yet, there has been no research with students in higher education.

7.7 Family constellations and student nurses

Family constellation work offered for my study an experiential route, in a safe context, into student experiences of difficult feelings and an opportunity for them to start to develop supportive peer relationships. I considered this strategy worthy of inclusion in this study because it allowed the students to have insights into the difficulties experienced in families when there is loss and grief. Examining conflicts in families would reflect the students' own deep feelings in terms of EQ and, where death was included, SQ. I was confident that, by exploring these feelings in a group over several weeks, the students' EQ/SQ could be enhanced.

Resolving fears to do with death and dying, as well as entanglements in a person's family life, could empower students to focus on current issues, such as the undergraduate programme. This strategy was innovative and unusual. There was little chance that the students would have met with the family constellation work prior to commencement of the programme and so this would not confound the research.

Family constellation work offered a way to interact with a group of students on a regular basis over six weeks, prior to their first placement. It was not known what effect it would have on the individual student, but it was probable that general issues to do with death and dying would be addressed during this time. It is unusual to experience a constellation where the dead are not represented in some way. Particular aspects of death that might be addressed were: fear of being dead; fear for significant others; fear of the unknown; fear for the body after death and fear of premature death (Neimeyer and Moore, 1994).

It takes two years to train to use these techniques and I completed the course in 2010. This involved a significant amount of experiential group work, as well as practicing the management

of family constellations. I was ready, by February 2011, to try to implement these skills with the new intake of student nurses, with their consent.

7.8 Conclusions

Both the DSD strategy and the family constellation strategy are seen to be equally relevant to potentially strengthening feelings within the affective domain. This chapter has discussed EQ and SQ. There has been a discussion of family constellation work, the theoretical underpinnings that this strategy is based upon and the contexts in which it can be used. The way in which work is facilitated has been described, although every family constellation is unique. A search has resulted in a discussion of the published empirical research on this work. This research, though limited to date, demonstrates the value and place of this work, both in developing groups and addressing problematic issues within an individual's life. After a review of the published research, and the deeper theoretical underpinnings, it appeared that this strategy would be worthy of exploration with student nurses. It is proposed that developing EQ and SQ within the students' would allow them to be more able to manage their own emotions and to be able to make sense of the contexts in which these emotions are experienced, such as in the care of dying people and their families.

Having decided upon the strategies that might contribute to the amelioration of fear when caring for dying people, a need for a coherent methodology was identified. This will be explored in the next chapter.

Chapter 8 The research design, methodology and methods

In order to set the scene for the choice of methods used, it was important to explore the philosophy and paradigm that underpinned the construction of this research. It was also important for me to link the philosophical underpinnings, the methodology and the methods and to see them as being related and harmonious. This is integral to the quality of the overall research. The ontology and epistemology of the inquiry were explored and this helped to identify the paradigm that frames this study. An emergent pragmatic paradigm helped to validate the choice of a mixed method approach that incorporated a heuristic perspective.

This chapter provides an overview of the research concepts underpinning the methods used. The factors that affected the choice of the methods are identified. There is a discussion regarding the issues that led to the use of a questionnaire and then interviews, which were analysed using Interpretive Phenomenological Analysis, (IPA) (Smith et al, 2009). The concept of hermeneutics was useful in the interview interpretation process and this will also be explored in this chapter.

8.1 A guiding paradigm

Guba (1990:17) defined a paradigm as "a basic set of beliefs that guide action". Social science paradigms provide overarching frameworks for research studies that explore the perspectives of the population. Denzin and Lincoln (2011) distinguished between paradigms and perspectives. Paradigms are said to be the constructions that give meaning to the organisation of a worldview, whereas perspectives are on a smaller scale. In order to explore the paradigmatic underpinnings, I considered the ontological and epistemological perspectives of this research. Ontology refers to one's perspective of how reality is constructed. Wand and Weber (1993:220) referred to ontology as "a branch of philosophy concerned with articulating the nature and structure of the world." In this research, I mostly take the view that the nature of the world is constructed through beliefs and experiences of individuals. This is a constructivist view, where reality is seen as socially constructed. This is a view that requires periodic revision, as the social actors within a context, which can change, are constructing reality.

This is the opposite view from the realists who see reality as a perspective that exists independently of observation and measurement (Woods, 2012). In the last chapter, a brief

introduction to quantum physics demonstrated that there are behaviours of sub-atomic particles that are empirically observed and measured. These phenomena could be said to be real, but they might be just a small part of a quantum level yet undiscovered.

It is possible to hold a constructivist and a realism view concurrently. Hammersley, (1992) suggests that one can hold a belief that there are independent phenomena within our view of reality, and that these can be explored from the subjective stance of human experience and beliefs. Woods (2012) explained that Hammersley (1992) named this 'subtle realism' and Pring (2000) named it 'robust realism'. Cupchik, (2001) added a third term, 'constructivist realism' and maintained that this ontological position accommodated the best of positivism and interpretivism. In terms of the development of knowledge within this research, my perspective reflects this position.

Hirschheim et al. (1995:20) defined epistemology as "the nature of human knowledge and understanding that can possibly be acquired through different types of inquiry and alternative methods of investigation." *How* we know is the realm of epistemology. The epistemological position used in this research reflects an interpretivist stance. This is where it is recognised that the social world differs from the natural world, where a more positivist stance is possible. In the social world, behaviour is interpreted through an understanding of people's perspectives. Knowledge might also be affected dialogically through discussion and acceptance of diverse perspectives. Woods (2012:4) sees this "as being in the spirit of an open approach to knowledge". This open approach to knowledge embraces a need for the research to be more than meaningful. In my research, the results need to be useful so that nurse education can enhance nursing practice.

The ability to learn through developing emotional and spiritual intelligence is a feature of my research. Research aims 1 and 4 relate to gaining an understanding of the students' feelings regarding death and their experiences with dying people. Aims 2, 3 and 5 refer to acquiring and using information to lead to recommendations regarding the amelioration of fear of death in neophyte student nurses. Developing this knowledge required the researcher to use methods that would explore the students' feelings regarding death and dying, and also how they felt in contexts where people were dying. These explorations contributed to the development of an epistemology that was based on interpretivism.

To summarise, the aims of this research relates to how people within this particular profession in society learned about fear of death and dying how they might learn to better cope with and manage these fears. Nurses cannot learn about death in isolation from peers and patients; any death involving nurses is a socially constructed event. This means that the people involved in the event (patient, family, friends and staff) will ensure that each death is a unique event, due to the combination of the people involved. Exploring these feelings of fear involved interpreting the students' views of reality and going on to construct useful ways to facilitate learning through the affective realm. An underpinning philosophical position that reflected an interpretivist, open approach epistemology that could affect practice was sought. Paradigms were explored and a pragmatic paradigm emerged as one that contributed to the epistemology through focusing on the relevance of change.

8.2 A pragmatic paradigm

The philosophy of pragmatism reflects the ideas of John Dewey, a philosopher who was publishing from 1884 onwards. Dewey argued that beliefs are based on actions that arise as outcomes of inquiry. Dewey (1905) asked us to refocus on inquiry as a central form of human experience. He argued that our experiences of the world are shaped by the nature of that world, while our understanding of the world reflects our interpretation of our experiences. If we understand that acting on beliefs will change the way we view the world, then we can effect change through acting on beliefs. Other paradigms do not eschew change, but the philosophy behind them is less fluent in terms of the outcome being a trigger for change.

The pragmatic paradigm draws our attention to the influence of experience on our views and knowledge. Pragmatism views the different approaches available to researchers as different social contexts for "using inquiry as a form of social action", where reality can change according to actions and their consequences (Morgan, 2014:1049). Because of the perspectives regarding inquiry into social reality, a pragmatic paradigm provided an accurate epistemological view of the research. After a clarification of the philosophic and paradigmatic underpinnings of the study, the approaches and methods used in the research are explored in sections 9.3 to 9.8.

8.3 A mixed methods approach

In this research both the quantitative and qualitative paradigms have been considered, and are valued. The focus on action determining change is the value of the pragmatic paradigm here.

Denzin (2012) also suggested that a methodological hierarchy in which quantitative methods dominate qualitative methods is perpetuated through the use of mixed methods. This can only be true when the quantitative findings are valued above the qualitative results, which is not the case with this research.

An epistemology based upon a pragmatic paradigm led me in the direction of using a methodology that embraced both quantitative and qualitative methods. Other paradigms could lead to the use of both quantitative and qualitative methods, but pragmatists advocate this approach because using both methods enables the researcher to gather data in more than one form, which facilitates a variety of views of the central issues within the research (Morgan, 2007). This mixed methods approach allowed for the research aims to be met in an effective and efficient way.

I have come to understand that mixed methods can be a useful way forward in considering a social phenomenon, such as death and dying. Johnson (2009) advocated a mixed methods approach using a dialectical pragmatism. This approach requires careful listening and sensitive consideration of multiple viewpoints. The researcher is required to consider the relationship and the tensions between the quantitative and qualitative methods and results. Johnson (2009) suggested that the goal is to produce an approach to research that synthesises relevant insights from both quantitative and qualitative perspectives.

I was exploring feelings around death experiences, where attitudes and beliefs are influenced by a number of factors. The literature (Chapter 4) had suggested that stressors from the academic preparation, and also from experiences in practice (including death experiences), cause students to decide to leave the programme in a variety of ways (Department of Health, 2006; Pryjmachuk et al, 2009; Eick et al, 2012; Crombie et al, 2013). This situation is unfortunate for both the individual and the profession and indicates that changes are needed.

The first two of the five research aims were concerned with understanding fear of death in new student nurses, and how these fears could be affected by using strategies that strengthen aspects of the affective domain. These aims could be achieved through the use of a quantitative method. The third aim, illuminating the demographic picture of the student group was also best achieved through quantitative strategies. I decided to search for a robust tool that would act as a self-completion questionnaire so that the required data could be gathered. The fourth research

aim reflects the desire to discern the emotions of the students in terms of their experiences with dying people. The fifth aim seeks to identify how educational strategies might ameliorate these fears. The data required to address the fourth and fifth research aims were gathered through the qualitative method of interviewing appropriate participants.

I planned to administer a self-completion questionnaire to a cohort of new student nurses in the first few weeks of their nursing programme. After the administration of the questionnaires, members of the group were randomly allocated to three groups. Two of these three groups experienced the proposed interventions (DSD and family constellations), and the third acted as a control group. Following the intervention period, clinical practice was undertaken. When the students returned to the university, the questionnaire was re-administered and the students received a request to be interviewed.

8.4 A heuristic inquiry

An heuristic inquiry is a form of inquiry that highlights the personal experiences of the researcher (Patton, 2002). The term 'heuristic inquiry' was adopted by Moustakas (1990) to illustrate the closeness of the researcher and participants when experiences had been shared. Sela-Smith (2002) related how, when Moustakas' daughter needed heart surgery, he explored the processes he needed to go through in order to make an informed decision with regards to her treatment. His fear for her prevented him being able to decide and his wife had to give consent. Moustakas stayed with his daughter and considered his own feelings and how his daughter and other patients might feel. This experience highlighted a life-long interest of Moustakas into loneliness and the influence of the experiences of the researcher on the research and also on the researcher themselves, in terms of transformative learning (Sela-Smith, 2002).

This experience led Moustakas to identify the need to further explore the journey of the inquirer during a research project. Moustakas suggested that through an exploration of difficult feelings, the researcher could find positive values (Kenny 2012). Speaking on loneliness, perhaps a feature of doctoral research, Moustakas (1961: 54) suggested that the person "maps new meanings and perceives new patterns for old ways and habits". Having been a nurse and looked after many dying people and their families, the exploration of difficult feelings and the effects of this exploration was a phenomenon that I understood. I wanted to explore how others experienced the context of death. Etherington (2004:99) stated, "In a heuristic inquiry the

researcher is required to have some personal connection with the topic through which they filter their participants' experiences". Being aware of this approach was important for my study because the researcher and the participants all belonged to the culture of nursing, with its shared values, language and regulations.

This research could not take place in the same way if a nurse was not the inquirer, with her own experiences of death and dying. My clinical experiences included ten years of caring for people who were dying. My early years as a nurse gave me many memories of how care could be improved. Many deaths felt sudden and shocking to an eighteen-year-old with no prior experiences. The trauma of death became familiar in a way that can perhaps only be understood by someone who also works with dying people. I also remember the relatives of many of my patients.

One day, during my early student years, an elderly gentleman had died unexpectedly after lunch. His wife did not have a telephone, but the nurses knew that she would soon be arriving for visiting time at 2 pm. She arrived and the staff nurse told her gently that her husband had died. She was shocked, but sat with his body until it was time to prepare him for his journey to the morgue. His wife accompanied the porters and we didn't see her again. The ward was extremely busy. I woke in the middle of the night, very upset, as I had no idea how she had got home, nor if anyone was there to care for her, to make her some tea, to help with the funeral arrangements. I imagined an old lady, bereft, waiting for a bus on a busy High Street. My concern for that woman has not diminished, although she must have joined her husband long ago. This memory illustrates the depth of the feelings that can be evoked at these times.

My many experiences in clinical practice had meant that I was familiar with the experiences of student nurses in relation to death and dying. One of my worst memories, as a nurse manager, was telling a young couple that their small daughter had died (after an accident causing major scalds). One of the student nurses accompanied me to observe, and I will not forget the look on her face at that time. There can be feelings of horror, sadness and vulnerability in these situations. By experiencing these moments, the student can learn to experience and express authentic feelings of empathy, and develop skills to function effectively at an appropriate professional level.

I continue to be closely connected to the lives of first-year student nurses; I have been the first-year tutor, have been on the first-year teaching team for twenty years and am at present teaching on three of the four first-semester modules. The disadvantage of being close to the students is that their perception of me would be more likely to be as a teacher, rather than as a practitioner of my clinical profession. My awareness of this potential hierarchy affected the choice of quantitative and qualitative methods, the data analysis and the discussion of results.

8.5 Strategies of inquiry – quantitative methods

Denzin and Lincoln (2011) suggest that quantitative methods enable the measurement and analysis of relationships where correlations can be shown between variables. Quantitative methods can enable the researcher to gather valuable information from large numbers of a population and can allow the researcher to develop models or constructs regarding the issue under examination.

In this research selected interventions were used to enhance EQ and SQ through the affective domain. It was important to have an appropriate sample and to use the best, most effective tools available in order to address the aims of this research.

8.5.1 Choice of questionnaire

Academically credible death anxiety scales were explored through databases and also from the 'death anxiety handbook' (Neimeyer, 1994). However, four of the six scales discussed by Neimeyer were found to be one-dimensional and unsuitable for student nurses. The scales had been designed and tested by researchers from the field of psychology but had not been applied to other groups. I felt that in order to challenge personal and professional perspectives of death ('how do I feel'? As opposed to 'how should I feel'?), a multidimensional tool was the most appropriate. A multidimensional tool would cover more than just the personal perception of the participants towards their own death. These tools also use questions on professional and other perspectives, but they are inquiring into subjective views and feelings.

The assessment tools I reviewed were all self-completion questionnaires, as the issue under inspection is fear of death and, therefore, the nature of the questions is personal. Neimeyer's book, although thorough, was twenty years old and I needed to assess work that had been done on death anxiety scales in the interim. A search was carried out using the databases Medline,

CINAHL and Google scholar. These searches enabled me to identify several newer scales that had been evaluated for validity and reliability (Curtis, et al, 2002; Wong et al, 2004; Peters et al, 2013). As well as identifying an established questionnaire that was multidimensional and useful for nurses, it was important to use one that was easy for the student to read and would not demand too much of their time. Using more than half an hour would be impractical, during this congested programme. The language needed to be appropriate for new student nurses, where previous academic achievements were not known, but would have been quite varied. The research design was intended to lead to results of the questionnaires that would produce clear, reliable data that would illustrate the orientation of the student group towards issues regarding the dying person and their families (research aims 1 and 2).

I identified six 'fear of death' scales within the literature that could be assessed for possible use. These had all been implemented in different locations with different sample numbers and had been found to be useful (Peters et al, 2013). One of these measured feelings surrounding death from the patient or relative's point of view. An example of this was asking questions regarding the importance of high-quality care at the end of life (Curtis, et al, 2002). These questions were more tailored to families evaluating care after the death of a loved one. I considered this inappropriate to use with student nurses, who needed a scale that offered a mix of personal and professional questions.

Another instrument, The Frommelt Attitude Toward Care of the Dying (FATCOD, 1991) Scale is a 30 item questionnaire that measures nurses' attitudes toward caring for dying people and their families. This scale was highly appropriate, as it was designed for nurses, but that also meant that those students who had no experience of death, or caring for dying people, would be disadvantaged. It was therefore discounted, although its use with more experienced students would be considered in the future. Four scales were found to be potentially useful for neophyte student nurses. They are summarised in table 8.1.

Table 8.1 A comparison of fear of death scales

Name of scale	Authors (date)	Advantages	Disadvantages
Death Attitude Profile (DAP)	Wong et al. (2004)	Multidimensional. Five areas of attitudes to death addressed Clear questions (32) Has been used with nurses.	No particular aspects for fear of the dead body. Significant focus on spiritual beliefs as well as death beliefs.
Fear of Death and Dying Scale (FDDS)	The Collett-Lester (1969) Updated by Lester (2004)	Multidimensional. Four dimensions of fear of death covered in depth (32 questions).	Has not been tested. Personal questions asked, no professional questions.
Death Anxiety Scale (DAS)	Templer, (1970) Updated by Nehrke (1974) Revised by Thorsen and Powell (1992)	Multidimensional. Wide range of 25 personal questions	Limited professional questions. Not previously used with nurses.
The Multi dimensional Fear of Death Scale (MFODS)	Hoelter, 1979	Multidimensional. Wide range of 42 questions in eight categories. Professional as well as personal questions. Trialled with student nurses.	Long questionnaire. Complex scoring.

The Death Attitude Profile (DAP; Wong et al, 2004) offered a 32-item Likert scale, which addressed fear of death in five areas. These were: fear of one's own death and that of significant others; the reality of death; aspects of the afterlife; death as an escape from a miserable life and death avoidance strategies. These aspects were important but did not give the breadth required of nurses who would be caring for people before and after death. I considered it important to include aspects of the handling of dead bodies in the questionnaire. I also examined the questions and found that ten of the 32 referred to belief in the afterlife, which was an aspect that was not central to the research aims of this study. Peters et al. (2013) used

a revised DAP scale with sixty trained nurses and obtained useful results. However, they agreed that the tool might not have captured all aspects of the nurse's feelings.

The Collett-Lester Fear of Death and Dying scale (1969) was also explored. It is British based and the revised version is only twenty years old (Lester, in Neimeyer, 1994). It covered four aspects; one's own death; one's own dying; the death of others and the dying of others. However, this scale has not been well tested. Also, the questions seemed mainly personal and I was looking for questions that reflected a mix of personal and professional fears. However, looking at this scale again, I feel that this is a very valuable tool, as the sentences are so sensitively constructed. I would consider the use of this tool in future work, with all levels of student nurses.

The next scale that was considered was the Death Anxiety Scale (DAS, Templer, 1970). This had been modified by Nehrke (1974) and then further revised by Thorsen and Powell (1992). This tool has been well tested and been shown to be reliable (Peters, 2013). Thorson has revised it over several iterations. It was convenient to use and seemed to cover personal and professional fears such as 'the pain involved in dying frightens me', 'I am worried about what happens to us after we die', 'I am not at all concerned with being in control of things' (Thorsen and Powell, in Neimeyer, 1994:39). It seemed the best tool for use until I read the Multidimensional Fear of Death Scale, which seemed to offer an enhanced dimension of professionally orientated questions.

The Multidimensional Fear of Death Scale (MFODS; Hoelter, 1979) has 42 questions that are rated on a 5-point Likert scale (see Appendix E). There are eight categories that cover variations on the fear of death and dying, the unknown, and issues to do with bodies. These were discussed in Chapter 5 (table 5.1) in relation to the feelings associated with these categories and shown again in table 8.2. It can be seen here that the eight categories cover a wide range of responses to death and dying.

Table 8.2 Categories of Fear of Death (Hoelter, 1979)

	Fear of death categories.
1	Fear of the dying process.
2	Fear of being dead.
3	Fear of being destroyed.
4	Fear for significant others.
5	Fear of the unknown.
6	Fear of conscious death.
7	Fear for the body after death.
8	Fear of premature death.

Neimeyer and Moore (1994) explored the validity and reliability of this scale and found it robust. They include a copy of the scale in Neimeyer's book "to encourage its use in future studies" (1994:104). I found the questions to be of a highly personal, but also potentially professional nature. Questions were included such as, 'discovering a dead body would be a horrifying experience', 'I do not want to donate my eyes after I die', 'I am afraid of things that have died' and 'there are probably many people pronounced dead that are really still alive' (Neimeyer, 1994:118-9). These were some of the issues that student nurses would be addressing. Post-doctoral research by Chen et al. (2006) reviewed and implemented the MFODS with undergraduate nurses in the US. Their findings validated the use of the tool and suggested that fear of the unknown (factor 5) is higher in nursing students than in the non-nursing student control group.

They concluded that death anxiety develops early in undergraduate nursing programmes. The work done with this scale indicated that it would be the one that would be most useful in this research, as it would facilitate the achievement of the first two research aims in a more efficient and effective way than the other four scales examined. The implementation of this tool is discussed in Chapter 9.

Denzin and Lincoln (2011) explain that quantitative data seeks to describe a state and does not attempt to explore human behaviour; that contextualisation is the domain of qualitative methods. The use of the MFODS enabled me to systematically compare the students' fear of death before and after the two interventions (DSD and constellations) and also their experiences with people

who were dying. The second part of the data collection involved exploring the experiences of the students with regards to death and dying.

8.6 Design of the qualitative Inquiry – phenomenology, phenomenography and Interpretive Phenomenological Analysis

In order to draw conclusions on the experiences of new student nurses and how best nurse teachers could prepare these students for meeting death within clinical practice (research aim 5), I intended to gather and record the experiences of student nurses. Interviews were chosen because this method best allowed me to achieve these research aims. I felt that this would be the most effective and efficient approach. I have carried out ethnographies in the past, which involved the use of interview and I was aware that the observation part of ethnography would not be time-effective on this occasion. Although observing incidences of caring for patients with new student nurses would have provided first order experiences for the researcher, the complexities of being a researcher when care is being provided, and the student is learning from her mentors, precluded this approach. Focus groups were not appropriate here, due to the extremely personal nature of the information that the student was expected to share. I decided that the best method would be the use of semi-structured interviews where the researcher can achieve flexibility and depth of questioning.

Fifteen semi-structured interviews of approximately one hour were carried out. This was a convenience sample, gathered through the students who were willing to be interviewed from the 56 students who had completed the second questionnaire. The design of the interview and the rationale for this, along with ethical considerations, are discussed in depth in Chapter 9. The interview was carried out in private within the student's clinical practice setting. A semi-structured approach was taken, using an interview schedule that reflected the research aims. These are shown in table 8.3.

Table 8.3 Semi-structured interview schedule

	Aim to guide questions
1	To explore with the student the reasons for differences between the MFODS responses at stage 1 (Feb) and stage 2 (Oct). Had any differences been related to participation in DSD/family constellations?
2	To identify if a journal had been kept during the first year of the programme.
3	If so, how was this helpful?
4	To explore an occasion where the student had cared for a person who was dying, in order to explore their feelings during and after the experience.
5	To identify sources of support during this time.
6	To identify any development of specific skills related to the care of dying people.
7	To explore what skills the student used and what skills were developed.
8	To explore what factors in the student's personal life support their work?
9	To explore how the student's age, gender, prior experience, ethnicity or spirituality affect their perspective of death.
10	To explore what factors would help to prepare new students to care for dying people and their families.

In the interview schedule, items 2 and 3 referred to a journal that the student had been asked to keep for a particular module that runs through their first year. It was hoped that the journals would help the students to record experiences that had been challenging and that reflection on these experiences would be helpful. In reality, only one of the interviewees had kept a journal, and she had kept the journal only for a few weeks. I decided not to pursue this thread after the first six interviews, particularly as the data being collected was extremely useful in terms of the other interview aims.

The semi-structured nature of the questions allowed the key areas to be explored, but also allowed me to diverge away when a new concept was shared. Gill et al. (2008) suggested that this approach allows for flexibility and for the students to elaborate on areas that they feel important but had not been anticipated by the researcher. The areas to be covered had been

stated in the information letter (Appendix F) and the students had all completed the MFODS questionnaires twice in the previous year.

The results of the quantitative data had led me to believe that there had been a change in fear of death over the period of eight months. The specific aims of the interviews arose from the results of the MFODS, as well as the literature that was discussed in Chapters 3, 4 and 5. These specific aims will be discussed in Chapter 9. In order to give due respect to the information provided by the interviewees and to meet the research aims, approaches to analysis needed to facilitate the most rigorous outcomes. Chapter 9 discusses the planning and implementation of the interview phase in some depth.

8.6.1 Using a phenomenological approach to the qualitative method

Phenomenology is seen as a study of the lived experience, where the researcher seeks to find the meanings that particular experiences have for the participants. This reflects the ideas of Heidegger (1994), where humans are seen to be 'a being-in-the-world' (Dasein) and the in-depth examination of experience yields valuable data. Heidegger (1994) saw phenomenology as an interpretative interaction. The researcher seeks to explore and illuminate an experience at several levels and seeks to expose the hidden layers. This can be illustrated in the case of this study by considering the perception of death, and how this might differ between the student, in this case, and the researcher. Meeting the research aims would require clarity based upon a shared understanding of death that can be negotiated between student and researcher, where the relationship is influential in the conclusions formed. This is in contrast to the earlier work of Husserl (1970) where phenomenology was seen as a descriptive inquiry.

The interpretive phenomenological approach fitted in with a pragmatic paradigm, as the uncovering of the hidden layers provides insights regarding possible changes in educational approaches to preparing student nurses for caring for dying people. This reflects a pragmatic paradigm, as the focus is on the positive change that will result from the research and how this might be facilitated.

Powers and Knapp (1995) describe phenomenology as an approach to enquiry in which prior knowledge and experience are suspended so that the item under scrutiny is seen afresh, without the pollution of previous perceptions. Bracketing, where one's natural assumptions are suspended, allows what is essential in the phenomenon of consciousness to be understood

without prejudice (Le Vasseur, 2003). The use of bracketing in the Husserl school is clear, whereas the importance or relevance of the use of bracketing in the Heidegger school seems obscured by a question of whether bracketing is ever really possible. With this research involving difficult experiences with people who are dying and their families, it seemed that bracketing would be a challenge. Having so much experience of nursing dying patients means that I have a context in which the student's perspectives will 'fit', as these are experiences where the death of an individual is central. Bracketing my personal life is a familiar professional requirement, but bracketing past professional experiences would be difficult. By doing so the degree of empathetic listening required might be negatively affected.

A phenomenographic method was then explored as a more appropriate strategy for analysis of the interview material. This appeared to offer a method that emphasised the perspectives of the researcher, as well as the participant. Sonnemann (1954:344) appeared to be the first to identify the term 'phenomenography', calling this approach "a descriptive recording of immediate subjective experience as reported". The seminal texts on phenomenography come from Ference Marton (1986), who saw this method as an empirically based approach that aims to identify the qualitatively different ways in which different people experience and understand various kinds of phenomena. This differs from phenomenology, as the researcher stays aware that information has been interpreted by the participant and is then filtered through the researcher.

A critique of phenomenography by Richardson (1999) seems to imply there is little difference between phenomenology and phenomenography, but Marton (1981) was clear that there is a difference: the phenomenologist records first order experiences (the story); the phenomenographer accepts that the perceptions of the participants have been 'filtered cognitively by the participant and so have more of a second order character (the participant's feelings about the story) but when also 'filtered' by the researcher becomes a third order observation (the researchers feelings about the participants account of the story). Hermeneutics is the theory of text interpretation (Forster, 2007). Phenomenography appears to reflect a double hermeneutic (Smith and Osborn, 2007) in the analysis of the text, where the records of the researched are examined along with the researcher's written analysis and conclusions.

Richardson (1999) argued that there was confusion throughout Marton's published work with a realist position often being expounded - as in the phenomenographer's role being that of a

collector and classifier of peoples conceptions of reality (Marton, 1994). Richardson suggested that rather than valuing Marton's realist perspective, a constructivist stance would be more valid. Richardson's argument was that by using a constructivist revision of phenomenography, the analysis of interview material would lend rigour to the researcher's quest for authentic understanding. This is compatible with a pragmatic epistemology, as the rigour achieved affects the value of the research and the application of research findings. I believed that using a more constructivist stance would render phenomenography useful to this inquiry.

In reviewing the features of phenomenological and phenomenographic approaches, I became aware of Interpretative Phenomenological Analysis (IPA), which offered a structured approach without being inflexible. Smith at al. (2009:36) describe IPA as "attempting to understand, both in the sense of trying to see what it is like for someone and in the sense of analysing, illuminating and making sense of something". Smith's framework fitted into the pragmatic paradigm and would be useful in the iterative process of identifying themes. Because of the nature of the research and the professional relationship between the researcher and participants, it was helpful to also consider heuristics and to incorporate these ideas.

8.6.2 IPA- a strategy for clarifying emerging themes

Smith, a psychologist, developed the IPA approach from the 1990s onwards (Larkin, 2014). Smith felt that psychologists were seeking to be objective at the expense of subjectivity. He developed the framework of IPA, focusing on phenomenology, hermeneutics and ideography (Smith, 1996). In IPA, heuristics play an important part, with the insights from the similarities between researcher and interviewee being identified and explored (Smith 1996).

Phenomenology, as used in IPA, is based upon the tension between reality, seen as subjective, and the value of interpretation. Critics such as Giorgi (2011) have asked for clarification regarding the difference between IPA and standard phenomenological inquiry, but it has been shown that IPA offers a roadmap for a more particular depth of inquiry through the use of an idiographic focus (Sydor, 2010). Ideography seeks to explore the understanding and meaning of an experience in a particular context. This focus considers the details within the interview. Each small element is identified and analysed in order to create meaningful conclusions about the participant, as well as the phenomena under scrutiny (Mcleod, 2007).

This seemed to follow on from my exploration of phenomenography and I could see that it would be useful to use an idiographic focus within the IPA method. Using this method would not obviate the need to be mindful of the double hermeneutic of phenomenography. This would translate what might be seen as a descriptive method into a more interpretive method.

In IPA, Smith advocates the use of a very small number of interviews (Smith et al, 2009). The reason for this is that a small number of transcripts, say five or six, allows for deep analysis. However, it seems that since initial publications in 2009, rather than generating themes across the transcripts, Smith more recently advises a more case-by-case approach (Smith, 2015). I had decided that in order to achieve the research aims, nine interviews would suffice. This was due to the depth and quality of material being recorded, as well as the significant difficulty in recruiting participants. However, from the data emerging, it became apparent that some emerging themes might be related to ethnicity. I reviewed this decision and, following advice, eventually managed to complete fifteen interviews in total. The additional interviews enabled me to get a greater breadth of views regarding important demographic and ethnographic perspectives, particularly in regard to fear of death in terms of organ donation.

IPA involves two hermeneutic strategies: empathic and questioning. An empathic strategy requires the researcher to have an awareness of the participant that allows a focus on the sensing of feelings (Gendlin, 1996). The questioning strategy in hermeneutics refers to the dialectical nature of the relationship between the transcript and the researcher. Gadamer (1981) advocated a question and answer approach, where knowledge is constructed through this conversation between the text and the inquirer. Both of these strategies were used in this research. The researcher had nursed dying patients and could empathise with the dilemmas that the students had described. However, questioning was appropriate within the text, as the students' descriptions of diverse experiences required in-depth exploration.

A researcher using IPA for the analysis of the interview transcripts tentatively identifies the themes from the coding of the sentences used (Smith et al, 2009). This is where ideography was used, as it is concerned with looking at the particular, the details. The process of carrying this out is explained and illustrated in Chapter 12. The idiographic approach allowed not only for the coding and themes to be identified, but also allowed for the valuing of the details of the stories within the transcripts. These vignettes and stories illuminated the emerging themes in a unique way, as they were examples of caring for dying people. The emerging themes were

compared and further explored, which led to the identification of superordinate themes, which represented the primary emerging central concepts.

To summarise, IPA is idiographic, where a detailed examination takes place. In this research, the researcher aimed to explore the particular experience of fear of death. A shared humanity linked the interviewee and the researcher, which allowed for a heuristic perspective to be taken. This humanity was linked to the experience of both interviewee and researcher as nurses, which was an asset of the interview method. The researcher also used a double hermeneutic, exploring the individual's perspective through her own lens. Both an empathetic and a questioning hermeneutic were adopted here. The exploration of phenomenology and then phenomenography provided a useful background to the choice of using an IPA method of pragmatic analysis. An awareness of the discussion around phenomenology and phenomenography allowed me to be aware of the potential depth of analysis from the participant's perspective and how that might be affected by the researcher's views and experiences. These insights allowed me to use IPA in a way that did justice to both phenomenological and phenomenographic approaches.

8.7 Conclusions

This chapter has considered the guiding paradigm of this research, resulting in a pragmatic paradigm being deemed the most useful here. This allowed the inquiry to proceed using the appropriate contexts for a methodology that employed mixed methods. A tool was identified for the quantitative method that would measure multidimensional fear of death in student nurses, before and after the interventions. In the qualitative method, semi-structured interviews were undertaken with 15 student nurses during their second year in the programme.

The concept of hermeneutics has also been considered, with the researcher needing to be mindful of the interpretation of the transcripts of the interviews. An idiographic approach assisted in this process. The events and feelings described were through the eyes and hearts of the students, then interpreted through the lens of the researcher, thus providing a double hermeneutic.

The place of the heuristic inquiry has been discussed, with the researcher having a particular professional insight into this area of research. This recognition is an important part of IPA. The differences between phenomenology, phenomenography and IPA have been briefly explored. A

rationale was provided for progressing with IPA as the method of eliciting valuable interpretations from the interview transcripts.

The next chapter describes and discusses the implementation of the chosen methods. Chapters that consider the findings of the quantitative inquiry and the outcomes of the interviews follow the next chapter.

Chapter 9 Interventions and data collection

The students commenced their programme in February 2011 and the first questionnaires were administered in the second week of the programme (stage 1). The two interventions commenced in the third week of the programme. The DSD intervention was self-administered and the family constellations were carried out for one hour every Thursday for seven weeks. At the end of that time, the students went to their clinical placements for six months and returned to university in October 2011, when the second questionnaire was administered (stage 2). After this, there was an unexpected hiatus (due to my ill health) in the research and 15 students were interviewed between July 2012 and January 2013.

This research set out to achieve five research aims. The first three of these aims were explored through the use and administration of questionnaires. All five were further explored through the interviews. These were to:

1. Gain an understanding of the fear of death in a group of first-semester student nurses.

2. Evaluate two strategies designed to reduce fear of death in first-year student nurses by strengthening aspects of the affective domain.

3. Explore the relationship between students' fear of death and their gender, age, prior experience, ethnicity and spiritual affiliation.

4. Gain an understanding of factors that affect the feelings of students who are caring for people who are dying and their families in clinical practice.

5. Identify teaching and learning strategies that help to reduce fear of death.

This chapter details how the questionnaires were administered and how the interventions were undertaken. It also gives an overview of the method of completing the interviews. These discussions provide an insight into some of the challenges encountered over the course of that year.

9.1 Ethical issues

Following approval being granted from one of the University Ethics Committees, the students were informed in writing of the nature and process of the research, and they then provided written consent. It was made clear that they could change their minds at any time and withdraw with no consequences. Although there was a need to develop a coding system with the interviewees, I have gone to great lengths to ensure that any student was not identifiable from the data findings, so anonymity was assured. No demographic data were collected, other than those that were relevant to the study. Responses with respect to gender, age, past experiences, spirituality and ethnicity were compared, but these data have not been used in a way that would make a respondent identifiable.

