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# TEACHING NURSING STUDENTS USING AN ADAPTATION OF THE SPIRIT OF MOTIVATIONAL INTERVIEWING: AN ACTION RESEARCH CASE-STUDY

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# Abstract

This study examines the impact that a teaching adaptation to the clinical engagement strategy known as the Spirit of Motivational Interviewing had on the attitudes, values and beliefs of qualified nursing students towards their own learning. This Spirit of Motivational Interviewing consists of several constructs (partnership, acceptance, compassion and evocation) and the proposed adaptation for the purposes of teaching is the addition of the construct of self-awareness. In order to qualify and practice as a nurse, the Nursing and Midwifery Council require that the delivery of care is based on the person-centred values of acceptance, respect and empathic understanding. Role modelling has been traditionally used as a way to transmit these values, but the creation of much larger classes as a result of a move by nurse education into universities has made this far more difficult to achieve.

The study examines research that suggests the deployment of the person-centred approach of Carl Rogers by educators leads to improvements to a range of outcomes such as motivation, self-esteem, grades, disruptive behaviour and absenteeism. It takes the position that the use of the adapted Spirit of Motivational Interviewing can transform learning, leading to changes to the attitudes, values and beliefs of students so that they become less distorted and prejudicial and more open, expansive and discerning. Participants in the study were a group of qualified nursing students on a substance misuse course, and their teachers. Qualitative and quantitative data were collected. In order to ascertain views about the nature of teaching and learning, interviews were conducted with both nursing students and with teaching staff, and the

students were asked to complete empathy questionnaires. Findings from the quantitative data revealed a statistically significant increase in student empathy at the end of the substance misuse module. The qualitative data indicated that the students and nurse teachers interviewed shared similar views about the value of forming collaborative relationships in order to enhance the learning potential of students, and this was best achieved through a process of encouraging and validating student experiences. Students felt that the willingness of teachers to share aspects of themselves was important in relationship formation. Some felt that attendance at the module had moved them in the direction of becoming more person-centred when they engaged with patients and clients.

When an adaptation to the Spirit of Motivational Interviewing is used for the purposes of teaching nursing students it seems able to increase student engagement in learning. When self-awareness, partnership, acceptance, compassion and evocation is shown by the teacher and through a process of role modelling and reciprocity by the students, it appears to be capable of changing the attitudes of students to becoming more person-centred towards the care of patients and clients. The study suggests that this teaching approach should be considered by all schools of nursing as a way of transmitting these values.

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# Chapter 1 - Introduction

If the creation of an atmosphere of acceptance, understanding, and respect is the most effective basis for facilitating the learning which is called therapy, then might it not be the basis for the learning which is called education? (Rogers 1951:384).

In 1996 I became a nurse teacher, ending five years specialising as a mental health nurse working with people experiencing problems associated with addiction to alcohol. The latter period of my clinical career witnessed a significant shift in how nurses engaged and subsequently treated health service users ('health service users' is the preferred term to denote patients and clients, although these terms will be used when it is more appropriate). This shift was largely a result of a decision made by the nursing team at the alcohol unit to incorporate a framework known as the Spirit of Motivational Interviewing (SMI) (Rollnick and Miller 1995) into how we formed relationships with health service users who had alcohol problems. This 'spirit' underpins a person-centred counselling style called Motivational Interviewing (MI) (see below). The emphasis when using this approach is to create a climate that encourages discussion on how changes to problem behaviours could be achieved. When I first started teaching, I found it difficult to engage nursing students in the process of learning. These early teaching experiences led me to reflect on whether this creation of a 'change atmosphere' in a clinical situation would have any relevance to the teaching and learning of nursing students. MI is a person-centred counselling style which aims to increase the likelihood of change to problem behaviours. It was devised by the psychologist William Miller in the 1980's after observations he made treating patients who were experiencing

alcohol problems. Rollnick and Miller (1995) started to train people in the approach but soon after became increasingly concerned that the trainees were demonstrating MI in ways that they did not recognise. They concluded that they had 'taught the words but not the music' (Miller and Rollnick 2013:14) and proceeded to construct a framework to guide the way MI should be delivered, which eventually became known as the SMI. The SMI rather than MI was considered more relevant to the practice of teaching because it is a guide to the way an intervention should be delivered; MI is more a set of clinical skills which are designed to increase the likelihood of a health service user changing problematic behaviours.

My clinical practices just before I became a nurse teacher proved to be crucial to the development of the ideas in this thesis and therefore this chapter will begin with a description of their relevant aspects. In addition, the person-centred approach of Carl Rogers, the SMI and MI had a profound effect on the way I engaged and subsequently treated people with alcohol problems and therefore a description of these constructs will then follow. Yet in order to understand the nature of these changes there is a need to describe the characteristics of an approach that I encountered when I first started caring for people with alcohol problems, often known as 'confrontational counselling.' This change to the way I conducted my clinical practice also affected my early experiences of teaching student nurses biological sciences and substance misuse, and so relevant aspects from both will be described. Issues regarding the transmission of values will then be discussed in the light of recent developments in how concepts such as empathy and respect are taught to nurses, since these changes

have implications for the way that care is now conceptualised and ultimately delivered.

## **Clinical experiences before introducing the Spirit of Motivational Interviewing**

Before I introduced the SMI into an alcohol treatment unit, nursing staff engaged and treated people with alcohol problems based on confrontation. This approach was justified because it was seen as the only way to break down 'denial,' understood as a defence mechanism in which health service users refused to accept their dependency on alcohol. In order to appreciate the differences that introducing the spirit of MI made to the way that nursing staff engaged and subsequently treated health service users, it will be useful to discuss the practice and implications of using a confrontational approach with dependent drinkers.

On becoming qualified as a mental health nurse in 1990 I began working with people with severe alcohol problems in an abstinence-based alcohol treatment unit. Health service users were admitted either for detoxification from alcohol (normally ten days) or for a group therapy rehabilitation programme (usually 3 weeks). Those who experienced alcohol withdrawal symptoms such as tremors and palpitations were treated using tranquillisers (normally Librium), administered and monitored by the qualified mental health nurses. All health service users were allocated a key nurse on admission, whose primary role was to be responsible for the organisation and delivery of care for that individual (Dunne et al 2005). A part of this care was for all health service users to engage in regular, individual counselling sessions which they were encouraged to continue after they were discharged. Regular attendance at group therapy sessions

after they were discharged from in-patient care was also advised. Both were largely undertaken in order to check on the progress of health service users on maintaining the goal of sobriety.

## **Confrontation as a treatment approach**

The three week, inpatient rehabilitation programme on offer at the alcohol unit consisted of group therapy sessions all of which were facilitated by a member of staff. Each patient on the programme also had an appointed key worker who they would see for individual, twice weekly counselling. The patients 'on the programme' (typically around 15) were expected to explore and try to resolve some of the psychological issues underpinning their excessive alcohol use, in an attempt to try to live a life without alcohol. It was here that I witnessed for the first time a confrontational style of engaging with patients. This primarily involved giving feedback about their thoughts, feelings and behaviour. What surprised me was the blunt, authoritarian and somewhat aggressive manner in which it was delivered.

It soon became clear that the main objective of treatment for inpatient and outpatients was to use confrontation, argument, ridicule and even humiliation to get health service users deemed as 'alcoholics' to accept that they were indeed alcoholics. Breaking down this 'refusal to accept reality' was considered a crucial group task, since it allowed others as well as themselves to 'see' the extent to which they had deluded themselves (Bassin 1975; Johnson 1986). The confrontational nature of group therapy was also practised by the staff in order to arouse anxiety, in the belief that this would increase motivation to change. Yet this anxiety often made it difficult or impossible for some to share personal information, with feelings

of shame and guilt commonplace (Yalom 2002; Wagner and Ingersoll 2013).

Many health service users in my care became frustrated, angry and deeply upset by the use of this confrontational approach in the group therapy sessions. Some discharged themselves before the programme finished. Even those that completed seemed bewildered and disillusioned. Relapse rates were generally high. Most staff did not see any reason to change the way they engaged with their health service users, citing their own experience of what worked. Health service users complained that when they wanted to talk to a nurse about their problems they were often told to take their concerns to their next group. Morale amongst the staff was low as were expectations of their health service users' ability to change. It seemed to me that much of the blame for this lack of optimism regarding change was due to the rather wholesale adoption of confrontation as the 'treatment' of choice.

It was around this time (1992) that I secured a position as a senior nurse in a different inpatient alcohol treatment unit, though one with a similar treatment philosophy and confrontational approach to that found in my first job. Two 'types' of health service users were encountered here; the first group were those experiencing alcohol withdrawals and they were subsequently admitted for a 10 day detoxification. The second group were those who wanted to live a life without alcohol and who were admitted to a 'contented sobriety' 6 week, inpatient programme. Patients received a mix of drug treatments used to alleviate the symptoms of alcohol withdrawals coupled with the provision of supportive group therapy, the likes of which I had witnessed in my previous employment. Both

detoxification and 'programme' health service users had to attend daily support groups (details below) but the 'programme' group also had 'skills acquisition' groups such as anxiety management, assertiveness training and relapse prevention. Educational sessions on topics such as the physical and psychological effects of alcohol also featured. All support groups were facilitated by nurses and the main focus was to help health service users to help themselves through the support, guidance and advice given by others. Facilitators were expected to be aware of group processes such as mirroring, ('seeing yourself as others do') universality ('we are all in the same boat') and the instillation of hope (change is possible) (Yalom 1970; Yalom and Leszcz 2005). How health service users performed in groups was the subject of much debate in terms of their ability to recover (remain abstinent) from alcohol. Unlike my previous employment at an alcohol treatment unit when I first qualified, no individual counselling sessions were provided.