Ethics application and subsequent approval had included consideration of the interventions and how the students would be appropriately supported. The family constellation intervention group explored issues of conflict and/or abuse. Inevitably this involved degrees of emotional challenge, which might have led to a review of the students' own relationships. There were a variety of support mechanisms in place to 'hold' students who could have found that the family constellations would evoke difficult feelings. These were the availability of personal tutors and the accessibility of the university counselling service. The students also had the choice of going home, if required, as no academic sessions followed the family constellations.

9.2 Planning the administration of the questionnaire – pilot study

At the University of Hertfordshire, there are two intakes of student nurses per year. In September around 400 students enter in order to study one of four specialties, or fields of nursing. These are adult, child, mental health or learning disabilities. The February intake is the smaller one, with around 130 students entering at this time and just specialising in mental health or adult nursing. The first active stage of the intervention would be the administration of the MFODS (Hoelter, 1979, appendix E) of 42 questions, along with five demographic questions, which I had added:
- Gender
- Age
- Length of previous caring work
- Ethnicity
- Spiritual/religious affiliation, if any.

Together these 47 questions formed the questionnaire. The completion of the questionnaire was piloted with 10 students from the previous (September 2010) cohort. These 10 completed the 47 questions in around 20 minutes. This gave me a feel for the time frame needed for first-year students to complete the questionnaire. These students had provided consent and were not asked to comment on the exercise. It was intended to administer this questionnaire to as many adult field students as possible from the February 2011 cohort.

9.3 Recruitment of participants

I managed recruitment by speaking with the entire February 2011 adult student cohort of around 100 students. The issue and the reasons for the research issue were introduced in a detached, professional manner. During those first days the students are drenched with information and it is possible that these students were feeling disorientated by the degree of change they were experiencing. At this stage in the programme, the new students were well supported by the programme tutor and their personal tutors, whom they had recently met.

The students were told that I would be using questionnaires, and then would divide the cohort randomly into three, and that two of the three groups would have an activity to carry out over the next six weeks. I explained that it was entirely their choice whether they would participate in the study. I let them know that, after their time in clinical practice, they would be asked to repeat the questionnaire. I also told them that, after the completion of the second questionnaire, I would ask some of the cohort for permission for me to interview them.

I handed out the information sheets and consent forms for the questionnaires (Appendix C, Appendix D) and returned to meet with the cohort the next day. I took more sheets and consent forms, in case the students were new or had forgotten to return with them from the day before. The population of a new student nurse cohort can change from day to day, as some students realise that this programme is not for them, and other prospective students are asked to take their place. Ideally, I would have left the forms and sheets with the students for a week in order for them to consider their feelings towards death and dying. However, it had taken a long time to get to this point and time was becoming precious. There were only seven weeks before they went out to the clinical areas. The students were fully informed regarding the research, and nature of the questionnaire, and were able to give informed consent.

I received back 76 completed consent forms. I then arranged for these students to remain behind while the others (those not willing to provide consent, plus the mental health field students) left the lecture hall.

9.4 Administration of the questionnaire

The students remaining were asked to complete the stage 1 questionnaire. This took between 20 and 30 minutes to complete. I was available to answer questions. The timing was not ideal, as a lecture had finished early in order to facilitate this happening. The students needed to get to a seminar. It would have been helpful to have a time period where the students were not timetabled for another session. Thankfully the students were, at this stage, anxious to be helpful and were enthusiastic. None of the students appeared to have any difficulty with the process.

One of the 76 questionnaires was unreadable and was therefore convenient, giving a convenient sample of 75 stage 1 questionnaires. I had been hoping to achieve a sample of around 90, but this was a good number for a February cohort. I was satisfied that this number would provide data that would enable me meet the research aims 1-3. Had I chosen to administer the stage 1 questionnaire later in the programme, I could have emailed the students the questionnaires and they could have returned them to me in the same way. However, this was not possible here, as the students' addresses were not yet on the university intranet system. In hindsight, this might not have improved the response rate, as the students were so overwhelmed by the demands of the programme that they would have had great difficulty in completing and returning the questionnaire. The students commenced their first clinical experiences at the end of the eight week theory block. They were allocated to two short placements before returning to university.

After their placement experiences, it was necessary to measure the students' fear of death using the same questionnaire (stage 2). The cohort was scheduled to have a lecture with me and I requested that the adult field students remain behind to complete the stage 2 questionnaire. This comprised of the MFODS only, as the demographic data were assumed not to have changed over the eight months. I received 54 completed questionnaires at the end of this session. A great deal of time and effort was then taken to try to get the maximum number of questionnaires completed. Despite several visits to the group, only 56 of the 75 completed the stage 2 questionnaire. One of these was discarded as the results were so untruthful. This is discussed in Section 10.7. Seven students had left the programme and 12 were in trouble

academically. These 12 were either withdrawn from the programme in the January, a year after their entry, or were re-enrolled with the following September cohort. In retrospect, it would have been interesting to explore their reasons for leaving, but this was outside the scope of this research. Table 9.1 shows the exact number of students at each stage of the study.

Table 9.1. Exact numbers in the study at each stage

	Number of students who completed stage 1 questionnaire	Number of students who completed stage 2 questionnaire	Number of students who participated in interviews
Group 1	25	17	4
Group 2	25	21	3
Group 3	25	17	8
Total	75	55	15

Results of the MFODS questionnaires were collated onto Excel files and then interpreted using SPSS (2012) to seek meaningful information. The stage 2 questionnaire results for the two intervention groups were also explored in relation to each other and to the control group. The five demographic dimensions of the students were also considered and analysed. These results are discussed in the next chapter. The Ethics Committee had approved the study for a fixed period. This had expired, so further approval to carry out interviews was sought from the Ethics Committee. Permission was gained and these interviews commenced the following summer.

There was no reason to think that this cohort of new student nurses was radically different from other cohorts of new student nurses in southeast England. Indeed, during the year prior to this research, a colleague had made a strong case in her doctoral thesis that UH was comparable to other southern England Universities (Karstadt, 2010). Although the results may not be generalisable, due to small numbers, it was hoped that they would yield insights that would be useful in other nurse undergraduate settings.

9.5 The interventions – DSD and Family Constellations

The names of the 75 students who had completed the stage 1 questionnaire were allocated to three groups. The paper questionnaires were returned to me in random order and so the first, fourth etc. students were allocated to group 1 (Control group). The second, fifth etc. students were allocated to group two (DSD) and the third, sixth etc. students were allocated to group three (family constellations). This ensured a random allocation into the three groups.

I arranged to meet briefly with group 2 and group 3 (the intervention groups) after lectures. The first group was the control group and needed no meeting. Group 1 students were thanked and informed that I would ask them to complete the questionnaire again at a later date. Group 2 were given a copy of the DSD book (see Chapter 6, sections 6.5 - 6.7). I explained how the book worked and asked them to complete this by spending a few minutes every day, trying one of the exercises in the book. They were encouraged to complete the book by the time they went out to clinical practice, six weeks later. I explained that I would contact them towards the end of those six weeks, to review their progress.

Group 3 was seen after a lecture in the same week. The family constellation work was explained (see Chapter 7, sections 7.2 and 7.8). I had previously decided to complete the two-year training in this strategy, which enabled me to facilitate family constellations. The training had been completed in the autumn before these students stated the programme. Group 3 were invited to attend a weekly meeting of one hour, after morning lectures, for six weeks. It was difficult to find a good time and this created problems with continuity. I had not anticipated that some students would not find the constellation work enjoyable. Some students felt overloaded with academic work and some students were not well for some of the sessions. Six meetings took place and 14 students attended. Not all the 14 were there every week and there were usually around 10 students present. Seven of these attended every session. Each week one of the students volunteered to explore an issue concerning their relationship with someone in their lives. The others in the group then became involved in representing members of the family. I acted as the facilitator in each session. Within the hour, the issue was explored and some resolution sought. At the end of every session, there was time for reflection on the process.

9.6 Reflective period

Just after the administration of the second questionnaire it became evident that I would need to devote several months to regaining my own health. I had been very suddenly diagnosed with stage three bowel cancer. This is the stage where cancer has spread to surrounding lymph nodes and is the stage before the tumour cells migrate to other areas of the body, a process called metastasis (stage four). At stage four cancer becomes untreatable, although perhaps is manageable.

Death is inevitable, although it might be held off for some time with treatments. I was fortunate not to have stage four and I spent the next six months experiencing chemotherapy, radiotherapy and then extensive surgery. Many researchers might have used the time available to continue with their research, but fear of death was a reality to my family and myself at that time. I needed to focus on anything other than death for those months and so the research was paused. The surgery left me with a rather different body than the one I had had before, but I was left grateful to be alive and cancer-free.

Quite soon after the surgery, my father fell and was admitted to hospital where he died three days later. I was not really fit to travel, but after an early morning phone call, we drove to get to the hospital and arrived four minutes after he had died. It was a privilege to be able to nurse him myself, after his death, and to care for him by washing him and preparing him to go to the mortuary) with one of the staff nurses. My mother was so shocked that she disappeared into dementia, where she now resides. I therefore returned to the research a very different person. My singularly professional orientation to death had been re-evaluated in light of my personal experiences and my losses.

I am grateful for the insights I gained from an emic, rather than etic perspective. I had not really had an occasion to mourn the loss of someone very close to me before this point, and could now understand how enormous a request had been made to these new students, many of whom had been through the grieving process themselves. Despite mourning for both of my parents, I was grateful to be alive and was also grateful for the contribution from these students. Many of them, especially from the family constellation group (group 3), had sent notes of support whilst I was going through the interesting first-hand experiences of cancer treatments.

I reviewed earlier discussion of using a heuristic approach (Chapter 8, section 8.4). I had come to this research as a nurse who had supported patients and families through hundreds of deaths within my professional life. Etherington (2004:99) stated, "In a heuristic inquiry the researcher is required to have some personal connection with the topic through which they filter their participants' experiences". This personal set of experiences changed my perspective on loss. The boundaries between my professional attitudes to death and dying and my personal views had shifted. My holistic views regarding death were now richer and more multidimensional. Like Moustakas (1961), faced with the possible death of his daughter (who did die, after her surgery), I felt very alone and different. Moustakas (1961: 54) suggested that people ... "map new meanings and perceive new patterns for old ways and habits". This was my experience. I returned to the research with, I feel, even more sensitivity and respect for death and for those who grieve.

9.7 The interview phase

I was aware from research with nurses that response rates to self-completion questionnaires can be poor (de Crespigny et al, 2000; Croser & McDowell, 2007; Brogger et al, 2007). The reasons given are primarily lack of time and a fear of being seen as foolish (Croser & McDowell, 2007). I had been fortunate with the response rate for the questionnaires, although there had been a 25% reduction by the time the second questionnaires had been administered. This reduction reflected the changes in the population of an undergraduate nursing cohort during the first year (Pryjmachuk et al, 2009).

The second phase of data collection was the semi-structured interviews that were designed in order to meet research aims 4 and 5.

> 4. Gain an understanding of factors that affect the feelings of students who are caring for people who are dying and their families in clinical practice.

> 5. Identify teaching and learning strategies that help to reduce fear of death.

The interviews were arranged by sending an email to each of the students who had completed the second questionnaire in the October before the July when I returned to work, after the six-month health break. The email invited each student to be interviewed in a convenient setting for a period of up to one hour. I was initially of the belief that seven interviews would be sufficient to

gain an insight into the research aims. However, after a conversation during a progression interview, it was decided that 15 would more richly serve the research aims. At that point, the tool of IPA had not been chosen for guiding the transcript analysis. The researcher who designed IPA (Smith, 2007) advised that seven interviews were adequate but, having now completed the analysis, I am sure that 15 have provided a broader, deeper insight into the student experience with death, particularly in terms of a better mix of students from BAME groups.

Initially, 10 students were keen to be interviewed and another five agreed later, after another two email invitations. Eight of the 15 were from the constellation group (Group 3). This reflected the relationship that had built up between the students and researcher over the six weeks of the constellation intervention. This was not ideal. I would have preferred five students from each of the three intervention groups, in order to gain a more even distribution and to be able to perhaps link the interventions, or lack of intervention, with their experiences. The process of gaining agreement for the interviews was so prolonged, due to a lack of response, that I was eventually grateful for the 15 respondents.

There were four students from the control group, three from the DSD group and eight students from the constellation group. I was satisfied that there were more than two students from each of the three groups and was confident that the research aims (4 & 5) could be met. The 15 interviews were carried out in the second half of the students' second year on the programme. By this time the students had all experienced caring for dying people and their families and, due to the time lag, ethical approval had been extended to cover the interview period.

The interviews were semi-structured and all took place within the clinical practice setting. This meant that the interview was carried out during the students' working day. I had recognised that their time was precious and did not feel that it was likely, nor fair for them to give up their off-duty time. It was also an advantage to know that the clinical team, particularly their mentor, was available to support the student if needed. This was supportive for me, the researcher, as I was confident that, between the mentor and myself, we could cope with any unexpected responses from the students. The nurse in charge and the mentor were informed of the nature of the interview before the interview started. This gave me a chance to establish a link with these two trained nurses, and to let them know that there was a very small chance that the student would be negatively affected by the interview. I was aware that, if the student became upset, then it

would be possible to stop the interview, to arrange support and for her to go home. This had all been clearly set out in the application for ethical approval.

Being in a clinical setting provided the appropriate context for the student to be relating their experiences of caring for people who were dying. This added to the heuristic approach, as using that context was a privilege only open to few. Being a link lecturer enabled me to arrange the interviews in practice easily. I was seen as an insider, part of the emic approach. The clinical setting enhanced the feeling of the importance of care of dying people. I was also aware of the influence of the setting on the double hermeneutic (discussed in Chapter 8, sections 8.6.1- 8.6.2) where the student's experiences are described to the researcher (first order) and then the researcher gains impressions of how these are interrelated (second order). The clinical setting enhanced the language of the professional nursing aspects of the researcher-student relationship.

An information sheet and consent form (appendix F) were emailed to the student at least five days before the interview. The information sheet listed sources of support and who to contact if there were problems or complaints with the interview. My work email address had always been available to all the students, in case they had needed to contact me. For each interview, a small quiet room was found and staff were asked not to interrupt. Prior to the interview, questions from the student about the study were answered and the consent form was signed by both of us. Interviews were recorded on a small digital recorder and also a mobile phone. It proved easier to use the phone to upload the recordings to the computer and transcribe the interviews. In addition, brief notes were taken during and after the interview. It was not necessary, nor appropriate, to take detailed notes when eye contact and focused listening skills were required. I was deeply honoured that profound experiences were being shared with me.

Following the IPA structure, the interviews were noded and coded with the help of QSR International's NVivo (2012). These were analysed to give rich data regarding the interventions and subsequent experiences in clinical practice. The stages of the process outlined by Smith (2007) are shown in Table 9.2. This allowed a certain discipline to be followed, which helped to maintain academic rigour.

Table 9.2. Stages in Interpretive Phenomenological Analysis (Smith, 2007)

	Activity
1	First encounter with text
2	Preliminary themes identified
3	Grouping themes together as clusters
4	Tabulating themes in a summary table

It can be seen that these stages allow for a logical progression through the data. The transcripts were read several times to get a feel for the weight of different experiences and ideas. An idiographic technique allowed for depth to be explored. The interpretation was cumulative within the transcripts and integrative across transcripts (Larkin, 2013). I was mindful of the context and meaning of the language, from an idiographic stance. However, the students had been professionally socialised by the time of the interviews, and the shared language of nursing had been established. This eased the process of interviewing, transcribing and also analysis.

There was a need to identify the patterns that emerged within each transcript and to interpret these within a context of student nurses, who were at the beginning of their second year of the programme. The context and description were explored to find the core experiential account, which identified the issues where experiences were typical, which were called nodes. The nodes were analysed, refined and then re-emerged as themes. Larkin (2013) advocates returning to the transcripts to identify concerns and conflicts, but then moving on from these to generate common meaning and shared perceptions from the accounts. Individual interviews were again reconsidered in depth and then the common themes across the 15 transcripts were finalised. Concerns of the students regarding experiences of death or the support that the student needed were identified and further explored. There was significant overlap, so the decisions to clarify and refine the themes took some considerable time. The 17 themes were then allocated to six superordinate themes. Results are presented and discussed in Chapter 12.

9.8 Conclusion

This chapter has discussed the way in which the quantitative and qualitative methods were employed. The students were recruited from the cohort and then randomly allocated to three groups. The implementation of the interventions over the course of 22 months has been explained here. The initial connection with students occurred as they commenced the course

(February) and then, after the data obtained from the first questionnaire, the students completed the interventions. The interventions have been discussed in depth in Chapters 7 and 8. The students went to practice and then repeated the questionnaire in October, eight months later. There was then a break in the research, with the interviews being commenced the following July (2012).

This has been a journey of gathering data using mixed methods, reflecting a pragmatic paradigm, where results are important in order to initiate change. The data were collected within a timetable that provided a framework for the data collection and interventions. This chapter has given an overview of how that occurred. Chapters 11, 12 and 13 report the results of these quantitative and qualitative methods.

Chapter 10 Results from the demographic questions

This chapter explores the data regarding the demographic picture of the student cohort, and of the three intervention groups. These data contribute to particularly answering the third research aim. The demographic data are analysed in order to determine how different or similar the groups were demographically. These similarities or differences are relevant to consider when analysing the results of the study concerning fear of death for the groups. The more similar the groups, the more they could be compared - in that any differences in demographic variables between the groups would be less likely to account for the differences in results. Chapter 11 will consider the results of the fear of death questionnaires (MFODS, Hoelter, 1979), and how these results meet research aims 1, 2 and 3.

The stage 1 (February) MFODS was followed by five questions that sought demographic data. These were designed to find out about:

1. Gender
2. Age
3. Length of previous caring experience/work
4. Ethnicity
5. Any spiritual affiliation/religion/none

No categories of response were offered for questions 2 to 5. Replies were subsequently categorised by me. The stage 2 (October) questionnaire included the MFODS, but there was no need to re-collect the demographic data. It was assumed that these aspects of each individual had not changed over the eight months. In this chapter, these 5 demographic characteristics are shown for the cohort and for the three groups. This enabled me to go on, in Chapter 11, to further address the third research aim of exploring the relationship between students' fear of death and these five dimensions.

This chapter discusses the demographic results at stage 1 (Feb) and uses these to compare the demographic profile of the cohort at stage 1 (n=75) and stage 2 (n=56). This number at stage 2 (October) was later reduced to 55. This will be explained in section 10.7. However, for the purposes of the majority of this chapter, the sample at stage 2 was 56 students. The data are

also explored in relation to any change in demographic profile in each of the three intervention groups between stage 1 and stage 2.

10.1 Gender distribution

Of the 75 students, three were male (4%). These three also completed the second questionnaire (5%). This percentage is lower than the national average of around 10% of qualified nurses, but this national average includes nurses from mental health and learning disability fields, where men are traditionally more prevalent (NMC, 2015). All three were over thirty years old and had experienced over three years of paid caring work, but had nothing else in common. There happened to be one male student in each of the three intervention groups.

10.2 Age distribution

Table 10.1 and Figure 10.1 show the age range of the students, at stage 1 and stage 2 of the research. The age distribution moved slightly upwards after the first questionnaire as the greatest attrition was from the two youngest age groups.

Table 10.1 Age distribution of participant student nurses

Age range	Number of students at stage 1	%	Number of students at stage 2	%	Difference between stage 2 and stage 1	Difference in %
18-20	19	25	12	21	-7	- 4
21-25	20	27	16	29	-4	+2
26-30	11	15	9	16	-2	+1
31-36	6	8	5	9	-1	+1
>36	19	25	14	25	-5	0
Total	75	100	56	100	-19	0
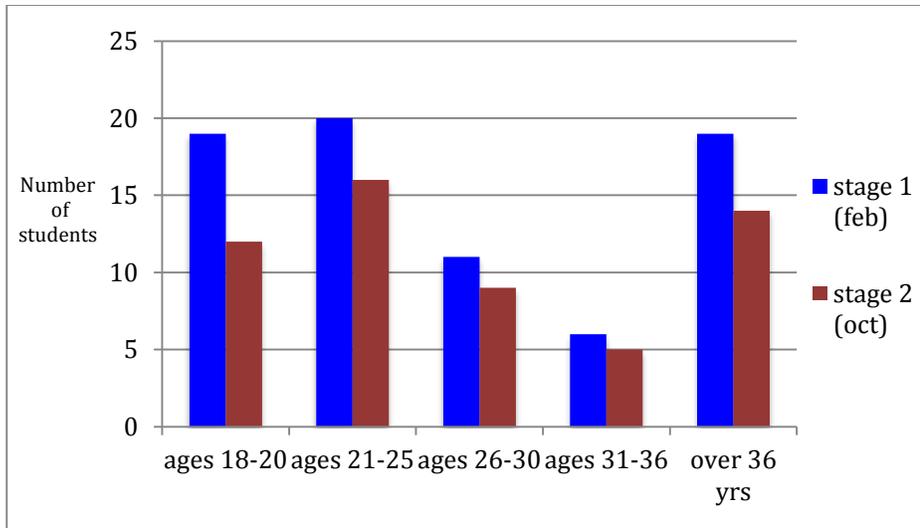
Figure 10.1 Number of students in each age band

It can be seen that seven of those who did not complete the second questionnaire were the younger students (20 years old or younger). Commencing university is a time of great change and research suggests that younger students might not be quite ready for the academic pressures of Higher Education (H.E.) (Pryjmachuk, 2009).

The number of students within each of the age bands in each group at stage 2 is shown in figure 10.2, where the control group is group 1, the DSD group is group 2 and the family constellation group is group 3.
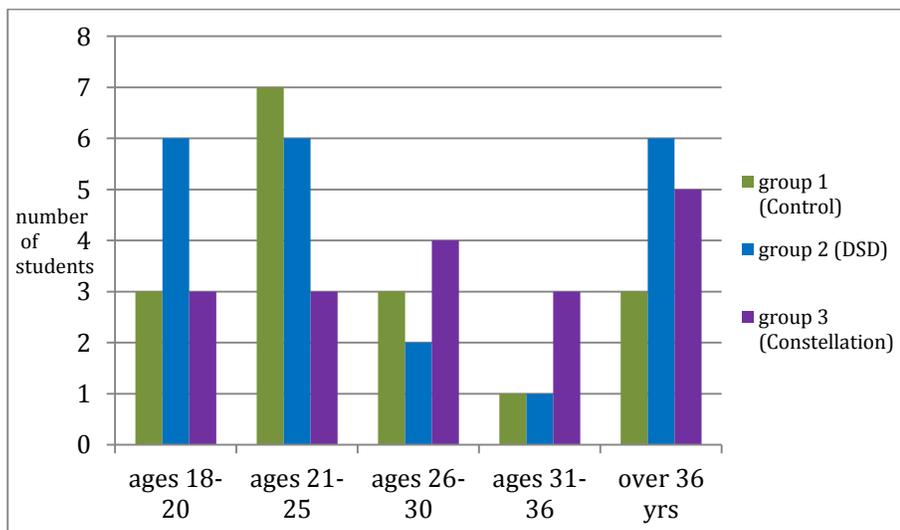
Figure 10.2 Age distribution between groups 1, 2 and 3 (stage 2)

Groups 1 and 2 have some similarities and Group 3 has a different distribution, with a higher number of mature students (over 25 years old). Since the numbers in some categories were fewer than 5, it was not possible to use Pearson's chi-square test to see if there were correlations. Fisher's exact test was used instead (McDonald, 2014).

The hypotheses were:

H0: the groups and age ranges are not dependent.

H1: the groups and age ranges are dependent.

Here the smaller the value of p, the greater the evidence for rejecting the null hypothesis. In this case the null hypothesis (H0) could not be rejected, indicating that there was no dependence found between the three groups and the different age categories ($p=0.702$, where the level of significance was 5%). There are no statistically significant similarities or differences across the groups and the age ranges. However, with such small numbers this result might not be useful.

10.3 Previous experience in clinical practice

Table 10.2 shows the length of previous caring experiences of the students at stage 1 and stage 2. The categories represent 5 different lengths of experience, ranging from none to over 6 years of caring experience.

Table 10.2 Previous caring experience, stage 1 and stage 2

Experience	stage 1 (Feb)	%	stage 2 (Oct)	%	Difference between stage 2 and stage 1	+/- (%)
None	25	33.4	18	32	-7	-1.4
< 3 months	3	4	1	2	-2	-2
3 months – 2 years	18	24	14	25	-4	+1
3-5 years	10	13.3	7	12.5	-3	-0.8
> 6 years	19	25.3	16	28.5	-3	+3.2
Total	75	100	56	100	-19	0

The students were asked "Length of previous caring experience/work?" I felt that fewer than three months experience could have still provided valuable insights into the caring role, as opposed to having no experience at all. Even a few days working with sick people can mean that the carer has an understanding of the notion of dependence and how illness can change an independent person into a dependent one. The journey into poor health is not a pleasant experience for people, so the carer was also likely to have experience of the psychological, emotional and spiritual changes that accompany a physical illness.

From Figure 10.3 it can be seen that there is a wide distribution of length of care experience across the total cohort. If there has been experience of caring for adults, then the type of experience might vary. There will be core experiences of communicating with adults and trying to meet their assessed needs.
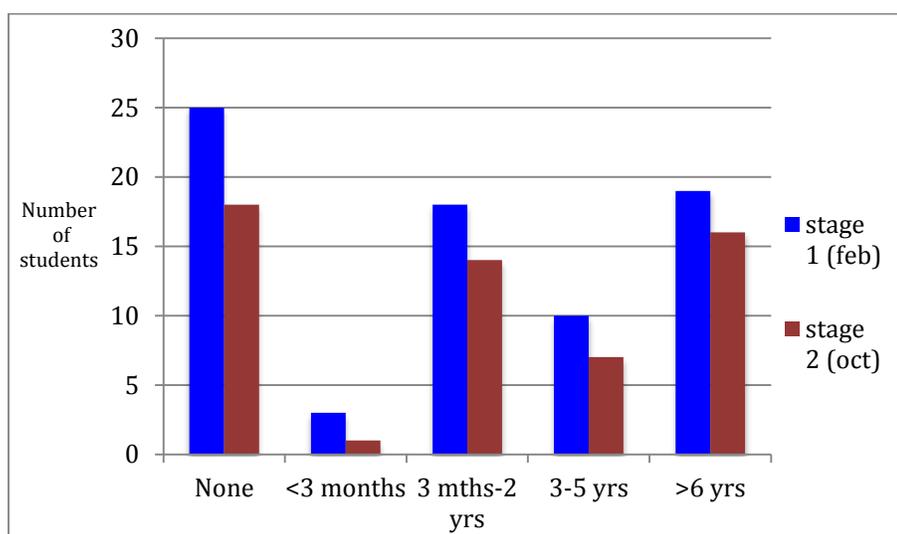
Figure 10.3 Differences in the number of students in the cohort having caring experience between stage 1 and stage 2

Although over a quarter of the cohort had no experience, 66.6% at stage 1 (n=75, Table 10.3) had previously cared for people for three months or more. This indicated that these students had an insight into the work of carers in care homes, which might have included caring for someone who was dying. Currently, two-thirds of people die aged 75 or over, with almost three quarters of women (74.4%) dying in this age group compared with 58.4% of men (National End of Life Care Intelligence Network, 2010). More than a quarter of the students had been caring

for over six years, which suggested not only an insight into caring for dying people, but also that they might well have previously developed useful skills.

The concept of caring experience contributing to more compassionate care was highlighted by Francis (2013) in the Department of Health response to the Mid-Staffordshire enquiry (UK Department of Health, 2013a), where it was proposed that from September 2014, neophyte student nurses need to have previously completed a year of caring experience (DoH, 2013a: 67). This change has been trialled and now there is a possibility that new students will have previously considered their attitudes to death and dying, as well as gained a skills set in this area of care. However, without their being a directive from Health Education England (HEE) there are concerns that the need to recruit to contracts may result in this idea being abandoned. More recently, 'The Shape of Caring Review' (Willis, 2015) also stressed the importance of widening access for care assistants entering nursing.

The differences between the three groups at stage 2, in terms of previous experience, are shown in figure 10.4.
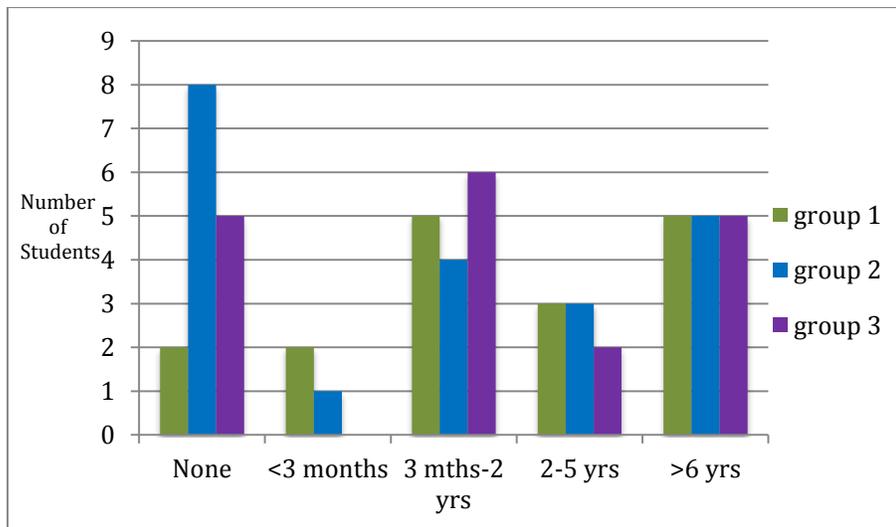
Figure 10.4 Length of previous experience between groups 1, 2 and 3 (stage 2)

It can be seen from Figure 10.4 that there was a range of previous experience across each of the three intervention groups. There are between 1 and 8 students in each category. The Hypotheses in this case were:

H0: the groups and length of previous care experience are not dependent

H1: the groups and length of previous care experience are dependent.

Here the level of significance is again 5%. The Fisher's exact test of independence (McDonald, 2014) shows that p=0.694. The null hypothesis (H0) cannot be rejected and the groups have no statistical similarities in terms of previous experience. Despite this lack of statistical similarity, it can be seen that there are broad similarities in the patterns of the groups, particularly if the first category (no experience) is ignored.

10.4 Ethnicity

The criteria for ethnicity categories were taken from the Office for National Statistics discussion of the 2011 census (ONS, 2013), which used the following criteria as broad categories:

- White.
- Mixed/Multiple Ethnic Groups.
- Asian/Asian British.
- Black/African/Caribbean/Black British.

The students were asked to state their ethnicity. It was straightforward to allocate these to the four categories identified by the ONS (2013). There were no Chinese, Arab or Traveller students in this cohort, although since this time the number of Chinese and Arab students has increased at UH, and in the undergraduate nursing programmes (UH student profile analysis, 2014). Table 10.3 shows the proportion of each of these four ethnic groups in the cohort at stage 1 and stage 2. It can be seen that there are large proportions of White and Black (i.e. Black/ African/ Caribbean/ Black British) students, with smaller groups coming from an Asian or mixed ethnicity background.

By comparing this with the 2011 England and Wales census (ONS, 2013) it can be seen that these data did not represent the picture of the ethnicity of the local population (Hatfield, Hertfordshire), but rather were related to the proximity of the university to London, from where many of the students from Black and Minority Ethnic groups originate.

The UH student profile analysis (U.H., 2014) shows that the students at UH reflect a wide diversity of cultures and that 49.5% of the undergraduate student nurses are from Black and

Minority Ethnic families. The proportions of the ethnicities within the total sample group reflected this.

Table 10.3 Number of students per ethnic group at stage 1 and stage 2

	stage 1 (Feb)	%	stage 2 (Oct)	%	Difference between stage 2 and stage 1	% difference	Census 2011
White	40	53	28	50	-12	-3	86
Mixed/Multiple	6	8	5	9	-1	+1	2.2
Asian/Asian British	5	7		3	5	-2	7.5
Black/African/ Caribbean/ Black British	24	32	20	36	-4	+4	3.3
Travellers/Other	0	0	0	0	0	0	1
Total	75	100	56	100	-19	0	100

Figure 10.5 shows the greatest difference regarding ethnicity between stage 1 and stage 2, was a drop in the number of White students. There was minimal reduction in the other three groups.
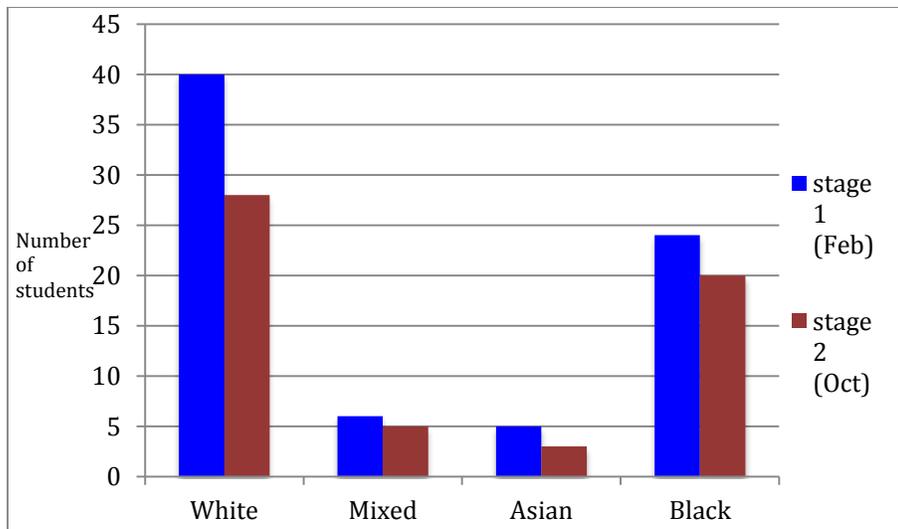
Figure 10.5 The numbers of students in each ethnic category at stage 1 and stage 2

The distribution of the students' ethnicities across the three intervention groups at stage 2 is shown in figure 10.6.
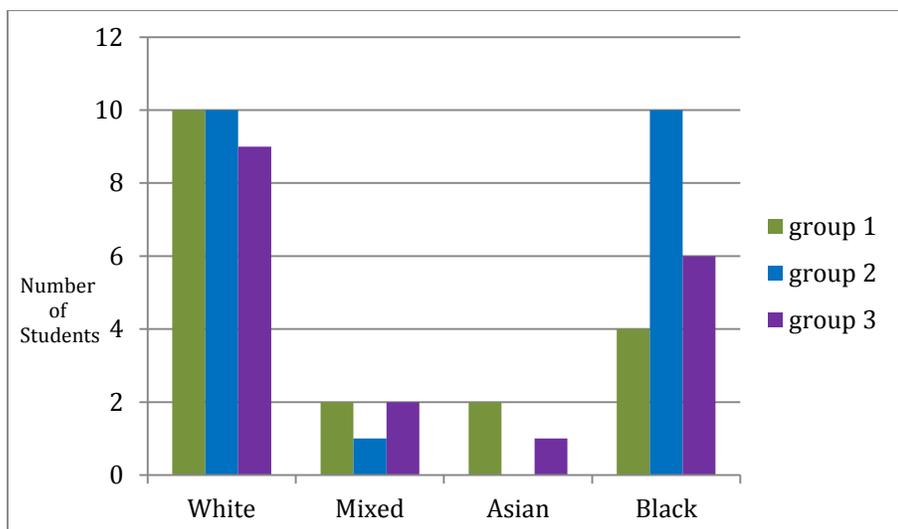
Figure 10.6 Distribution of ethnicity across the three groups 1, 2 and 3 (stage 2)

It can be seen from figure 10.6 that the mix of ethnicities within each group appears to be similar. However, this was not supported by statistical inquiry. The hypotheses in this case were:

H0: the groups and ethnic origin are not dependent
H1: the groups and ethnic origin are dependent.

The level of significance is again 5%. The Fisher exact test (McDonald, 2014) shows that $p=0.591$. The null hypothesis cannot be rejected and there are no statistical similarities across the groups.

10.5 Spiritual affiliation

The wording of this question was "Any spiritual affiliation/ religion/none?" A few of the students chose not to complete this question (stage 1= 6; stage 2=1). Table 10.5 shows the proportion in the whole cohort, of the main religious /non-religious groups.

Table 10.4 Religious affiliation or none at stage 1 and stage 2

Spiritual affiliation or none	stage 1 (Feb)	%	stage 2 (Oct)	Difference between stage 2 and stage 1	%
No response	6	8	1	-5	2
None	27	36	25	-2	45
Christian	34	45	23	-11	41
Hindu	3	4	3	0	5
Muslim	5	7	4	-1	7
Total	75	100	56	-19	100

It can be seen that the largest group in stage 1 was the 45% who aligned with Christianity, followed by those (36%) who had no stated religion or spiritual affiliation. At stage 2 the position had reversed, with the largest group having no affiliation (45%) followed by those aligning with Christianity (41%). There were very small numbers of Muslims and Hindu students, which is reflected in the ethnicity data in table 11.4. Many of those who identified their ethnicity as Black/African/ Caribbean/Black British, also identified themselves as Christian. Figure 10.7 shows the difference in these numbers between stage 1 and stage 2.
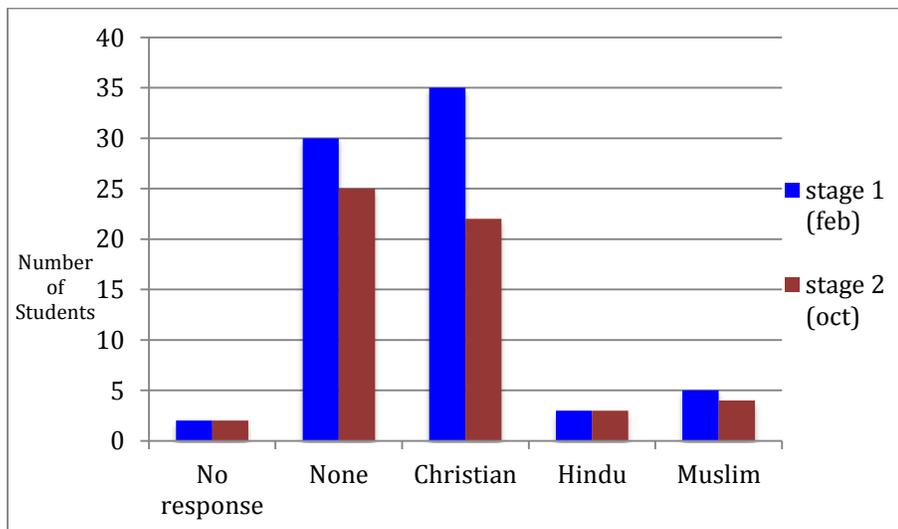
Figure 10.7 The number of students with spiritual affiliations at stage 1 and at stage 2

The majority of those who did not complete the second questionnaire were of a Christian faith. The differences across the intervention groups at stage 2, in terms of spiritual affiliation, are shown in figure 10.8. This shows the three groups in terms of how the members of those groups identified their spiritual affiliation.
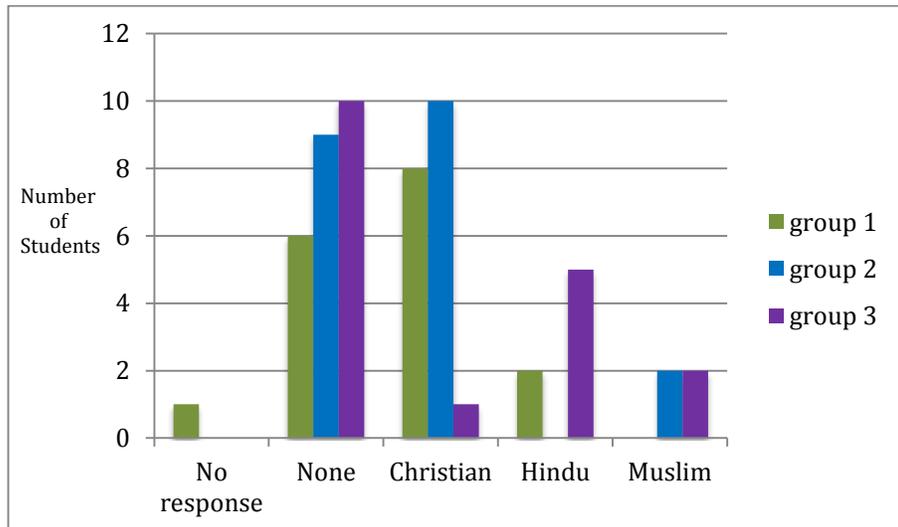
Figure 10.8 Spiritual affiliations across groups 1, 2 and 3 (stage 2)

Apart from a difference in the number of students identifying themselves as Christians in the constellation group (group 3), there appeared to be some similarities across the groups.

The Hypotheses in this case were:

H0: the groups and spiritual affiliation (or none) are not dependent
H1: the groups and spiritual affiliation (or none) are dependent.

The level of significance is again 5%. The Fisher exact test (McDonald, 2014) shows that p=0.005. Therefore, the null hypothesis can be rejected and the groups have a statistically similar relationship. The spiritual mix of students in each of the groups is similar. It is accepted that the sample size renders this merely indicative.

10.6 Results of the Multidimensional Fear of Death Scales questionnaire

The MFODS questionnaire (Hoelter 1979) was administered at stage 1 (February 2011) and again at stage 2 (October 2011). The students were asked to use a Likert scale for their responses. In response to each of the 43 statements, they awarded 1 for strongly agree, 2 for mildly agree, 3 for neither agree, nor disagree, 4 for mildly disagree and 5 for strongly disagree to the 42 statements. The results of the stage 1 (n=75) and stage 2 (n=56) MFODS were collated and calculated, firstly using Excel and then SPSS software packages.

A table was created of all the students' results both for stage 1 (appendix G) and stage 2 (appendix H). Five of the questions were checks, in that they had been constructed to reduce response bias (Neimeyer, 1994). The scores for these five items were reversed for each student. The final fear of death (FOD) mean scores for the whole cohort and for each group, in each of the eight categories of FOD, was compared. The objectives of the questionnaire data collection method was to contribute to enhancing understanding of the fear of death in a group of first-semester student nurses (thereby contributing to Research Aim 1) and provide an indication of whether the interventions were associated with a reduction in fear of death (thereby helping to address Research Aim 2). The data on the FOD scores for the whole sample and for the groups are reported and discussed in Chapter 11. Section 10.7 explains the process by which FOD scores were calculated.

The FOD results for the cohort were also analysed in relation to the demographic data. This allows me to address Research Aim 3, which is to explore the relationship between student's fear of death and gender, age, prior experience, ethnicity and spiritual affiliation. Section 10.8 reports the findings on the relationship between the demographic factors and FOD.

10.7 Processing the data and the FOD scores at stages 1 and 2

Each student's MFODS questionnaire produced a total score of fear of death (FOD) for each of the eight categories. These categories are shown in table 10.5. Each student had a sub score for each category and a total score, which was the sum of the eight sub scores. These were calculated for stage 1 (Feb) and stage 2 (Oct). The range of potential scores for each category is also shown in table 10.5.

Table 10.5 Categories of Fear of Death (Hoelter, 1979)

	Fear of death categories.	Minimum possible score	Maximum possible score
1	Fear of the dying process.	6	30
2	Fear of being dead.	6	30
3	Fear of being destroyed.	4	20
4	Fear for significant others.	6	30
5	Fear of the unknown.	5	25
6	Fear of conscious death.	5	25
7	Fear for the body after death.	6	30
8	Fear of premature death.	4	20
	Total	42	210

The possible range of MFODS score, as shown in table 10.5, was 42-210, with 42 being the highest fear of death and 210 being the lowest fear of death.

Turning to the set of stage 1 questionnaires, the lowest total obtained at stage 1 was 66, which indicates a high fear of death. The highest total at stage 1 was 173, which illustrates a low fear of death. The range of 66 to 173 revealed a mean score of 104.4 and a median score of 99. The scores were divided into percentiles, where the data is arranged in 100 equal values. The students at the 33rd percentile (below which 33% of the scores were found) scored between 66 and 93, which I have called a high fear of death (n=25, 33.3%). Those at the 66th percentile that scored between 94 and110 were in the central group (n=25, 33.3%) and those at the 100th percentile that scored between 111 and 173 were said to have a low fear of death (n=25, 33.3%).

Each student had a total score value that identified their FOD at stage 1 and at stage 2. This number represented their overall fear of death. In order to calculate the change in fear of death between stage 1 and stage 2, the difference in value between stage 1 and stage 2 was calculated. An increase in the numerical value meant a lowering in the FOD.

The number of students at stage 1 was 75 (n=75). The number at stage 2 was initially 56 (n=56) but before analysis commenced this was changed to 55 (n=55). This was because one student

in the Constellation group (group 3) had a decreased FOD score of +73 (from +76 to +149). With such an unusual score, the picture was tilted. This result raised the question of validity, as the change was so extreme. I knew the student concerned, as she had expressed a resistance to the nature of the research. It was possible that this change in FOD could have reflected a wish to confound the research. This datum was removed and the sample size reduced to 55. These 55 students comprise the total on which comparisons between intervention groups are made.

The phenomenon of participants being untruthful is not new and happens in research into particularly sensitive areas (Bleek, 1987; Agustín, 2004). The subject content here is emotive. Teachers asking student nurses to complete questionnaires on fear of death within a large group might provoke particular students to confound the results.

At stage 2, the lowest total obtained was 74 and the highest total was 150. This range revealed a mean score of 112 and a median score of 111, indicating an overall reduction in fear of death. At stage 2, 15% of students scored between 66 and 93, (high fear of death, n=8, 15%). Those with scores between 94 and 110 comprised 31% of the group (n=17, 31%). 54% of the stage 2 students scored between 111 and 173, with a low fear of death (n=30, 54%). This is shown in table 10.6.

Table 10.6 Number of student and percentages for high, middle and low Fear of Death

	Number of students with High FOD 66 to 93 (%)	Number of students with Middle FOD 94 to 110 (%)	Number of students with Low FOD 111 to 173 (%)	Total (%)
Stage 1	25 (33.3)	25 (33.3)	25 (33.3)	75 (100)
Stage 2	8 (15)	17 (31)	30 (54)	55 (100)

These results demonstrate that there was a reduction in fear of death between stage 1 and stage 2. The results of the demographic are discussed in section 10.8 and the results of the groups are discussed in Chapter 11.

10.8 Demographic influences on fear of death

The demographic were explored in terms of FOD and the change of FOD between stage 1 and stage 2. There was one man in each of the three groups and this low number meant that considering fear of death related to gender was impractical. However, the four other dimensions were explored for the whole cohort. These were age, length of time as a carer, ethnicity and spiritual orientation. The value of the sum of the FOD scores for each student in each category was divided by the number of students in that category. This provided the mean value for each particular student demographic category. The bases for each category are shown in the figures.

10.8.1 Age differences and fear of death

Table 10.7 shows the number of students within each age category across the cohort.

Table 10.7 Number of students in each age category at stage 1 and stage 2

Age (years)	stage 1 (Feb)	stage 2 (Oct)
18-20	19	12
21-25	20	16
26-30	11	9
31-36	6	5
>36	19	13
Total	75	55

Figure 10.9 shows the mean value of FOD for each category of age in the cohort.
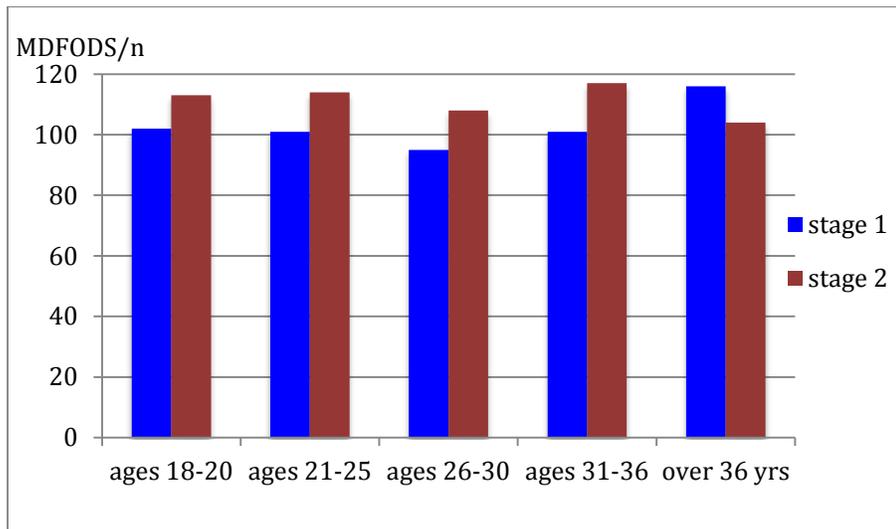
Figure 10.9 Age categories and fear of death

There was a reduction in fear of death (i.e. an increase in mean FOD score) over all the age ranges except for the most mature students, those over 36 years old. However, a paired-samples t-test indicated that scores were not significantly different for stage 2 (M = 103, SD = 7.78) than for stage 1 (M = 111, SD = 5.17), t (4) =-1.6, p < .0.184, d=-1.211.

Although the difference in the scores between stage 1 and stage 2 cannot be said to be substantial or statistically significantly, the reduction in fear of death in those 36 years old or under is interesting. Older female student nurses showed a lower score of fear of death on entry than younger students, but their fear of death increased, rather than decreased. This might indicate a heightened awareness of mortality issues with the older students. The findings relating to older students supports findings by Cox et al. (2013) who found that older people consider mortality more often than younger people. Eick et al. (2012) found that younger students adapt quickly to stressful experiences. These results indicated that younger students were getting more used to death in their work. It could also indicate an increased climate of contextual stress from the enhanced level of responsibility expected of mature students in practice, by their mentors. This is further discussed in the qualitative findings.

10.8.2 Length of previous experience and fear of death

Table 10.8 shows the number of students in each category for caring experience.

Table 10.8 Number of students according to experience at stage 1 and stage 2

EXPERIENCE	stage 1	stage 2
None	25	18
<3 months	3	1
3 months - 2 years	18	14
3-5 years	10	6
>6 years	19	16
Total	75	55

It can be seen that the largest category comprises the students who entered the programme with no experience of caring. Figure 10.10 shows the mean value of FOD for each category.
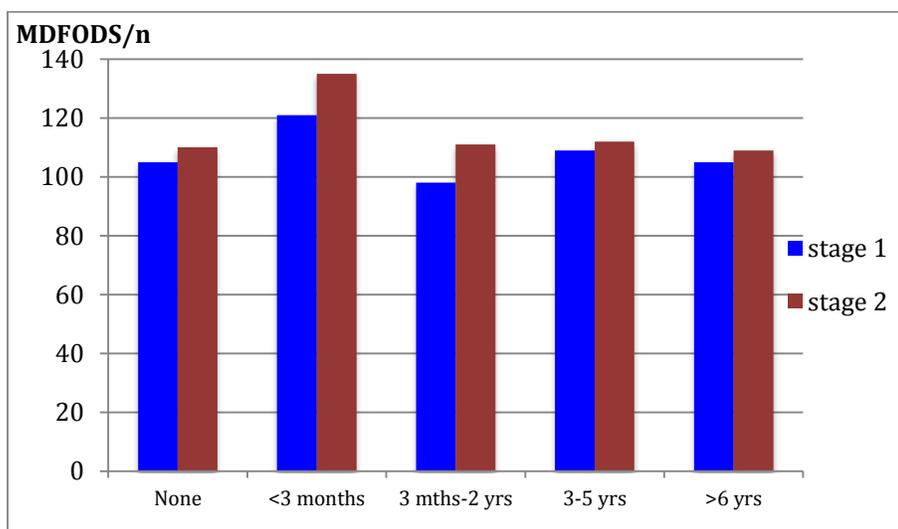
Figure 10.10 Length of previous caring experience and fear of death

The results suggest that those with some experience, but fewer than 3 months, had the least fear of death. There was a reduction in every category with regard to the fear of death between stage 1 and stage 2, so this might have been due to the effects of the programme or their clinical experiences. A paired-samples t-test indicated that scores were not significantly higher

for stage 2 ($M = 115$, $SD = 11.01$) than for stage 1 ($M = 108$, $SD = 8.47$), $t(4) = -3.3$, $p < .0.02$, d=-0.71.

Overall, the largest numerical reduction in fear of death (from 121 to 135) was with those students who entered the programme with less than 3 months experience. These students would have had some skills on entry to the programme but had gained a great deal of experience over the eight months between stage 1 and stage 2. The students with no experience prior to entry would take some time to have confidence in their abilities in practice (Melia, 1987).

There appeared to be a relationship here with the students in the younger age categories. Fourteen (58%) of the 24 students who entered the programme with no caring experiences at all, were under 25 years old. Whereas 11 (58%) of the 19 at stage 1 who had had over six years of experience were over 36 years old. These more mature students had indicated an increased fear of death between stage 1 and stage 2. However, this was not reflected in the results on length of previous caring experience, which implied that the relationship between the age and prior experience categories, in those over 26 years old, was not straightforward.

10.8.3 Ethnicity and fear of death

Four ethnic categories were identified (section10.4) and each of these was compared in terms of fear of death. The number in each ethnic category at stage 1 and at stage 2 is shown in table 10.9.

Table 10.9 Number of students in each ethnic category at stage 1 and stage 2

ETHNICITY	stage 1	stage 2
White	40	28
Mixed	6	5
Asian	5	3
Black	24	19
Total	75	55

The largest category was white students, followed by black students. Figure 10.11 shows the mean value of FOD for each ethnic category.
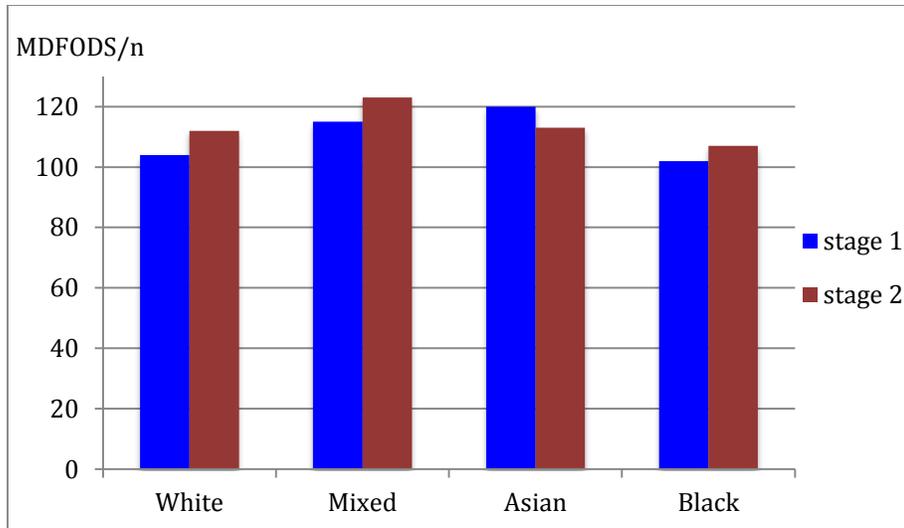
Figure 10.11 Ethnicity and fear of death

The fear of death in three of the four categories reduced between stage 1 and stage 2. Due to small numbers in categories 2 and 3 (mixed ethnicity and Asian), there was no indication from the data that would identify fear of death as substantially different in any ethnicity. A paired-samples t-test indicated that scores were not significantly higher for stage 2 (M = 110.25, SD =8.65) than for stage 1 (M = 113.75, SD = 6.7), t (4) =-0.98, p < 0.40, d= -0.52). The difference between stage 1 and stage 2 is not statistically significant.

10.8.4 Spiritual affiliation/religion/none and fear of death

Five categories were identified in terms of spiritual affiliation or none (section 10.5). Table 10.10 shows the number of students in each category at stage 1 and stage 2.

Table 10.10 Number of students by spiritual affiliation at stage 1 and stage 2

Spiritual affiliation	stage 1 (Feb)	stage 2 (Oct)
No response	2	2
None	30	25
Christian	35	21
Hindu	3	3
Muslim	5	4
Total	75	55

133

Table 10.9 shows that the largest category at stage 1 was Christian but by stage 2 the largest category had become those who had no spiritual affiliation. Figure 10.12 shows the mean value of FOD for each category.
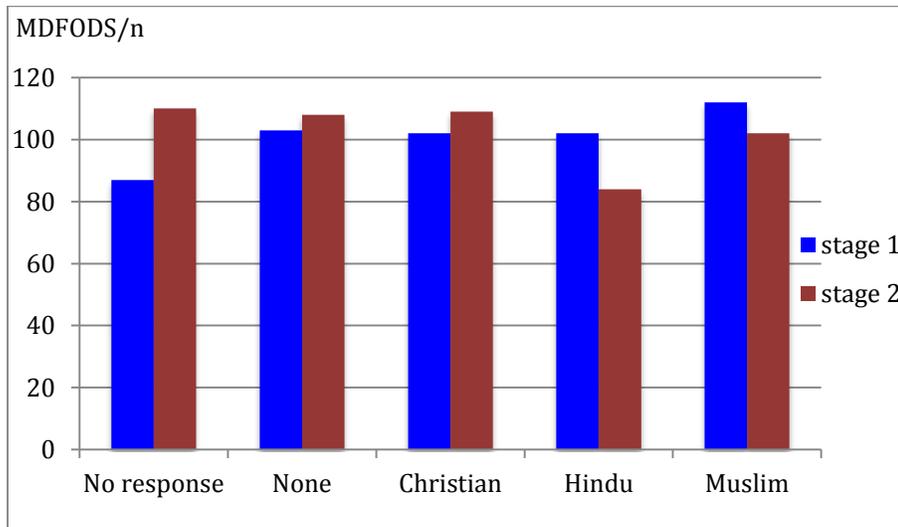
Figure 10.12 Spiritual affiliation/religion/none and fear of death

The two largest categories (no religion and Christian faith categories) showed no substantial change in fear of death. The numbers for the Hindu and Islamic students, and those not responding about spiritual affiliation are so small that conclusions cannot be drawn from them. A paired-samples t-test indicated that scores were not significantly higher for stage 2 ($M = 102.6$, $SD = 10.85$) than for stage 1 ($M = 101.2.75$, $SD = 8.98$), $t(4) = -0.2$, $p < 0.85$, d= -0.14. Overall there was a reduction in the fear of death, but nothing of note in terms of statistical similarities or differences between the categories.

10.9 Conclusion

From these data, the profile of the student that discontinued the programme was a white Christian female with little caring experience who is either very young or over 36 years old. This profile suggests that further research could lead to a deeper understanding of where recruitment and retention can focus, in order to address attrition more effectively.

These results provide the character of the whole cohort. It is overwhelmingly female, spread across age groups from 20 years or under, to older than 36 years and in terms of caring experience from none to over six years, predominantly White or Black (Black/African/

Caribbean/ Black British) and either Christian or having no spiritual affiliation. The characters of the three groups in terms of demography have also been analysed. The results indicate a degree of demographic similarities and differences between these groups. The patterns have been identified and I have concluded that the demographic snapshot of each of the three groups looked to be of a similar nature. Differences between the groups in terms of the demographic data were not found to be statistically significant. However, it was notable that affiliation to Christianity was represented much less in group 3 (constellation group) than other spiritual affiliations.

With regard to the loss of students between stages 1 and 2, my conclusion is that those who left the programme would not distort the findings, as there was an even spread across the three groups. The demographic data showed that the three groups could be compared in terms of fear of death, as the demographic differences were not substantial and would not affect the findings of the fear of death within the cohort and between the three groups.

The third research aim set out to explore the relationship between students' fear of death and their gender, spiritual beliefs, ethnicity, age and prior experience. The results showed that these factors were not related to fear of death in any statistically significant way. However, there were indications that age and prior experience might be related to changes in fear of death. Older students showed an increase in fear of death. Researchers in Hungary (Hegedus et.al. 2008) found that older health work students had lower levels of fear of death. These researchers delivered a death and dying programme to 168 health care workers and measured fear of death before and after the programme with half the sample. There was statistical evidence that men and older female students had a lower fear of death before and after the programme. My research supports the finding of a lower score of fear of death on entry, but my findings indicate that older female student nurses can experience a raise in fear of death during the programme.

This suggests that further research could be useful in terms of establishing the relationship between fear of death, age on entry to the programme and length of previous experience. The DoH recommendations in 'Patients First and Foremost' (DoH, 2013a), regarding student nurses having at least a year of caring experience prior to entry have led to pilot schemes to consider the value of this idea. These pilot schemes will provide data that could be further explored in terms of previous experience and fear of death.

Chapter 11 Results from the cohort and three groups with regard to fear of death (FOD)

This chapter further explores the results of the two administered Multidimensional Fear of Death Scales (MFODS, Hoelter 1979) at stage 1 (February 2011) and stage 2 (October 2011). The previous chapter considered the data regarding research aim 3. In this chapter, the data relating to research aims 1 and 2 are reported and any limitations identified. I conclude by stating how the data have addressed the research aims. There were anomalies in the data that warrant an explanation and these will also be discussed.

11.1 Findings in relation to the cohort

Fear of death among the cohort appeared to be varied (see Chapter 10, section 10.7), as were the changes in FOD score between stage 1 and stage 2. The results demonstrated that there was a reduction in fear of death between stage 1 and stage 2. The changes in score from stage 1 to stage 2 were calculated for the 55 who completed the MDFOD questionnaire at both stages. The mean change was calculated by dividing the sum of the changes of the students' FOD scores by the number in the sample (n=55). When ranked in order of change of FOD, the mid value provided the median. The mode was the value of the FOD that appeared the most number of times. At stage 2, the mean change was +11.6, the median was +13 and the mode was + 19. This mean value of +11.6 shows that there was a decrease in FOD on average across the cohort. The range overall was -26 (an increase in FOD) to +45 (a decrease in FOD). One student showed no change in her scores. The standard deviation from the mean (+11.6) was 25.56.

The students who experienced a reduction in fear of death (n=34) produced a range of plus 1 to plus 45, where these values are the differences between their stage 1 and stage 2 total scores. The mean was 18 and the median 17. The range of the students who experienced an increase in FOD (n=20) was minus 1 to minus 26, where the mean was 8 and the median 7. The majority of students (62%) experienced a reduction in FOD between stage 1 and stage 2.

11.2 Variations across the groups

This research sought to identify if particular interventions would have an effect on FOD (research aim 2), bearing in mind that students in the three groups had similar nursing experiences in their first placements. The students had been randomly allocated to the three

groups, and allocations to clinical placements in the three groups were also randomised. Those who were allocated to the DSD group were given a daily task through the use of the DSD journal. It was not possible to assess how many of the 25 students completed this task.

The weekly constellation sessions had lasted about an hour and involved exploring a relationship conflict for a different member of the group every week. There were several students who were regular attendees, but time management also seemed to be a major issue, as there were only 14 of the 25 who managed to attend. It was later noted that many of the regular attendees were among the mature students in group 3 (>26 years).

In order to explore the differences of the effects of the two interventions, the total FOD scores of each group were compared with each other, and then the totals of each of the eight dimensions of FOD in each intervention group were further compared.

The base figures used for all calculations were:
Group 1, n=17
Group 2, n=21
Group 3, n=17.

The total FOD score for every student in each group was combined to reveal a group total for stage 1 and a group total for stage 2. A mean value was calculated for each stage by dividing the total of students' individual scores by the number of the students in each group. This calculation gave a mean value for the groups at stage 1 and a mean value at stage 2. These are shown in figure 11.1
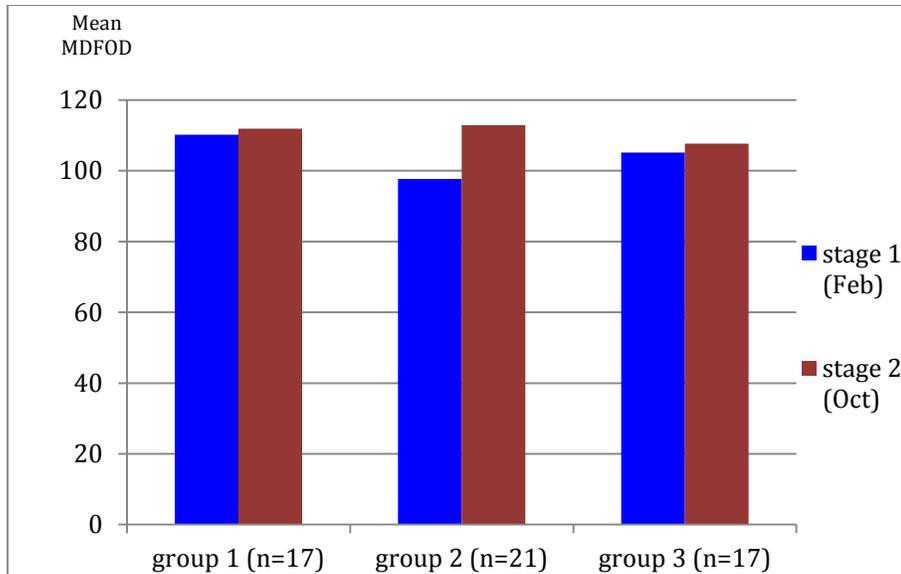
Figure 11.1 Mean MFODS for the three groups (stage1 and stage 2)

The differences in mean values were all in the direction of a reduction in FOD and were:

- Control (group 1):   +1.8

- DSD (group 2):   +15.3

- Family Constellations: (group 3)   +7.4

There was a decrease in FOD in all the intervention groups, as can be seen in Figure 11.1, where the control group (group 1), the DSD group (group 2) and the constellation group (group 3) are shown side by side. The mean scores for the three groups (1, 2 and 3), at stage 1, were 110.2 (SD= 24.51), 97.7 (SD=15.06) and 105.2 (SD=19.21), so there were no unusual differences. This is as would be expected with random group allocation. Figure 11.2 shows that each of the three groups experienced an overall reduction in FOD, with the largest reduction being seen in the DSD students (group 2).

A paired-samples t-test was conducted to compare the mean of the three groups between stage 1 and stage 2. The results were:
Control (group 1) at stage 1, Feb (M=110.2, SD=24.51) and stage 2 (M=112, SD=20.04). Conditions; t (40) = 0.24, p=0.81

DSD (group 2) at stage 1, Feb (M=97.7, SD=15.06) and stage 2 (M=113, SD=16.9). Conditions; t (44) = 3.25, p = 0.002.

Constellation (group 3) at stage 1, Feb (M =102.5, SD =19.21) and stage 2 (M=109.9, SD=15.88). Conditions; t (41) =1.34, p = 0.189.

The results showed that there was no statistically significant reduction in FOD for the group 1, or group 3. For group 2 there was a significant difference in reduction in FOD between stage 1 and stage 2. This result suggests that use of the DSD reduces fear of death.

Figure 11.2 shows the changes in FOD scores of each student in each of groups 1, 2 and 3 at stage 2. The bars above the x-axis (a positive value) indicate a reduction in FOD; the bars below the x-axis indicate an increase in FOD (a negative value). Only one student showed no change in FOD.
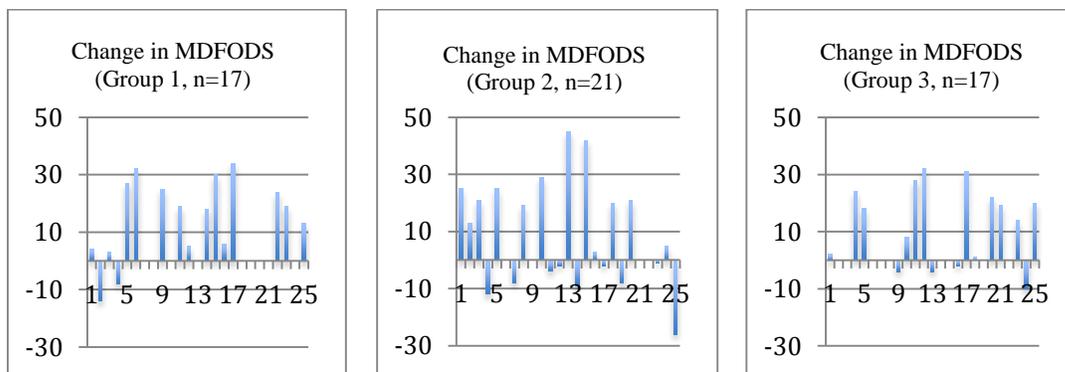
Figure 11.2 Change in MDFOD scores for each student within the three intervention groups

These results provide a valuable indication of the reduction in FOD. Figure 11.2 also shows that more extreme range of scores was obtained from group 2. The second research aim has been addressed and the results show that a self-directed intervention that aims to enhance EQ (DSD) is associated with a statistically significant lowering of FOD, compared to group 1 (control). The constellation intervention (group 3), that aims to enhance EQ and SQ, is also associated with a lowering of fear of death compared to the control group. The quantitatively measured change in the constellation group is lesser when compared to the DSD group, and is not supported by statistical significance.

11.3 Findings on the eight categories of fear of death in relation to the cohort

The eight categories of fear of death (F1-F8, table 5.1) were analysed separately to try to identify particular areas where fear of death is more prevalent in student nurses. The first research aim (to gain an understanding of the fear of death in a group of first-semester student nurses) could then be answered more fully.

Figure 11.3 shows the comparison of mean fear of death in the eight categories for the whole cohort for stage 1 (n=76) and stage 2 (n=55).
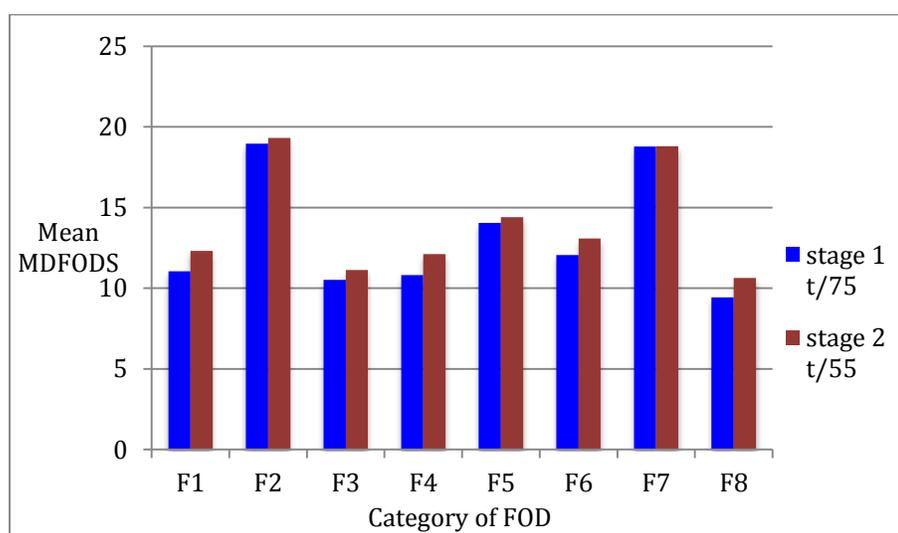
Figure 11.3 MFODS for the cohort at stage 1 and stage 2 in the eight FOD categories

It can be seen from this figure that there was a general decrease in FOD, but the main categories in which the highest overall FOD was found were the fear of premature death (F8) and the fear of being destroyed (F3). This was unsurprising for student nurses who care for people during the dying process and where harming a patient breaks the nurse's professional code of conduct (NMC, 2015). There are nursing procedures that can go wrong and can result in the death of a patient, such as inaccurate recording of physical observations or drug errors. Student nurses are reminded of these possibilities during the programme. These findings support the research by Cooper and Barnett (2005) that found that students felt anxious about the suffering of patients and found premature death especially difficult. Also, nurses and other health professionals are socialised into believing in the biomedical paradigm, which attempts to prolong life as much as possible (Helman, 2007).

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The categories with the least FOD in the cohort were the fear of the dead (F2) and the fear of the body after death (F7). Again, these results are unsurprising, as these were two areas where the students would have some experience and be familiar with the body before, during and after death. Niederriter's research (2009) found that student anxiety focussed on communication issues. These two categories (F2 and F7) might not involve the same need for communication as the other six categories. These data have helped me to address the first research aim, and to gain an understanding of the fear of death in a group of first-semester student nurses.