## **Implications for Treatment**

The justification of aggressive psychological treatment in groups was derived from the widespread acceptance from the 1960's onwards of combining certain elements of medical, spiritual, moral, and psychological models concerning alcohol problems (Jellinek 1960; Miller and Hester 1995). This can be summarised as follows; 'they are ill' (medical model), they are weak and in need of guidance (moral and spiritual models), they distort reality and are dishonest (flawed personality model). Most of the assumptions on which these models are based were accepted by the majority of the staff whom I worked with. This had implications for engagement and treatment. For instance, health service users would be



told by staff that they could not drink again even in small amounts because as alcoholics they suffered from a 'lack of control.' However, because of their problem personalities many of the staff believed their patients and clients were prone to self-deception, which explained why many thought they were not alcoholic. The key task then for the therapist/nurse was to get the patient to accept the diagnosis of alcoholism before therapy could proceed (Tiebout 1953). However, a rational, reasoned approach to get alcoholics to accept they were alcoholic was considered likely to fail because the health service users were 'in denial.' A blunter, direct approach which challenged the patient with the 'reality of the situation' was therefore deemed as the only way to proceed.

During my nurse training I had cared for people with mental health problems such as depression and seen changes to their behaviour when they were treated with kindness, respect and dignity. The conventional wisdom was that people with alcohol problems should be excluded from a treatment approach that included caring and compassion because it would not help them to tell the 'truth' about the extent of their drinking problem. As a student nurse I also spent some time at an alcohol treatment unit, where I found myself 'forgetting' to confront the patients' denial, as I was advised to do by the trained nursing staff. When I just listened respectfully to what the patients had to say, I was surprised to find that more often than not they came up with good ideas as to how to stop or reduce their drinking. It seemed to me that people were willing to talk about change if I was willing to listen.

These were key experiences in trying to find an approach to the treatment of problem alcohol users that had two aims. Firstly, it had to be

an approach that was respected and was non-judgemental to what health service users had to say about their own experiences of using alcohol. Secondly, it needed to include a theory of addictive behaviour that had a fundamental belief that change was at least partially achievable through the formation of a person-centred relationship. A person-centred approach seemed a possibility since it assumes that individuals have an innate tendency to grow (change) in order to maximise their potential (Maslow 1968, Rogers 1961) (discussed in the next chapter), achievable through developing a person-centred, therapeutic relationship (Rogers 1957). In addition, person-centred approaches were already familiar to most mental health nurses, since they were adopted as a way of working with those in distress in a revision of the English nursing curriculum of 1984 (Hopton 1997). Yet the founder of person-centred therapy Carl Rogers had not specifically written about treating addictions and I wondered about the applicability of using a person-centred approach in this context.

## **Person-centred approaches to care**

### **Carl Rogers**

In 1951 the psychologist Carl Rogers claimed that in order for therapeutic change to take place in a patient certain 'conditions' (which he had earlier called attitudes and because of its wider recognition this is the term I will subsequently use) had to be demonstrated in a relationship formed by the nurse/therapist. These attitudes became widely known as the 'core' conditions of congruence, unconditional positive regard (UPR) and empathy (Wilkins 2003). Provided these attitudes were present, 'positive change [*to problem behaviours such as harmful drinking*] will occur, regardless of the techniques employed (Rogers 1957:101). Rogers

(1951:384) then went on to argue that these same attitudes should be applied to a variety of situations that involve relationships including the 'learning called education' and because of this he began to refer to it subsequently as the 'person-centred approach' (Rogers 1980:115). This approach is described in detail below. Somewhat confusingly, Rogers used different terms to describe and explain these attitudes and this approach continues today with scholars writing within the person-centred tradition. For example, congruence in the later writings of Rogers is described as being 'transparent,' 'genuine' or 'real,' while Cornelius-White (2007) refers to this condition as being 'self-aware'. Similarly, unconditional positive regard (UPR) is often referred to as 'acceptance,' 'warmth' or 'respect.'

In the person-centred approach people are construed as possessing all of the resources needed to change themselves. The first attitude, congruence is being open to what you are feeling and experiencing at any given moment. The second attitude, unconditional positive regard (UPR), can be conceptualised as being non-judgemental. The third attitude, being empathic, is understood as a willingness to convey to the health service user what the helper senses are the feelings of the person and requires what Rogers (1980) calls active listening. This is an attempt to really understand what the person is experiencing and according to Rogers (1980:116) is '... one of the most potent forces for change that I know.'

This change is theorised to occur because the presentation of these attitudes by the therapist or teacher enables the patient or student to become more willing to listen to and accept their own experiences through a process of reciprocity. The relationship thus becomes a safe place for the person to experiment with the changes being contemplated.

## **Motivational Interviewing**

Motivational Interviewing (MI) is a person-centred counselling style hypothesised to increase the likelihood of change to a patient's problematic behaviour. MI's emphasis is on an empathic style of communication as described and understood by Carl Rogers. A recent definition states that 'Motivational Interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment for change' (Miller and Rollnick 2013:12). It is an attempt by the nurse/ therapist to work with a health service user to help him or her articulate what they want to change and how they would go about making it happen.

A central concept of MI is that health service users are in a state of ambivalence or 'two minds' (I want to...I don't want to) about change and this state is regarded as normal whenever any change is being contemplated. The task of the nurse/therapist then is to explore and resolve this ambivalence, through the formation of a collaborative relationship rather than a confrontational, authoritarian one. In this relationship, a person's own motivation to change would be strengthened by using strategies designed to increase the amount of health service users' 'change talk' (Miller and Rollnick 2002:15). Change talk is any 'self-expressed language that is an argument for change' (Miller and Rollnick 2013:159). A number of ways have been identified to increase the amount of 'change talk' (Miller and Rollnick 2002), including asking open questions about past, current and future behaviour. Questions regarding past behaviour could involve asking whether this kind of change had been tried before and how successful or otherwise it turned out to be. Questions concerning current behaviour could be centred on its perceived advantages

and disadvantages (for example, excessive drinking) and contrasted with the advantages and disadvantages of change (for example, drinking less). Questions in relation to future behaviour could focus on exploring what life might be like if these changes did/did not take place. Asking about the constructs of importance and confidence about change using scales is also a technique often used. So for example, typical questions would be how important is this change to you on a scale of 1 to 10 with 1 being the least important? Also what would you need to do to move your 'score' to a higher number? Similar questions could be asked about confidence. Considering change to be important but not having the confidence to proceed is not untypical of many people facing what to do next (Bandura 1997, 2006). Another technique used to elicit change talk is exploring health service users' goals and values. These are conversations in which conflicts between what people perceive as important (for example 'settling down and having children') are contrasted with current behaviour (such as 'taking drugs to escape'). Exploring these discrepancies can move people in the direction of changing their behaviour. Increasing the amount of change talk has been shown to lead to increases in behaviour change (Amrhein et al 2003; McCambridge and Strang 2004; Baer et al 2008). In this approach, statements made by health service users that reveal a reluctance to change (the 'I don't want to' side of the ambivalence) are met by empathic rather than the more traditional confrontational responses (see below for further detail). Statements about the positive side of change on the other hand are explored further by the therapist ('can you give me further examples').

Being empathic is a central feature of MI and is demonstrated through the skill of reflective listening. By giving time to allow people the time to hear what they said again from someone else can deepen understanding, legitimatise further exploration and improve the quality of the therapeutic relationship (Rautalinko et al 2007; Egan 2009). Evidence for the effectiveness for MI is growing with more than 200 randomised controlled trials and several meta-analyses conducted so far. Small to medium positive effects have been found across a wide range of problem behaviours and illnesses such as drug use and prevention, HIV infection, medication adherence, obesity, diabetes, management of domestic violence prevention and brain injury (Burke and Menchola 2003; Rubak 2005; Knight et al 2006; Apodaca et al 2009; Lundahl et al 2013). MI has been shown to have a positive effect when compared to 'standard' treatment or no intervention and when added to treatments such as cognitive-behavioural therapy (CBT) (Hettema et al 2004; Moyers and Houck 2011). Some trials have shown no signs of effectiveness (Miller and Rollnick 2013) and there is a great deal of variability across different trials and between different clinicians delivering MI, even between different sites of the same trials. There are no trials to date however that are able to show what level of MI therapist proficiency is necessary to effect change, which has implications for training (Madson et al 2008).

According to Miller and Rose (2009) the beneficial effects of MI are a result of 'general' therapeutic factors such as acceptance and empathy (found within the spirit of MI, discussed below), together with a specific factor (the therapist proficiency in eliciting 'change talk'). The general consensus from the wider psychotherapy research is that much of the

variance in client outcomes can be attributable to the amount of empathy displayed by the therapist (Elliott et al 2011; Moyers and Miller 2013). The quality of the therapeutic relationship seems to be important in promoting change but which aspects are more important than others is still a matter of ongoing research. These issues will be explored in more detail in chapter 2.

## **The Spirit of Motivational interviewing**

The Spirit of Motivational Interviewing (SMI) is the 'guiding philosophy' (Rosengren 2009:12) without which MI cannot take place and is considered to be 'the mind set and heart set' of MI (Miller and Rollnick 2013:14). This SMI is also useful as a framework to operationalise the elements of Rogers's person-centred approach, thereby making it potentially valuable for the purposes of training and teaching. What follows is a brief description of the SMI, followed by some of the 'methods' employed in order to practice MI.

The SMI consists of 4 elements, constructs or attitudes; partnership, acceptance, compassion and evocation. The first attitude of *partnership* requires the therapist to establish a relationship with the patient, in which both people are considered equal partners and one where mutual trust, respect and commitment are in evidence. The person is considered an 'expert on themselves' and the helper is seen as a 'companion' (Miller and Rollnick 2013:15). It requires the establishment of rapport and a shared understanding and seeks to meet the needs of the patient or client. It means being non-judgemental and using skills such as open questions, active listening and empathic responding (Tudor and Worrell 2006). This is contrasted with a confrontational approach which is authoritarian, lacks

respect and trust and clearly places 'expertness' to lie with the therapist and not with the health service user.