The FOD scores of each of the three intervention groups were compared for each of the eight categories of fear of death. This provided further information that related to the efficacy of the interventions in reducing fear of death (research aim 2). This enabled me to identify any relationships between the interventions and particular areas of fear of death. The findings will be reported under each category and then conclusions drawn at the end of the chapter.

11.3.1 F1: Fear of the Dying Process

Fear of the dying process was measured through six questions on the MFODS:
Q1.   I am afraid of dying very slowly.
Q13.   I am afraid of dying in a fire.
Q22.   I am afraid of experiencing a great deal of pain when I die.
Q27.   I am afraid of dying of cancer.
Q31.   I am afraid of drowning (including suffocating).
Q42.   I am afraid of dying violently.

The range of possible scores for this category was 6-30. The mean score for each group was calculated by their total FOD score divided by the number in the group. Figure 11.4 shows the group's mean scores at stage 1 and stage 2.
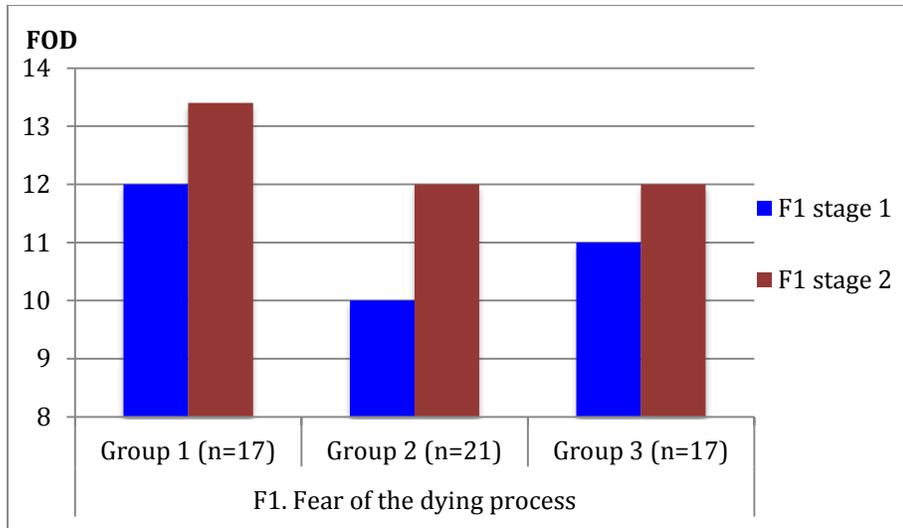
Figure 11.4 Comparison of stage 1 and stage 2 scores for F1: Fear of the dying process

A Wilcoxon signed rank test showed that there was no statistically significant change in fear of the dying process for:

Group 1 (Z =.901, p = .367);

Group 2 (Z=1.825, p=.068)

Group 3 (Z=1.587, p=.113).

All three groups show a decrease in fear of the dying process. The mean FOD score for all groups at stage 1 was 11 and at stage 2 was 12.5, further illustrating a reduction in FOD.

11.3.2 F2: Fear of the Dead

Measuring fear of the dead involved asking the students to respond in the same way as F1 to six questions:

Q2.   I dread visiting a funeral home.

Q14.   Touching a corpse would bother me.

Q23.   Discovering a dead body would be a horrifying experience.

Q26.   I would be afraid to walk through a graveyard alone at night.

Q32.   It would bother me to remove a dead animal from the road.

Q39.   I am afraid of things which have died.

Figure 11.5 shows the comparison between results of the mean scores for FOD for F2 at stage 1 and stage 2 for the three groups. For F2, the range of possible scores was 7-29.
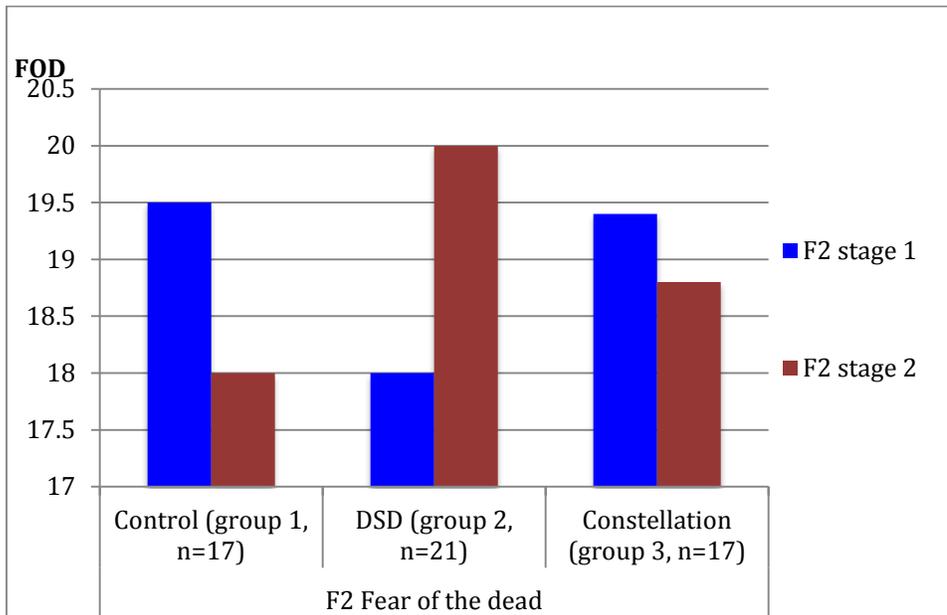
Figure 11.5 Comparison of stage 1 and stage 2 scores for F2: Fear of the dead

The results followed a normal distribution and, therefore, a paired T–test could be carried out.

For group 1 (Control), there was no significant difference in the increase in FOD between stage 1 (M=19.35, SD=5.34) and stage 2 (M=18, SD=4.757); t (16) = 1.526, p = 0.147.
For group 2 (DSD), there was a reduction in FOD between stage 1(M=17.95, SD=5.104) and stage 2 (M=20, SD=5.109; t (20) =-1.563, p=0.134. This is statistically significant.
For group 3 (Constellation) there was no significant difference in the increase in FOD between stage 1 (M=18.89, SD=5.03) and stage 2 (M=17.61, SD=6.43):
t (16) =.757, p=0.459

Group 2 (DSD) showed a decrease in fear, whilst the other two groups showed a slight increase in fear of the dead. The mean FOD score for all groups at stage 1 was 18.9 and at stage 2 was 18.6, further illustrating a slight increase overall in FOD.

11.3.3 F3: Fear of Being Destroyed

This dimension of fear of death required the student to identify her responses to four questions:

Q3.   I would not like to donate my body to science.

Q15.   I do not want medical students using my body for practice after I die.

Q24.   I do not like the thought of being cremated.

Q33.   I do not want to donate my eyes after I die.

The possible range for F3 was 5-19. Figure 11.6 shows the results of the comparison of the mean FOD for each group for F3 at stage 1 and stage 2.
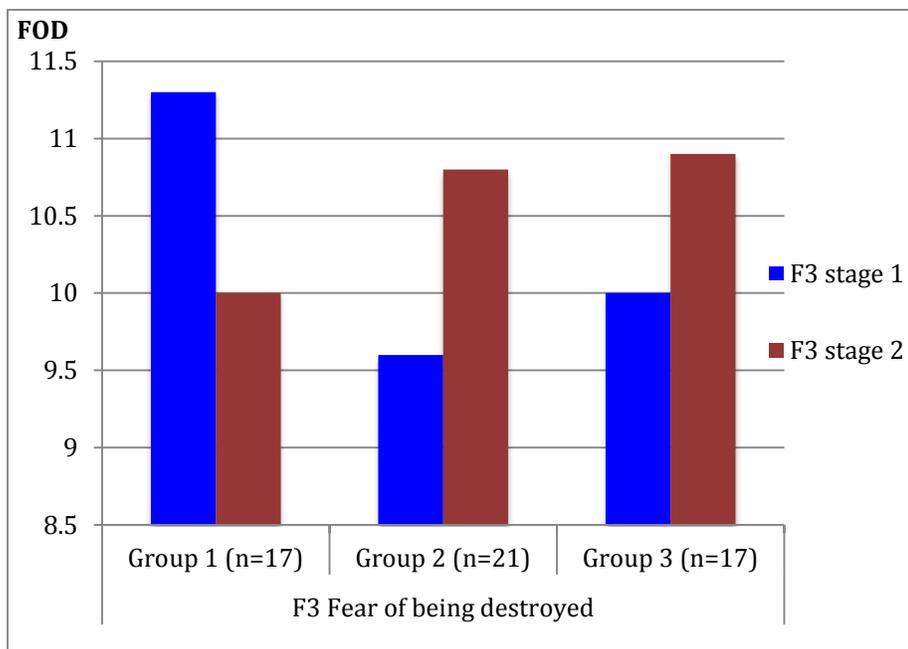
Figure 11.6 Comparison of stage 1 and stage 2 scores for F3: Fear of being destroyed

A Wilcoxon signed rank test showed that, for all three groups between stage 1 and stage 2, there was no statistically significant change in the fear of being destroyed:

Group 1: Z = -.713, p = .476;

Group 2: Z=1.24, p=.229;

Group 3: Z=1.83, p= .067.

The stage 1 the mean FOD score for the three groups was 10.3 and at stage 2 the mean FOD score was 10.6. This further illustrates a small overall decrease in FOD.

11.3.4 F4: Fear for Significant Others

Measuring this dimension of fear involved the students providing responses to six questions:

Q4.   I have a fear of people in my family dying.

Q16.   If the people I am very close to were to die suddenly, I would suffer for a long time.

Q17.   If I were to die tomorrow, my family would be upset for a long time.

Q25.   I will be upset when my friends die.

Q34.   I sometimes get upset when acquaintances die.

Q37.   If I die, my friends would be upset for a long time.

The range of possible scores for F4 was 7-29. Figure 11.7 indicates the results of the comparison of the mean FOD scores for stage 1 and stage 2 FOD for each of the three groups.
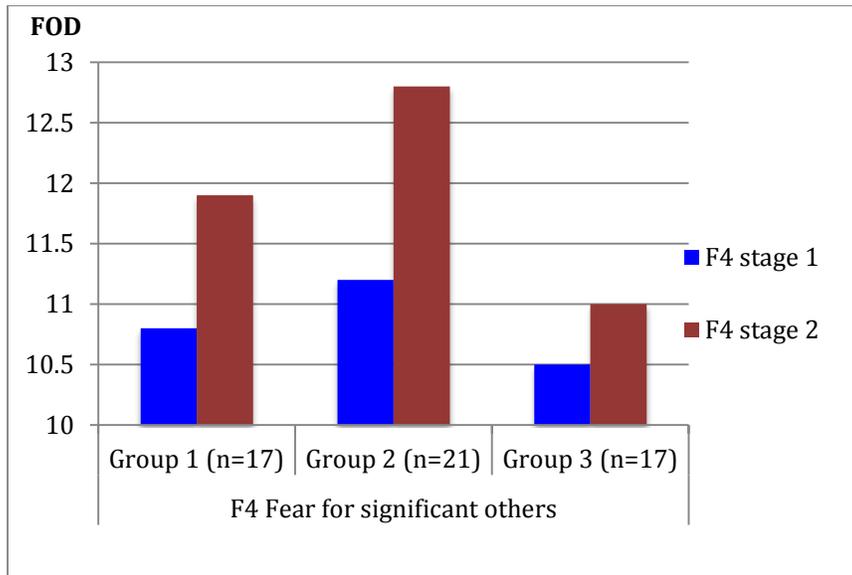
Figure 11.7 Comparison of stage 1 and stage 2 scores for F4: Fear for significant others

A Wilcoxon signed rank test showed that there was no statistically significant change in fear for significant others:

Group 1: (Z =.318, p = .751);

Group 2: (Z=1.015, p=.310)

Group 3: (Z=-.546, p=.585).

The mean FOD score for all groups at stage 1 was 10.8 and at stage 2 was 11.9, further illustrating a slight decrease overall in FOD.

11.3.5 F5: Fear of the Unknown

This aspect of fear of death was measured through the student's responses to five questions:

Q5.   I am afraid that there is no afterlife.

Q9.   I am not afraid of meeting my creator.

Q18.   I am afraid that death is the end of one's existence.

Q30.   I am afraid that there may not be a supreme being.

Q36.   No one can say, for sure, what will happen after death.

The range of possible scores for F5 was 6-24.The mean FOD value for each group was compared for stage 1 and stage 2. These are shown in figure 11.8.
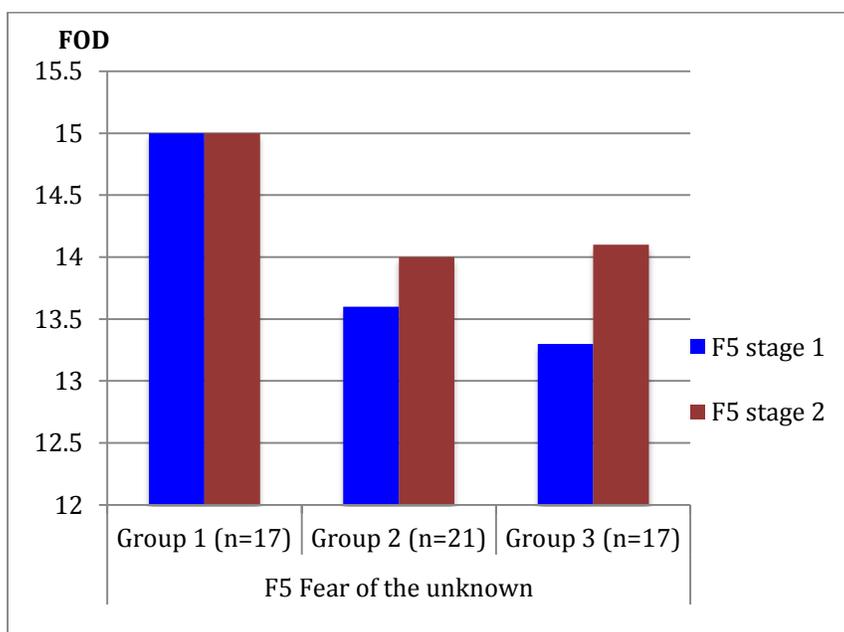
Figure 11.8 Comparison of stage 1 and stage 2 scores for F5: Fear of the unknown

The results followed a normal distribution and, therefore, a paired T–test could be carried out: For group 1, there was no significant difference in reduction in FOD between stage 1 (M=15.24, SD=3.94) and stage 2 (M=15.24, SD=3.86); t (16) =.000, p=1.000.

For group 2, there was no significant difference in reduction in FOD between stage 1 (M= 13.86, SD= 4.27) and stage 2 (M=13.95, SD=4.22; t (20) =-1.563, p=0.134

For group 3 there was no significant difference in reduction in FOD between stage 1 (M=12.94, SD=3.81) and stage 2 (M=14.17, SD=3.57): t (16) = -1.154, p=0.264

The mean FOD score for all groups at stage 1 was 14.0 and at stage 2 was 14.4, further illustrating a slight overall decrease in FOD.

11.3.6 F6: Fear of Conscious Death

Fear of conscious death was measured by asking for the student's responses to five questions:

Q6.   There are probably many people pronounced dead that are really still alive.
Q10.   I am afraid of being buried alive.
Q19.   People should have autopsies to ensure that they are dead.
Q29.   It scares me to think I may be conscious while lying in a morgue
Q38.   I hope that more than one doctor examines me before I am pronounced dead.

The range of possible scores for F6 was 5-25. Figure 11.9 shows the totals for the results of stage 1 and stage 2 FOD from the mean scores for each of three groups.
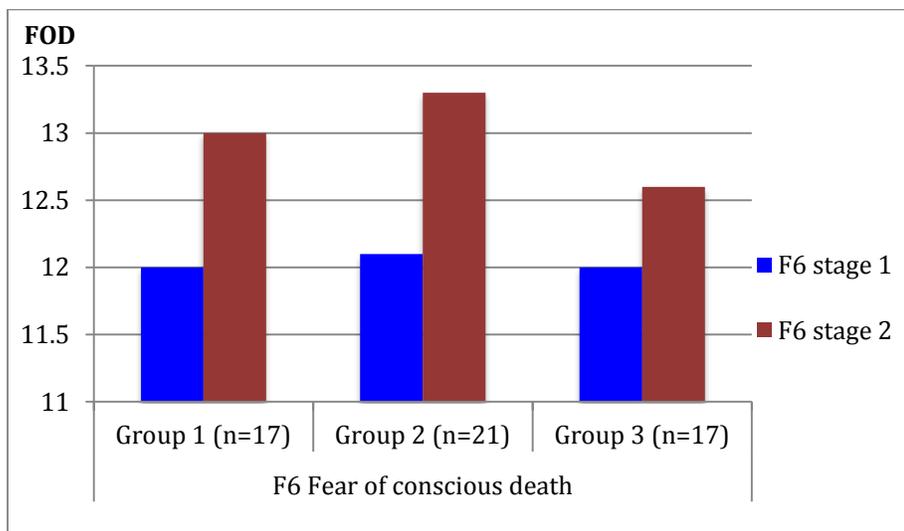
Figure 11.9 Comparison of stage 1 and stage 2 scores for F6: Fear of conscious death

A Wilcoxon signed rank test showed that there was no statistically significant change in fear of conscious death:

Group 1: (Z =1.314, p = .189);
Group 2: (Z=1.545, p=.122)
Group 3: (Z=1.116, p=.264).

The interventions seemed to have had little impact on this dimension of fear of death. All the groups show a decrease in fear of conscious death. The mean FOD score for all groups at stage 1 was 12.0 and at stage 2 was 13.0, further illustrating a decrease overall in FOD.

11.3.7 F7: Fear for the Body after Death

Fear for the body after death was measured using six questions:

Q7.   I am afraid of my body being disfigured when I die.
Q11.   I dread the thought of my body being embalmed someday.
Q20.   The thought of my body being found after I die scares me.
Q28.   It does matter whether I'm buried in a wooden box or a steel vault.
Q35.   The thought of being locked in a coffin after I die scares me.
Q40.   The thought of my body decaying after I die scares me.

The range of possible scores for F7 was 7-29. The groups' mean scores at stage 1 and stage 2 are shown in Figure 11.10.
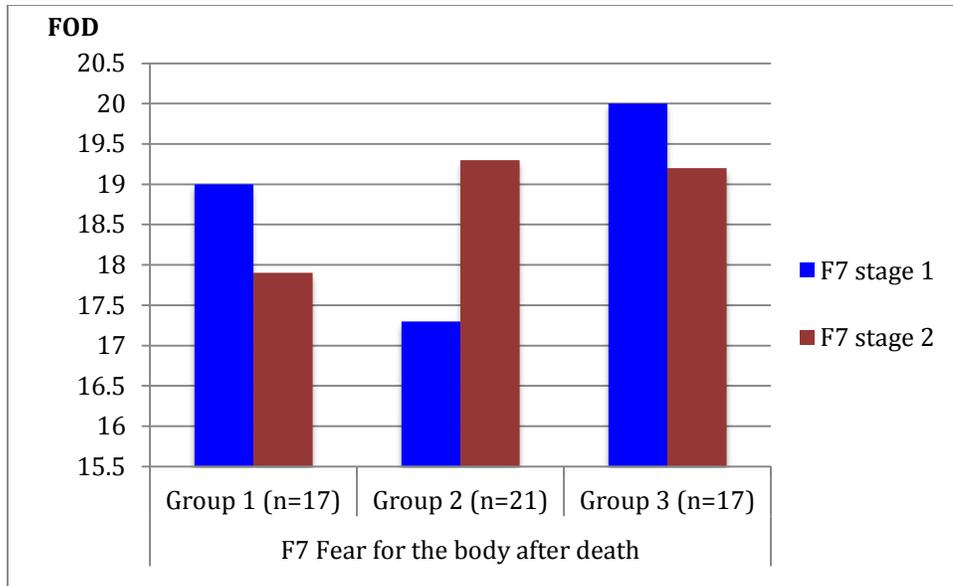
Figure 11.10 Comparison of stage 1 and stage 2 scores for F7: Fear of the body following death

A Wilcoxon signed rank test showed that there was no statistically significant change in fear for significant others for group 1 and group 3, but a statistically significant change for group 2;

Group 1: (Z =-.912, p = .362);

Group 2: (Z=1.660, p=.097)

Group 3: (Z=.337, p=.736).

While group 3 shows no changes, group 1 shows a slight increase in fear, and group 2 a slight decrease in fear for the body after death. The mean FOD score for all groups at stage 1 was 18.8 and at stage 2 was 18.7.

11.3.8 F8: Fear of Premature Death

In order to measure the differences in fear of premature death, the students were asked four questions:

Q8.   I have a fear of not accomplishing my goals in life before dying.

Q12.   I am afraid I will not live long enough to enjoy my retirement.

Q21.   I am afraid that I will not have time to experience everything I want to.

Q41.   I am afraid I may never see my children grow up.

The range of possible scores for F8 was 4-20. The results of the averages for each group at stage 1 and stage 2 are shown in figure 11.11.
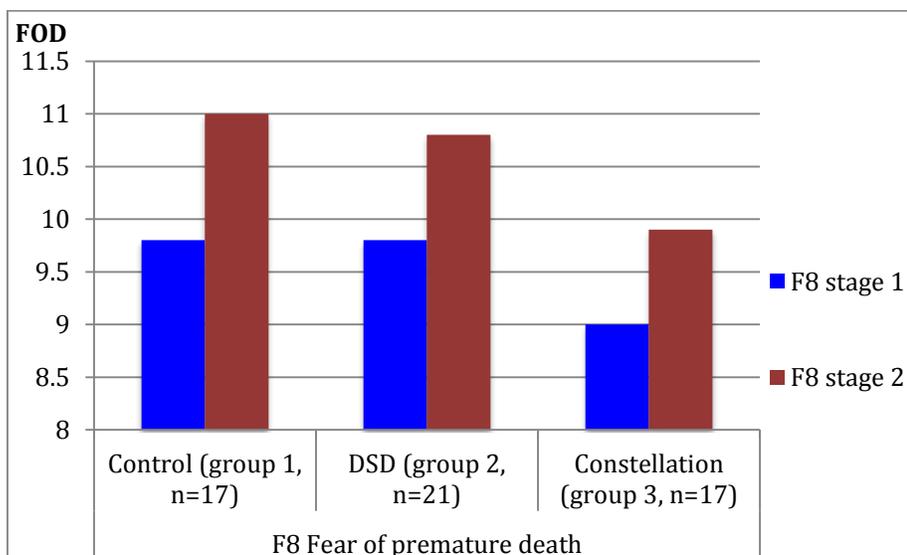
Figure 11.11 Comparison of stage 1 and stage 2 scores for F8: Fear of premature death

A Wilcoxon signed rank test showed that there was no statistically significant change in fear of premature death for:

Group 1: (Z =1.643, p = .100);

Group 2: (Z=.406, p=.684)

Group 3: (Z=1.194, p=.232).

All the groups show a decrease in fear of premature death. The mean FOD score for all groups at stage 1 was 9.4 and at stage 2 was 10.5, illustrating a slight decrease overall in FOD.

11.4 Summary of results for F1 to F8 for the three intervention groups and the cohort

The differences in FOD between stage 1 and stage 2 were considered for each of the groups for each of the categories of FOD. The mean change was 0.7 and so I decided that a substantial change was 1.4. Table 11.1 shows these differences where a substantial change of 1.4 or more for each group has been emboldened.

Table 11.1 differences in FOD between stage 1 and stage 2 for the intervention groups

Intervention Group	F1 (stage 2-stage 1)	F2 (stage 2-stage 1)	F3 (stage 2-stage 1)	F4 (stage 2-stage 1)
Group 1 (Control)	**+1.4**	**- 1.6**	- 1	+ 1
Group 2 (DSD)	**+2.0**	**+ 2.2**	+ 1.2.	**+ 1.6**
Group 3 (Constellation)	+1.2	- 0.6	+ 0.8	+ 0.5

Intervention Group	F5 (stage 2-stage 1)	F6 (stage 2-stage 1)	F7 (stage 2-stage 1)	F8 (stage 2-stage 1)
Group 1 (Control)	0	+ 1	- 1	+ 0.6
Group 2 (DSD)	+ 0.3	+ 1.2	**+ 2.0**	**+ 1.5**
Group 3 (Constellation)	+ 0.8	+ 0.6	- 0.9	+ 1.3

Although the results are not statistically significant (except for F2), it can be seen that group 2 has five of the eight as a substantial change. Group 3 has no substantial changes and group 1 has two substantial changes. These changes can also be seen in Figure 11.12. This shows that most changes for each category (F1-F8) were in a positive direction, indicating a reduced FOD. Group 1 showed an increase in FOD in F3 and F7 and group 3 showed an increase in FOD in F2 and F4. Group 2 show a consistent decrease in FOD.
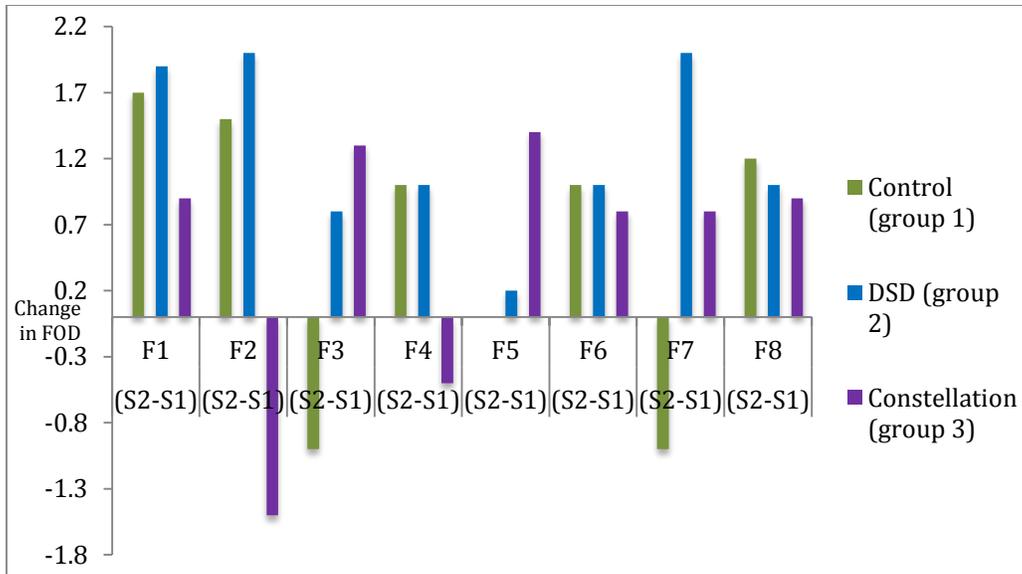
Figure 11.12 Differences in FOD for F1- F8 for the three groups

Table 11.2 and figure 11.12 show that only F1 (fear of the dying process), F6 (fear of conscious death) and F8 (fear of premature death) had a similar change in FOD for the three intervention groups. In these three categories of fear of death all three groups experienced a reduction of fear. This indicates that either the educational input or experiences in clinical practice reduce the students' fear of death in these categories. Again, with such small numbers it is difficult to draw helpful conclusions.

The use of the MFODS (Hoelter, 1979) revealed that all three of the intervention groups experienced an overall slight reduction in fear over the first eight months of the programme. Table 11.2 shows a comparison of stage 1 and stage 2 scores for the F1-F8 categories of fear across the cohort, ranked from greatest to least FOD.

Table 11.2 Comparison of stage 1 and stage 2 scores for the F1- F8 categories of fear

FOD (stage 1)	TYPE OF FEAR (stage 1)	t/75		FOD (stage 2)	TYPE OF FEAR (stage 2)	t/55
F8	Of premature death	9.4	HIGH	F8	Of premature death	10.6
F3	Of being destroyed	10.3		F3	Of being destroyed	10.7
F4	For significant others	10.8	FEAR OF DEATH	F4	For significant others	11.9
F1	Of the dying process	11.0		F1	Of the dying process	12.5
F6	Of conscious death	12.0		F6	Of conscious death	13.0
F5	Of the unknown	14.0		F5	Of the unknown	14.4
F7	For the body after death	18.8		F7	For the body after death	18.8
F2	Of the dead	18.9	LOW	F2	Of the dead	18.9
	Total:	105.2			Total:	110.8

The first research aim sought to gain an understanding of the fear of death in a group of first-semester student nurses. Table 11.2 shows that the hierarchy of fear for the cohort changed little between stage 1 and stage 2, with the primary fears being premature death (F8) and fear of being destroyed (F3). The least felt fear for the cohort was of the dead (F2) and for the body after death (F7), which is an interesting perspective from nurses and one that implies a familiarity with bodies.

The range of the differences in mean scores for the cohort between stage 1 and stage 2 was -0.3 to +1.4. The most marked change for the cohort was for F1, decreased fear of the dying process (+1.4) and F8, decreased fear of premature death (+1.1). These represented aspects of death that reflected a developing familiarity with the students' role in nursing dying people.

Research aim 2 sought to evaluate two strategies designed to reduce fear of death. From the analysis of the MFODS (Hoelter, 1979), the results indicate that use of the DSD reduces fear of the dead (F2) and fear for the body after death (F7). Overall for F1-F8, group 2 showed a decrease in fear between stage 1 and stage 2 of a total of 9.9, whereas the changes overall for

group 1 was 4.4 and for group 3 was 4.1. This further indicates that DSD is a strategy that can be useful in ameliorating fear of death for new student nurses.

The results from group 2 and group 3 arise from datum from a proportion of the group sampled (group 2, n= 21 and group 3, n= 17). It was difficult to discern to what extent the DSD had been completed or the number of constellation sessions attended. Only 14 of the 25 in the constellation group attended the weekly sessions. This might be reflected in the results, which could have shown a more significant reduction in FOD had more attended.

11.5 Limitations of the MDFOD data

Four of the students who were later interviewed stated that the questionnaires had been a shock for them. In hindsight, it would have perhaps been more effective to use a simpler, less graphic set of statements, as used in the Collett-Lester Fear of Death and Dying Scale (1969, revised 1994). In this way, the students would have had fewer questions and would not have been over-challenged by the scale and depth of the questions. There was no harassment or coercion, but the time limit was less than half an hour to complete the 42 questions, which might have put pressure on any students who had learning difficulties.

The student numbers of the cohort at stage 1 (n=75) seemed sufficient to provide useful data. I had not foreseen a reduction in the numbers of quite so many students at stage 2, down to 55. This meant that some categories became small and statistical calculation became unreliable. The US National Center for Health Statistics feels that statistical data based on a number less than 20 do not meet their requirement for a minimum degree of accuracy (New York State DoH, 1999).

One student might have confounded the results and the datum was removed. The phenomenon of the topic of death possibly causing offence was interesting. This suggests that further research could consider the effects of asking questions to student nurses where the issue is culturally challenging or taboo for them.

The process of carrying out a group intervention (family constellations, group 3) raised problems that have been identified in section 9.5. The small number of students who regularly attended the sessions meant that the MFODS was also completed by members of that group who had

been unaffected by the work. It was therefore not possible to evaluate the true change in MDFOD within group 3. The qualitative results will provide further information on this issue.

11.6 Conclusions

The first research aim was to gain an understanding of the fear of death in a group of first-semester student nurses. The findings reported in this chapter have contributed to addressing this by identifying that the primary fears in this group of new student nurses were fear of premature death and fear of being destroyed. The least felt fears were fear of the dead and for the body after death.

The findings in this chapter have also contributed to the second research aim. This was to evaluate two strategies designed to reduce fear of death in first-year student nurses by strengthening aspects of the affective domain. After analysis using SPSS (2012), there was a small change of fear of death between two of the groups (group 1, control and group 3, constellation). The DSD group (group 2) showed a statistically significant decrease in fear of death. In this group, F2 (fear of the dead) and F7 (body after death) showed a statistically significant change. The quantitative findings are consistent with the proposition that the DSD programme was effective in ameliorating fear of death.

The quantitative results of the DSD group support the theory that DSD increases behavioural flexibility. Fear of death was reduced in all eight FOD categories for DSD students, indicating an increase in acceptance and flexibility in these areas.

Although there was no statistical evidence to support the proposal that Family Constellation work can reduce fear of death, there is more of a decrease in fear of death in this group than in the control group. A much larger sample size would have been necessary to provide results with greater validity and reliability. However, these findings indicate that spiritual work can decrease fear of death in new student nurses.

The quantitative data have enabled me to address the first three research aims to a limited degree. However, regarding the interventions, their impact might have had subtle effects that could not be measured in this manner. The next chapter will discuss the results of the interviews with fifteen of the students and will explore some of these more subtle influences.

Chapter 12 Qualitative results from the interviews

The complex picture of the student in terms of her journey with fear of death is not reducible to quantitative measures on a single scale, or even multiple scales. It is necessary to explore the experiences of the student in order to understand the impact of the programme, the impact of the interventions and the impact of her experiences on her perceptions of fear of death. This chapter discusses the process, practice and outcomes of interviews that were carried out with 15 students. The data discussed are relevant to answering all five of the study's research aims.

In Chapter 8 (section 8.6), the concept of Interpretive Phenomenological Analysis (IPA) (Smith, 1996, 1999) was discussed. The analysis of the transcripts used principles drawn from IPA. Themes and Superordinate Themes (SOTs) emerged through the exploration of the transcripts. Themes were identified from the students' feelings related to death. The SOTs are the broader categories of these themes. This chapter is structured as follows. Each of the themes that contributed to the identification of an SOT is identified and examples provided from the data. Then the SOTs are set out and explained, noting their complexities, as there were issues that crossed the boundaries between the SOTs. Finally, conclusions are drawn with respect to how the qualitative data have contributed to addressing the research aims.

12.1 The interviewees

The process of students volunteering for interviews was discussed in Chapter 9 (section 9.7). The students who had completed the stage 2 questionnaires were emailed and asked if they would consider being interviewed. Four students responded within a day and these were all students who had participated in the constellation intervention (group 3). As I had facilitated the constellation intervention, I was unsurprised by this, as the students knew me well.

After three more email requests, there were eventually four students from the control group, three from the DSD group (group 2) and eight students from the constellation group. It was unfortunate not to be able to interview more students from the DSD group (group 2), but this was deemed to be a sufficient sample of the stage 2 students. I was grateful for the enthusiasm from the constellation group (group 3). This suggested that those who knew me well had more motivation for participating in the interviews. Five of the eight from the constellation group had

attended the constellation sessions on a regular basis and the other three had attended at least once.

It was moving for me to witness the candid way in which all of the students shared their feelings and experiences. This was an illustration of the heuristic nature of the inquiry, as discussed in Chapter 8 (section 8.6). It felt to me as if they were almost chatting to a friend, as there did not seem to be any feelings of formality. One of the interviews took place in quite a noisy location and so was not lengthy, finishing after twenty-eight minutes. There were several of the students who were very happy to talk and would have carried on for much longer than an hour and a half if it had been possible.

The 15 students who agreed to be interviewed were from stage 2, where the 55 students had been part of the three intervention groups. Table 12.1 shows the demographic characteristics of these 15 students.

Table 12.1. Demographic data from the 15 interviewees

Age		Experience		Ethnicity		Religious/ spiritual affiliation or none		Gender	
18-20	5	None	4	White	9	None	8	Male	1
21-25	3	<3/12	3	Mixed	1	Christian	6	Female	14
26-30	3	3/12-2yrs	2	Asian	1	Hindu	1		
31-36	1	3-5yrs	1	Black	4				
>36	3	>6yrs	5						
Total	15		15		15		15		15

The data above show that at least one student from every part of the demographic categories was represented. There was a fair and satisfactory distribution of gender, age, previous experience, ethnicity and spiritual affiliation. The distributions of these factors fairly reflected the stage 2 group, although there was a possible bias in that there were more students from group 3 (constellations) than from the other two groups.

12.2 The interviews

Recruitment and implementation of the interviews were briefly discussed in Chapter 9 (section 9.7). The interview venue, within the student's clinical placement area, was always carefully chosen. There was (apart from one interview) privacy and quietness, and also, if the student had become upset, then help was at hand from their mentor. If I thought that it was possible that she felt upset, then I checked this with the student. Some students became emotionally moved when talking about the courage of patients and relatives, but none said that they were upset, nor wished to end the interview. In all but one interview, it was possible to be comfortable and unhurried.

Experiences could be explored in depth and different perspectives discussed. The content of the interviews covered the student's preparation, experiences and the support available to them with regard to caring for dying people in clinical practice (appendix I).

In IPA, Smith (2015) advocates starting from an empathetic perspective. This meant re-forming a connection with the student. I did this by reminding her that I had nursed many people who had died and that I was interested in learning about her experiences. Later on in the interview, Smith (2015) advocates moving from an empathetic perspective to a more critical stance. This is where I asked specific questions about the experiences that the students shared. This was the sub-framework for each interview. It was important, given the nature of the inquiry, to come from an empathetic perspective. This was demonstrated by being flexible with regard to the structure of the interviews.

If a student was describing a set of experiences that had influenced her learning, then I gave her time to complete this and did not attempt to control the pace of the interview. I could later question particularly interesting or relevant aspects. This empathetic approach allowed the students to share feelings that contributed to meeting the fourth aim of the research (to gain an understanding of factors that affect the feelings of students who are caring for people who are dying and their families in clinical practice).

After a greeting and settling down time, the student was given the opportunity to ask questions and the format of the interview was described. The student was then shown her stage 1 and stage 2 scores for the MFODS and the results were discussed. There had been a decrease in their fear of death (FOD) in 11 students (i.e. an increase in their FOD score), but six had shown

a substantial decrease in FOD of 20 or more (an increase in FOD scores). Table 12.2 shows the variation in FOD across the 15 students.

Table 12.2. FOD at stage 1 and stage 2 for the 15 interviewees

Student	Intervention group	stage 1 MFODS score	stage 2 MFODS score	Difference
1	1	88	66	-22
2	1	139	150	11
3	1	130	119	-11
4	1	98	105	7
5	2	96	88	-8
6	2	97	117	20
7	2	76	118	42
8	3	90	118	28
9	3	99	131	32
10	3	98	94	- 4
11	3	113	123	10
12	3	99	121	22
13	3	84	103	19
14	3	97	111	14
15	3	88	108	20

The range of these 15 students' change between stages 1 and 2 was 64 (-22 to 42); the mean was 12, with a median of 14. Identifying the student's FOD increase/decrease was an effective way to 'break the ice' and to set a scene for the discussion.

There was a need for flexibility when the students introduced new aspects and these needed to be explored. Each student was encouraged to give examples of her experiences with dying people, with further clarification and detail elicited through open questioning. The interviews lasted between just under half an hour, and an hour and a half. At the end of the interview, I gave the student a cake or box of biscuits.

The interviews were recorded digitally and transcribed by me over the following days. I aimed to have the transcription completed as soon as possible after each interview. The transcripts were

loaded into QSR International NVivo 9 (NVivo, 2010) and then reviewed to code into nodes and identify emerging themes. NVivo helps to organise the data but does not play any part in its analysis. Contemporaneous notes were also taken during the interview. These were minimal, as the subject of the discussion required my full attention and eye contact was, in the most part, maintained. The notes were used in the analysis of the data. The coding process is discussed in more depth in the next section.

I found conducting the interviews rather challenging, as they moved me emotionally. Sometimes I had to struggle to remain unbiased and, therefore, avoid leading the student or suggesting ideas to them. The nature of this struggle reflects the heuristic approach that was discussed in Chapter 9. This closeness between the interviewees and myself proved to be a strength of the study, as the students were keen to share explicit experiences and did not appear to be concerned about presenting feelings of vulnerability.

I questioned the whole interview structure at times because the formality of our positions of teacher and student reminded me of interviewing students for a place on the programme, or for a job. However, this was also part of the heuristic inquiry and the students seemed relaxed. I was aware that there might have been areas that were not discussed, such as any criticism of the support from the university, or stories of the student not coping at all, or of them acting unprofessionally. I assume that my opinion of the student was significant to her, but believe that this would be true of any interviewer that was a qualified nurse and automatically 'senior'.

There is a particular style of language that takes place between nurses and this helped the interview to be more comfortable. No patients were ever identified, but the students were aware that my professional Code of Conduct (NMC, 2015) would not allow a breach of confidentiality. The interviews were strangely enjoyable. Not because the subject concerned the painful experiences of these students in terms of their journey of becoming familiar with death, but because of the level of honesty and intimacy that was evoked. A kind of magic was constructed in the space between the listener (who has an old acquaintance with death), and the speaker (the enthusiastic, caring practitioner). Within the IPA approach, Smith (in Willig, 2012:206) identified this feeling clearly where he says "there's something magical happening, sort of elemental happening in the 'here and now', where the two of you are constructing space and something strange happens with time in terms of the way it can happen".

I experienced this with most of the interviewees; a feeling of surreal pleasure that I was sharing their experiences. I was being honoured with their feelings and their secrets. I was being allowed to enter a world that I miss, where the intimacy between nurse, patient and their family is a special and wonderful privilege, where real and bloody life and death are experienced first-hand. I do not believe that the depth of these interviews could have been achieved with anyone who had not experienced the intimate care involved when nursing dying people.

An example of a dilemma I faced in the interviews was in relation to a specific negative experience a student had in one placement. My dilemma was whether to include the experience in the analysis (with the risks this entailed) or to exclude it (and lose valuable data). After much reflection, I decided that it was too personal to include here and that there were unacceptable risks of breaching confidentiality. I started to reflect upon whether even discussing the role of nurses in death and care after death was somehow trespassing into almost a sacred area, which should not be shared with those who do not work in the health services. The paradox is that I believe that students would be better prepared for this work if these matters were more widely discussed and acknowledged in public. I also feel strongly that, as death affects all people, discussing these issues and publishing research into death matters might help to develop our understanding of death and the fears that surround these events.

12.3 Noding and coding

After the transcription and the examination of the content using NVivo, the identified concepts were called nodes. The NVivo software allowed me to gather parts of each interview into areas of commonality (nodes) ready for further refinement, as suggested in the IPA framework. These nodes were then refined into themes, which were then clustered as SOTs (Biggerstaff & Thompson, 2008). The term 'theme' is used here to signify a bigger collection of texts created by analysis, which was the term used by Smith et al. (1999). The themes and SOTs all reflected aspects of death and dying. The SOTs contributed to addressing all five of the research aims.

The reading and allocation of data to nodes was a cyclical process that was repeated several times to ensure that nothing important had been omitted (Smith et al, 1999). The allocation of raw data to nodes facilitated a quantitative approach to part of the data analysis. It could be seen through this process that not all of the interviewees mentioned all of the node terms.

The notes that I had made in the interviews also contributed to the analysis as they offered a context for some of the quotes, which allowed me to make observations on the process of the interviews.

An idiographic approach was taken throughout, which had been recommended by Smith et al. (1999). Themes that arose in the first interviews were identified and subsequently checked in later interviews. The same questions were asked in each interview, but the students' different experiences meant that new themes emerged throughout the interview process. The double hermeneutic of the textual experiences of the students being analysed through the experiences of the researcher was kept in mind throughout. This resulted in me being aware that my own perspectives were framing these experiences and that a non-nurse might not have reached the same depth of awareness of these death and dying themes.

After the analysis of all 15 interviews, a grid was constructed to identify the themes and to explore how these could be amalgamated into broader SOTs. The 15 accounts of becoming familiar with death had commonalities that were drawn out. The relationship of the emergent SOTs to relevant theory will be briefly explored in this chapter. It can be seen from table 12.3 that there were 15 identified themes, although overlap was a difficulty. The title and content of each of these themes are explained in the following sections. The column 'sources' gives the reader information on the number of students who spoke of the theme. The 'references' column provides the number of times the theme was identified within the entire interview transcripts.

Table 12.3.Themes and super-ordinate themes

	Themes	Sources	References	Superordinate Themes (SOTs)
1	Death and dying	15	130	Death and dying.
2	Emotions	15	94	Emotional issues.
3	Fear	12	38	
4	Demographic variables	12	22	Cultural aspects.
5	Culture and ethnicity	10	37	
6	Family trauma	15	53	Families.
7	Hospice versus hospital	5	12	Care at the end of life
8	Liverpool Care Pathway	7	15	
9	Care after death	15	88	
10	Interventions (DSD or Constellations)	7	11	The student and her nurse education.
11	Communication	6	16	
12	Mentors	15	78	
13	Support	14	67	
14	Learning experiences	15	147	
15	Nurse education	14	53	

After reading and reflecting on the themes, these were grouped into the 6 final SOTs. The research aims were considered throughout the IPA analysis, and the data had thus been organised and integrated with these in mind. The relationship between the SOTs and the research aims are discussed in the next chapter. It was important here to move between explaining and understanding the texts, and aiming for an interpretation at deeper levels, in order to address the research aims.

The use of NVivo (2012, Appendix J) facilitated the grouping together of related passages under each theme and SOT. This made it straightforward to identify the quotes that illustrate the SOTs most clearly. Quotes were chosen in order that the student's voice would be present in this research and that they would illuminate the research aims directly. These quotes are reproduced in this chapter verbatim, so repetitions, grammatical errors and colloquialisms are included.

Each of the six major SOTs will now be explored in some depth, with the themes identified and discussed within each one. The use of 'K' identifies a question or comment from the researcher. The students' quotes will be cited with an 'S' with their allocated number between 1 and 75. The students were not aware of this number. The voices of the students are clear within this chapter and each section is followed by an exploration of the meaning and context of the students' comments. The double hermeneutic that was identified in Chapter 8 took place here, in that the experiences described in the text had been filtered by the student and were then re-filtered by the listener. The reality that both were nurses helped the identified central concepts within the SOTs to be relevant to addressing the research aims.

12.4 SOT 1: Death and dying

This section will explore the core issues of experiences of death and dying in terms of familiarity with the concept of death. The substantial theme of death and dying contributed to creating one SOT. There are two aspects to this theme. Death refers to the event. Dying refers to a longer period, perhaps even days, before death occurs. However, the boundaries between these terms are blurred. Each of the 15 students had experienced various interactions with death. All of those interviewed had experienced at least one death on the wards. Some of those students who had been placed in a hospice had experienced weekly deaths. These quotes illustrate the interaction between researcher and student:

> K: 'How many patients died at the hospice when you were there?'
> S40: More than 10 or 15. I was there for 8 weeks, so every week someone would die.
>
> K: 'Did you feel there was quite a lot of death?'
> S67: Yes, there was (sic) about 4 or 5 on there. I was there for 6 weeks. Yes, it was quite odd and one day there were 6 deaths in the whole of the unit [4 areas]. There were 2 deaths on one day; some weeks there weren't any, but they all seemed to come at once.

These responses illustrate that the experience of death is not unusual in nursing and that in some clinical placements death is an irregular occurrence. All of the 15 students stated that they had experienced a change in attitude with regard to death. These students demonstrated a developing familiarity and appreciation for a peaceful death. Some had positive first experiences with death. This quote illustrates this learning:

S67: Before I started the course I hadn't had any experience of death, but once I'd seen it, I realised that it wasn't as bad as people made out and it could be quite nice in a way if you know what I mean. Peaceful. If it is a peaceful death, then it is quite nice.

The journey of the dying person had an emotional and spiritual effect on the students. One said:

S62: Once you've had that experience, everything completely changes, so it was more honourable for me to be, I felt quite, what's the word, yep, honoured to be able to do, and it happened quite a few times, but looking after the dying, I think maybe my experiences were quite nice because everybody around me was so thankful for what we were doing and I didn't have anybody ranting or raving or 'you're not doing the right thing', it was so much more nicer than that. Everybody has a time to go, but I didn't think like that before.

There was a development of cognitive strategies by the students, such as analysing the nursing care, that helped with the making sense of these experiences, a making sense of the unfamiliar, an owning of their new knowledge. This came across clearly in all the transcripts and notes.

The interviews were mostly carried out at the end of the students' second year of the programme. This is reflected in the way that most students had come to understand the nature of death. There was a tacit acceptance. Dying did not seem to be a problem in their working lives. A general feeling across the 15 students was illustrated by this quote:

S32: I realised that nothing really happened. They just die and we coped. It gradually sank in. I was no longer scared or anything and to understand that it is natural. We all live and then grow old and then die.

When I reflected on the traumatic experiences that the students shared from the beginning of their clinical placements, followed by their acceptance of death as part of their work, it became clear that there had been a development in their thoughts about the nature of dying. The students' reflections implied that a transition had taken place and that the shock and strangeness of the dying process had given way to an acceptance of the experience of death.

12.4.1 Summary of death and dying

These students had acquired skills in the cognitive and psychomotor domains that enabled them to provide appropriate nursing care in a context of death and dying. This development also suggests an emotional and spiritual development within the affective domain. This had developed as death became more familiar and less frightening to the students. These students had witnessed that the body of a person after death is quite different from the body of a living person. The presence of life suggests that the nurse is in a therapeutic relationship with the person. This relationship changes at the moment of death when the nurse becomes the custodian of the body during the person's journey to the mortuary or morgue.

All of the students showed that there had been a development in their skills within the cognitive domain. Over the past two years, they had learned to become familiar with concepts of death and dying. Although they enjoyed recounting their traumatic experiences, across all of the 15 students there was a clear acceptance that death was going to be the way it was, death as part of life. There was a need to get on with managing the situation, for the sake of the patient and the patient's family.

12.5 SOT 2: Emotional issues

This SOT refers to the emotional experiences of the students, and how learning through the affective domain had taken place. Further substance to the study's understanding of the development of the affective domain is provided in this section. This is the arena of feelings and refers to areas of the transcripts that deal with emotions, particularly fear. There were challenging, difficult deaths and positive deaths. There were comments from the students which included these words: afraid, fearful, apprehensive, surprised, pathological fear, sad, anxious, heart breaking, crying, quite moved, upsetting, breaking down, shocked, 'oh my God', and tearful. The words upsetting, shocked or scared were used by all 15 of the students.

Some of these words referred to their first experiences of being with a body and needing to wash the dead person, and to traumatic deaths. Although 12 students had positive first experiences with death, three students expressed a lack of emotional preparation for how patients look and feel when they die. An example of these first experiences was:

S67: The health care assistant called me behind the curtain and I thought it was to help her with bed bathing the patient, but it turned out that he had actually died. I didn't realise what had happened so when I saw him lying there and we started putting on the shroud but I just kind of broke down. After I kind of broke down, she did feel very bad because she didn't realise I hadn't experienced it before, so she apologised to me.

K: Did you break down in front of the patient?

S67: Behind the curtain, yes. So I went to the staffroom for a bit… I was very shocked, I was so shocked. I wasn't expecting to cry, but I think I was so shocked, I didn't know what else to do.

There were also feelings, during initial experiences with death, that went along the lines of needing to live life to the full and identifying themselves with their own death. This demonstrates that students can start to develop their own EQ/SQ through their experiences. Dealing with difficult experiences can enhance EQ, whilst considering the quality and quantity of their own life can affect the development of their SQ. Three students expressed this concept. One example of this was:

S40: I was like, 'no, I'm too young, I can't be doing that' and then I couldn't even sleep…these are dead bodies, they are not breathing anymore.

If a person had had a traumatic death it was an emotionally challenging experience. The students remembered and recounted these deaths in some detail:

S71: He died and the family were around and I went in with the other nurse because he had oxygen on, just to get a few things from the room so the family could go in. He had dried tears down his eyes. Like, oh God, isn't it supposed to be peaceful? Isn't death supposed to be like a nice sleep? How could someone be so scared? The whole night he was crying. It was literally the whole night, and then he died about half-past four in the morning.

Some patients experience sudden deaths, where the nurses are not quite ready. This seemed to be shocking for the student and it had taken time to come to terms with the experience:

S73: I fed him. I'm there with the staff nurse. We are still taking care of him. He said no, he said the porridge he had was enough. I put the things away, 2 minutes later the staff nurse called me. She said 'you should hold him', so I held him. She said 'he is dying'. But he was not for resus [resuscitation]…so I just held his hand.

This death was peaceful, as most were. Death could even be seen as a positive change. One student said that she sometimes felt relieved when it happened. This is an example of a developing SQ. This student gave as an example a middle-aged adult patient, whose elderly mother had been caring for her for a long time. The student saw death as an end to a difficult period of suffering for the patient's mother:

S02: I know it sounds bad, but I just thought, at least now her mum sort of you know, it's happened and she doesn't have to worry about it anymore.

S11: I have seen a few ladies, and men...people who are at peace with themselves. They seem to be actually encouraging you and you know, wishing the best for you and they are actually... actually caring for you and I've seen a few people like that and I think they have had the most peaceful deaths ever.

Students appeared to have commenced the programme with fears regarding death and dying, but their EQ was developed both by the content and context of the experiences. There was also an impression that all of the students resolved to continue to develop their SQ through their challenging experiences. This quote is an example of the altruism that was developing in this student.

S02: ...at the same time I felt like I'm going to have to do it at some point. Somebody had to do it for my grandfather, so even though I was upset about it, I was still pleased that I was doing it for somebody else and looking after that person.

Fear was expressed tacitly in the majority of the interviews, through facial and body language, but three students gave examples of feeling fear. One of these was the first experience of seeing a dead body:

S40: So I said to myself that I would give it a try and then I was very, very scared of dead bodies. Very, very scared.

Fear had been experienced by a substantial number of the students, but the students clearly expressed that they felt that they had developed personally since their early days on the programme. Twelve of the 15 students believed that their early fears had been reduced and that they were more able to manage difficult situations in a positive way, indicating the development of EQ and SQ within the affective domain.

12.5.1 Summary of emotional issues

Traumatic deaths were remembered clearly, and peaceful deaths were appreciated as the goal. Recollections of their early days in nursing evoked some strong feelings from the students. There were indications that most of the students had overcome those early fears and had developed their EQ and SQ, as discussed in Chapter 7. There was a feeling for an appreciation for life and the development of feelings of pride in their work.

The students' EQ/SQ had developed to a stage where they saw their work as the provision of an important service. They were in the process of acquiring effective EQ/SQ skills in order to be able to manage difficult situations in the future. This does not mean that the students' personal fears of death continued to diminish (or increase) but might mean that familiarisation enabled them to develop their professional perspective and to perhaps more effectively compartmentalise their feelings, demonstrating the development of an EQ skill. This suggests that longitudinal studies could provide useful data on the fear of death over the three-year student-nurse programme.

12.6 SOT 3: Cultural aspects

This SOT contained two themes. The first of these was demographic variables and the second theme was culture and ethnicity. Twelve students had commented on demographic variables and ten students had commented upon culture and ethnicity issues. There was a diverse spectrum of opinions and thoughts about maturity, religion and ethnicity.

12.6.1 Demographic variables: gender, age, experience, ethnicity and spiritual practice

I did not ask specifically about gender. However, two (female) students mentioned that male students might find it easier to deal with the emotional side of nursing. The one male student who was interviewed thought that there were no differences between being male or female as a student nurse.

The discussion with regard to maturity reflected the students' personal perspectives and there was also insight into 'the other'. Four of the students had a view on the differences between being a younger student or an older student. Examples of the comments were:

S40: When you are young they kind of understand you more, but if you are a little bit mature, the way they treat young people is different. There is a massive, massive gap [laughing]. I've noticed. Because I can possibly come and say, 'no I don't know but can you explain this to me?' …The way they respond is different for a mature student. They would probably say, 'how come you don't know how to do it?'

S70: I don't know if it's because I'm older and a mature student and because I've dealt with it, that nobody asks if I'm OK. I don't know if it's that or I come across that I'm dealing with it well, but no-one feels the need to ask.

S11: There is a misconception that only the, maybe the young people are more protected. 'Oh she is still young, do you need to talk to someone?' You find the older, you know... I know I was just thrown in there. You just go and do it. There was an assumption. I was quite comfortable, but I did feel that if somebody else was just thrown in the deep end without the actual support that they needed, that could be a problem.
K: So there is an assumption that mature students can cope?
S11: Yes, there is that assumption.

The students' comments supported the perspective that the younger students (<30 years) received more support than the more mature students. There is an assumption that mature students can cope better than younger ones. This assumption could mean difficulties for some of the mature students.

However, there were also particular difficulties with being younger.

> S22: It's a lot harder to be young. I can tell straight away just from talking to other people that they have experienced death a lot more than I have, or they've been Health Care Assistants or had family members pass away. Whereas it's only been one family member that's passed away, when I was a lot younger. I think when it comes to death they are a lot more experienced in how to handle it all and what to say to people. When I'm trying to comfort someone who had a relative pass away, or someone who's dying, it's a lot harder for me to relate to them. I don't have much experience in that.

Comments from the younger students were mainly about a lack of confidence in dealing with families of dying people. The examples above are typical of the comments from either the older or younger students and appear to reflect the perspective from their age range.

In terms of spiritual practice, many of the students (n=7) interviewed expressed the importance of their own personal beliefs, and how this affected their work. Christians (n=6) seemed to appreciate the framework of having a life after death, as did the one Hindu student.

> S11: I take the view, the Bible views as it is, and to me it tells me the dead know nothing, the living know that they shall die. So that dead people don't experience pain, they don't speak out, they have no feelings. So that gives me comfort that if someone did pass away, I know that they are asleep. They are resting until Jesus Christ comes to take them. That is what I believe, so that gives me, kind of hope.
> K: Yes, and a framework?
> S11: And a framework - and I know that death is not final according to the scripture. Christ will come and the dead in Christ, as it says, will rise and be with him, so I know that it is not final. It helps to have that faith, but saying that as well, even if there was no resurrection, I would feel what I have gained with the faith, is just, you know, amazing.

> S32: Another mentor I worked with said that she would say a prayer for the patient - not there, when she got home…and when she came in, in the mornings, she would say that she had been praying for the patient. She would whisper to me that she had been praying. When there was a little bit of response, we were so happy. All the praying worked. Whenever we worked with that patient she would say that she had been praying. He was

getting better. It was so encouraging. When I left, he was sitting up and they were trying to get him out of bed and we were so happy with that.

From the seven students who identified the importance of having a spiritual practice in their lives, it was clear not only that their beliefs played a part in the development of their EQ/SQ skills, but also that the students were aware of this. The specific EQ/SQ skills were related to questioning the purpose of life. The conclusions from these considerations seemed to affect how they managed difficult situations, by enhancing their clarity on the purpose of life and death. However, all seven of the students were very clear that their own beliefs were personal to them and that they would not express these views in the clinical setting. The students who did not identify themselves as having a spiritual practice had different perspectives of the meaning of death. However, one student described herself as 'spiritual', but did not have any spiritual practice. She felt that her perspective had been useful in dealing with death.

> S62: If I wasn't this way inclined [being 'spiritual'] I wouldn't have [survived], no no no. I think it makes a lot of difference. And when I hear other students speaking, I think 'Gosh if I could put your mind to where I am now', but it takes a lot of work doesn't it? It's not just about academic growth it's about personal growth.

There was a difference between the beliefs of those with a spiritual practice and those without. Those who had a spiritual practice appeared to have a longer view, beyond death. Those who did not have a spiritual practice were less sure about what happened to a person after death.

12.6.2 Culture and ethnicity

This section focuses on the differences between the white and the black students. All 15 students were British. The nine white students were English and had been born and raised in England. There was one Asian student, who had come to the UK as an adult, and one student who described herself as mixed race, but culturally identified herself fully with her African family and culture. She had recently come to the UK with her partner and children. Two of the four black students had come to the UK as adults and the other two had been raised in England. Every one of the five students from Africa expressed their belief that death was 'more respected' in their culture. It seemed that belonging to their community, either in their country of origin or in England, conferred a particular support when there was a death. It was seen that it was important for the family not to be alone until the funeral was over. There were also issues of

where a burial would take place for a person who died in England. All five students mentioned that older members of the family would expect to be buried back in the country of origin. This cultural norm affects how the students feel about death, supporting relatives and the grieving process.

S32: Death was familiar [back home]. You heard about it, you attended funerals, so you knew it was there.... To balance the two is a bit difficult, but now that we are into the nurse training, we see a patient and we understand that they have gone. There is nothing there. They can't hear you. They can't talk to you. You are able to cope better. But say you never went into nurse training or medical, you would struggle to cope with balancing culture and your beliefs. …In my culture, we always give a lot of respect for the dead. But at the same time there is this fear that if you don't do the right thing the dead person will come back to you.

S71: No…ummm… I come from a culture where death is not a topic of conversation, ever.

S39: There, there is not really much of a difference from how I live, because if you are …people feel sad in the same way. People cry the same way. But I think that there is a difference from tribe to tribe. Because in my tribe it is just you feel sad, you feel everything that a human being can feel and then you go. The only difference is the funeral. Here the funeral is for a few but there a funeral is for the whole community. The community they come together for support…people will come and help you. You don't do much because they are there doing everything. They come to your house they support you in every way. They bring bedding, they bring food, everything is done and then the funeral is at home, it is not in the cemetery. You are buried …in your own space.

I heard and appreciated that some students have experienced a 'home' culture different from that in England. These students felt that practices related to death and dying are very different here. The black students expressed the differences between burial, which was the tradition within their culture, and cremation, which seemed to them to be more usual here. This was an example of an area that could also cause tension within the student's family.

S71: Where I come from they start doing the shovelling thing when everyone is still there. No, we don't need to see that. I like [in the UK] the curtains opening and you go in and

then it's shut, then that's it. It is really over. Take the ashes and just scatter them. The children can start moving on. And things are happening………My mum said that 'you will never wake up when Jesus comes, if you have been cremated, so if you die and get cremated I will mourn forever. I'll never take off the black dress'. 'Cos Africans in mourning put on their black dress for a year …and then she said that 'I will wear it for the rest of my life'. That's my mum - she likes saying things to make me feel really bad.

This is an example of second-generation immigrants finding that their current home country can adjust their traditions and beliefs and that this might lead to practical problems in their future. Braun et al. (2008) found that there were significant difficulties when younger generations needed to make end-of-life decisions for older family members here. There was a need to try to conform to the older persons' cultural beliefs.

Returning a body to the country of origin was an aspect of death that concerned those students from black African cultures. This is another example of the dissonance between those from older and younger generations. Awareness of this expectation for the black students affects how they approach death within their own families. This is a consideration when nursing people from African cultures:

> S71: There are a lot of unresolved issues with my family and his [her husband's] issues in terms of what happens if we die here, do we get buried here or do we take them home and things like that and my husband blatantly refuses to answer those questions. Yes, he carried our lives back in *** and I'm like 'I'll bury you here' and he just looks at me and says like 'I don't know what goes on in your head'.
> K: So if your mum died here, she is still young of course, but if she died here would that be sad?
> S71: Yes, yes, if she died here, she would be taken back.

This demonstrates the specific difficulties for some student nurses who come from BAME groups. They will be working in a context of dying which follows Western traditions, whereas their culture, perhaps coming from a different influencing climate, affects their personal life in a different way from their professional lives.

Organ donation was another example of a breadth of cultural perspectives. The students from BAME groups all expressed the difficulty of people from their culture donating their organs. It seemed that the perspectives of older people within their cultures might differ from the younger, second generation people.

> S71: It has changed…the biggest most significant thing, I think, is my willingness to donate my organs. It is taboo where I come from. I think that might be the only thing.
> K: How would your mother feel about that?
> S71: She would be very upset…she'd refuse. She would take everybody to court, yeah the whole thing…the way I look at it, if anything happened to me and I needed organs, my mum would be praying for somebody out there to give something to me. Then why not donate blood or your organs if you are expecting to get something from someone else? It doesn't make sense…they have never donated. But we have no traditions or anything about giving blood, but we are happy to receive. I have donated blood many times. But it is organ donation that is lacking in ethnic minority people. It is like – 'what are you thinking?' It is just taboo.

There seemed to be an acceptance of the paradox of older people wanting to receive if it saved a life, but being unwilling to donate. However, this seemed to be an issue in transition. Student nurses from these cultures could see the value of donation. They would want themselves and their families to receive blood and organs. They understood clearly that donating their own blood and organs was necessary for the future of their families and their communities.

12.6.3 Summary of cultural influences

It was clear that the students thought that the younger students had a more difficult time with death and dying experiences, but that they were also more supported and protected by the mentors and other staff. The students felt that maturity had certain advantages in that it had helped to have life experiences (e.g. parenting), as well as end of life experiences before entering the programme. These perceptions have implications for mentor preparation and updates.

The culture of the student's country of origin was a significant influencing factor for the black students but did not appear to be relevant for the others. There appeared to be a cultural dissonance between the contexts of death in their original culture as compared to traditions

surrounding death in England. There was also a difference between the generations, so that if the student had been born here or had been here a long time (in their view), their parents might feel differently from the student and have different requirements. Regarding end of life decisions, interment practices and donation of blood or organs; these were seen to be issues that could potentially cause family tensions.

A student's spiritual practice did influence the way that they dealt with dying people and their families. Their faith was seen as a source of strength, particularly when their faith was connected to their communities. Of the seven students interviewed who felt that they had a spiritual practice, it was clear that they did not allow their beliefs to be expressed verbally in their nursing practice. These seven students expressed the view that their faith affected and effected the provision of emotional and spiritual care to patients and their families. They believed that their perspectives helped them in their nursing. They said that this helped them to be more confident when nursing dying people and caring for their families. This development of confidence is an indicator of an enhanced SQ. However, this was not supported by the results of the MFODS. At stage 2 (Oct) 53% of the cohort stated a belief in a religion. There was no greater reduction in FOD with this group when compared to the other 47%. Whilst their spiritual practice might have helped them in clinical practice, it did not appear to make a difference to these students when completing the MFODS questionnaire. This could reflect the particular way that the questions have been worded in the MFODS, and requires further study.

12.7 SOT 4: Families

The literature suggests that students find dealing with relatives and families as difficult as caring for the dying person (Peterson et al, 2010). This was reflected in all of the interviews and therefore families became both a theme and a SOT. The students expressed significant compassion and empathy for those who were grieving. Dealing with family members was found to be extremely difficult, but acting appropriately was seen to be an important skill to develop.

> S67: Most of my experiences of death have been pleasant ones; it's just the death that upsets me. I find it's also the family. When the family's there I find it really hard, because it must be so hard for them…I think that sometimes you don't always know what you can do for the family, I think that there needs to be more support for people who've died. Sometimes I feel like I'd really like to talk to them, but I just don't know what I can say to them. Do you know what I mean?

S70: They were really busy on the ward and the sister said 'can you go and sit with her…because nobody deserves to die alone'. That's really stuck. I'd not met this lady before so I just went in and I spoke to her and said I'm [student's name], I'm going to sit with you, and I held her hand. I was in there probably about a good 45 minutes, but the daughter never made it. It was such a shame, I was holding her hand and all that time I was talking about my family and children and that her daughter was on her way, and if you can hang on it would be lovely but, unfortunately, she couldn't hang on and then she passed away. About 10 minutes later her daughter came and I was SO upset. So it's that experience that really stuck, but I was glad that I was with her and that she wasn't on her own and maybe we made a little friendship thing. I'd never met her before; I didn't know anything about her, but she knew a lot about me! The daughter was so upset, but she was kind of reassured I was with her.

S16: That's something that's worrying me and that's one of my objectives, speaking to family and telling them a relative has passed on - that's one thing I'm not looking forward to. I like to think that I have a caring nature and I will be there for them but obviously I have come across families who get upset and angry and I will have to help them in the best way I can. I am getting apprehensive about telling someone that their mother or father, or whoever, has died.

S32: The family were saying goodbyes and preparing for the patient to leave. There was no way I could leave. I was supporting the whole family…. about 5 of them, just me with them. I had not even managed to get the time to even read the notes, no proper briefing about the patient. To the extent that if they were to ask me anything, I couldn't answer, as I had no clue whatsoever…and then he died, in front of me. The family were there and everything. I was just trying to comfort them, but I was at a loss, I didn't know what to say. Everything was too much for me.

S61: At first I felt like their grief for them, I was thinking, their mum has just been living her life and two days later …this is the situation. I was heartbroken for them. I just thought this is your role - you need to be there to support them as well. I think that really opened my mind up to how much you have to support the families as well in these situations.

S71: When the last man died I was fine with it, but when the relatives came in I had to run to the bathroom, you know.

These observations illustrate the challenges and concerns that can be experienced when dealing with the families of patients.

12.7.1 Summary of the issues when nursing family members

The students' accounts suggest that they saw that caring for the dying person and their family presented in stages. While the patient was alive, their focus was there, whilst also trying to support members of the person's family. Once death had occurred, there was a range of multi-faceted emotional and spiritual issues for the student to address. The emotional demands from the family (grief, loss, anger) needed to be addressed and the student's own feelings needed to be managed. The spiritual issues were around the belief systems of the patient and family, related to their orientation towards an imminent death. However, there was still holistic care that needed to be given to the patient. There was a clear awareness of the special emotional and spiritual nature of this situation for all involved. It was difficult for the students to deal with grieving relatives and they appeared to see this as a learning opportunity.

12.8 SOT 5: Care at the end of life

There were three themes under this SOT. These were hospice care versus hospital care; Liverpool Care Pathway and care after death. These will be explored here in turn. From the data, the students appeared to understand that the quality of care at the end of life is of paramount importance. A substantial number of students had witnessed both good and poor care in practice. All 15 students communicated to me that high-quality care was person-centred and involved listening carefully to what the person wanted. Provision of care involved the development of a relationship, the implementation of a framework for nursing care, trying to provide hospice level care and also following the policy for care after death.

12.8.1 Hospice care versus hospital care

Five of the 15 students had worked in a hospice and seemed to have appreciated the opportunity to work in such a setting. The feeling was that there was more time available to deliver excellent care in the hospice.

S11: In the hospice you could see there was more awareness…as far as the hospice itself, there is more awareness. They have got people that deal with their religion; they do take note of people's faith. The way that they deal with the family is very different. It is much more considerate, much more planned. Whereas, within the hospital, I have seen people being, you know…. no proper communication with the relatives and the relatives have come and found out that somebody has actually died when...and they haven't been told, or the body is actually on its way and they have been stopped mid-way and they just want to see the face and it has been a really awkward situation.

S63: I think the pressures that are on nurses, what you expected to do…you are expected to have ten thousand pairs of hands. I will say OK, that wash can wait 10 minutes and talk to that patient, but I think all in all it is a very…some people think death is quite a blasé situation, they think OK that patient's dead now. Like 'off the ward, we need that bed'. I am like hang on a minute now'. I like to do their hair and put them in their own clothes when possible, just make the time and the effort.

It seemed that the students were surprised that nursing in a hospice was such a positive experience. They felt that care there was of a high level and that patients, families and staff were well cared for. This was not always the case in hospital placements, such as trauma units and general medical and surgical wards, where doctors sometimes tried treatments for the sake of the family, so that the need for the family to face their loved ones' death could be delayed. This intervention sometimes gave false hope. Four students experienced this in their clinical placements. One student found it upsetting that the family could be the reason for an intervention:

S33: The doctors prescribed some sort of diuretic to kind of relieve the bleeding from the brain and even though it is futile, it's not going to do anything; we were more doing it for her husband. That was pretty horrendous.

The four students who mentioned these interventions found the experiences difficult because the staff knew that there was no hope, but the family was still expecting some recovery.

S63: During my placement you can see how they [doctors] can intervene by doing suctioning, prescribing Frusemide [diuretic drug], taking it [fluid] off the lungs. It's still,

obviously, death. You do worry about death isn't it? You always think that if you are going to die you want to just drop down dead; you don't want…anything tragic about it.

S71: They forced liquids down her mouth. It was obvious she was going to die [but] they kept on washing her. She would sleep for days and she would only wake up and cry when they were bathing her and I was like 'does she need a bath, she has not gone anywhere, she has been semi-comatose for days, can't you leave her alone?' They were trying to give her porridge, which I was…'leave her alone, just make her comfortable give her some painkillers and just leave her alone'. They said 'she can't have pain killers on an empty stomach'. I was like 'who cares?'