The second attitude of the SMI is *acceptance* and is conceptualised in much the same way as Rogers understood it (Miller and Rollnick 2013). Acceptance is a word Rogers (1980) used to convey the meaning of unconditional positive regard (UPR), one of his so called 'core' attitudes for change to take place (see below). This is construed in the SMI to have four aspects to it; absolute worth, affirmation, empathy and autonomy. Absolute worth embodies the essence of UPR; it is a fundamental belief in the uniqueness of the individual and that they are worthy of respect and trust. The second aspect of acceptance is the therapist's use of affirmations. These intentional statements by the therapist comment on the strengths of the patient. They involve 'noticing, recognising and acknowledging the positive' (Rollnick and Miller 2013:65). An example would be 'despite all of your problems you have managed to get through this week without drinking.' Alternatively, a more 'global' (generalised) statement such as 'you are a very determined person' could be used. Rogers did not specifically mention the use of affirmations as a way to engage or promote change but they are very much in the person-centred tradition (Rosengren 2009).

Showing acceptance can be demonstrated through the use of the skill of empathy, the third aspect. Empathy is defined as an ability to:

...perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition (Rogers 1975:2).



The 'as if' is added to remind the helper/therapist that the primary focus is the experiences of their health service users and not their own. Miller and Rollnick (2002) state that a practical way to achieve being empathic is to demonstrate the skill of reflective listening. Reflective listening is making a guess in the form of a statement about what the person has just said. It can be simple or complex.

Simple reflection: Client: 'I am drinking too much.' Therapist: 'Your drinking is getting out of hand.' A more complex reflection tries to explore what the client says in a little more depth, often trying to infer meaning. Therapist: 'You have noticed changes to the way you think and feel about your drinking recently.' Using a reflective approach to client speech sends out the message that you are sharing what you thought you heard (Miller and Rollnick 2013) with no attempt to criticise or judge. Reflecting client responses often leads health service users to say that when this happens they feel understood (Shatell et al 2006). Feeling understood is often a prerequisite to instigate changes to behaviour (Elliott et al 2011).

The last aspect of acceptance is a belief in autonomy. It means that a nurse/therapist respects the right of the client or patient to have complete freedom to choose what to do with their lives (Rogers 1961), even if this means continuing with a behaviour that to others is plainly destructive. When attempts are made to restrict choice (for example, when a helper/therapist says to a client 'you must stop drinking') it is not unusual to find people thinking and doing the opposite ('no one is going to tell me what to do') (Karno and Longabough 2005). Autonomy means rejecting assumptions that a nurse/therapist can make people change (Miller and

Rollnick 2013), a view that is common amongst other therapies such as CBT (Westbrook et al 2007).

The third attitude of the SMI is *compassion*, described as 'a willingness to promote the best interests of the other' (Miller and Rollnick 2013:20). There seems to be no agreed definition of what it entails, with several authors pointing to its multi-dimensional psychological and social aspects (Nussbaum 1996; Gilbert 2009; McLean 2012). However, a consensus that it contains two aspects seems to be emerging. It is responding with kindness and humanity together with a commitment to the removal or relief of suffering (Von Dietze and Orb 2000; McLean 2012; Crawford et al 2013). All definitions describe a commitment to act, which for Von Dietze and Orb (2000) is the key element that differentiates compassion from empathy, a process which they perceive as an essentially passive one. There is evidence that psychological techniques have been used to exploit others (Cialdini 2007) and the inclusion of compassion is an attempt to address these concerns (Miller and Rollnick 2013). Although there are many similarities between empathy and compassion this emphasis on 'doing' can be understood as an essential difference between the two, and is a commitment to behave at all times in an empathic manner towards a health service user.

The fourth attitude *evocation* is a conviction that people have much of the knowledge and wisdom already within them to implement change and that the task of the nurse/therapist is to use strategies to 'draw this out.' The SMI is not trying to educate or place information into people; the task is to evoke what is already there. In MI, reasons for changing and reasons for staying the same are assumed to already lie within the individual and

the expectation would be that when this ambivalence is resolved, health service users would go ahead and change on their own accord without further therapist help. This is a finding that has been replicated in several studies with problem drinkers (Edwards et al 1977; Miller et al 1981; Bien et al 1993). This belief in evocation is contrasted with the conviction of other therapies such as CBT that something needs to 'be inserted' into people (for instance skills and knowledge) before change can take place. Arguments for change and not changing (ambivalence) are already assumed to exist within the individual and the task of the therapist is to evoke and reinforce what is already there.

To summarise, the SMI is a set of attitudes that are non-judgmental, empathy-based and collaborative in approach.

### **The SMI, MI and the person-centred approach of Carl Rogers: a comparison**

There are similarities yet important difference between the SMI, MI and the person centred approach of Carl Rogers (see table 1 below). The SMI provides a framework or a set of guiding principles of how a Rogerian, person-centred relationship can be established and maintained. Yet advocates of MI argue that although the attitudes inherent in the SMI are required to form a therapeutic relationship they are not sufficient in themselves to evoke change, a position that Rogers (1957, 1980) would certainly reject. Indeed the stance taken by Rogers that the techniques or approaches to learning and/or therapy are less important than the person-centred attitudes demonstrated by the teacher and/or therapist is supported by two large systematic reviews, one into person-centred teaching in schools and the other into a wide range of different

psychological therapies (Cornelius-White 2007; Elliott et al 2011). These findings will be discussed later in the chapter.

Table 1. Similarities and differences between the SMI, MI and person-centred therapy

Title	The Spirit of Motivational Interviewing (the SMI)	Motivational Interviewing (MI)	Person-centred therapy
<b>What it is</b>	A way of being with a patient. It is a framework consisting of attitudes that underpins the practice of MI	A counselling style that focusses on the <b>skills</b> that promote behaviour change	A way of being with people. It consists of a set of attitudes but is also regarded as a counselling approach in its own right
<b>Assumptions</b>	Building relationships is crucial to achieving change	Using skills that increase patient talk about change leads to an increase in changes to problem behaviour	The presentation of congruence, UPR and empathy is sufficient to lead to change – no techniques are required
<b>Aims</b>	To form a person-centred relationship	To increase the possibility of change to problematic behaviour <b>through</b> the use of techniques	To form a person-centred relationship in order to increase the possibility of change to problematic behaviour <b>without</b> the use of techniques

### **The Spirit of Motivational Interviewing and my clinical practice**

In 1992 I was promoted to a position as a senior nurse in a different but still hospital based alcohol treatment unit. It was in this new job that I was able to introduce changes to the way that treatment was organised and delivered. One of the first changes I made was to ensure that all in patients would receive regular one-to-one counselling sessions. This was added to the traditional, mandatory psychological treatment approach of group

therapy. In these new sessions staff would be allocated several health service users and they would spend time with each one establishing relationships based on the attitudes found in the person-centred approach and subsequently in the SMI. Feedback taken from satisfaction surveys conducted by the staff found health service users were positive about this new way of working, feeling that it complimented group therapy sessions. The consensus was that it was an opportunity in which health service users could discuss and explore issues that were too difficult, painful, embarrassing or stressful to explore in the treatment groups.

Several staff commented on how the changes in their way of working had produced positive results. Being more empathic, respectful and understanding seemed to be linked to changes that ranged from decreases in incidences of aggression and violence to improvements to a range of patient outcomes such as engagement and retention in treatment. Increased motivation to change and reductions in the frequency and duration of relapses were also reported. Interestingly, observations and discussions with the staff revealed that they had changed as well. Being warm, accepting and empathic towards others seemed to increase the likelihood that they would then receive these attitudes in return (reciprocity), a finding that Rogers predicted in his 1957 person-centred approach (further details in chapter 2). However, several staff did point out that this way of working although more satisfying was more exhausting, primarily because of the effort they needed to put into developing a person-centred rapport with patients.

## **Earliest teaching experiences**

On becoming a nurse teacher in 1996 I was initially asked to teach biological sciences and some two years later taught issues around substance abuse. The next section will highlight several features of the experience of teaching both subjects that led me to shift my teaching approach to incorporate the elements of the SMI.

### **Teaching biological sciences**

All students on preregistration nursing courses spend 50 per cent of their time in clinical practice and 50 per cent of their time in university. All must acquire competence in a range of academic subjects including biological sciences, irrespective of whether they work in hospitals or in the community (NMC 2010). I initially delivered lectures on biological sciences to different groups each containing approximately 40 first or second year nursing students. Several challenges were evident from the start. The biological sciences (anatomy, physiology, microbiology, biochemistry and pharmacology) are generally considered 'hard' to learn by nursing students (Akinsanya 1987; Jordan et al 1999; Friedel and Treagust 2005; Craft et al 2013), with success at GSCE and 'A' level proving significant to future results (McKee 2002). Two complaints were common amongst students in relation to biological sciences. First of all many students felt they were expected to know 'too much' concerning these subjects in the first 18 months of a 3-year nurse-training course. Secondly, students felt that learning was hampered by the large number of 'technical' terms in these subjects, exacerbated when they tried to read the recommended textbooks. Unfortunately there is no agreement within the nursing educational establishment as to what depth is required by nursing students in the biological sciences (Jordan et al 1999), with little in the way of

guidance from nursing curricula regarding as to what constitutes competence. This has led to different interpretations in different schools of nursing as to how much, and to what depth biological knowledge is required for a nurse to be deemed competent (Wharrad et al 1994). Although I could do little with the first complaint, I felt that I could make an impact with the latter. I therefore set out to revise the content of the course into language they could understand.

My first change was very modest; I altered my lecture presentation slides so that they had simpler alternatives to the technical language they had complained about. I deduced that reducing the number of words would give me more time to explain the concepts and this would then encourage them to read more around the subject. Disappointingly, some students found this innovation worse, stating that finding time to read was difficult. What they wanted was what they 'needed to know to become a nurse.' As I wanted to 'reach' those who were unable to learn this subject, I decided that an alternative approach was needed. Before contemplating change I began to identify and then reflect on what assumptions I was making when I was teaching, greatly helped by reading 'On Becoming a Reflective Teacher' by the adult learning theorist Michael Brookfield (1995). Brookfield argues that that much of what is understood as teaching and learning rest on unexamined assumptions about its nature. These assumptions are the 'taken for granted beliefs about the world and our place in it' (Brookfield 1995:2) and subjecting them to a process of critical reflection is thought to lead to new ways of thinking, feeling and acting (Fook et al 2006). Being critically reflective is considered to be the first stage of a change to attitudes, values and beliefs, so called transformative



learning (Mezirow 1997). This process of reflecting on practice in order to change practice is also a fundamental aim of Action Research, the research methodology of choice for this study.

Examples from my own practice of these unexamined assumptions would be that good teaching is a function of your ability to form relationships with students and that role plays are the best way to learn to develop skills such as empathic responding. For the first time I started to identify, examine and subsequently revise several of my perspectives on teaching and learning. The assumption that my role was to 'fill up' 'empty' students with knowledge was the first to be scrutinized. I had also assumed that because of the difficulty expressed by some students about biological sciences, my initial task was to exercise control of the space in which I taught. This was based on the assumption that the more they could listen attentively the more they would learn, one that went unchallenged for most of my early teaching career.

I then went through a process where I objectified what I thought I did when I taught in the hope that this process would reveal a way forward. The biological sciences sessions consisted of information presented on 20–30 transparencies and lasted 2–3 hours. All of this information would be read out using repetition and summarisation as ways to reinforce it. I would always ask if they understood. Some would nod, some appeared bored, some disinterested, the odd student seemed hostile. I did not spend time recalling their nursing experiences on the grounds that it rarely matched the subject under discussion and that few in any one student group would have had similar clinical experiences at any one time. My own clinical experience as a mental health nurse gave me limited opportunities to care

for people with physical problems so sharing relevant clinical experiences when teaching biological sciences was rarely possible. Very few sessions left me satisfied that much meaningful learning had been achieved. It seemed that my teaching had reached an impasse.

Each subject within the biological sciences was evaluated at the end of the module, some 15 weeks later. Student evaluations revealed that the students blamed teachers and themselves in roughly equal measure for experiencing difficulty in learning this group of subjects. Discussions with colleagues as to why students were struggling with learning focused primarily on two, conflicting aspects. The first was successive curriculum changes, reflecting the expectation that nurses should have more scientific knowledge and secondly the drive to widen participation. Several lecturers thought that many students would now struggle to learn as an inevitable consequence of not having the basic qualifications or background in the sciences. Yet this argument seemed to exonerate the teaching and to apportion all of the blame for not learning on the students, an argument that seemed somewhat unconvincing. Students did seem to blame themselves, with phrases like 'not being clever enough' sometimes heard when discussing their own personal failings with this subject. I interpreted this concern as an opportunity for innovative teaching.

## **Teaching substance misuse**

In 1998 after approximately 2 years as a nurse teacher, I started to teach pre-registration nursing students about the problems facing people who have issues with drugs and alcohol. I initially adopted similar teaching strategies to the ones used in teaching biological sciences but with one crucial difference. In these sessions I was able to illustrate the 'facts' about an issue (for example, symptoms of alcohol withdrawal) with my own clinical stories of some of my perceptions of the problems that health service users experienced when detoxifying. This sharing of my clinical experiences seemed to be the catalyst that brought about quite dramatic changes in the teaching environment. Some students seemed far more engaged (witnessed primarily through non-verbal changes such as leaning forward, facial expressions and increased eye contact), when I told stories about some of my experiences as a nurse working with people with alcohol problems. The number of students was much the same as when I was teaching biological sciences and the methods of delivering the information were similar but the difference was clearly my degree of participation. Some students reacted by sharing stories from their own clinical practice, a development I had never witnessed before. Adding my own clinical experiences to the teaching seemed to enable some to tentatively share their own clinical anecdotes. The way I reacted was the key to what happened next; when I responded to student stories with the person-centred attitudes inherent in the SMI such as acceptance and empathic responding, further debate and exploration of the subject happened more frequently. Using these attitudes seemed to serve as a way to interact with

other students; they began to react not only to my clinical stories but also to the stories of others.

The learning climate changed from a largely passive, one-way movement of information from teacher to student to a dynamic, multi-directional activity in which other students were seemingly more involved in their learning. Although the sharing of my clinical experience appeared to be the trigger for this increase in students contributing to their own learning, the crucial element appeared to be how I reacted to their stories. Communicating in the way that is compatible with the SMI looked as if I was able to validate and authenticate their experiences, which subsequently appeared to increase their motivation and eagerness to learn.

Yet it soon became apparent that using a teaching approach that is compatible with the SMI needed an awareness of group processes. An in-depth discussion of group dynamics is outside the scope of this thesis but this approach to teaching would need to acknowledge and work with the dynamics that operate in all groups, whether these groups consist of health service users, work colleagues or students (Yalom 1970; Forsyth 2009). Successful group development relies on developing a commitment to the group (cohesion) itself based on each of the members feeling safe and supported (Wagner and Ingersoll 2013). Using the SMI in teaching sometimes resulted in what seemed a competition by the students for my attention. This is a recognized phenomenon in groups (Wright 1989) and is often a result of fears that their contributions are being judged with issues of competence and expertise at stake (Wagner and Ingersoll 2013). Summarising these contributions and finding commonalities such as the

need to treat health service users as individuals as a way to promote recovery increases group cohesiveness. Yet issues of power, avoidance, control, dominance and conflict are never far away from influencing the ability of a group to work together (Cranton 2006) and therefore needs effective management by the teacher.

An important task then of the teacher is to develop group cohesiveness, seemingly achievable through teaching in a manner that is consistent with the SMI. Using the skills inherent in a person-centred approach encourages the development of a dialogue via the telling of teacher and student experiences. The teacher acknowledges and reacts to the emotional component of these student experiences and encourages other students to do the same. Accepting their individual views promotes engagement and participation (Rogers 1969; Ironside 2006) making it easier to accept the views of others. This increases their sense of being an active member of the group, which in turn tends to increase faith and belief in its processes (O'Hara 2003). Increasingly, students begin to believe that the group is a safe place in which their unexamined attitudes and perspectives can now be scrutinised, the first stage of transformative learning (Mezirow 2000). Transformative learning is a process in which assumptions, values and attitudes are challenged 'in order to make them more inclusive, discriminating, open, reflective and able to change' (Cranton 2006:236). The evidence base for both the SMI and for transformative learning is part of the literature review in chapter 2 not least because it is theorised that an adapted version of the SMI is able to promote this change in assumptions, values and attitudes.

When I reflected on these experiences, it was difficult not to come to the conclusion that student involvement in the sessions had increased. Using person-centred, therapeutic skills such as empathic responding and being non-judgemental (showing acceptance) seemed to amplify and reinforce this process. This combination of using these skills and bringing my own personality and experience into the lecture theatre was the start of a process of change to my understanding and practice of teaching. I had been re-examining my assumptions about teaching, the first stage of Mezirow's (2000) transformative learning process. This process involved periods of critical self-reflection, recognised as a way to develop greater self-awareness (Bulman and Schulz 2013). Despite the lack of a universal definition for self-awareness it is understood to have several features in common. It is:

a multidimensional, introspective process used to become aware of, scrutinize, and understand one's thoughts, feelings, convictions, and values on an ongoing basis, with the use of this understanding to consciously and authentically guide behaviour (Eckroth-Bucher 2010:43).

Self-awareness is thought to lead to more effective interpersonal relationships (Kondrat 1999) and greater insight into how one's own values, attitudes, prejudices and assumptions impact on others. As I engaged in reflective practice, new pedagogies of learning began to develop, based on my clinical experience. These new pedagogies were and are still characterised by an interpersonal, reflective, skills based, relational approach to the process of teaching and learning (Conklin 2008) which according to Rogers (1951) can be created using the same conditions

needed for therapy namely, congruence, unconditional positive regard (UPR), and empathic responding (O'Hara 2003). Apart from congruence, these attitudes are all part of the SMI.

These new pedagogies were not restricted to the teaching of substance use. I was initially more reluctant to use this approach in the teaching of biological sciences feeling that it had less application in subjects that are characterised by the acquisition of 'hard facts.' However, when I began to incorporate this approach to the teaching of biological sciences to my surprise the opposite seemed to be the case; adopting a relational approach to teaching a subject that is defined by most students as hard seemed to galvanise them, especially when I shared my own feelings of the difficulties I experienced when learning this subject. The key strategy that appeared to engage the students in learning seemed to be an acknowledgement of its difficulty, the sharing of my own issues with the subject and a discussion of what to do to overcome these problems.

The teaching of values has proved difficult since nurse training moved to universities in the 1980's and 1990's (Griffiths et al 2012). This is chiefly because of curriculum change that emphasised the acquisition of skills but also because using the traditional method of role modelling to transmit these values was proving problematic to achieve in classes that could now reach 400. Yet the importance of instilling values such as respect, dignity and compassion has remained a constant feature of the standards required to become and maintain nurse registration (NMC 2012, 2015).

When student nurses finish their course they are trained to be able to assess, plan, implement and evaluate person-centred care (Nursing and Midwifery Council, NMC 2002, 2010), which incorporates the

aforementioned values. Consideration will now be given to whether changes to the content and delivery of nurse education are responsible for the marginalisation of the teaching of these values. The implications of these changes for practice will then be considered. This section will also consider how teaching in a way compatible with the SMI might be capable of restoring these values to a central place in the nurse curriculum.

## **Changes to the content and delivery of nurse education**

Caring is a complex construct which some have argued has three aspects; the possession of competent technical skills, high levels of interpersonal sensitivity and the ability to display these through the formation of relationships based on Rogers's 'core' attitudes (Griffiths et al 2012; Fingelt-Connett 2008). Being able to care is often used as the hallmark of what it means to be a 'good' nurse (Griffiths et al 2012). Nurse teachers and nurses (especially ward sisters and charge nurses) have had a long tradition of using role modelling (Bandura 1977, 1982, 1986; Donaldson and Carter 2006) as a way to convey expected standards of professional conduct, including the complexities of caring (Griffiths et al 2012). It still has some currency as a teaching method in the health care professions (Johnson and Pratt 1998) but discussions with colleagues revealed that fewer and fewer nurse teachers are using this approach. The reasons for this are complex but changes to the way knowledge was conceptualised by those responsible for developments of the preregistration nursing curriculum in the 1990's may be significant (Scott 2008).