These four students have learned that artificially prolonging life with medical treatment might not be the best option for the patient and they had experienced the value of a peaceful death as opposed to a painful, undignified life.

12.8.2 Liverpool Care Pathway and end of life care planning

The Liverpool Care Pathway (LCP) (Ellershaw et al, 1997) was developed in Liverpool by a team of doctors and nurses in the 1990's. The pathway was constructed to assist members of the care team in matters relating to continuing medical treatment, discontinuation of treatment and comfort measures during the last days and hours of a patient's life (Jack et al, 2003). The LCP provided a framework on which end of life care could be planned.

It has now been superseded by the 'One chance to get it right' document (National Leadership Alliance for the Care of Dying People, 2014). The documents (LCP and the NLA) are similar in that they give valuable guidance for care planning at the end of life, but there is more emphasis on communication with families in the 'One chance' document. However, at the time of interview the students were familiar with the LCP and there were a small number of comments about its use. The quote below is a typical perspective from the 7 students who mentioned the LCP. It shows that they accept that the withdrawal of treatment, and sometimes fluids, can be the best thing for the patient, as death is accelerated and suffering is limited.

S16: I remember one patient, who was near to death and I was just making him as comfortable as I could. I didn't realise he was on the LCP and I was trying to take his

blood pressure. They said not to worry about it. I thought that was what I was expected to do, but I was expected to make him as comfortable as possible.

S40: They can make sure that the patient is pain-free so that the patient can die peacefully. That is one thing I have learned.

All of the 7 students appreciated the use of the LCP in assisting in the provision of excellent end of life care. The nurses preferred to move into the palliative phase at the appropriate time and not to give false hope to the families of dying people.

12.8.3 Nursing care after death

All 15 of the students had come to appreciate the opportunity to participate in care after death but felt that they needed support from their mentors in this activity. This procedure involves washing the patient and preparing them for the journey to the morgue or mortuary. At the time of the interviews, this care was called 'last offices' or 'laying out'. The 15 students found this a challenging part of their role:

S70: What I hated was them [the nurses] covering his face. I hate that. I hate them putting sellotape on the sheet. I didn't know what I expected them to do with him, but it was, like, so final. They were very respectful and they knew him, they were talking to him. The nurse, she had her own things going on in her head - she obviously like 'I'm not going to do last offices now, I'm just going to open the window to let the spirit out and I will come back and do the last offices when he is gone'. I went 'OK'. Then she came back and said 'I am going to do this' and she talked to him throughout which I thought was really nice, but you could see that he had gone and wasn't there. You do wonder where has he gone to - is he lurking about. Is he watching what you are doing?

S63: I was left holding the patient and the sides of the bed were up as well. And when she [the student's mentor] rolled her [the deceased person], because, I know it sounds silly, but I was really afraid to touch the patient, but when she done it I said 'careful, her head is going to hit the side of the bed'. She said 'well, hold her head then', but because I was so scared to touch her, I was a bit like (K: nervous?) Yeah, it was really scary…and also with washing the patient as well… I said, 'oh I'll go and get some water from the other room because it is warm, hot water. This room doesn't have any hot water'. She said 'the

patient is dead it doesn't really matter'. But I said 'but you wouldn't wash a patient that's, a normal patient… with cold water, so why would you do it to a dead person'. She pulled the sheet over the patient's head and I, my instant reaction, I took the sheet and I put it over, back over so, so… (K: you could see her face?). Yeah, and she said 'we need to do that because she's dead' and I said 'Yeah, I know, but it doesn't feel right'. It was just really strange. And then she said, 'oh, after a person has died, I like to open the window to let the spirit out' and things like that. It was good because she [the deceased person] still had the ECG stickers on her and things like that. So I dealt with it by talking to her [the deceased person] and saying 'I'm just taking the stickers off' and I think that helped me deal with it more as if she was…pretending that she's still alive.

S16: Was really surprised by how the stiff the body was and the colour drained. That really surprised me and I was really quite scared of hurting the person, I didn't want to tug them, obviously I wasn't going to hurt them, but…

Care generally seemed to be seen as at a high standard. However, there were 3 examples of poor care where staff appeared to be disrespecting the patient. One student related that she had been working with trained staff who were 'talking over' the patient, when he was near the end of his life. Another example was where a student had a negative experience that was related to respect and professional standards:

S67: We did last offices for another lady and she was quite a big lady so there were about 4 or 5 of us who needed to complete last offices with her. It wasn't a great experience because the people I was doing it with they were all like talking and laughing while they were doing it, which I didn't, I found quite awful actually. When you do something like that, I just don't think it was carried out in a very nice manner to be honest.

Another student expressed sadness at a trained nurse having her mobile phone on during a shift:

K: Did she talk to the patient?
S75: No, actually she wasn't very professional
K: In what way?

S75: Like her phone went. Yeah…her phone went and she picked it up. It was like, so unprofessional.

The students appeared to appreciate the concept that they are taught in university, that they should treat patients as if they are one of their own family members:

S61: I remember thinking 'this is absolutely horrendous'. I just remember thinking that we should OK, like the nurse I was working with was like, 'come and follow me' and it was just like just another job and I just remember thinking that this isn't a job and I didn't know how it was done, but it shouldn't be done like this. I remember thinking next time I do this I want to take my time and treat this person as if it was my mum, my nan or one of my relatives. I was young and I think that now if it was me as a student nurse or even a trained nurse, I would always take my time and do it properly, it's more dignified for the patients.

The comments from students revealed that the training that they had received prior to the commencement of their placement had been useful in terms of respecting the privacy and dignity of the patient. Three students mentioned that there could be emotional rewards when carrying out care after death:

S62: Before I had done this I kind of thought gosh that would be a terrible experience for me and for them, but I think what changed was I actually felt honoured when I was doing it …it was more honourable for me to be, I felt quite, what's the word, yep, honoured to be able to do it.

S61: I've actually cared for patients that were palliative and were dying and I think that might have changed the way I think about it and you know it's nice to see how dignified it actually can be…I was happy actually. I thought 'I've done a good job here'. Someone said to me once as well, 'you are lucky to be doing this because you are the last person to touch that patient apart from people in the morgue'. I thought, 'yes that's true', so I was quite honoured really. I was happy, I knew I had done a good job.

S67: I feel quite privileged 'cos obviously it is such a...It's such a significant stage in so many people's lives. Like it's the end of someone's life for the family. They have got to

carry on with it…obviously it's going to change their lives forever. It's quite honourable to be involved in it and be able to help people if they do need help and stuff.

These comments, although from only three of the interviewees, did show that for some students this work can be emotionally rewarding, developing their EQ. The word 'honourable' also implies that for some students, end of life care might encourage them to be their best selves, bringing an awareness of spiritually rewarding work and enhancing SQ.

12.8.4 Summary of care at end of life

The students were passionate about providing a high quality of nursing care. It emerged from their experiences that dying in a hospital can be more difficult for the patient, family and staff than dying in a hospice, where there is more time and space for end of life care. They had learned that active treatment might not be helpful and that disturbing the patient to record vital signs or fluid output is not appropriate at the end of life.

There was an understanding that there needed to be a different style of nursing at this time and the majority of the students (11/15) said that their fear of participating in end of life care and care after death had reduced because of their experiences. Although these students had witnessed a variety of approaches, they all valued person-centred care. They knew that the person should be treated with great care, should be listened to, and should receive respect throughout all procedures, pre and post death. Although most of the 15 students still had many months before graduation, they appeared to be practising a high standard of nursing care. Their fear of death appeared to be in perspective and to be managed in a professional manner. Three students talked about the emotional and spiritual rewards of nursing people at this time.

12.9 SOT 6: The student and her nurse education

This SOT contained the six themes of research interventions, communication, mentors, support, learning experiences and education strategies. The divisions were sometimes arbitrary and there were overlaps with other themes.

12.9.1 Research interventions

During the interview, the students were asked about the research interventions. Those following the DSD programme (through the DSD book) or participating in a weekly session that explored family issues (constellations) were asked about their experiences of the intervention. The nodes

that emerged from students' responses to the research interventions were: the pressure of time, awareness of other people, reduced judgementalism and the importance of a sense of belonging to a group. These ideas will be explored separately, as they provide an insight into the effects of the interventions.

With regard to the *pressure of time*, 11 of the students mentioned that the time when they entered training was very intense and they remembered little about the first month. There was a feeling of being overwhelmed. Only one (S70) of the 15 students interviewed had managed to keep the journal that had been requested by the module team for one of the first-year modules (Chapter 8, section 8.6). It was hoped by that module team that students would keep the journal for the first year, but this student had kept the journal going just for her first placement:

> S70: Only on placement I did a little diary. I read it back. Over Christmas, I was preparing my folders for the end of this year, sorting out work of what I'd done. In all my folders I've got my placement information and my little diary and I read that and it is quite good because I use them for reflection and things, even just for personal development and see how my feelings have changed.

Three of the other students who were asked 'Did you keep a journal?' replied:

> S16: I'm not good at keeping diaries. I do try, but it's about a couple of weeks then I stop. I also remember there are always some people you remember more than others and I reflect back on them.

> S61: No. I'm too busy. There are so many interesting things that have happened throughout my training that I wish I had really.

> S75: No. I have my mum to talk to and my dad and partner, so I didn't feel that I had to keep a journal.

The three students from the DSD group did not provide clarity in terms of how much the DSD book had been used, or if they felt the book had helped them. Two of the three gave me the impression that most of the book had been completed and that they were positive about the experience. One said:

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S32: The book helped me to feel more confident, although it was difficult to find the time and I didn't manage it every day.

The other DSD student had not finished the workbook.

With the constellation group, seven of the 25 regularly attended and five of these seven were interviewed; the other two had academic difficulties and dropped out of the programme. There were certain advantages that were perceived by the student to arise through attending the constellation group. The following quotes typify the comments regarding two aspects (the second and third nodes): *heightened awareness of others* resulting in a *reduction of judgementalism* and the impact of the changes on their own family relationships.

S62: [The constellation group had a] major effect because I…it made me feel, I can remember them clearly, especially the one regarding my mother… it made me feel a lot stronger and sometimes I feel like I'm not sort of a strong character but it made me feel like an adult and that's what changed. And now it is really…when I visit my mum, it is as if she has so much respect for me. So maybe the constellation helped me believe what I thought I believed, but I wasn't very sure. Does that make sense? I kind of complicate things a bit.

S63: I think I am probably very more open-minded because of them [constellation sessions], it's easy to judge and make decisions about somebody just by their looks and appearance and that's not the case. Don't get me wrong, I do think 'Oh my God, look at them', but then I keep it to myself and I think that whatever somebody's saying, there's always a reason and there's not always just that one reason, there could be another reason or another reason. It's not just one person's version, listen to others before you get the full story. No, I really enjoyed doing the constellations. I felt sometimes a bit of a pillock doing it, but then you realise afterwards it does really help you. I think death is always going to be one of those things that you can expect to a certain degree.

S67: It [the constellation work] just kind of makes you more aware… less likely to make assumptions …listening skills.

S70: It [the constellation work] made me kind of look at myself…mainly positive because I got my relationship with [husband]. That was very positive and my relationship with my mum got better - it never was bad, but we are in contact more. And that had kind of got lost… but definitely with my brother…a lot has changed there, we phone each other every week, it's lovely, we make sure we see each other.

The fourth aspect (node) of the interventions theme was *group belonging*. The students gained a sense of belonging from the constellation group that has affected their relationships within the group. There seemed to be a bond (although sometimes tacit) that was underpinned by the intimacy of their sharing.

S62: The group…they will see me and it's like there's a respect for each other, such nice people, as well. There's a respect and there's definitely a depth with all of us.

S63: I think there was one student, we were always quite friendly anyway, but it has brought us closer together in the group. There are a couple of others every time we see each other we always say hello and there is always that bond.

S70: Definitely, with [another student in the constellation group, called x] we have a relationship. There is a group of us and even though with [her] we don't have to say anything. It's almost like and we've never discussed our outside issues with our little group, we don't have to say anything… it's a little special relationship I have seen [another constellation student], it's not the same as [x] but maybe because I am around her more. It's that nice little feeling, it's not a secret, but we know a little about each other, it's almost like we have been a support network because we know, but we don't have to be in each other's shoes. It's been a good experience, the constellations.

It can be seen that the deep recognition of each other, arising from the constellation work, facilitated the bonding between members of the constellation group. This happened with the students who attended the group sessions on a regular basis. The impact of the intervention on death and dying was tacit. The feeling of belonging to a group helped the students to navigate their way through challenging experiences to do with death and dying. The other benefits of the intervention - heightened awareness of others and reduced judgementalism - also served to help the students to improve their communication skills.

12.9.2 Communication

The students recognised that a high level of communication between staff members, between nurses and patients and between nurses and families was key to the provision of effective nursing and was particularly necessary at challenging times, such as during and after the provision of end of life care. As in any nursing interaction with a patient, communication is both verbal and non-verbal. The skills are complex and underpin the way in which a nurse establishes a therapeutic relationship with each patient and their family. The goal of the nurse is to establish a therapeutic relationship with the patient as soon as possible after their first meeting (as discussed in Chapter 5, section 5.6). A demonstration of effective communication skills involves the establishment of empathy and rapport. The nurse demonstrates respect for the patient. She uses empathy to show the patient that she cares and that she is there to help and support the patient through their journey to health or (in this case) death. Rapport is established. A level of self-awareness is required for the development of the student nurse's sensitivity in these contexts. In theory periods, the student nurse is taught to be reflective and reflexive so that she can use these tools to further develop her self-awareness and sensitivity. These skills are part of the affective domain and reflect the development of EQ.

There seemed to be a perceived development of communication skills that related to the students' experiences of death in practice and was facilitated by working with effective role models. These particular skills reflect the development of sensitivity and confidence in terms of dealing with death, indicating an enhanced SQ.

> S71: Yes I'm quite happy to do last offices. The only thing I'd feel very uncomfortable about is communicating, communicating with someone dying. We can talk about other things apart from dying ...and their relatives as well.

> S63: I think communication - I think she [the nurse] should have sat down with them and said look, we have done all this - this is what we've gone through. Not say they are 'not very well and we think he hasn't got much longer' but to go in and say 'we've tried this and tried that' a little bit more, because as far as they [the family] were aware, it hadn't been done - but it had been done. Again, it's communication.

One student spoke of a patient that had been ignored after pressing the nurse call alarm. The student was working with the nurse specialist for pain management and they happened to visit this patient. They found the patient distressed in that she had been pressing her call bell, but no one had responded. This example (below) showed how the student learned the value of quickly developing an effective therapeutic relationship with the patient:

> S70: She was in so, so much pain. And the nurse spoke to her; she went off and came back and gave her feedback of what had now been done. She had changed her medication, some new strategies. But even before she [the nurse] had put the syringe driver up she [the patient] said 'thank you so much, I feel so much better. I buzzed and I thought everybody would come to me, I was in pain from the cancer, but they never did.' She [the nurse] just made her feel better just be being there. Is it so hard to go back to your patient and say 'I am still working on it, I'm not getting much luck, but I'm still working on it', come back in 5 minutes and say the same thing? Rather than disappear to the point where someone gives up buzzing? If she hadn't got that long to live, is that too much to ask for that lady?

One student talked about her mentor having particular sensitivity for when a patient might die. The student appreciated that this aspect of SQ is almost indescribable and is learned over a great deal of time.

> S71: I don't know how many times I saw it at xxx. Come about 12 midnight …when a dad was in the hospital, 'Can we take mum [the patient's wife] home now? Do you think dad will make it through 'till morning or do you think she should stay? Is it going to happen tonight?' And I'm just thinking, of course, I have to get my supervisor to answer that.
> K: With experience you get a feeling for what is going to happen?
> S71: Yes…she [the nurse] said to me 'you know when it is going to happen'. She said about the Irish gentleman when we went to give him drugs, 'He's not going to make it' and I said to her 'He's just got out of bed, he will make it'. But she knew, and I thought 'Oh my God'.

There was, with three students, a sense of a deeper feeling, a stretch for advanced therapeutic skills. It seemed that they were aware of the significance of this event in a family. They were

aware that there was a lot to learn and that the skills of nursing dying people and their families were going to be important in their careers.

> S70: I haven't got the answers - just in case they ask me things that I don't know. You want it to be perfect and you want to take away someone's pain and you want to comfort them, but you are dying - there is no way I can comfort you. What am I going to say to you - that it's OK? It's not OK.

The 15 students all recognised the particular sensitivity that is needed in situations where a patient is dying. They were full of admiration for the EQ/SQ skills of their mentors. They found that they could learn a great deal about empathy and the development of rapport from observing inter-professional interactions within the clinical placement. These students saw the differences between good and poor role models in terms of these advanced communication skills. The following section will explore this further.

12.9.3 Mentors

The student is allocated a first-level nurse mentor at the beginning of her placement. Although this nurse needs only to work with the student part of the time, it is she who is responsible for the assessment of the student in practice. All 15 of the students expected their mentor to support them in all practice placements, although experiences of this support were mixed. The three nodes that became the theme of mentors were: the role of the mentor, mentorship in a hospice placement and the mentor as a role model.

The first node referred to the role of the mentor in a general nursing context, rather than a hospice. These placements would be trauma and high dependency units, general wards, specialised wards or community placements. The students all recognised the importance and value of being allocated to a mentor who was professional and was proactive in supervising them. The students appreciated a mentor who showed EQ in that they cared about them (the student) and could be patient with them, but could also provide new learning experiences. Three students mentioned that in their experience there was a difference between how mature students and younger students were mentored. This was discussed in section 12.6.1. One student suggested that the mentors should not consider that the older students have less need of these experiences (last offices) or of their support.

The quote below is from a student who was talking about her experiences on general wards where patients had died.

> S22: I have had one very good mentor who has made sure that I am ok, that they're there if I need someone to talk to or [I can] just go and sit a while in the staff room. Then I've had others that just haven't been there at all and haven't taken any interest in mentoring or seeing that I'm OK at work. It's been a mix.

One student had been upset after a sudden death of a patient. She broke down crying and went to the staffroom for a rest. She returned to the ward and was supported by a staff nurse:

> S67: I just kind of stuck around with one of the staff nurses who I knew and had worked with. She bought me a bar of Galaxy [chocolate] to cheer me up…she asked if I'd had an experience of death before and I said 'no'. She comforted me, but she didn't really talk to me about it as such.

There was one example of a negative experience of a mentor:

> S32: I was allocated to work with my mentor, and the mentor had a very critical [critically ill] patient. I introduced myself at handover. She [the mentor] was in a mood…I didn't know what was happening. All the coming and going. My mentor and the other lady during handover… were pulling faces and she [my mentor] said to me 'Look, I wasn't told you were coming'. It was awkward. It was not my fault. [She said] 'You need to talk to whoever is in charge'. I didn't know who was in charge. I didn't know anything. I didn't know what was going to happen next. Oh, they went on and on, and over the handover they went on and on. I decided to keep quiet and see how we go. When they left, I left with my mentor. The patient has to come first and so I just followed. It was difficult. She was still fuming and was not engaging. Not telling me anything that she was doing. She didn't talk to anyone, she was rude.

This was an example of the importance of support during that first day in practice. According to the student's account, this mentor had not been prepared and was not willing to support this student. The day became very difficult for the student, as there was no welcome and no sense of being part of a team. This contrasted sharply with the accounts from the interviewees about mentorship in a hospice placement, which became the second node. When it came to the

provision of end of life care in a hospice, the students reported that they found the mentors to be available and to be good listeners, to be empathetic and sensitive to each student's fear of death and showing high EQ/SQ skills. The mentors in the hospice had the particular sensitivity needed to support the student nurses in this context.

> S70: My mentor in my last placement, a young nurse, she was lovely. When we used to go to do last offices, she was like 'are you OK?' and she would touch me and ask if I was OK. I used to say 'I'm fine'. That was her…she was just checking.

The students' expectation of being well supported in a hospice was met in the five students interviewed who had been allocated a hospice placement. They had come to understand the notion of death and dying within a supportive context. The specific skills of mentors in end of life care were seen as pivotal to the student having a positive learning experience.

> S61: After I left that hospice I felt much more confident. I had had a great, great mentor who spoke to me about death and explained to me about the procedure, how to go with things and if I feel upset, this is how I have to deal with it [and] I should go for help.

> S62: I think I've been fortunate in the way that my, a lot of my mentors have really pushed me. Sometimes you think 'Oh God', but sometimes I think it is good for you because I need that because of the confidence thing, which has grown in this last two years. It's just like turning a key. I think this [entering the nursing profession] is the best decision I could have made.

> S40: I was a first-year student, but he still pushed me to do things and he explained to me. …'I want you, after here, to be a good nurse, not just to be any kind of nurse out there, but [also] to be a good nurse. To care for your patient in a way that if they leave the hospice (because some people came in just for pain control), if they leave the hospice they will remember that I had a student nurse caring for me and this is how she was, a great student nurse'.

These are examples of how the students experienced mentors within a hospice to be supportive and caring. The mentor needed to have high levels of EQ/SQ in order to be sensitive to the student's emotional and spiritual status. A good mentor, from the viewpoint of these students, would facilitate, encourage and sometimes push the student into new experiences. These

comments suggest that going to a hospice early on in the programme can be a very useful learning experience for the student. The students appreciated choices. If it was the first time to see a dead person then they liked the choice of touching the body or being involved in the preparation of the body for transfer to the morgue. The students felt supported when the mentors checked that the student was not feeling emotionally disturbed, and the students felt that they were really listening to how the student felt.

The third node was the mentor as the role model. These mentors showed the students qualities that further developed the students' abilities to provide excellent holistic care. As mentioned in Chapter 1 (section 1.2), holistic care is regarded as essential to nursing and has been explicated as 'the 6 C's'. These are Care, Compassion, Competence, Communication, Courage and Commitment (DoH, 2012). A mentor who was also a role model particularly embodied these qualities, but seemed to particularly help to develop (in their students) a sense of commitment to the nursing profession.

> S62: The nurse I was working with was so passionate about it; it wasn't just like 'oh they've gone now, that's it'. She said to me 'this is always a part of life and I feel very honoured' and it kind of impressed that into me and we put his hand in the right place. She said 'it's always nice to have the hand so his family can touch his hand', I actually felt, I don't know, didn't feel sad, I felt quite moved. It was amazing, really.

> S67: I had quite nice experiences there and the staff nurse I worked with, she was a really nice person she did it in a respectful way…she was a good role model

> S70: My ward manager was a lovely, lovely lady, and a brilliant role model. So inspiring and I think if it wasn't for her I probably wouldn't have done my training because she always pushed me.

> S71: She just made her [the patient] feel better just by being there…and I just thought 'isn't that lovely to be able to do that and ...hopefully at some time, in years to come, I will be able to do that for some people'.

All the students had a mentor allocated (or two) but role models seemed rare. Of the 15 students interviewed, only five mentioned role models. Good mentors had high levels of EQ and

so were encouraging, good communicators, respectful and caring. The good mentors had high levels of SQ, in that they were respectful and sensitive in dealing with religious and spiritual, issues, including death. A role model had these skills but was also found to be inspirational in the particularly sensitive level of care they provided to the patients and families.

12.9.4 Support

The interviews revealed specific aspects of the support needed by student nurses. The main theme was that they needed an opportunity to cry, to talk, and to share their experiences. They needed to be heard and to be heard by specific people. These tended to either be a member of their family (usually a parent or partner) or a friend from within the nursing profession. Some students had family members who were also in the profession, so felt advantaged by this. Several students expressed the view that it would be inappropriate to talk to someone other than a nurse.

There was a sense that feelings from work are compartmentalised until the student gets home and can talk to someone they trust. They were clear regarding issues of confidentiality and the need for patients' identities to be protected.

> S33: I didn't cry when I was there; it doesn't take much for me to cry, so I am surprised that I didn't while I was there. But no, there was nothing there, was no talking about it afterwards or anything. I think that's why when I got home, it just all came out.
> K: Did you want to talk to your mentor about it?
> S33: In a way yes, but no because it would have made me cry.
> K: So did you talk to your mum?
> S33: Yes, that night, and my dad, I think I cried.
>
> S67: They [students] need someone to talk to if they ever do have a bad experience, whether it's a friend or family or someone at the University, or someone in practice.

The student's family was particularly important in terms of being able to share experiences. This might be because of the need for confidentiality, and family were trusted, or because of the students' depth of feelings.

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S16: I relate to my dad a lot because he works within the healthcare sector, he works in a hospice so he understands and he has had to deal with a lot of deaths before as well… a lot of the time I say 'I'm fine' but sometimes I say 'this has happened' so I think my parents are the most supportive of me, but again I don't like to worry other people, it's silly, but I don't like to put my problems onto others

S40: I remember calling my mum because I was living at Uni then. She was like 'what is the matter?' I said 'this is what happened and I can't sleep, I feel like I can see the dead body beside me'…My mum said 'give it another try…it is not that we don't understand, but it is good. That is what you have to do. You have to care for them, just see them as [people]'. I said… 'I can't do it'. My mum was like, 'no, you have to'. I said, 'OK, no problem'. I went to the placement in *** and it was great, it was a great experience…I felt OK, I can deal with it and that is why I am still in the course.

S73: I have my mum…She had told me that I have to deal with it in my career. It will happen more often so I have to find a way of getting over it. You can already get over it but also learning how to deal with it. Sometimes it is too much and you have to look for some help.

Those students who had a spiritual support system, as stated earlier (12.6.1-12.6.3), did share that they felt supported by their faith. However, the students who did not identify a faith felt supported in other ways, primarily by family and friends. Those students from BAME groups emphasised the support that they experienced from their communities, as well as their families. This aspect of a community was not found in the non-BAME students, but again, these (white) students felt well supported by specific members of their family or specific friends. There was no sense of lack of support from any of the 15 students.

Although the primary source of support for all 15 students were family and partners, another important source of support were friends from within the profession. There is a language in terms of experience that is peculiar to nurses (Irving et al. 2006), which students can use with colleagues who are also nurses and carers. Although family members were extremely important, they could not necessarily understand what it feels like to be in these situations in the same way as nurses and carers understood. It was helpful where family members and friends

were also in the caring professions (mostly as nurses or carers, but also paramedics), as many were.

> S61: I talk to friends that are nurses, or talk to staff members. I don't go home and tell my mum exactly who it was, but I do. I would say to my mum 'there was this patient today'. I don't want to sound heartless, but it does help for me personally. I would tell my mum about it or tell one of my nursing friends, but it's not something I would tell my best friends that I've gone to school with. I just keep it separate, I talk to my nursing friends about that, but it's not something I would be able to tell my friends or my partner. It's just professional.

> S63: I don't really talk to anybody. I deal with it either at work especially if it's a traumatic one and I have a very good neighbour, who is a mental health nurse, and I may say to her I have had a really crap day, this happened, but we don't discuss details. Once I've said it and got it off my chest that's it. I don't talk about it no more. No. I've told somebody that doesn't know that person so no confidentiality is being breached. It is a relief to be able to tell somebody. They won't get emotional or whatever, only if I've had a really crappy day.

One student's partner was a police officer and had the capacity to understand experiences of death.

> S33: My partner definitely, he's brilliant. He is so understanding, even though we have very different views on death and dying. He understands that… that's how I am and he's just always there for me. He's my rock, basically. He's wonderful. Although when this incident happened, he was at work, so I went round to see my mum and dad and they were great as well.

None of the students discussed the support available from the university. I believe this was because the interviews took place during the clinical placement and that there might be a strong psychological divide between theory and practice for the student (Curtis et al, 2012; Houghton et al, 2013). One student implied this:

S61: I think for new students, I think all teachers can do really is just tell them that they will be supported, then you just hope for the best that they do get a good mentor that will support them.

It is apparent that a student needs to identify the people who are 'safe' in terms of the student telling them her day's experiences and being allowed to show her emotions. These people are usually members of their family or other nurses. There appears to be a deep human need for the students to share the difficult emotional and spiritual feelings that they experience. The student chooses a person that they can trust to provide them with close, personal support. This support is provided in a variety of ways. These interviews showed the value of talking and being heard in order to feel supported and part of a valued team.

12.9.5 Learning experiences

The interviews illuminated the general feeling of being initially unprepared to meet death in clinical practice. Few of the students (two) considered this aspect of nursing prior to commencing the programme. The themes here were that learning takes place primarily in practice and that preparation is valuable. There were strong feelings regarding the inevitability of learning the hard way, through one's own experience with difficult feelings.

S02: I don't think I was prepared in my first year really at all. I think it is just something that you sort of cope with at the time… when it happens really and your mentor should be more supportive when it does come to that stage where you are looking after palliative patients and…I feel like that they should explain to you.

S63: I knew that I had to do it, but thinking 'I have to go in there, I have got to sit with him, and do I hold their hand, is that the right thing to do?'. Or you start thinking 'do I start talking to them?' I just sat there stroking his hand.

S67: I think nothing quite prepares you for it [seeing a dead body]... I hadn't been prepared, not at all.

The students had not considered that they would be caring for people during and after death. This group had not had any input, other than Cardiac Resuscitation, prior to going to their first clinical placement. There was a feeling that they had to learn from experience, but they were not

really able to judge what difference some preparation might have had on their first experiences with death.

12.9.6 Nurse education

Although the students did not know how they could be better prepared, there was a feeling in 14 students that preparation would have helped. They felt that discussing death and dying issues was important and should be delivered in a sensitive way, prior to their first placement.

> S2: So I think that [preparation] could be brought forward really, just to prepare, because you don't know. You could go out and your first placement could be a palliative placement and then you experience that …and I think that's quite a lot for a first-year student to experience.

> S73: They should know what they are getting into…I learned from the nurses and my mentors that sometimes you can talk to the body and tell them what you are doing, despite the fact that they are dead…Yes, they can't hear you but it respects them, it's that dignity that ....it is different I would say but, I didn't expect it, I didn't at all.

> S75: Maybe at University a talk to the students about dying and what last offices entails 'cos I didn't know. I didn't know until I'd done it, what actually happens.

Undergoing preparation for caring for people who are dying, caring for their families and for delivering care after death was thought to be worthwhile. The students had various suggestions, some more realistic than others:

> S16: I think you should [prepare for care after death/last offices] as I think sometimes nurses aren't always aware of what it involves. Personally when I first heard of last offices, I wasn't completely aware of what it was and what it did, so I had to learn about that as well. I think it's a good idea.

> S22: I think it's quite important for students to see a dead patient before they go out into practice because they are in a controlled environment where they can have support from the lecturers and time to talk to your friends about it. Whereas when you are on placement you see a dead body, then you carry on with the work and you don't…

sometimes you don't get that support from your mentor or some other nurses and you can't really speak to them about how it has upset you…or even just in small groups - there's a day when they visit the mortuary or something like that, in hospital?

S32: I think this [care after death] should be taught before first placement - just a lecture. What you might come across. You might come across it; you might not come across it. But it would need to be just before they go out to placement, not when they come in because there is just so many things that are happening and people are not prepared.

S33: I think we actually had a session [at the end of year 1] on death and dying and it really wasn't very helpful. I seem to remember the tutor was talking about losing things and we were talking about what things you lose and people were saying you lose your car keys etcetera. It was about loss, it wasn't about death. It wasn't well utilised that lesson, so I think we definitely need more than one session as well.

All students agreed that early preparation was essential, before they went to clinical practice.

12.9.7 Summary of the student and her nurse education

The six themes within this section have covered a wide range of issues. At the time of the interviews, the students saw the research interventions as being in the distant past, at a time when the students were short of time. There was a feeling that the first semester was a time of great changes and that to be carrying out any extra work, such as keeping a journal, following a DSD book, or attending every constellation session, was a challenge. Management of their time was a cause for concern. Despite the pressure of time, five of the students from group 3 regularly attended the constellation sessions. It is difficult to tell how many of group 2 completed the DSD.

The benefits of the DSD intervention were unclear. The DSD students could not describe the benefits of the intervention, but there was a suggestion from one student that she felt 'strengthened' by the programme. The students who had attended the constellation sessions were clearer on the advantages of the constellation intervention. These benefits focussed around enhanced awareness of others, a reduction in judgementalism and a sense of group cohesion and support between the group members.

The students saw the development of communication skills to be an extremely important part of effective end of life care. The particular skills were identified as being observant, being sensitive and being able to listen to patients and their families. These skills were used to develop empathy and the ability to establish rapport. The overall provision of high-quality care meant that the student needed to use empathy to establish rapport and to enter into a therapeutic relationship with the patient and their family. This relationship required the student to be emotionally and spiritually intelligent in terms of meeting the needs of the patient and their family. EQ and SQ skills were developed through reflecting upon the feelings experienced by the students during extremely challenging times. These skills were demonstrated through improved communication, enhanced sensitivity, reduced judgementalism and increased confidence.

Mentors played a large part in how students managed end of life care. Students discussed the role, the particular skills needed and the attributes of a good role model. The role of the mentor embraced the need to demonstrate 'the 6 C's': Care, Compassion, Competence, Communication, Courage and Commitment (DoH, 2012). A mentor who was also a role model particularly embodied these qualities, but seemed to particularly help to develop (in their students) a sense of commitment to the nursing profession. Some mentors were also able to be a source of inspiration to the students.

Support came from a variety of sources. All students leant heavily on family and friends for support, carefully choosing people who would understand their experiences. There were friends and family who were allied to health professions and these were particularly valued. Students of faith also felt that this supported them. Students from BAME communities also made a point of discussing the role of these communities in their support. All 15 of the students appeared to need to feel safe and valued by the person with whom they shared their feelings. The depth of the students' experiences with death meant that they needed a particular quality of relationship with those who supported them most closely.

In terms of learning experiences and nurse education, the students mostly were in accord with the view that there should be early preparation for end of life care, before first placement. Although it was clear that full preparation in terms of both skills and emotions would be difficult, it was felt that some early and varied input would help the student to cope with difficult situations in practice. This is explored more fully in Chapter 13.

12.10 Conclusion

This chapter has identified and explored the super-ordinate themes that arose from the interviews with 15 student nurses. It has been seen that working with dying people and their families can help the students to develop particular emotional and spiritual skills in terms of their own personal development, as well as for becoming a nurse. From working with dying people, the shock and fear of death become reduced. Students indicated that they had experienced a reduction in their fear of death. Students appreciated the opportunity to provide excellent care to the patient and their family members. They also came to appreciate the value of a peaceful death and how effective nursing, forming a therapeutic relationship and using skills such as pain management can contribute to this peaceful death.

Differences were highlighted in the way that younger and more mature students experienced death and dying in clinical placements. Ethnicity was also a feature and it became apparent that those students who come from a different culture have particular challenges to face. These challenges might extend to the way they relate to their own older family members who adhere to their traditional beliefs and values. It was seen that those students with a faith or spiritual belief felt supported by that belief and that this helped them in clinical practice.

Students found that caring for the family members of the patient who had recently died became emotionally challenging for them. However, students appreciated the need for specific end of life care and had learned that it was important to help a dying person to be comfortable and symptom-free, rather than persisting in treatment. In terms of caring for dying people being a learning experience, the students felt that communication skills were paramount in this arena and that they could learn a great deal from excellent mentors and others in the inter-professional team. The students seem to have learned the multi-faceted richness of the therapeutic relationship and the complex skills required in its establishment. The students had observed the ability of experienced nurses both to provide excellent nursing care using this close relationship with patients and their families and to anticipate the imminence of death.

Support was important in the clinical environment, at home and from parents, family and friends, even if they were at the other end of a phone. The students were careful regarding sharing their experiences outside work and only spoke with selected family members and other nurses. There were significant personal factors involved in the quality of the relationships that allowed

students to share experiences with members of their family, their partner or their friends. This was based on deep trust and understanding. Students also emphasised the value of effective mentorship and a supportive environment. An example of this was hospice work, where particular support to the students had been provided. Some students had experienced working with role models who had been inspirational.

The research interventions had impacted upon the interviewees at a period in their programme when the student's time was precious. The DSD group students seem to have completed at least part of the book. Only one of the students appeared to have kept a journal. The students who had regularly participated in the family constellation group work felt that the sessions led to an increased sensitivity for other people, a reduction in their capacity to be judgemental and a particular supportive bond between the members of the group.