The rationale given for the move into higher education was its desirability as an ideal environment in which students would be best able to develop and enhance their critical thinking skills. This was considered vital for developing independent practitioners in health care (Watkins 2000; Watson 2006). Some have argued though that these changes led to a shift away from teaching students how to engage and relate to health service users to an approach to nursing where the emphasis was on acquiring specific psychomotor skills such as the measurement of temperature, pulse, respiration and blood pressure (Winskill 2000; Cowan et al 2005). Others claimed that this change of focus played a major role in the neglect of the teaching of values (Watson et al 2002; Finfgeld-Connett 2008; Griffiths et al 2012). As a consequence, some have argued that an inevitable consequence of the pursuit of greater professional status when nursing became an all-graduate profession would be a less compassionate and caring nursing workforce (Scott et al 2008; Griffiths et al 2012).

### **The importance of role modelling**

Recent recommendations to changes in the preregistration nurse curriculum have reinforced that the education of nurses needs to be based on professional values such as empathy based care as well as knowledge and skills (NMC 2010). How this teaching of values is achieved in nurse education settings is open to debate but role modelling has traditionally been used to achieve this objective (Felstead 2013). Role modelling is the ability to learn from observing others and is dependent on factors such as the extent to which there is a relationship between the teacher and learner, student motivation, the perception of how useful the learning is, and the

confidence the student has in their ability to achieve what is being role modelled (Bandura 1977). Initiating, establishing and developing person-centred relationships with students based on the principles inherent in the SMI is able to demonstrate values such as respect dignity, empathy and compassion. Using the SMI in a teaching approach is therefore able to role model these same values.

Many of the lecturers interviewed however, felt that role modelling was much more effective as a vehicle for the transmission of values when class sizes were small and therefore somewhat difficult to achieve in large lecture theatres. In addition, if the effectiveness of role modelling is indeed associated with the quality of the relationship that has been formed with students (Atack et al 2000), larger class sizes makes this more difficult to achieve. Curriculum changes to reflect the growing desire to become an all graduate nursing profession emphasised intellectual over emotional development, a change that has been blamed by some as the reason why the teaching of professional ways of behaving has declined (Carr 2007).

On the other hand, the notion that the raising of academic standards is incompatible with person-centred values seems unlikely. There is likewise little research on the impact that large cohorts and different teaching approaches have had on the ability of nurses to deliver high quality, person-centred, evidenced-based care. The move to universities has led to a disconnection for some nurse teachers between theory and practice (Rolfe 2012). Whether the clinical setting is currently able to influence the attitudes and values of nursing students positively is still a matter of debate, given that senior nurses have been given more managerial responsibility. This means that their traditional role of modelling standards

of care is more difficult to achieve. Moving nurse education to universities has meant that nursing students now spend less time in clinical practice than they used to. In addition, most qualified staff spend much less time in direct patient contact than ever before (Maben et al 2007) and therefore nursing students are much more likely to witness the delivery of care from unqualified health care assistants. This is potentially problematic because these health care assistants are often poorly trained and many focus on tasks such as eating and drinking, mobilising and eliminating. This focus on a task-based rather than on a person-centred approach does not acknowledge the uniqueness of the individual (O'Driscoll et al 2010), which many health service users describe as dehumanising (Griffiths et al 2012). Given the power of role modelling to influence subsequent behaviour (Bandura 1977; Davies 1993), exposing students to a system of care that emphasises performance over needs has been identified as a possible contributory factor in the neglect and abuse of health service users (Royal College of Nurses, RCN 2002).

Some students complained that attitudes such as compassion, understanding and fairness, deemed essential qualities when they qualify as nurses (NMC 2002, 2008) were in short supply from some of their teachers. I wondered to what extent the traditional lecture format of teaching was partially to blame for this apparent disengagement from learning. I had personal experience of health service users responding positively when an individualised approach using the person-centred attitudes of the SMI was introduced into a treatment unit for dependent drinkers. I had also witnessed as a clinician that engaging and treating health service users using these attitudes seemed to tap into their own

resources regarding hope and optimism towards positive change, a finding that has found some support in the research (Snyder 1994; Yahne and Miller 1999).

### **Implications of teaching in a way that is compatible with the SMI**

Teaching in a way that is compatible with the SMI seems able to model attitudes such as self-awareness, acceptance and empathy, theorised to occur through a process of reciprocity. Reciprocity thrives when a person-centred relationship is established, developed and maintained (Rogers 1980). Whenever health service users and students are asked how they would like teachers and carers/therapists to behave towards them similar findings emerge. They want to feel respected, accepted for who they are (being 'cared' for) in a warm, trusting climate that highlights their strengths (Miller and Rollnick 2002; Cranton 2006), irrespective of the teaching/therapeutic approach employed. It seems that health service users want relationships with staff who they perceive to be genuine, empathic and non-judgmental (Kirschenbaum and Jourdan 2005; Elliott and Friere 2009). There is research that indicates that nursing students would also welcome their nurse teachers to show a caring attitude towards them (Gillespie 2002, 2005; Griffiths et al 2012).

An individualised approach to therapy using person-centred principles seems to increase the likelihood of attitudinal change (Rogers 1951; Baldwin et al 2007). Moreover, attitudinal change is considered a worthwhile goal of education (Rogers 1951, 1961; Cranton 2006). I therefore wanted to investigate whether the changes I had brought to my teaching as a result of incorporating the SMI were more likely to increase

the likelihood of my students becoming more willing to learn. I also wanted to know if they would subsequently become more caring and compassionate towards their health service users. No research as far as I know has evaluated the use of the SMI in teaching. Person-centred principles inherent in therapy and education proved to be hugely influential in generating some thoughts and ideas towards developing some theoretical perspectives for this thesis. My clinical experience regularly confirmed that when I engaged with health service users in an accepting, respectful, caring and empathic manner I witnessed positive changes to their attitudes, values, beliefs and behaviour. This change did not only occur towards the target behaviour of excessive alcohol use, but also towards how they felt and thought about themselves and how they interacted with others.

When teachers are genuine, accepting and empathic, students seem to become more accepting and empathic towards themselves in response to the presence of this facilitative climate (Rogers 1961; Foster 2008). The experience of being 'cared for' seems to make it easier to be kinder to oneself and reciprocate these attitudes and values to others. I reasoned that if students could make some progress towards this goal of becoming 'fully functional,' (a process which Rogers (1969) argues is the ultimate function of education and in which caring for themselves is an integral part) then a consequence might be that they would be more likely to treat health service users in the same way. This is significant because there is some evidence that nurses view values such as caring and compassion with less importance than they once did (Fingelt-Connett 2008). Motivation to learn is associated with a sense of belonging (Maslow 1954) and belonging is a

function of a demonstration of caring (Chhuon and Wallace 2014). Students it seems want teachers to show that they care about them (Conklin 2008). Whether nurse teachers failing to demonstrate caring attitudes towards their students (real or imagined) has had knock-on effects on their health service users is not known but role modelling these attitudes and values seems to be less common in nurse teaching than it once was (Carr 2007). Whether this is true is open to debate, but what is undeniable is that role modelling in order to 'teach' caring behaviours in nursing has changed. As a student nurse I had incorporated these values into my practice principally through observing teachers and clinicians. It seemed that opportunities for current student nurses to do likewise were fewer for the reasons outlined above. I therefore wanted to find out whether a change in teaching approach could be the way forward to achieve this aim.

## **Aims of the study**

My experiences as a nurse working with patients dependent on alcohol and those from teaching nursing students proved to be significant in developing ideas as to what I wanted to achieve in this research.

The variances regarding health service users' outcomes when they experience illness and/or problems are linked more to the extent to which a therapist engages in a relationship based on empathy, respect and trust than on the type, duration or intensity of treatment (Elliott et al 2011). These constructs are the essential elements of the person-centred approach. Person-centred approaches have been advocated in education as a way to engage and improve student outcomes in learning (Cornelius-White 2007). Concern has been expressed over the perceived lack of

values such as acceptance, autonomy, compassion and caring in nurses (Royal College of Nursing 2010; Francis 2013) and the difficulties in role modelling these values in nurse education (Baldwin et al 2014). Changes to attitudes, values and beliefs are the goals of transformative learning but current perspectives need to be explored through a process of reflection before change can take place (Mezirow 2000). Reflecting can arouse feelings of fear and anxiety and is therefore best achieved within the safety created by a teacher who uses person-centred principles. Being congruent or self-aware (one of the 'core' attitudes in Rogers' person-centred approach) encourages the teacher to share clinical stories; this sharing has the effect of encouraging students to share their experiences. This can create a safe environment in which to examine the 'distortions, prejudices, stereotypes and simply unquestioned or unexamined beliefs' (Cranton 2006:23) that make up our attitudes. Employing the elements of the SMI (partnership, acceptance, compassion and evocation) in teaching gives students opportunities to witness and practice this 'way of being' (Miller and Rollnick 2002:34). Using the SMI is therefore a way to adopt attitudes that become 'more inclusive, discriminating, open, reflective, and emotionally able to change' (Mezirow 2003:58-59), the goal of transformative learning.

Role modelling is a powerful predictor of behaviour change in health service users and its significance in the development of personality is a central principle of social-cognitive models of learning (Bandura 1977, 1991; Zimmerman and Schunk 2001). Similarly in teaching, modelling by teacher educators has been shown to be a powerful influence in how teachers' trainees end up treating their students (Loughran and Berry

2005; Lunenberg et al 2007). I believed I was already teaching using the SMI in teaching and my initial thoughts were that I was getting 'results,' in that students acted as if they were engaged in the learning process. The atmosphere in the room when I used this approach often felt transformed; the students were not only asking me questions but responding to those from their colleagues. They also began to share and comment on their clinical experiences. The students appeared to have moved from a largely passive approach to their learning to one where this learning was now characterised by participation, energy and enthusiasm.

As far as I am aware, the SMI has not been formally used in an educational setting. This spirit recognizes that attitudes/values such as collaboration, compassion, acceptance, autonomy and evocation need to be established before changes to problem behaviour in health service users can be tackled.

When I decided to embark on this research my aims were to:-

- Examine whether changing my approach to teaching would affect student attitudes towards their learning.
- Explore whether the teaching styles of my colleagues incorporate the elements of a person-centred approach.

The remainder of this thesis is structured as follows. The second chapter reviews the literature on the SMI, MI, theories of adult education and its relationship to person-centred approaches to teaching. My thoughts and feelings about using these are also included here. The third chapter focuses on action research as the chosen research methodology, describing the essential characteristics of the participants in the study and the data collection instruments used. The fourth chapter presents an analysis of



teacher and student data about their experiences of teaching and learning when I used the SMI in teaching. The fifth chapter discusses the implications of these findings not just for nursing students but for students as a whole. The sixth and final chapter highlights the flaws and weaknesses of not just all aspects of the research process with a view to how it could be improved in the future, but also some of the assumptions inherent in the person-centred approach to teaching and learning.

# **Chapter 2 - Literature Review**

## **Background and Rationale**

This review will critically examine a range of literature concerning the use of person-centred approaches both in therapy and in education and its ability to instigate change. The essential elements that make up the clinical strategy, the Spirit of Motivational Interviewing (SMI), were described briefly in chapter 1. However, given its centrality to this thesis, this chapter will begin by critiquing its four constructs (partnership, acceptance, compassion and evocation). Since the SMI is based on the person-centred approach of Rogerian therapy, its component parts and the theory as a whole will also be described and critically analysed. Empathy and acceptance are constructs often found in mainstream psychotherapy research, and since Rogers (1980) believed that the demonstration of these attitudes has relevance for teaching, this literature will therefore be examined. Several adult learning theorists besides Rogers consider changing attitudes to be crucial to the process of learning (Knowles 1984; Brookfield 1995; Mezirow 2000; Cranton 2006) and as a result these theories will be described and critically analysed. In my research, class size was described as an issue by several of the lecturers interviewed who advocated a collaborative learning approach, so this literature will be critically evaluated also.

My experience of using the SMI in my teaching reinforced the belief that being congruent ('being self-aware') is essential yet not covered explicitly in this framework. Therefore the adaptation of the SMI to include self-awareness for the purposes of teaching will also be described in some detail. References will be made throughout the chapter concerning the

extent to which these concepts are applicable to my own teaching and compatible with the aims of nurse education.

## **The Spirit of Motivational Interviewing**

### **Partnership**

Partnership is the first element of the Spirit of Motivational Interviewing (SMI) and is understood as the initiation, establishment and maintenance of a collaborative relationship by the practitioner with the health service user. Being collaborative encourages the establishment of rapport, allowing the attitudes for trust to develop between therapist and patient or client. Skills such as the use of open questions, active listening, being non-judgmental and empathic are considered essential for this rapport to flourish (Wilkins 2003). However, several scholars have corroborated the assertion from Rogers (1957) that successful therapy requires the establishment of the attitudes associated with person-centred relationship formation, and has little to do with techniques (Sexton and Whiston 1994; Bozarth 1997; Wilkins 2003; Hibbard et al 2007). Likewise, positive relationships with teachers are also associated with improved academic and motivational outcomes in students (Goodenow and Grady 1992; Meece et al 2003; Cornelius-White 2007), irrespective of the pedagogical approach used. Conversely, when person-centred attitudes were absent in student relationships with teachers, motivation and achievement were reduced (Murdock 1999; Frieberg and Lamb 2009), and found to be a significant factor in dropping out from school (Fine 1991).

Engaging with students is a prominent feature of student or learner-centred approaches to learning (Harden and Crosby 2000). Although there is an ongoing debate as to what constitutes student-centred learning,

O'Neill and McMahon (2005) argue that it is characterised by an inquiry based, cooperative, process rather than content approach to learning, and one which they claim is capable of developing critical thinking. This way of teaching also perceives the student as an equal, active partner in the learning process (Brandes and Ginnis 1986; Gibbs 1995; Burnard 1999; Cornelius-White 2007), a feature that interested me very much in the development of ideas for this thesis.

The importance of the element of partnership found in the SMI for teaching was confirmed in my interviews with nurse teachers. All those interviewed for this research were in agreement about the importance of forming relationships based on trust and acceptance (the second element of the SMI) when teaching; for example Helen, an adult teacher of several years' experience saw 'teaching as engagement,' whilst forming relationships were crucial to Joyce, an adult nursing lecturer, so that they would be 'wanting to hear what I have got to say.' Helen, a mental health teacher I interviewed, called it a willingness to share your own experiences ('being congruent') in the promotion of learning.

### **Acceptance**

Acceptance is the second attitude of the SMI (Miller and Rollnick 2013) and as mentioned in chapter 1 consists of absolute worth, affirmation, empathy and autonomy. This attitude reveals a fundamental belief in the uniqueness of human beings and their right to make their own decisions (Wilkins 2003). What is striking is that much of this language is found in the Standards for Pre-registration Nursing Education (NMC 2010). The first paragraph of this document describes nurses as people 'who practice autonomously...[who are] responsible and accountable for safe,

compassionate, person-centred, evidence-based nursing that maintains dignity and human rights' (NMC 2010:22). This clear statement of the importance of a person-centred approach to care by the governing body of nursing in the UK puts the onus on educational institutions to ensure that student nurses qualify with these values and skills in place.

Research evidence on the presence of acceptance for successful therapeutic outcomes is considerable (Bozarth 1998; Wilkins 2003; Elliott and Friere 2008) as is the research on the conveying of acceptance or caring for the facilitating of learning in schools (Elbaz 1992; Goldstein 2002; Noddings 2005). Nevertheless, the findings have to be interpreted with some caution, given that sample sizes were often small and the ever present difficulty of extrapolating from correlation studies. Teacher acceptance (conceptualised here as 'warmth,' a willingness to be non-judgemental) in the meta-analysis on school teaching conducted by Cornelius-White (2007) had the second largest association with increases in academic and motivational learning outcomes after empathy ( $r=.32$ ), indicating a 'moderate' relationship between the two variables (Cohen 1988). Students felt better about themselves, socialised more, felt more motivated and achieved higher grades when they perceived that the teacher cared about them (Birch and Ladd 1997; Noddings 2005).

Transformative learning is a multi-stage process in which attitudes, values and beliefs are re-evaluated to ascertain if they have merit and worth (Mezirow 1997). An important part of this process is critically reflecting on experience (see below) which according to Brookfield (1995) is a process where taken for granted assumptions are questioned and challenged, leading to the development of a new perspective. This new

perspective can not only change attitudes but is thought to lead to changes in behaviour (Mezirow 2000). Promoting an atmosphere in which transformative learning can thrive requires the teacher to create and maintain an environment in which person-centred attitudes such as acceptance are operating (Cranton 2006). Assumptions about what it is to mean for example to be a student nurse can then be articulated and contested by other learners in this safe, non-threatening climate. This could then develop into a discussion of the power imbalances that exist in educational nursing institutions and clinical practice and how they may or may not impact on learning.

Interacting with nursing students in an empathic, acceptant and congruent manner was a transformational process for my teaching. When students became aware that the voicing of their views, feelings and opinions were not only being encouraged by me but also not judged, it seemed to dramatically change the teaching and learning climate. It seemed to me that the way I was teaching was still the same in a pedagogic sense but what had changed was the way I was trying to relate to the students. It appeared to substantiate that 'students desire authentic relationships where they are trusted, given responsibility, spoken to honestly and warmly, and treated with dignity' (Poplin and Weeres 1994:20). The key to the process seemed to be communicating in a caring, empathic way, refraining from judging their comments and acknowledging their individuality through the formation of person-centred relationships.

## **Compassion**

Another dimension of the spirit is compassion, a willingness to ensure that the therapist acts so that the interests of the health service user are the primary focus of the intervention. Gilbert (2009) maintains that compassion has a motivational aspect to it since it requires engagement, empathy and a commitment to think, feel and behave in ways to alleviate the suffering of others. Von Dietze and Orb (2000) claim that because of this commitment to act, compassionate care allows the care-giver to reflect on the implications of its delivery. Reflecting on nursing practice is considered an essential activity in order to achieve lifelong learning (NMC 2010) and evidence of its use has now become a requirement of the revised code of conduct for all registered nurses (NMC 2015).

Compassion involves not only 'developing understanding for others but also bringing attention to the social conditions that lead to suffering' (Conklin 2008:664). Conklin (2008) asserts that an awareness and understanding of the role that a student teacher's experience and background plays in forming attitudes is vital in order to change. An example here would be disadvantaged students experiencing negative attitudes from others. The way in which this is achieved is important; Conklin (2008) asserts that change only occurs when people are exposed to relational teaching approaches that emphasise acceptance and respect rather than confrontation and derision, a sentiment that many person-centred therapists would endorse (Wilkins 2003; Tudor and Worell 2006; Mearns and Thorne 2007). Nurses have always been expected to be compassionate in their delivery of care (NMC, 2010). This position was reinforced through the publication of the document 'Compassion in

Practice' (DH, 2012) produced in part as a reaction to the poor care and neglect exposed in the recent past both at Winterbourne View (a care home) and at Stafford hospital, run by the Mid Staffordshire NHS Foundation Trust. The values of care, compassion, communication, commitment, competence and courage ('the 6C's') became recommendations for all health care staff to adopt when they come into contact with health service users (DH 2012, 2014).