All the students appreciated that caring for dying people was an important learning opportunity and agreed that preparation before their first clinical placement would be beneficial. They expressed the view that preparation would reduce the fear and strangeness of the experience and help them to function in a more effective way.

This chapter has provided insights that help to meet all five of the research aims. The next chapter will further discuss and interpret the results, leading to conclusions regarding the research aims. There will be a discussion on the limitations of the study and recommendations for future nurse education and research will be provided.

Chapter 13 Conclusions and recommendations

I set out to investigate fear of death in new student nurses and how that might be ameliorated. Earlier this year the report from the Parliamentary and Health Service Ombudsman (Mellor, 2015) made it clear that end of life care still needs to improve. This report suggested that people who are dying in England have been suffering from a lack of communication and inadequate symptom control. Mellor (2015) goes on to report that in some instances care planning has been poor and there have been delays in the provision of services. These findings echo earlier reports, such as the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013).

Knowledge gained through my research could make a difference to how students are prepared to care for dying people and their families. This would influence the provision by student nurses of high-quality end of life care and could result in less anxiety and stress for the student nurses. Also, a more confident student nurse can take some pressure off their mentor and other nurses, which can facilitate the delivery of a high standard of holistic care, as recommended in the 'One chance to get it right' document (National Leadership Alliance for the Care of Dying People, 2014). The NICE guidelines for the care of the dying adult will be published in December 2015.

This, the final chapter, seeks to summarise the learning from this research. The results are explored in terms of each research aim. The strengths and limitations of the study are also discussed. Consideration is given to the implications for both nurse education and nursing practice and recommendations are made. The chapter concludes with suggestions for further research that could contribute to nursing knowledge and nurse education.

13.1 The research findings

Research aim 1 set out to gain an understanding of FOD in a group of first-semester student nurses. The findings show that neophyte students have a range of substantial fears regarding death. The evidence from my research suggests that the students' experiences during the first semester have the effect of reducing many of these fears in most students. This finding supports research by Cooper and Barnett (2005); Terry and Carroll (2008); Niederriter (2009) and Anderson et al. (2015).

The results of the two multidimensional fear of death scale (MFODS) questionnaires showed that fear in student nurses was reduced after a period of time on the programme. The levels of FOD within the cohort appeared to be varied. At stage 1 (prior to the interventions), the range for the cohort was 66 to 173, with 104.4 as the mean value for FOD. The identification of substantial FOD at stage 1 supports research (discussed in Chapter 5) by Cooper and Barnett (2005) and Niederriter (2009). Student nurses can only permanently avoid caring for people who are dying by leaving the programme. Terry and Carroll's (2008) research with London student nurses found that 100 of the 184 returned questionnaires (54%) indicated a first experience of death in their first placements, sometimes even on their first day. Anderson et al.'s (2015) research concluded that the first experience with death could be a salient event that has a lasting impact on the student. This illustrates that difficult emotional and spiritual experiences in relation to death can happen from the very beginning of a student's placement.

My research found that at the beginning of their programme the students' two greatest fears were of premature death (F8) and of being destroyed (F3). These were followed by fear of death of significant others (F4) and of the dying process (F1). The least felt fears of death across the group were fear of the dead (F2) and fear of the body after death (F7). These two least felt fears remained stable between stage 1 and stage 2. However, the other six fears were reduced. It is worth noting that data from the interviews highlighted that individual students can feel particularly frightened of these two aspects of the dead body. These findings support the results of earlier research that found that aspects of death and dying are a particular source of stress for student nurses (Cooper and Barnett, 2015)

The interviews were with student nurses who were then in their second year of the programme. In their first year of the programme, some of the students with high FOD had left the programme, but others stayed, showing that more research is needed regarding high FOD as a predictor of attrition. However, the findings here support those of Pryjmachuk et al. (2009), Eick et al. (2012) and Crombie et al. (2013). These three studies concluded that emotionally difficult placement experiences contributed to the student's decision to leave the programme.

The change in FOD was measured between stage 1 and stage 2 (after the interventions had been completed). At stage 2 the range for the cohort was 74 to 150 and the mean value of FOD had increased to 112 (from 104.4 at stage 1), showing a small overall reduction in FOD. Kurebayashi et al. (2009) had explored stress and anxiety in student nurses. They had found

that these feelings were higher in students than in qualified nurses, indicating that a reduction in these feelings takes place with experience. Specific reductions in FOD were seen in F1, fear of the dying process; F8, fear of premature death; F4, fear for significant others and F6, fear of conscious death. The other four categories showed a small overall change or none at all. The four categories that showed a change do relate to the work of the student nurse in caring for people who are dying and their families. Familiarity with death would appear to ameliorate F1, fear of the dying process; F8, premature death and F6, conscious death. Perhaps a familiarity with death also reduced F4, fear for significant others, although this was one of the most substantial fears across the cohort. These changes indicate that working with people who are dying can reduce fear of death in first-year student nurses. This finding supports the findings by Cooper and Barnett (2005) who found that fear of death reduced over the three year programme. This finding also supports the findings of Kurebayashi et al. (2009) who had found higher levels of fear in students when compared to qualified nurses.

Research aim 2 evaluated two interventions designed to reduce fear of death in first-year student nurses. The results from the questionnaires showed a statistically significant reduction in FOD following the use of the DSD journal (Fletcher and Pine, 2009). The quantitative results from my study suggest that students can benefit from this intervention. The DSD intervention was chosen because it was a straightforward tool, well researched and easily accessible. Prior research on DSD indicated that after four weeks of spending a few minutes a day on an exercise, the person would experience enhanced behavioural flexibility and this would result in an enhanced EQ (Fletcher, 2010). This appears to have been borne out by the quantitative findings of my research. These results support earlier research by Hanson (2008) and Sharma (2010) who both found positive outcomes from using the FIT concepts that underpin DSD. This programme requires people to try simple new behaviours in their everyday life. It does not require any cognitive or thinking approach. The programme is now available online (www.dsd.me) and can be provided as an individualised programme based on diagnostic measures, which can enhance the effects (Fletcher, 2015).

Although the quantitative data led to statistically significant results that indicated that DSD could be effective, the qualitative data found no evidence to support the quantitative findings. This could be because of the time lag between the interventions and the interviews, although students from the family constellation group (group 3) remembered the experiences. The

vagueness that I experienced when I asked the three students about their thoughts and feelings on the DSD led me to suspect that these particular students had not completed the book.

There was no statistically significant change for those following the spiritual intervention of family constellation work. All members of the group (n=17) did not equally undertake participation in the family constellation intervention, yet the quantitative data on change in FOD was collected from all members regardless of their level of participation. Six meetings took place and in total 14 students attended. Not all the 14 were there every week and there were usually around ten students present. Only seven of the 14 regularly attended all the sessions. These were seven of the eight students from group 3 (family constellation group) that volunteered to be interviewed.

I had not anticipated that some students would find the family constellation sessions difficult. There were several reasons for this. Some students felt overloaded with academic work and some students were not well for some of the sessions. Others seemed to be troubled by the work due to their religious or cultural traditions. The quantitative results from group 3 did not indicate any statistically significant reduction in FOD. The results are insecure because the level of intervention was markedly different across the group. A more robust implementation of the research strategy might have resulted in a more useful insight into the effect of family constellations on FOD. However, the qualitative data from interviews with students who had participated regularly in the family constellation sessions indicated a substantial impact.

Themes that arose from the interviews suggested that subtle changes took place in the students who participated in the family constellation sessions. A particular bonding took place between group members that resulted in a sense of being supported. A key insight from my findings is that, by sharing deep emotional and spiritual feelings, the students find that their relationships with other members of the group can support them through the most difficult times in clinical practice, and also perhaps through academic challenges. Students also reported that the family constellation sessions resulted in them feeling less judgemental and more accepting of the views of other people. These feelings indicate a development of EQ and support earlier findings by Cohen (2008). The students' sense of group identity and a value for that group (a sense of belonging) reflects a development in SQ.

These outcomes have shown that interventions can make a difference to the fear of death experienced by student nurses. Directed work via a journal (DSD) or facilitated group sessions appear to have different outcomes. The family constellation work might not have resulted in a significant change in the MFODS scores, but there was qualitative evidence of its being effective in providing a sense of useful support; aloneness was reduced. This indicates that family constellation work might not be appropriate for all students, but that for some students it is a powerful tool in order to facilitate the development of EQ/SQ. This supports earlier research by Cohen (2008) and Weinhold et al. (2013) where emotional and spiritual intelligence (EQ/SQ) were enhanced through family constellation sessions.

In my research, both interventions were innovative. The quantitatively measured reduction in FOD was more substantial in the DSD group, but both intervention groups experienced a greater reduction in FOD than the control group, even if this could not be shown to be of statistical significance. Considered with the qualitative results, these findings suggest that it is worth nurse teachers considering interventions that can potentially enhance EQ/SQ development. They have a value in encouraging other nurse teachers to find strategies that might be appropriate for their own particular students. There are research findings that support this perspective (Liu et al. 2011; Cavaye and Watts, 2014; Doyle, 2014; Adams, 2014; Dwyer and Hunter, 2015).

Research aim 3 set out to clarify the relationship between students' fear of death and their gender, age, prior experience, ethnicity and spiritual beliefs. The results of the two questionnaires found that these dimensions did not result in any statistically significant differences in fear of death. Those with less than three months' clinical experience on entry had a lower fear of death, but it became clear that this was not related to the age of the student in a straightforward way. This supports finding by Cox et al. (2013) that attitudes to death and dying are influenced by life experiences, as well as maturity.

There were indications that a small amount of prior caring experience is helpful in terms of fear of death. It was found that younger students were more likely to leave the programme within the first year. This supports findings by Pryjmachuk et al. (2009), and Crombie et al. (2013) who showed that younger students were more likely to prematurely leave the programme than older students. Eick et al. (2012) had found that mature students (over 25 years old) with clinical experience have more resilience than younger, inexperienced students and Peters et al. (2013)

had also identified that fear of death was higher in younger student nurses. My study also found that although the older students (over 36 years old) had a low fear of death on entry, this fear had increased over the first year of the programme.

From the interview data, the students' comments supported the perspective that the younger students (<30 years) received more support than the more mature students. The younger students believed that mature students were more confident than younger ones in clinical practice. Although the mature students agreed with this perspective, they indicated that this could mean difficulties for some older students. For example, the interviews revealed that there might be a propensity for mentors to offer more learning opportunities to younger students than older students.

It was also evident from the interview data that ethnicity is a factor in end of life care. This research shows that students from some other countries, such as Africa or the Caribbean, have experienced a 'home' culture with regard to death practices that is quite different from the indigenous culture in England. It was found that perceptions and beliefs about death could vary within a student group. The interviews revealed that some students maintain their traditional beliefs and others feel that they need to blend the cultures. This seemed to cause challenges within their families, where older members adhere to traditional beliefs and practices. This cultural dissonance could mean that the student's professional perspectives are kept separate from their beliefs within their family life. This supports earlier research by Harris et al (2014) who found that there were specific stressors for students from BAME groups.

One particular concern of the black students was the distress of their elders regarding a cultural move away from burials, which are the chosen method for disposing of the body in Africa, to cremations, which are the more common method in England. The black students who were interviewed were also aware of the challenges arising from intergenerational differences in attitudes towards organ donation, which is culturally unacceptable in some traditional cultures. This supports earlier research by Morgan et al. (2013, 2015), and Gauher et al. (2013) who had found that the cultural barriers to organ donation, such as concerns with intactness of the body and religious aspects, were more prevalent among BAME groups compared with the majority population.

Spiritual beliefs appeared to affect fear of death in subtle ways. A student's spiritual practice did influence the way that they dealt with dying people and their families. Their faith was seen as a source of strength, particularly when their faith was connected to their communities. The students said that this helped them to be more confident when nursing dying people and caring for their families. However, this was not supported by the results of the MFODS. These findings support earlier research by van Leeuwen et al. (2008) who concluded that the student's spiritual beliefs can enhance the quality of provision of spiritual care. Research by Ross et al. (2013) suggested that this factor could be related to students' perception of competency with delivering spiritual care.

Research aim 4 was to gain an understanding of factors that affect the feelings of students who are caring for people who are dying and their families in clinical practice. The results include those of research aim 1, where the students' primary fears were identified. The factors that affected the feelings of the students were fear of dead bodies, problems with communication, quality of care and provision of mentorship and support. These findings reflect those of Cooper and Barnett (2005) who found that factors that affected students were related to the deterioration of the bodies of patients; the change in the student's relationship with the patient who was dying; feelings of helplessness and inadequacy where people died prematurely or when the student was required to participate in resuscitation procedures. Niederriter's research (2009) found that communication difficulties and ethical dilemmas resulted in feelings that included sadness and fear.

My research identified several issues that affect the feelings of students who are caring for people who are dying and their families. The results of the quantitative data suggested that the students were more fearful of other factors than that of the dead body. The interviews provided a deeper, broader picture. The students were clear that they were initially anxious about delivering care after death, and that they were also worried about communicating with bereaved relatives. The students felt that they lacked the communication skills to function well at this time. This finding supports Cavaye and Watts (2014), who concluded that further preparation for developing communication skills was necessary in early undergraduate preparation. Students also felt an obligation to the (deceased) person, namely that preparations for the transfer to the morgue were carried out in a professional, respectful manner.

All of the first-year students experienced their first semester, including clinical placements. Some had also experienced the research interventions. The interventions and experiences led to the development of EQ and SQ skills. EQ skills included demonstrating regard, mutual respect, listening skills, regard for cultural and ethnic needs, the appropriate use of touch and using empathy with the patient and their family. SQ skills were shown through sensitivity to religious, spiritual, death and dying issues. For example, the students' acquired the ability to cope with feelings of conflict, such as needing to carry out care after death whilst being aware that the person's family needed support. These findings support earlier research by Cockell & McSherry, (2012) who concluded that high-quality nursing care involves the recognition of the importance of spiritual care in patient interactions. The development of these EQ and SQ skills strengthened the affective domain and were related to a reduction in fear of death. These skills underpin the demonstration of the 6 C's: Care, Compassion, Competence, Communication, Courage and Commitment (DoH, 2012). The students appeared to be developing the skills needed for building a therapeutic relationship with the patient and family, where this relationship is central for the delivery of efficient and effective palliative nursing care (Wright et al, 2010).

A kind, caring mentor was found to be central in terms of the student coping with the placement. The quality of support in the clinical area was of high importance to the student. They really appreciated a mentor who was interested in them and their development, who was proactive and a good role model. A few mentors were remembered as being inspirational, which clearly meant a lot to the students who had worked with them. Equally important was the support of family and friends, who could listen to the student's traumatic experiences in a safe context. The selected family members were often parents or partners. The helpfulness of this retelling was enhanced if these people were personally experienced in the helping professions. The students were selective with their choice of friends in terms of who they could share clinical experiences with and it tended to be friends from within the nursing profession. The students' experiences with death had left a deep impression that necessitated a particular quality of support from those close to them. This specific support enabled them to continue caring for dying people and their families. These outcomes support the research findings of Cooper and Barnett (2005), Niederriter (2009), Crombie et al. (2013) and Harris (2014) whose research found that effective support was instrumental in the student remaining on the programme.

Research aim 5 set out to identify teaching and learning interventions that reduce FOD. The research findings from the MFODS showed the value of the DSD intervention. This finding

indicates that some students who wish to undertake a learning intervention could reduce their FOD through improving their behavioural flexibility and enhancing their EQ.

Data from the interviews indicated that there were distinct benefits to those students who regularly attended the teaching intervention of family constellation sessions. This intervention appeared to enhance the EQ/SQ of the students, as they felt supported in a specific way. This supports earlier findings by Cohen (2008) and Weinhold (2013). These experiences could have helped them to form therapeutic relationships with patients.

The discussion by the group of American student nurses in Marcial et al. (2013) enabled them to voice their concerns that emotional burn-out would compromise their ability to carry out excellent nursing care and could even lead to them harming patients. They wondered why more emphasis on emotional health was not part of their programme. My research underpins the argument for the value of preparation early on in the programme that helps to strengthen the affective domain through the development of EQ/SQ skills. In Crombie et al.'s (2013) research, they concluded that feelings of being unable to cope can often lead to students not being able to complete the pre-registration programme and that resilience (which could be related to enhancing EQ/SQ) reduces the feelings of being unable to cope.

Findings from my research support research by Wong (2009), who found that a pre and post-test around a course on death and dying showed a statistically significant reduction in fear of death in those who had participated in the course (n=300). McClatchey and King (2015) compared the provision of death education to two groups of health workers in the US. They also found that a course on death, dying and bereavement reduced fear of death (n=168). My research findings concur with these earlier findings and indicate that interventions that enhance EQ/SQ are worth delivering to new students. Enhancing EQ/SQ might affect the student's capacity to deliver spiritual care. Cockell & McSherry, (2012: 959), state that "spiritual care is closely bound up with dignity in care, holistic care and the perspective of the patient". If the student develops her confidence in delivering spiritual care, then both student and patient have a positive experience.

The data from the interviews were clear, in that the students felt that preparation for meeting death in clinical placement is important. Although the students were not clear on how this could be implemented, nurse teachers can decide which interventions are best for their particular mix

of students. Teachers could also offer a range of learning and teaching strategies that address EQ, SQ or both areas of the affective domain. Previous research by Liu et al. (2011), Adams (2014), Doyle (2014), Cavaye and Watts (2014) and Dwyer and Hunter, (2015) point to the need to address these aspects in the preparation of students for clinical practice. They suggest that experiential methods, including simulation, can be useful strategies for nurse teachers.

13.2 Strengths and limitations of this research

Carrying out research over six years incurs a number of advantages and disadvantages. The main advantage is the 'long view'. There is an ability to reflect on earlier work and to weigh the value of concepts and findings from the first ideas onwards. I can now see the field of research differently and from several perspectives. This contributes to the heuristic approach used in this research. I have realised how vitally important the early decisions are, in order to set up a robust context for research. The long period has also meant two changes of supervisory team. This too has had advantages and disadvantages, with each of my four supervisors contributing different gifts and perspectives.

Shortly after the quantitative data were gathered at stage 2, I became ill. I had not experienced a serious illness before and suffered more from the treatment than the illness. Some illnesses would have allowed me to carry on with the research, but there was a tangible fear of death around at the time, so the research was set to one side for six months in early 2012. I am now grateful for the emic perspective that I gained into the world of advanced cancer and its treatments. I met many people who were dying that did not know I was a nurse and saw me as just a fellow patient, and this insight was extremely precious. Through their courage, my personal feelings of fear of death were changed and I certainly appreciated the full benefits of a heuristic approach. When it came to undertaking the interviews, I had a better understanding of death, dying and bereavement through my own illness, the death of my father and the loss of my mother's personality to advanced Alzheimer's disease.

Prior to February 2011, I had little experience of carrying out research with student nurses. Any previous work had been carried out within timetabled sessions. I had little insight into the pressure on the new student nurse to keep up with four different modules and to prepare for assignments. It was also naive to believe that all students would want to be helpful. There were some students who did not approve of the research, particularly of the ancestral part of the constellation work. Two of the African students made it known that this was why they would not

attend the group. I have learned the value of considering the variety of religious and cultural beliefs and of finding a way to embrace a cross-cultural group.

The interviews took place in the clinical placement areas, usually in an office off the main ward area. This was a distinct advantage for the student and, therefore, the research, despite the difficulties in arranging the interviews. The students were comfortable and relaxed during the interviews and an abundance of information was elicited. In hindsight, the results might have been enhanced if the interview schedule had been better constructed, with more focus on the interventions. There was a paucity of data regarding the actual implementation of the DSD journal. However, all of the students interviewed seemed very honest and I was extremely grateful for this.

13.3 Implications for nurse education and practice

The outcomes of my research have wider implications than those arising from the interventions and are summarised here. This leads to three clear recommendations for nurse teachers in theory and practice contexts.

My findings suggest that communication skills need to be taught more explicitly and to be part of every module. 'The Shape of Caring Review' (Willis 2015: 46) recently highlighted the need for communication skills for bereavement. It would be interesting to explore further work on the degree and extent of communication skills taught across the four fields - mental health, learning disabilities, child nursing and adult nursing. Communication is central to all areas of nursing (Mellor, 2015) and affects the students' abilities to quickly develop therapeutic relationships with patients. It can be seen from the students' views (through the interviews) that specific communication skills need developing prior to the delivery of end of life care. These skills are sporadic amongst mentors, with some trained staff demonstrating poor practice, such as chatting to colleagues when performing care after death. Students are also working with nurses who demonstrate excellent communication skills. It would be helpful for these nurses to receive feedback when the students have witnessed and learned from these skills.

Students believe that preparation for end of life care is useful, that it should be direct, but not frightening. This research suggests that it is not acceptable to delay preparation for end of life care to academic time after first placements. The findings of my research indicate that sharing emotional and spiritual journeys can facilitate bonding in a small group. The family constellation

sessions facilitated the sharing of deep feelings that led to the students identifying a strong, supportive bond with other students in the group. I suggest that before students go out to their first placement experiences, discussion on death in small groups will provide an opportunity to share feelings and experiences. This would be a useful strategy for all four fields of student nurses (adult, child, mental health and learning disabilities).

Students felt that it was important that they be aware of the framework of delivering care after death before they meet this situation in practice. The procedure and policies for this are reasonably standard. Clinical placements in Hertfordshire adhere to the guidelines in the Royal Marsden Hospital manual of clinical nursing procedures (Dougherty & Lister, 2011). There might be schools of nursing in the U.K. where this procedure is not included in the curriculum during the first semester. The findings of this study suggest that this procedure needs to be taught prior to the students' first clinical experiences. It is also essential that this is taught in small groups, as teaching staff need to be sensitive to the feelings of all of the participants.

During one interview, the student suggested showing new students a dead body. This was interesting to me and would certainly raise challenges in nurse education. In my judgement, visiting the mortuary would be premature for new students and also raises ethical issues of potential voyeurism and possible disrespect. After this, I found that post–mortem explorations are viewable on YouTube. However, I feel that directing students to see these films would be unwise, as they could find the films more distressing than the reality of clinical practice. During the second half of 2015 there have been many pictures of dead bodies in the media, reflecting the difficulties experienced by people who are migrants and refugees. It might be that the media's propensity for photographing and filming death prepares new nurses in unfortunate ways.

Nursing literature suggests that nurse teachers are considering the need for the implementation of death, dying and bereavement sessions early on in the undergraduate programme (Poultney, Berridge & Malkin, 2013; Cavaye & Watts, 2014; McClatchey & King, 2015). This research does two things in relation to this discussion. Firstly it contributes the voice of the student. Secondly, it demonstrates that self-help programmes can be another option for developing EQ/SQ.

This study has also identified the importance of using teaching and learning strategies to prepare mentors for the unique challenges for the student when caring for dying people and

their families. These nurses play a central role in supporting the student in placement and specific preparation is required. Mentors might consider the different experiences of younger and more mature students, the different cultural perspectives on death and dying and the particular support that student nurses need when delivering end of life care and care after death.

The results showed that the DSD programme reduced fear of death to a statistically significant degree. This finding would be strengthened if the DSD intervention could be replicated with a larger sample of student nurses, with more data gathered regarding the completion of the intervention. DSD has been well researched and there was strong evidence that, by following the DSD programme, the student would experience a reduced fear of death. However, there is now a fee to students for the journal or online programme and this might be a factor in offering DSD. Investigating the results of using a free self-development programme with a less clearly defined evidence base, such as mindfulness, meditation or Neuro Linguistic Programming (N.L.P.) would be useful and might contribute to knowledge and the improvement of practice. Simulation can also be a most effective way of learning about death and dying (Fluharty et al. 2012). However, some of these suggestions are thinking-based, whereas the DSD is an unconscious process, which could explain its success.

The family constellation intervention was expensive in terms of time and emotional investment. It was difficult to find a good time and this did create problems with continuity. With more preparation and planning, it would be possible to deliver a form of supportive group work that is culturally sensitive and spiritually helpful for students. Family constellation facilitators are still few in number. However, the concept of a small group that shares emotional and spiritual work can be translated into the undergraduate nursing programme in a number of ways. I suggest that small peer support groups (4-6 students) be a feature of the first-year student experience and that these are related to placement allocation and allow discussion of deep feelings during theory sessions

13.4 Recommendations

Based on the discussion of implications in the previous section, recommendations and suggestions for practice arising from this research are summarised under three headings.

1. Recruitment of student nurses

Where this is not implemented already, those involved in recruitment should bear in mind that the youngest students are among those most likely to leave the programme prematurely. There could be a recommendation to recruiters to consider the maturity of candidates in terms of their experiences with life and death. Those with minimal experience of these matters will require more preparation for clinical practice. The DoH recommendations in 'Patients first and foremost' (UK DoH, 2013a: 67) were that student nurses must have "previously completed a year of caring experience" prior to entry to the nursing programmes. However, this is a recommendation, rather than a requirement, and recruitment might be a challenge in many universities. Despite this, it might be helpful if this recommendation became an unqualified requirement. More research is needed in this area.

2. First- semester curriculum content

Teachers who run first-semester modules could do more to prepare student nurses for the certain emotional and spiritual challenges ahead. Caring for dying people and their families is only one example of a situation where emotional and spiritual intelligence is required. The following are suggestions of some of the ways this might be implemented:

a) Essential, in my judgement, is the provision of a death, dying and bereavement session before the first clinical placement. This would need careful planning in order to facilitate maximum attendance. This would align with the recommendations of the Spiritual Care at the End of Life reviewers (Holloway et al, 2011). These reviewers considered that translating theory into practical skills was a priority in order to enhance care. The content of the session would be to assess the student's knowledge and experience and then discuss aspects of death and dying in a gentle way. Some might have had experiences to share and might have had family members who have died. A discussion of the breadth of dying experiences could be helpful. Courses on death, dying and bereavement incorporate elements of sharing that would encourage friendship bonds to develop, perhaps in subgroups. Small group sessions with a focus on sharing emotional experiences and cultural beliefs might help students to review their own feelings. These strategies might also be useful for students from other professions where death can occur at any time, such as doctors, paramedics, physiotherapists and radiographers.

b) Student nurses will need to be prepared for performing care after death. This would be covered after the sessions on the emotional aspects of death and dying. This need not be a skills-based practical session, but would gently introduce the student into the aspects that this study has identified as challenging. This would include the concept of the physical changes that happen at death, such as coldness of the skin, as well as the need to wash, label and wrap the body prior to the journey to the mortuary or morgue.

c) There is a need to recognise that students have had different experiences and that they learn in different ways. This could be done in the first modules where learning styles are introduced and discussed. The concepts of EQ/SQ would be identified and discussed. The value of evaluating past experiences in terms of the development of EQ/SQ within the affective domain could be integrated into the module.

d) Teachers might consider the provision of a choice of self-directed development programmes, such as DSD, which some students could undertake. These individuals could be directed to choose from a range of options to suit their particular preferences. These would be free or funded, according to the student and the department. The University of Hertfordshire has a programme of study skills workbooks that are completed on-line, although Becker (2013) has concerns that emotional skills cannot be taught through e-learning. Simulation exercises could also be further developed and implemented to enhance knowledge, skills and attitudes. I'm suggesting that links to self-help strategies could be collated and provided on-line, so that students have a choice of meditation, mindfulness, NLP and other self-development strategies.

3. Mentor preparation

The findings of this study lead me to put forward a number of suggestions with regard to mentor preparation:

a) Include an example of a student who has not met death being asked to deliver care after experiencing death for the first time. It would be interesting to ask mentor students to discuss this scenario.

b) Include in mentorship updates the possibility of students not being able to cope with dying people and their families.

c) During the preparation and updating of mentors, suggest that they consider that mature students might need as much support as the younger students.

d) Remind mentors that they themselves might choose to implement self-development strategies in order to deal with their own stress and distress more effectively.

e) Inform mentors that they can ask for feedback on their mentoring skills from students.

f) Inform mentors that students' feedback to undergraduate teachers tells us that mentors can be excellent role models. Mentors can mean the difference between them staying on the programme or them leaving. Mentors can even be inspirational in influencing a student's choice of speciality.

g) Remind mentors that link lecturers are available to support them in practice and to help them in their role with student nurses.

The preparation for mentorship and the required annual mentor updates could include a short discussion on the EQ/SQ aspects of student development. Each area will have different learning opportunities for students who wish to develop EQ/SQ and this might be incorporated into the welcome pack for each student. These suggestions are supported by the findings of the 'Shape of Caring Review' (Willis, 2015), where ongoing learning for registered nurses was recognised as vital to the provision of high quality care.

13.5 Suggestions for further research

This research has clarified the need for further exploration in several areas to do with the preparation of student nurses to deliver high-quality end of life care. Some of the research questions that it would be valuable to address are:

1. How does emotionally and spiritually challenging work, such as the care of dying people and their families, contribute to student nurses leaving the programme prematurely?
2. What are the relationships between cultural beliefs and the emotional/spiritual difficulties experienced by student nurses?

3. What are the particular challenges of establishing a therapeutic relationship with patients and their families within an end of life care setting?

4. To what extent are these challenges common across adult, child, mental health and learning disabilities fields?

5. Is there a relationship between a student's spiritual beliefs and their FOD as measured by the MFODS? (This was unclear in this study and requires a bigger sample.)

6. What would be the effect of the use of the DSD journal when programmed into a module with a large group of students?

7. How could family constellation work more clearly contribute to the reduction of FOD in student nurses? If students are well informed of the strategy and choose to participate in a workshop, would family constellations be more effective in reducing FOD?

8. What are the effects of other self-development programmes on fear of death (e.g. meditation techniques)?

9. What are the effects of structured sessions on death, dying and bereavement on EQ/SQ in large cohorts of students?

10. How can students most effectively prepare their own family and friends to provide them with support throughout the programme?

11. What are the thoughts and feelings of mentors in regard to supporting new student nurses in the provision of end of life care?

13.6 A final sign off

"Your profession is not what brings home your weekly paycheque, your
profession is what you're put here on earth to do, with such passion
and such intensity that it becomes spiritual in calling." Vincent van Gogh.

I am most grateful for the opportunity to have learned so much, both in relation to fear of death and also with regard to research methodology. I am a very different person from the one who commenced this journey. I remain, though, totally committed to the emotional and spiritual support of student nurses throughout their three-year nurse education. Universities have a duty of care to these people. A student nurse who leaves because she cannot cope with the stress is a loss to the profession and she could be left with long-term feelings of failure.

This study has enabled me to learn a great deal regarding the role and value of emotions and spirituality in nursing practice. My strongest feeling is the desire that the affective domain be

addressed equally, alongside the cognitive and psychomotor domains, within nurse education. In this way, we develop holistically prepared nurses who are able to overcome emotional and spiritual challenges in order to deliver excellent nursing care. The formation of a therapeutic relationship is central to the role of the nurse and does make a difference to the quality of care perceived by the patient and his family (Wright et al., 2010). This research provides insights that can help nurse teachers to find strategies to teach students to understand and implement these unique relationships.

I am committed to the provision of the highest possible quality of care to all those who are dying, as well as their families. For this to become 'the norm', nurses and students need to be confident and competent in dealing with death and its consequences. Nursing is complex and difficult work and those providing this care require and deserve appropriate care and support themselves.

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Appendices

Appendix A: Critical Appraisal Skills Programme (CASP) – an example of use of the framework with Crombie, A., Brindley, J., Harris, D., Marks-Maran, D., & Thompson, T. (2013) 'Factors that enhance rates of completion: What makes students stay'? *Nurse Education Today.* 33 (11) pp.1282-1287.

Question:	Yes	Can't tell	No
1. Was there a clear statement of aims of the research?	x		
Comment: The objective of the study was clearly stated. The objective was to explore the factors that influence the attrition and completion rates of year 2 students on the ad pre-registration nursing programme. This is important because of the current situation and retention in nursing. This is discussed in the article. The relevance of the research discussed in the background and introduction section.			
2. Is qualitative methodology appropriate?	x		
Comment: The researchers are seeking to illuminate the problem of student attrition. This involved seeking the actions and experiences of the participants. Several strategies were used to gather data to address the research objective.			
3. Was the research design appropriate to address the aims of the research?	x		
Comment: The research methods are complementary. The researchers approach the issue from four angles. This is justified in the research design.			
4. Was the recruitment strategy appropriate to the aims of the research?	x		
Comment: The students were self-selecting and from one HEI, but this strategy was appropriate for this research. The students were relevant to the research objective. Selection of participants for focus groups and interviews is discussed.			
5. Was the data collected in a way that addressed the research issue?	x		
Comment: The variety of strategies used helped to thoroughly address the research issue. It is clear how data was collected through non-participant observation, focus groups and interviews. These methods have been justified. The data was collected and analysed in a rigorous way.			
6. Has the relationship between researcher and participants been adequately considered?		x	

Comment: The nature of the relationship between the facilitators of the focus groups and the students and also the interviewer/interviewee relationship has been discussed. The researchers were not teachers within the students' HEI experience.			
7. Have ethical issues been taken into consideration?	x		
Comment: Ethical approval was gained. Students were well informed of the nature of the methods and provided consent. Appropriate ethical standards were maintained throughout.			
8. Was the data analysis sufficiently rigorous	x		
Comment: The data was analysed thoroughly. Two main themes clearly emerged. Sufficient data was obtained to support the findings. However, the researchers do not appear to have explored their own role.			
9. Is there a clear statement of findings?	x		
Comment: The findings are discussed and examples of the themes are provided. These are discussed in terms of the research objective.			
10. How valuable is the research	x		
Comment: The findings offer a different way of considering the reasons for student attrition, highlighting the role of clinical experiences. Suggestions for further work on these issues are suggested.			

Reference: Critical Appraisal Skills Programme (CASP) (2013) '*Critical Appraisal Skills Programme - making sense of evidence'*. Qualitative checklist. Available at: http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf
[Accessed: 16 February 2015]

Appendix B: Ethical Approval

FACULTY OF HUMANITIES, LAW & EDUCATION

Application for approval of a study programme involving human informants
Applicants: Kim Goode
Supervisors: Dr Eddie Blass, Professor Ben Fletcher
Date: 20 October 2010
Title of study programme: EdD – Strengthening the affective domain of first-year student nurses

Protocol no: 10-11.1

_____

Dear Kim,
I am pleased to confirm that your application for the above study programme has been
circulated to the members of the Faculty Ethics Committee and approved with an investigation
end date of 1 June 2011.
If this investigation is ongoing as at 1 June 2011, we would like to remind you that your
application should be resubmitted to the Faculty Ethics Committee for extended approval. I will
contact you nearer the time asking you to confirm whether or not the investigation is still
ongoing.
I hope your research goes well.
Kind regards
Rachel Cox

Rachel Cox
Senior Administrator (Academic Quality)
R.L.Cox@herts.ac.uk
R343 de Havilland

FACULTY OF HUMANITIES, LAW & EDUCATION

Ethics Application: Approval Confirmation

Applicant: Kim Goode **Supervisors**:   Dr Eddie Blass, Professor Ben Fletcher

Date: **23 May 2011**

Title of study programme: EdD – Strengthening the affective domain of first-year student nurses.

Protocol no 10-11.1

_____

Dear Kim

I am pleased to confirm that the Faculty Ethics Committee have approved your extension request to your project on EdD – strengthening the affective domain of first-year student nurses. The extended investigation end date will now be 1 June 2012.

If this investigation is not completed by 1 June 2012, then may I remind you that your application should be resubmitted to the Faculty Ethics Committee for extended approval.

I will contact you nearer the time asking you to confirm whether or not you would be interested in applying for an extension to your project or if you intend to meet the agreed deadline.

If you have any further questions regarding your application or any other ethical issues then please do not hesitate to contact me.

I wish you all the best with your project.

Kind regards

Julia

Julia Ratcliffe

Senior Administrator (Academic Quality)

Faculty of Humanities, Law and Education

Room R343, de Havilland Campus

Tel: 2649

Email: J.Ratcliffe@herts.ac.uk

From: Ratcliffe, Julia A
Sent: 16 April 2012 14:16
To: Goode, Kim P
Subject: FW: Completion of Ethics Application

Dear Kim,

I am emailing to confirm that the ethics committee are happy to extend your deadline date to the 31 December 2012, as requested. I will shortly send through a extension confirmation for your records.

Kind regards
Julia

From: ssahecda, uh **Sent:** 11 May 2015 09:58 **To :** Goode, Kim P **Subject :** Confirmation of Protocol Extension - 10-11.1 Goode K
Importance: High

To whom it may concern,

I can verify that the application from Kim Goode for the study entitled *Strengthening the affective domain of first-year student nurses* was seen and approved by the then ECDA for Humanities Law and education (protocol number 10-11.1), and that an extension of six months was granted on 7 January 2013 (before the current (EC 2) documentation was in use.)

Yours faithfully

 Tim Parke
Chair, Ethics Committee with Delegated Authority, Social Science and Humanities Research Institute

Appendix C: Participant information Sheet – MFODS

Strengthening the affective domain of first-year student nurses.

This is an invitation for you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask 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. If you have any questions my contact details are at the end of the leaflet.

What is the purpose of the study?

Earlier studies suggest that fear of stressful situations in clinical practice can affect a student's progress. The purpose of the study is to explore the feelings of student nurses in relation to the care of dying patients and their families. It is suggested that using strategies that reduce fear of death may enhance progression on the programme. The findings will be used to refine the programme in terms of student support.

Why have I been invited?

You have been invited to take part in this study because you a student participating in first-semester nursing modules and are destined for adult branch nursing.

Do I have to take part?

No, it is up to you to decide whether you would like to take part. If, after you have had time to read the information sheet and discussed it with others, you would like to take part I will meet up with you. I will go through this information sheet, which I will then give to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect your educational programme in any way.

What will happen to me if I take part?

If you agree to take part I will ask you to complete a rating scale that measures your fear of death. I will then implement a strategy that might reduce fear of death with some of the students. Each group will include around 25 members and the first group will aim to meet on a weekly basis for about an hour to explore issues of belonging. The second group will be using a psychological self-development tool and the third group will not have an intervention. No matter which group you are allocated, you will get a chance to try both of the interventions if you wish. I want to see if your feelings regarding death change as you progress through the module. After the interventions have finished I will ask all the participants to complete the rating scale again. Some students will be asked to meet with me for an interview to discuss their experiences.

The sessions will be facilitated by a senior lecturers from the nursing team. The sessions and interviews will last between one to one and a half hours. The information you provide will remain confidential and the interview tapes will only be heard by the researcher working on this

study. The record of the tapes will not identify you by name and so anything you say will be confidential.

Participation in this study is voluntary and there is no funding available to you for taking part. For this reasons disturbance to you will be kept to a minimum and all meetings will be held at a time and location that is convenient for you. All sessions will be at times when you would be at the university anyway.

What will I have to do?

You will need to meet up with me so that I can explain the study and gain your permission in writing.   At this meeting I will answer any questions you may have. If you would be willing to take part in the first group, you will need to meet up with the group on six several occasions. Each group will last one to one and a half hours.   You are free to stop at any point during the group or withdraw from the study at any time.

What are the possible benefits of taking part?

Taking part in this study will help the nursing team to consider your feelings about stress in clinical practice, which will benefit you in the second and third year of the programme.   Your views may help to develop strategies that will support students more effectively in the future.

Are there any risks?

There are no risks or disadvantages to you in taking part in this study.   The study only involves you sharing your experiences with the group and the researcher/lecturer. Your nursing programme will not be affected in any way.   If you have any concerns about this study you should contact me, Kim Goode on 01707 285934 or e-mail k.p.goode@herts.ac.uk so we can discuss them. If you want to make a complaint about this study you should refer to the University Policies and Regulations (UPRs) SA05 which gives details of the student complaints procedure.

Will my taking part in the study be kept confidential?

Yes. Only the researcher will know your name. No identifying information will be given to anyone. Records will be kept on a secure computer, only accessible by the researcher. If you disclose information during the group that I feel your personal tutor should know about, I will discuss it with you and ask for your permission to let them know. At the end of the study all audiotapes and transcripts will be stored in a locked filing cabinet for a period of seven years. After this period they will be destroyed.

What will happen to the results of the research study?

The study will be completed in the summer of 2014. Results from the study will be shared with nurses during workshops and conferences to help us to disseminate good practice. The findings will also be made available in relevant health and social care and educational journals. If you wish I will send you a summary of my findings.

Who has reviewed the study?

All research in the University is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the University of Hertfordshire Faculty of Humanities, Law and Education Ethics Committee

What if you have some questions about the study?

If you would like to find out more about this study before deciding whether to take part, you can contact me, Kim Goode (01707 285934) or e-mail on k.p.goode@herts.ac.uk. I will get back to you as soon as possible. If you have other concerns about taking part in this study, your personal tutor may be able to answer them.

What happens now?

If you agree to take part in the study I will meet up with you to explain the study in more detail and answer any questions that you may have. If you have decided you do not want to take part in the study, I will not try to persuade you. If you decide to take part, I will ask you to sign a consent form before the study commences.

Kim Goode
Senior Lecturer/Researcher
k.p.goode@herts.ac.uk
Telephone 01707 285934

Thank you for taking the time to read this information and please do not hesitate to ask for any more information if you need it.

Appendix D: Consent for MFODS form

CONSENT FORM

Title of Project: Strengthening the affective domain of first-year student nurses.

 (Ethics approval has been granted from the UNIVERSITY OF HERTFORDSHIRE FACULTY OF HUMANITIES, LAW AND EDUCATION Ethics committee. Reference number   10-11.1

Name of Researcher: Kim Goode
Please initial in the box

I confirm that I have read and understood the information sheet dated 29th September 2010 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my educational programme or legal rights being affected. Any information collected before I withdraw from the study may be used by the researcher

The content of any discussions that I have with the researcher will normally remain confidential. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998. However if during completion of the group or interview significant information arises that could impact on my educational programme I understand that the researcher will seek permission to share this information with relevant academic staff.

I agree to take part in the above study.

Name of Participant   :

Date: Signature:

Name of Person obtaining consent:

Date: Signature:

Appendix E: Multidimensional Fear of Death Scale (Hoelter,1979)

Instructions: Listed below are the death-related events and circumstances that some people find to be fear-evoking. Indicate the extent to which you agree or disagree with each statement by circling <u>one</u> number for each item. Please do <u>not</u> skip any items if you can avoid it.

1=Strongly agree
2=Mildly agree
3=Neither agree nor disagree
4=Mildly disagree
5=Strongly disagree

1	I am afraid of dying very slowly.	1	2	3	4	5
2	I dread visiting a funeral home.	1	2	3	4	5
3	I would like to donate my body to science.	1	2	3	4	5
4	I have a fear of people in my family dying.	1	2	3	4	5
5	I am afraid that there is no afterlife.	1	2	3	4	5
6	There are probably many people pronounced dead that are really still alive.	1	2	3	4	5
7	I am afraid of my body being disfigured when I die	1	2	3	4	5
8	I have a fear of not accomplishing my goals in life before dying.	1	2	3	4	5
9	I am afraid of meeting my creator.	1	2	3	4	5
10	I am afraid of being buried alive.	1	2	3	4	5
11	I dread the thought of my body being embalmed someday.	1	2	3	4	5
12	I am afraid that I will not live long enough to enjoy my retirement.	1	2	3	4	5
13	I am afraid of dying in a fire.	1	2	3	4	5
14	Touching a corpse would not bother me.	1	2	3	4	5
15	I do not want medical students using my body for practice after I die.	1	2	3	4	5
16	If the people I am very close to were to die suddenly, I would suffer for a very long time.	1	2	3	4	5
17	If I were to die tomorrow, my family would be upset for a long time.	1	2	3	4	5
18	I am afraid that death is the end of one's existence	1	2	3	4	5
19	People should have post-mortems to ensure that they are dead.	1	2	3	4	5
20	The thought of my body being found after I die scares me.	1	2	3	4	5
21	I am afraid I will not have time to experience everything I want to.	1	2	3	4	5
22	I am afraid of experiencing a great deal of pain when I die.	1	2	3	4	5
23	Discovering a dead body would be a horrifying experience.	1	2	3	4	5
24	I do not like the thought of being cremated.	1	2	3	4	5
25	Since everyone dies, I won't be too upset when my friends die.	1	2	3	4	5

26	I would be afraid to walk through a graveyard, alone, at night.	1	2	3	4	5
27	I am afraid of dying of cancer.	1	2	3	4	5
28	It doesn't matter whether I am buried in a wooden box or a steel vault.	1	2	3	4	5
29	It scares me to think I might be conscious while lying in a morgue.	1	2	3	4	5
30	I am afraid that there may not be a Supreme Being.	1	2	3	4	5
31	I have a fear of suffocating (including drowning)	1	2	3	4	5
32	It would bother me to remove a dead animal from the road.	1	2	3	4	5
33	I do not want to donate my eyes after I die.	1	2	3	4	5
34	I sometimes get upset when acquaintances die.	1	2	3	4	5
35	The thought of being locked in a coffin after I die scares me.	1	2	3	4	5
36	No one can say, for sure, what will happen after death.	1	2	3	4	5
37	If I die, my friends would be upset for a long time.	1	2	3	4	5
38	I hope that more than one doctor examines me before I am pronounced dead.	1	2	3	4	5
39	I am afraid of things that have died.	1	2	3	4	5
40	The thought of my body decaying after I die scares me.	1	2	3	4	5
41	I am afraid I may never see my children grow up.	1	2	3	4	5
42	I have a fear of dying violently.	1	2	3	4	5

1=Strongly agree
2=Mildly agree
3=Neither agree nor disagree
4=Mildly disagree
5=Strongly disagree

Additional questions about YOU:

Name (printed clearly please)…………………………………………...........

Female/ Male (please delete appropriately)   Age………….…....

Length of previous caring experience/work………………………………

Ethnicity……………………………………………………………………..

Any spiritual affiliation/religion/none…………………….……..

THANK YOU, Kim

Appendix F: Information Sheet and Consent form for Interviews

Information sheet for consent

Study title

You are being invited to take part in a research study. The purpose of this information sheet is to fully inform you of the study and what being a study participant will involve. Please take time to read the following information carefully.

What is the purpose of the study?

The aim of this study is to significantly reduce student nurses fear of caring for patients who are dying.

Why have I been invited to participate?

As a first-year UK undergraduate nursing student you have been chosen because you are beginning your academic training and clinical placements. You have had experience of clinical placements where people are receiving end of life care and you have contributed to the care of these patients and their families.

Do I have to take part?

Your participation in this research study is voluntary. If you do decide to take part please retain this information sheet for future reference. By voluntarily opting to complete the interview you will be giving your consent to include your anonymised data in the study analysis. If you decide to take part it will not be possible to later withdraw your response due the anonymity of responses. The researcher will be unable to identify your response from other responses. Please be assured that your decision whether or not to take part in the study will have no impact on your marks, assessments or future studies.

What will happen to me if I take part?

You have already completed two sets of the Multidimensional Fear of Death Scale. These questionnaires have shown an increase or decrease in the fear of death over the first eight months of the programme. I would like to explore the factors which contributed to your change in attitude to death and caring for dying people. The possible disadvantages to completing the interview will include the use of your time (approximately 45 minutes), and it may raise personal and professional concerns over your confidence and knowledge in caring for dying people and their families

What are the possible benefits of taking part?

The suitability of nursing students to enter clinical practice and to provide care to dying people is not well known. This study could inform UK nursing degree programme planning, and NHS mentorship training models to prepare first-year student nurses for providing end of life care.

Will what I say in this study be kept confidential?

Subject to legal limitations, confidentiality, privacy and anonymity will be ensured in the collection and storage of your data through the security systems of the encrypted transcripts. From the point of collection your data will be completely anonymous and data will be handled as one large data set. Data generated by the study must be retained in accordance with the University's policy on Academic Integrity. Data storage will follow legally defined criteria.

What should I do if I want to take part?

Please discuss the questions with Kim and allow for recording of the interview and later transcription of the interview.

What will happen to the results of the research study?

The results will be used in a thesis for submission for a Doctorate in Education. The paper may be published. You are welcome to obtain a copy of the transcript in March 2013. If you would like a copy of the study findings please use the email address provided for the researcher. A final copy of the thesis is also available to you and this will hopefully be completed mid 2014.

Who is organising and funding the research?

This study is being conducted as a student project for the EdD at the University of Hertfordshire. The study is not receiving funding.

Who has reviewed the study?

This research proposal has been approved by The Research Ethics Committee of the Dept of Humanities at the University of Hertfordshire. Approval code 10-11.1

Contact for Further Information
For further information or if you have any concerns about the way in which the study has been conducted please contact the Research Supervisor, Professor Philip Woods (p.a.woods@herts.ac.uk) or the researcher Kim Goode (k.p.goode@herts.ac.uk

Thank you for taking the time to read the information sheet.

CONSENT

I have had the opportunity to read the sheet and ask any questions

My questions have been answered to my satisfaction

I am willing to be interviewed by Kim Goode

I understand that this consent form and the data collected will be stored securely at the University of Hertfordshire in accordance with the Data Protection Act (1998). It will be destroyed 5 years following completion of the study.

I agree to talk about caring for dying people and their families and that this conversation will be recorded.

I understand that any poor practice I have witnessed may need to be reported to the appropriate authority.

I agree to any words that I say during the interview being used anonymously as quotations in the presentation of the research

I agree to take part in this study
Participant name………………………………
Date…………………………………………..

Researcher name…………………………..
Date…………………………………………..

Date: February 2013

Appendix G: Example of results from MFODS (February 2011)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
1	3	1	5	1	3	3	3	3	1	1	5	3	1	4	5	1	1	3	5	3	3	2	3	3	1	4	2
2	1	2	1	1	5	4	2	2	1	1	1	4	1	3	5	1	5	3	5	2	2	5	2	1	1	3	1
3	2	4	1	5	4	4	5	4	1	1	2	3	1	3	1	1	1	3	4	3	2	1	1	3	1	1	1
4	1	1	4	1	5	3	3	5	1	1	3	5	1	4	4	3	1	5	2	2	5	2	2	3	4	1	1
5	3	2	1	2	5	4	2	5	1	1	1	4	1	2	1	4	1	5	1	3	4	2	2	1	2	1	2
6	1	2	2	1	5	2	1	2	4	2	2	2	1	4	2	1	1	2	3	5	1	1	1	5	1	3	1
7	1	2	1	1	1	3	2	2	5	1	1	1	1	5	1	1	1	1	1	2	1	1	3	1	1	1	1
8	3	2	3	2	4	5	2	1	1	1	3	5	2	4	1	3	1	2	3	3	5	5	3	3	3	1	1
9	1	3	3	1	1	5	5	1	3	1	5	1	1	5	5	1	1	1	5	5	1	1	5	5	1	3	1
10	2	3	1	2	3	4	2	3	2	3	3	1	3	1	1	3	1	3	1	3	2	1	2	2	3	4	2
11	1	5	2	1	5	3	5	1	4	1	5	3	1	5	4	3	3	5	3	5	2	1	3	4	4	5	3
12	3	5	1	1	5	4	3	3	1	5	5	3	1	5	1	1	1	5	5	3	3	1	5	1	1	1	1
13	1	1	3	1	5	1	1	1	1	1	5	1	1	5	3	4	1	5	1	1	1	1	2	5	1	1	1
14	1	3	1	1	2	3	2	1	3	1	3	2	1	4	1	1	1	3	2	1	1	2	2	1	1	2	2
15	3	3	3	3	3	5	3	5	3	1	3	5	1	2	5	3	1	1	2	3	3	1	3	3	3	3	3
16	3	4	1	4	3	4	5	2	1	2	5	3	4	4	4	3	3	4	3	3	1	3	2	4	2	2	3
17	3	5	5	2	3	3	5	2	1	1	3	5	2	5	5	1	1	3	1	3	3	4	5	4	1	2	4
18	5	5	5	2	5	5	5	5	1	5	5	5	5	5	5	2	2	3	5	5	5	5	2	5	4	5	4
19	2	2	3	2	4	5	5	5	1	5	5	5	5	2	4	1	1	4	1	2	2	2	1	3	1	5	5
20	1	4	5	1	5	4	5	5	1	4	5	4	5	5	5	4	1	5	1	5	5	2	5	1	5	5	5
21	1	5	5	1	1	5	5	1	1	1	5	3	5	5	5	1	1	5	1	5	1	5	1	1	1	1	5
22	2	2	5	2	3	1	4	4	3	1	3	4	1	2	5	1	1	3	1	2	2	1	1	5	1	2	4
23	2	5	1	2	5	5	1	1	1	4	5	1	5	3	1	1	1	5	3	5	1	1	4	1	1	5	4
24	3	2	3	2	3	4	2	3	4	1	2	3	1	1	2	4	3	3	4	2	2	4	5	4	4	4	3
25	1	2	1	2	5	5	2	1	1	1	1	1	1	2	1	1	2	5	5	3	1	1	2	5	1	2	1
26	2	5	3	1	1	5	5	3	1	4	4	4	1	5	3	2	1	1	4	3	3	1	3	1	2	3	4
27	3	2	4	4	2	3	2	1	4	1	3	1	1	2	1	1	2	1	3	1	1	1	1	5	2	5	1
28	2	3	2	2	4	4	4	2	2	2	3	2	2	5	4	1	1	2	4	2	2	2	2	4	2	1	2
29	2	3	3	2	4	3	4	3	2	5	3	5	4	5	5	2	1	5	4	3	2	1	5	4	2	2	2
30	1	5	1	1	3	1	1	2	1	5	5	5	1	5	3	2	1	1	2	1	2	3	2	3	2	1	1
31	1	4	3	1	1	2	1	1	2	1	1	1	1	3	3	1	1	4	2	5	1	1	2	1	1	4	4
32	1	1	3	2	5	3	5	1	2	1	5	3	1	3	5	1	1	5	1	3	2	1	1	1	1	1	3
33	1	4	5	1	2	3	4	1	1	2	1	1	2	2	5	1	2	1	3	4	1	1	4	5	1	2	1

28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	F1d	F2d	F3d	F4d	F5d	F6d	F7d	F8d	total feb
5	1	5	1	4	5	1	5	1	1	3	5	5	1	1	10	21	18	6	13	13	26	10	117
1	1	1	1	4	1	2	1	1	1	1	5	1	1	1	10	19	8	11	11	12	8	9	88
2	1	4	2	5	1	2	1	1	2	1	3	3	1	1	8	17	6	12	13	11	16	10	93
4	1	5	3	1	1	1	5	2	2	2	3	5	1	1	7	13	12	12	21	9	16	20	110
1	1	5	1	2	1	1	2	2	1	4	2	5	1		10	13	4	12	18	8	10	18	93
4	1	3	2	1	1	1	1	1	1	3	3	3	1		7	14	10	6	15	9	16	8	85
1	1	1	1	5	1	3	1	1	1	3	1	1	1	1	6	19	4	8	9	7	8	5	66
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5	4	3	2	2	1	3	4	1	2	4	5	5	3	1	11	23	8	11	7	21	26	13	120
3	1	3	1	1	1	3	1	1	3	1	5	1	3	1	8	16	11	15	11	9	11	6	87
1	2	5	1	1	1	2	2	1	1	1	5	2	2	1	10	17	11	9	14	13	14	8	96
3	2	3	4	5	5	2	4	2	2	2	5	3	3	2	15	25	17	11	16	16	20	13	133
1	5	3	1	4	1	1	3	1	1	2	1	2	5	3	10	18	8	8	8	13	13	13	91
2	1	1	2	4	1	2	2	1	2	1	2	1	1	1	10	19	8	8	9	7	12	4	77
3	1	5	1	3	3	1	2	5	2	1	2	3	1	1	8	11	12	8	22	7	21	7	96
3	2	3	2	2	5	1	1	2	2	3	5	3	1	1	8	19	20	8	9	13	16	4	97

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1	3	4	3	1	3	3	3	3	1	1	5	2	1	3	3	1	1	3	5	3	2	2	2	3	1	2	1	5	3	5
2	1	3	1	1	3	5	2	2	1	1	2	2	1	1	3	1	1	3	1	1	2	1	1	2	1	2	1	1	1	3
3	2	4	1	1	3	2	2	3	1	1	2	2	5	2	1	2	2	3	4	4	3	1	2	3	2	1	2	2	3	3
4	1	2	1	1	5	3	5	2	1	1	3	4	1	5	1	1	1	5	1	5	1	1	1	3	1	1	1	1	3	5
5	3	2	1	4	5	4	4	4	1	1	2	5	1	2	5	4	1	5	2	4	5	1	2	1	1	1	2	1	1	5
6	3	3	4	1	2	2	2	1	3	2	3	3	4	5	4	1	1	3	5	5	5	1	4	3	1	5	3	3	3	3
7																														
8																														
9	5	1	3	5	3	1	1	5	3	5	1	1	5	5	5	4	4	1	1	5	1	5	1	5	3	3	1	5	5	5
10																														
11	1	5	3	2	5	4	5	1	3	1	5	3	1	5	3	3	3	5	4	5	1	5	4	5	5	5	3	5	1	5
12	2	3	3	1	5	3	1	1	1	1	5	5	3	5	3	1	1	5	5	2	4	2	2	1	1	4	3	3	1	5
13																														
14	1	3	2	1	3	3	2	2	3	1	3	2	1	4	4	1	1	2	3	2	2	1	3	1	2	2	2	3	2	3
15	3	3	1	5	5	1	5	5	1	5	3	5	3	4	1	2	5	5	1	5	5	3	2	5	1	1	3	4	3	5
16	2	4	3	2	3	4	2	1	1	1	4	2	2	4	3	2	3	3	2	3	1	3	2	5	1	4	4	1	4	5
17	1	2	1	2	2	1	2	4	5	4	2	4	4	3	1	5	5	5	4	1	5	5	4	4	5	5	4	1	5	1
18																														
19																														
20																														
21																														
22	2	3	5	2	4	2	3	4	1	1	3	3	2	1	5	1	3	3	2	2	3	1	1	5	1	1	3	5	1	3
23	3	1	1	1	3	5	2	1	1	1	5	5	2	2	1	1	1	5	5	1	3	5	4	1	1	5	2	3	5	3
24	4	4	3	2	3	3	3	3	2	2	2	3	2	2	3	2	2	4	3	4	3	3	2	4	2	2	2	2	3	3
25	1	3	1	1	3	5	1	1	1	1	1	1	1	5	1	2	1	3	5	2	1	3	2	5	1	1	1	3	5	5
26	5	5	4	2	1	5	5	4	2	4	4	4	2	4	4	2	2	1	5	5	4	4	4	2	2	3	3	2	4	4
27	1	3	3	3	3	5	1	1	4	1	3	1	1	3	3	1	3	1	3	3	2	1	1	5	4	5	3	3	1	1
28	2	4	3	1	4	5	3	5	1	3	2	4	4	5	2	1	1	2	5	3	4	4	4	2	1	2	3	1	5	4
29	2	3	4	2	3	3	3	2	4	4	3	4	3	4	1	2	2	3	3	4	2	4	5	4	2	2	2	3	2	3
30	2	2	4	2	1	2	1	1	4	1	1	5	1	4	3	3	1	1	4	4	4	4	4	1	2	1	1	1	5	1
31																														
32	1	4	1	5	1	2	5	1	1	1	5	1	1	3	1	1	1	1	1	3	1	1	1	1	1	1	1	5	1	3
33	1	5	5	2	2	3	5	1	2	3	5	2	2	2	5	1	2	2	3	5	1	1	2	5	1	2	1	4	3	5

	31	32	33	34	35	36	37	38	39	40	41	42	F1	F2	F3	F4	F5	F6	F7	F8	total
1	1	2	1	1	5	1	2	3	5	5	1	1	9	18	10	7	13	15	26	8	106
2	1	2	1	1	1	1	1	1	3	1	1	1	6	12	7	6	11	9	8	7	66
3	1	2	1	2	1	1	2	1	3	3	1	1	12	14	6	11	11	11	14	9	88
4	1	1	1	2	5	5	1	1	4	5	2	1	6	14	6	7	21	9	24	9	96
5	1	5	1	2	1	5	1	1	1	2	5	5	13	13	8	13	21	9	14	19	110
6	2	1	1	1	2	1	1	1	3	3	5	1	14	21	12	6	12	13	18	14	110
9	1	5	5	1	1	1	3	2	5	5	1	1	18	20	18	20	13	14	18	8	129
11	1	5	3	1	5	5	3	5	5	5	1	5	16	29	14	17	23	15	30	6	150
12	1	1	1	2	5	1	1	1	5	3	1	2	13	20	8	7	17	11	19	11	106
14	1	3	3	2	2	1	1	1	3	2	2	2	8	18	10	8	12	10	14	8	88
15	3	4	1	2	5	3	1	3	3	3	3	3	18	17	8	16	19	13	25	18	134
16	5	4	5	2	4	1	3	3	4	3	2	2	18	22	16	13	13	14	17	6	119
17	5	4	1	5	1	5	5	5	5	3	5	5	24	23	7	27	18	19	10	18	146
22	1	1	5	3	3	1	2	1	3	3	3	3	12	10	20	12	12	7	19	13	105
23	1	5	1	2	5	3	1	1	5	2	3	5	18	22	4	7	15	17	18	12	113
24	2	1	2	3	1	3	2	3	3	2	3	2	15	15	10	15	15	14	14	12	110
25	1	2	5	3	5	1	2	5	5	5	5	1	8	18	12	10	13	21	17	8	107
26	3	4	4	4	3	1	3	5	4	4	4	4	21	24	14	15	9	23	23	16	145
27	1	3	3	2	3	1	5	3	3	1	1	1	8	18	14	18	10	13	14	5	100
28	4	1	2	1	4	1	1	2	5	2	2	2	19	21	9	6	12	20	15	15	117
29	3	2	3	2	3	2	2	2	4	4	3	3	17	20	12	12	15	14	20	11	121
30	4	4	4	4	4	4	4	4	4	3	3	3	15	19	12	16	11	16	14	13	116
32	1	5	1	1	5	5	1	1	5	5	1	1	6	19	4	10	11	6	28	4	88
33	2	2	5	2	5	1	2	3	5	5	1	1	8	18	20	10	12	15	29	5	117

Appendix I: Interview Schedule

EdD Interview Schedule – Jan 2013
Greetings and gratitude.

Show MDFOD scales and identify intervention group.

What were the differences?

What factors might have affected this difference? Intervention?

Did you keep a journal for the first few months of the programme?

What help was this?

Can you tell me of an occasion when you have cared for a patient who was dying? How did it feel during and afterwards? Who supported you?

What skills did you use and what skills were developed?

What factors in your personal life support your work?

How does your age, gender, prior experience, ethnicity or religion affect your perspective of death?

What factors would help to prepare new students to care for dying people and their families?

Thank you (Cake)

Support services:
GP and GP Practice Counsellors
Personal Tutor UH
UH Counselling   - 01707 284453 counselling.centre@herts.ac.uk
SU Services Advice and Support Centre 01707 285022 asc@herts.ac.uk
Samaritans 08457 909090   jo@samaritans.org
British Association of Counsellors and Psychotherapists www.itsgoodtotalk.org.uk/therapists/

Problems with the research?
Please contact…
Researcher: Kim Goode k.p.goode@herts.ac.uk
Supervisor: Prof Philip Woods. p.a.woods@herts.ac.uk

Appendix J: NVivo screenshot of the coding and SOTS

Appendix K: Example of an Interview Transcript. Student 62

K: Have a lot of things changed for you in how you looked after dying people?

62: Before, obviously I haven't worked on a ward before the start of my nursing, but when I did and we were doing, mainly what sticks in my mind is the last offices of a couple of people which I actually, before I had done this I kind of thought gosh that would be a terrible experience for me and for them but I think what changed was I actually felt honoured when I was doing it and I felt, I can remember the first time in xxx and somebody said to me, would you like to come along, you don't have to - if you feel that you can touch you can but you don't have to do anything. I actually felt and I was still talking to the person because I was still looking at them as a person and I wasn't looking at the person as a dead body I was still looking at that person and I don't know if that makes sense, as still a person, whereas before I was thinking it's a dead body before I actually had the experience. I think it's the same for everything, before you have had the experience you have certain thoughts before you have had the experience, but once you've had that experience everything completely changes, so it was more honourable for me to be, I felt quite, what's the word, yep, honoured to be able to do, and it happened quite a few times, but looking after the dying, I think maybe my experiences were quite nice because everybody around me was so thankful for what we were doing and I didn't have anybody ranting or raving or you're not doing the right thing, it was so much more nicer than that. Everybody had a time to go but I didn't think like that before.

K: Did you ever see a dead body before you started?

62: No

K: Had any close family died?

62: My Granddad, but my Nan wouldn't allow us to see him. I wanted to go and see him because I was here in Hertfordshire and she said no, I've seen him and I want you to remember him how he was. I don't want you to see. But from the feedback I've had from other people they were saying it's a dead…it looks awful but I didn't actually find that.

K: How many dying experiences have you had?

62: Since I started probably 4 or 5 and last offices probably 4 or 5. Not single handed. There was one situation which I can clearly remember, when a lady had passed over and the nurse left me in the room on my own and that was the only time I felt a little bit, because it was a side room that she was in, and I felt ooh gosh, then I felt why are you so, it was a person and that person is still a person. Then another experience in xxx where we tried to resuscitate a man (and I did as well, CPR and afterwards). I did the whole process of trying to resuscitate with others, then last offices and the nurse I was working with was so passionate about, it wasn't just like oh they've gone now that's it. She said to me "this is always a part of life and I feel very honoured" and it kind of impressed that into me and we put his hand in the right place, she said it's always nice to have the hand so his family can touch his hand, I actually felt, I don't know, didn't feel sad I felt quite moved. It was amazing really so and most of the nurses I have worked with have, so maybe my experiences have been. So the whole concept of not been frightened of death and dying, I think that is what may be reinforced that for me. I don't know really, that's just…Beforehand it was very negative and now it's not which It could be, should my experiences change. I could go somewhere and they could be awful and I could think oh gosh and it could move me back!

K: Did you have many negative experiences in ******?

62: I did but what we have to realise is that is a completely different culture and a completely different way of life and they do what they have to do. They can be quite harsh with the patients but then what do they have? Here we have equipment, we have everything going, we don't have to really use our initiative to the level that they do. They really have to think outside the box don't they and I've found I was very lucky, all the deliveries were, every delivery I saw and was involved with was positive. I did see some negative things, there was a little girl who came in with literally, I've never seen anything quite like it, her legs was… the bone, I do not know what had happened but she, I knew she would lose her leg because they do not have plastic surgeons. They literally have nothing. It is amazing what they do and that was really negative. I think on 3 occasions I cried over things I'd seen, because we are not used to that and then one was to do with children like licking our plate when we'd finished a meal. Three things affected me and the little girl with the leg was one of them. You do find a way because you do need to; we are so lucky really we really are.

K: So what skills have you developed in terms of dying patients, looking after dying patients and families?

62: I think one of the main things it's really not such a skill but I've learned to be able to adapt and not to show too much emotion. Because I was quite an emotional, well I still am. But to not let on how you're feeling because you have to have a certain amount of professionalism, don't you? You can't be crying. I don't know it depends on the circumstance. That is one skill. I think taking the positive from the negative really is another, not that they are clinical skills, I think they are really, really important in nursing. I think we can sometimes get mixed up in ...a lot of people think, well I've been on a placement and I haven't learned clinical skills. It's clinical, clinical actually it's not really, it's all about growth isn't it and it's about people, so that's my main.... for me that's the main…yeah.

K. It sounds like you've had good mentors, good trained staff to work with.

62: I have, I have been pushed really. My last placement I hated, I really did.

K: Where was that?

62: Some of it I liked, it was theatres in **** and the day surgery nearly sent me berserk. I cannot do that day in and day out. And scrubbing, I was allergic and scrubbing, not too bad but I can't be enclosed here all day…bad for my nerves. But I think, because you do speak to other students I try not to, because about anything really because I think it's hard when somebody has had a good placement and other people haven't. I think I've been fortunate in the way that my, a lot of my mentors have really pushed me. Sometimes you think Oh God, but sometimes I think it is good for you because I need that because of the confidence thing, which has grown in this last 2 years. It's just like turning a key. I think this is the best decision I could have made.

K: So the first time you laid out a patient, your mentor was good?

62: Fabulous yes. Absolutely.

K: It wasn't that one that had left you alone with a patient?

62: No the first time was in xxx and she was a newly qualified member of staff and she was fresh. She was very enthusiastic and she asked me if I was OK with this, if you don't want to touch… would you like to help? She gave me choices, and I obviously did and all the way

through the process - like if you knock somebody I said 'I'm sorry' – like you would with a patient, and that's the way I'll go on now.

K: Did you have a break or did she give you a break or did she check you were all right?

62: She checked I was all right, but I didn't actually feel that I needed it.

K: Have you ever actually got involved with families?

62: I have.

K: Has that been difficult?

62: Yes the situation in xxx where there was a 47 year old and she was going to die that night and her mother, I still think about it and that really does bring tears to my eyes. I had to walk away because she was wailing down the corridor and she was in her 70s and her daughter was like 47, just to hear that….she was riddled with cancer. It's really strange because that affected me more than doing CPR on 2 men aged 65 that died. I think it's the suffering as well. I actually escorted them to another ward where she was going to be. Again the nurses were fabulous and I think I've been quite lucky really, I really have and I do appreciate that, I do.

K: How do you think being a bit more mature has affected your experiences?

62: It's been helpful. I think maturity is the key and I do think if I'd come into nursing in my 20s I wouldn't have lasted because I didn't have that level of - I'm not saying I am the most mature person but I think I've matured in these 2 years. I've just suddenly become a woman rather than a girl, I feel that definitely, I think having a more mature approach made my experiences a lot more positive and I think that's what happened in xxx. It happened to C as well because she is very mature for her age and a lot of experiences were positive as well. As well as negative but you have to, you need to turn them into a positive.

K: And your spiritual background? Do you think that has helped?

62: Definitely, if I wasn't this way inclined I wouldn't have, no, no, no. I think it makes a lot of difference. And when I hear other students speaking I think Gosh if I could put your mind to where I am now – but it takes a lot of work doesn't it. It's not just about academic growth it's about personal growth and it really has - even my family. It's very strange because I go home and it's as if they've got more respect for me. It's not just the academic because I'm not really academic, but it's not that … it is the personal growth.

K: One more question. If we could prepare a new student before they go onto the wards how could we prepare them better to care for dying people?

62: That's a really tough one because I don't think anyone can prepare anybody because everybody's experience is going to be individual to them. And if they've had something in their life that's going to impact on what happened I don't think there is a way, I think it's impossible.

K: Do you think we should do last offices with new students before they go out?

62: How?

K: Talk them through how an experience is when you lay a person out.

62: I think could talk them through it, like text book, but I think some nurses have been in it so long that they just see it one after the other and then a student could be involved with that nurse and think gosh she was awful. I think you could maybe give a talk on last offices and possibly what to expect. But actually I think what would be a good idea is to have maybe a student that has experienced a bad one and a student that's experienced a good one, like for instance myself I've experienced positive experiences and then sort of give the two so it gives them a slight insight into what they are going into. Maybe students who have been involved recently?

K: One more thing, family constellations. We did some work with constellations when you first came in, what effect did that have on you?

62: Major effect because I it made me feel, I can remember them clearly, especially the one regarding my mother. It made me feel a lot stronger and sometimes I feel like I'm not sort of a strong character, but it made me feel like an adult and that's what changed. And now it is really…when I visit my mum, it is as if she has so much respect for me. So maybe the constellation helped me believe what I thought I believed, but I wasn't very sure. Does that make sense? I kind of complicate things a bit.

K: Do you think it also affected your peer group to become quite close to x and y and z

62: Yes they will see me and it's like there's a respect for each other, such nice people as well. There's a respect and there's definitely a depth with all of us.

K: Because you were so intimate during those sessions?

62: Yes, definitely, I'd love to do more.

K: Thank you.