## **Evocation**

The final aspect of the 'spirit' is evocation, the belief that the person has all of the resources and motivation needed to effect change. This approach is contrasted with most models of therapeutic change, which have an underlying belief that something is missing from the patient which an expert needs to 'insert.' An example here would be the use of cognitive-behavioural therapy which believes that what lies at the heart of many patient problems is 'thinking errors,' requiring therapist guidance to be 'corrected' (Scott 2009). In contrast, using the SMI assumes that the patient has 'a deep well of wisdom and experience from which the counsellor can draw' (Miller and Rollnick 2013:21). This is an assumption that is central in person-centred approaches and is fundamental to the spirit and practice of MI (Miller and Rollnick 2013). According to MI, when health service users are prevaricating about changing destructive behaviours they are assumed to be in a state of ambivalence about change. The therapist assumes that arguments for change and arguments for staying the same are often well rehearsed and already dwell within the individual. The task then of the therapist is not to convince the person of the rightness or otherwise of their decisions to carry on or change their



behaviour but to utilise skills and expertise in order to allow scrutiny of what is already present. Given that this view perceives the person 'as skilled, knowledgeable and insightful enough to create change' (Curtin and Trace 2013:85), the task of the nurse/ therapist is then to use the SMI so that this 'wisdom' can emerge. Similarly, one of the assumptions of student-centred teaching is that the learner has all of the resources needed for learning (Gibbs 1988) and that the teacher's role is to create the attitudes that allow these resources to appear and then flourish (Huba et al 2000; O'Neill and McMahon 2005). The next section will now describe and examine the person-centred approach of Carl Rogers.

## **The person-centred approach of Carl Rogers**

The person-centred approach of Carl Rogers has been hugely influential in the development of Motivational interviewing (MI) and the spirit of MI, the set of principles to how engagement and treatment should proceed. However its worth pointing out the the spirit of MI does not include all of Rogers's attitudes, which he claims have to be in place before therapeutic or indeed educational change can occur.

Rogers (1957:96) claimed that six attitudes (which he originally called 'conditions') are necessary and sufficient for change to take place irrespective of which therapeutic approach was being used. These attitudes are as follows:

1. Two persons are in psychological contact.
2. The first person, whom we shall call the client, is in a state of incongruence, being vulnerable or anxious.

3. The second person, whom we shall call the therapist, is *congruent* or integrated in the relationship.

4. The therapist must experience *unconditional positive regard* (UPR) for the client.

5. The therapist experiences an *empathic understanding* of the client's internal frame of reference and endeavors to communicate this experience to the client.

6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

Rogers (1957) stated categorically that only these six attitudes were necessary for change or learning to take place. Because the first two are taken for granted when a therapist meets a health service user, attitudes 3, 4, and 5 are often referred to as 'core,' although Rogers rarely used the term himself. When exposed to these attitudes the person:

sees themselves differently..., becomes more flexible [*and*] self-confident and self-directing ..., more accepting of feelings ..., more accepting of themselves and others ..., behaves in a more mature fashion ..., changes behaviours such as chronic alcoholism ..., [*and*] becomes more open to the evidence' (Rogers 1961:280).

The next section will go on to describe and critique Rogers (1957) 'core' conditions of congruence, UPR and empathy. The purpose is to determine if they are indeed necessary and sufficient for therapeutic or educational change to transpire. This will then be followed by a critique of the whole approach itself since these conditions are rarely used in isolation.

Congruence is being 'yourself' in the relationship with the client whatever that 'self at that moment may be' (Rogers 1959:214). Rogers (1980) also called this condition being 'real' 'transparent' or 'genuine' and contrasted it with wearing a professional front; 'to act one way on the surface when I am experiencing something quite different underneath' (Rogers 1961:17). According to Baldwin (2013) it is an essential ingredient in all therapeutic encounters. Congruence is given a central role in Rogers' (1957) theory, since without the client perceiving you as willing to express the feelings that you as the therapist are experiencing ('being genuine'), the delivery of UPR and empathy becomes difficult to imagine (Haugh 1998; Bozarth 1998). Rogers (1959:240) points to the importance of being congruent for change to occur; the more often congruence is demonstrated the more likely the other person will reciprocate with the same qualities, leading to both parties experiencing 'improved psychological adjustment, functioning and satisfaction in the relationship.' Yet the construct is controversial since the lack of a consistent definition (Irving and Dickson 2004) makes it difficult to research. Masson (1988) claims that there is no way of knowing whether a therapist is being genuine with a client and therefore doubts that this condition has any usefulness in promoting change.

A recent meta-analysis by Kolden et al (2011) of 16 studies on therapist congruence found an effect size of .24, regarded as 'small' (Cohen 1988) but still considered an important aspect of forming therapeutic relationships. However, these findings and therefore the overall effect size in the meta-analysis need to be interpreted with some caution, since several of the studies had small sample sizes. For example, the studies of

Fretz et al 1966, Stables and Sloaone 1976, Melnick and Pierce 1971, (all cited in Kolden et al 2011) had sample sizes of 17, 18 and 17 respectively, with only one study in the review (Athay et al 1974) with a sample size larger than 100). In addition, researchers in some of the studies (Hansen et al. (1968); Jones & Zoppel (1982); Melnick & Pierce (1971) cited in Kolden et al (2011) had varying levels of experience and training in data collection and analysis. Kolden et al (2011) themselves point to a lack of Randomised Controlled Trials (RCT's) on congruence as a potential weakness in the studies undertaken so far. However, RCT's are not able to reveal which health service users will benefit directly from an intervention since they are designed to increase the internal rather than the external validity of the research under scrutiny (Robson 2011). Moreover, they rely on 'blindness' with either one or both of the researcher and participant unaware of who is in the control or intervention group. This is important because this type of trial, often regarded as the gold standard of research in terms of deciding the effectiveness of an intervention, would be difficult or almost impossible to do in an educational setting (Goldstein and Blatchford 1998).

Turning to the field of education, congruence on the part of the teacher in schools was shown to be linked to improvements to learning outcomes such as participation, satisfaction, motivation to learn, self-esteem, IQ and grades in the meta-analysis conducted by Cornelius-White (2007), although it was deemed to be less important than a teacher adopting UPR and empathy.

### **Unconditional Positive Regard**

The second 'core' condition is showing unconditional positive regard (UPR) towards a health service user. Rogers (1957, 1980) used other words to describe this condition such as 'acceptance,' 'prizing,' 'warmth' or 'caring.' It is being non-judgmental and is underpinned by a fundamental belief that the thoughts, feelings and opinions of the person are worthwhile (Rogers 1980). Rogers (1980:208) called it a 'key construct,' and it is one of the attitudes (labelled as 'acceptance') found as part of the SMI.

The findings from reviews of research undertaken on UPR have been somewhat ambivalent. Some have shown a positive association between therapist UPR (here conceptualised as 'warmth,' see above) and client outcomes (Truax and Carhuff 1967; Orlinsky and Howard 1978), whilst others showed no association (Mitchell et al 1977; Orlinsky and Howard 1986). In a recent meta-analysis of 18 studies investigating a potential association between client outcomes and therapist positive regard (Farber and Doolin 2011), an average effect size of .27 was found, regarded as 'small' (Cohen 1988). However, as with the papers on congruence, small sample sizes, wide variations in outcomes and a lack of RCT's makes it difficult to make any firm conclusions about the extent to which UPR is important in client outcomes. Nevertheless, a consistent finding is that UPR impacts positively on outcomes especially when client rather than therapist ratings of its presence are evaluated. Two other conclusions have been drawn from this body of research. Demonstrating UPR increases the likelihood of the patient engaging in therapy (Wilkins 2003). It also increases their sense of self-worth (Mearns and Thorne 2007), itself important in increasing motivation to change (Miller and Rollnick 2013). The research on teaching (Cornelius-White 2007; Elliott and Friere 2009)

and therapy (Elliott et al 2011; Moyers and Miller 2013) seems to come to similar conclusions on the importance of engagement and acceptance in the process of change, whether that change is towards learning or towards the resolution of problem behaviours.

An important consequence of this research is to reinforce perhaps the obvious notion that individuals do not always feel positive about the process of learning. Teaching in the SMI accepts that some students will sometimes be frightened or indifferent to learning as well as keen and enthusiastic. When students are 'prized,' an essential belief and fundamental trust in the person as worthwhile in their own right is conveyed. It accepts learners as 'imperfect human beings with many feelings, many potentialities' (Rogers 1980:272).

## **Empathy**

The third 'core' condition is being empathic. It has been described over time as a feeling, a perception, an attitude, an ability, an interpersonal process and a way of being (Rogers 1975; Sunderland 1993; Kunyk and Olson 2001). There are those that believe that empathy is innate and therefore cannot be learned (Truax and Carhuff 1967; Kohut 1978; Morse 1992), whilst other scholars choose to understand empathy as a teachable, communicational skill (Mehrabian and Epstein 1972; Morse et al 1992; Egan 2009; Miller and Rollnick 2013). This is still a source of some debate (Wilkins 2003; Irving and Dickson 2004) although Rogers (1975) made it clear that empathy was ineffective if it had not been communicated and acknowledged by the person receiving it. Empathy is understood by some as a complex, multi-dimensional construct containing cognitive, affective and behavioural components (Reynolds et al 1999; Elliott et al 2011;

Moyers and Miller 2013). William and Irving (1996) reject the notion espoused by Rogers (1980) that empathy is a 'way of being' instead regarding it as essentially a communication skill that emerges from two people entering into a relationship. Yet, Rogers's definition (1957, 1980) in which empathy is viewed as sensing what the person is experiencing and then endeavouring to communicate this interpretation back to that person through the skill of reflective listening is accepted by some (Elliott et al 2011; Moyers and Miller 2013). This interpretation is found in MI, in the SMI and is the approach used in my teaching. Empathy based care has been a requirement in undergraduate nursing curricula since 2007 (NMC 2007), but wide variations exist as to how it is taught. This is due in some part to how it is understood and delivered, primarily because this is left to the discretion of each individual UK school of nursing.

Conceptualising empathy as a reflection of what was meant by the patient in which a 'guess is made as to what the person means' (Miller and Rollnick (2013:61) does has the advantage that it can be measured. This can take various forms such as using questionnaires, direct observation, the use of manuals (see below) and/or by asking the patient (Moyers and Miller 2013). Miller et al (1992) argue that the only reliable way to determine if someone is being empathic is to measure it through direct observation by independent observers. This created the impetus to construct guidelines for measuring the frequency and depth of constructs such as empathy and evocation used by a therapist (Miller and Rollnick 2013). Instruments for this purpose have been specifically developed such as the Motivational Interviewing Treatment Integrity Code (MITI) (Moyers

et al 2005) and the Behavioural Change Counselling Index (BECCI) (Lane et al 2005).

A recent meta-analysis of empathy (Elliott et al 2011) from research conducted into the effectiveness of psychotherapy analysed 59 studies and found that it accounts for 9% of variance in outcomes with an effect size of .31, regarded as 'moderate' (Cohen 1988). Client perceptions of empathy were more predictive of change than therapist or observer perceptions, a finding that has been replicated elsewhere (Kolden et al 2011; Moyers and Miler 2013). This may strengthen arguments for measuring empathy from the perspective of students rather than that of the teachers. Yet this result cannot be interpreted as 'better' outcomes will ensue if more empathy is provided because of the acknowledged limitations of the review. Elliott et al (2011) point out themselves that many of these studies are correlation in design and therefore cause and effect cannot be established. As for congruence and UPR, many of these studies of the effectiveness of empathy had sample sizes that were small and also heterogeneous, potentially problematic in terms of generalising the findings. Doubts have also been expressed over the validity of some of the variables and possible confounds between the experience of different data analysts, the sampling methods used and the different timing of the assessments. All of the above adds to the view that caution needs to be expressed when trying to generalise these findings.

The educational and the therapeutic literature affords empathy a central role in effecting change. Change is achieved through the establishment and maintenance of forming person-centred relationships, a finding that seemed to match my own clinical and teaching experience. The



introduction of empathy into my clinical practice and then subsequently into my teaching approach seemed to impact positively on being able to engage with both health service users and students.

Using reflective listening as a means to convey empathy when teaching students proved challenging initially. Many students seemed puzzled and confused when I began communicating in this way. It seemed likely that for many students this was not a common experience in a university lecture or seminar and therefore they may have been unsure of what to say or do. Other reactions included smiles and more eye contact which I thought might be because they were reacting positively to not being judged or criticised; some seemed to be wondering what this had to do with 'teaching;' others I thought appeared somewhat suspicious of what I was doing.

As I became more adept at communicating in this manner the number of students who seemed to enjoy my attempts at trying to listen to what they had to say through reflective responding grew. It seemed to me that greater numbers of students now appeared to be fully engaged and enthusiastic about learning more. It felt that my role was shifting increasingly towards a facilitator of learning. The key for this transformation of attitudes towards learning seemed to be a consequence of a shift in my attitude towards them.

## **The person-centred approach: a critique**

I will now explore some of the limitations and shortcomings of the person-centred approach and its implications for teaching. Although many therapies have embraced the Rogerian, person-centred attitudes of congruence, UPR and empathy as providing the therapeutic attitudes necessary for change to take place in health service users, many scholars have argued that it is not enough on its own and that specific techniques or skills are needed (Ellis 1973; Beck 1976; Miller and Rollnick 2002; Westbrook et al 2007). Debate continues as to the 'necessity and sufficiency' of the conditions. Dryden (1990) maintains that warmth (unconditional positive regard) is not needed but that congruence and acceptance are. Lietaer (1984) asserts that it is highly unlikely that positive regard can be given unconditionally. Bozarth (1998) and Wilkins (2003) both emphasise the importance of being able to communicate UPR (acceptance) as they regard it as the main facilitator of change. Natiello (1987) feels that therapeutic success is impossible without a consideration of the power imbalance that exists between a therapist and client and argues this should be a fourth condition. According to Land (1996:73), only one condition is necessary and sufficient, described as a '...sustained and generous interest.' Land (1996) goes on to assert that it is the inner resources of health service users that dictates the success or otherwise of therapy.

Others have suggested that the 'core' conditions of congruence, UPR and empathy are neither necessary nor sufficient and that change occurs all the time to people irrespective of their presence (Barrett-Lennard 1986; Bozarth 1998). Change does not need therapists (Tudor and Worrell 2006)

and according to Bozarth (1998), those with greater inner resources to help themselves are most likely to succeed in changing. Several commentators have claimed that person-centred approaches are simplistic and even harmful because they fail to acknowledge the role that political and social structures play in the production and the resolution of distress (Masson 1988; Hopton 1995; Purdy 1996).

As pointed out in chapter 1, Rogers (1951:384) maintained that the conditions that were necessary and sufficient for therapeutic change in health service users (congruence, acceptance and empathy) would also promote the 'learning called education.' He reiterated this view on several occasions (1961, 1969, 1980, and 1983). This has implications for the use of the SMI in education since many of its components such as partnership, acceptance and compassion are derived from person-centred principles. In the 1970's several large scale studies undertaken in the USA and in Germany found improvements to a wide variety of outcomes when person-centred methods of teaching were introduced into schools where teaching methods could be described as 'traditional.' Traditional teaching is understood here to mean an approach that emphasises memory and recall, and where 80% of the talking in classrooms was undertaken by the teachers. Outcomes such as better grades, lower absenteeism, higher levels of confidence, more motivation, greater levels of initiative, more independent thinking, greater spontaneity and fewer feelings of anxiety were found when teachers became empathic, non-judgmental and genuine (congruent). The research was also able to show that lower levels of teacher empathy, acceptance (UPR) and genuineness gave rise to poorer

academic performance and higher numbers of negative experiences of the teaching by the students (Aspy et al 1972, 1975; Tausch 1978).

Frazer et al's (1987) seminal synthesis of 134 meta-analyses of educational innovations in teaching based on over 7,800 studies found an overall average correlation between these innovations and positive outcomes of  $r=.2$ . The conclusions drawn from this research state that anything above this value is educationally worthwhile and above  $r=.3$  as worth pursuing. A large meta-analysis conducted by Cornelius-White in 2007 of the effectiveness of the use of person-centred principles in schools considered 119 trials over a period of 50 years that included over 355,000 students from 8 different countries. The general conclusion was that it was effective. Higher than average correlations between person-centred principles and achievement compared to the Frazer et al (1987) benchmark were found for cognitive and creative thinking outcomes ( $r=.31$ ). Stronger correlations were found between outcome measures such as participation, satisfaction, motivation to learn, self-esteem, IQ and grades ( $r =.35$ ) and measures of person-centred teaching attributes such as warmth (understood here as UPR), empathy and being non-directive, irrespective of ethnicity, culture, class and background of the students. Forming constructive relationships with students based on all three 'core' attitudes (congruence, UPR and empathy) gave rise to positive student outcomes with larger effect sizes than for each condition separately. The conclusion reached was similar to earlier findings; the whole person-centred approach is greater than the sum of its parts (Bozarth 1998). Specific findings from the review of Cornelius-White (2007) included a relationship between person-centred methods in teaching and high levels of participation

( $r=.55$ ) and motivation to learn ( $r=.32$ ). Students seem to thrive through becoming more engaged in person-centred environments. These positive findings are encouraging for the use of the SMI in teaching.

Cornelius-White (2007) asserts that the terms 'student or learner-centred' and 'person-centred' can be used interchangeably since their definitions share several similarities. For instance, both constructs emphasise that the key to change is the formation of relationships that are characterised by certain attitudinal qualities such as honesty, warmth, openness and respect. By negotiating with the student at every stage of the process of learning including the most appropriate method to decide how best to evaluate progress, the student grows in confidence and self-esteem in his or her ability to learn (Milligan 1997).

Using these learner-centred approaches also resulted in a fall in drop-out rates, absences and behaviour that caused disruptions (Cornelius-White 2007). Establishing relationships with students based on congruence, UPR and empathy did not however, reduce or avoid passivity towards learning, although these students would more than likely increase their compliance with school structures. Fielding (2009) advocates student-centred education in schools, but warns teachers that much of what purports to be student-centred is a fabrication. He believes that the current practice of seeking out student views is disingenuous, driven by those that are more interested in adopting the label 'student-centred' because of its current fashionable status. Truly engaging in a meaningful student dialogue requires, for example, a need to actively engage all students which includes those who are either reluctant to say what they think or choose to remain silent. These students who respond in this

manner do so because of 'fear...alienation and indifference' (Fielding 2009:308).

Two large systematic reviews which examined all of the published literature over the last 60 years into the effectiveness of the person-centred approach come to broadly similar conclusions with regards to its use in therapy and learning (Elliott and Friere 2009; Cornelius-White 2007). Forming relationships based on trust, respect and understanding with health service users or students improves therapeutic and educational outcomes. The implications of this research for education suggests that teachers need to 'connect' with students using these 'core' attitudes before tasks such as information giving are carried out. This 'connection' with the student can be achieved by teaching in a manner that is consistent with the SMI, since its values, beliefs and practices are consistent with those enshrined in the person-centred approach.

### **Self-awareness**

The process of becoming more congruent (more self-aware) is considered to be crucial for the delivery of the other Rogerian attitudes of unconditional positive regard and empathy (Wilkins 2003). Both UPR and empathy are part of the SMI but congruence or self-awareness is not. I therefore suggest that this is needed as an adaptation to the SMI when it is used in a teaching context. The attitude of congruence or self-awareness is missing from the clinical formulation of the SMI but is described as the most 'basic of these essential attitudes' to facilitate learning (Rogers 1980:271). I therefore wanted to include this as an adaptation of the SMI when teaching in person-centred way. It promotes the development of

collaborative relationships (Cranton 2006), the essential prerequisite for person-centred approaches to facilitate change.

Being self-aware is given prime importance in the person-centred approach because the more the teacher tries to be 'themselves' and refuses to wear a 'professional front or personal façade' the more likely change will occur (Rogers 1980:115). Being self-aware or congruent is a '...way of being' and is a '... matching of awareness and experience' (Wilkins 2003:79). It does not require the therapist to do or say anything, although Rogers (1980) did point out it is at least a willingness to express what the therapist is experiencing. Disagreement exists within the person-centred tradition as to the nature of congruence and how it is demonstrated. Tudor and Worrall (1994) for instance, argue that self-awareness is a component of congruence and that there is a need for the therapist to be willing to share their experiences of being with a client or patient whilst others (notably Bozarth, 1998) do not. According to some, being congruent is deemed crucial because without it the delivery of UPR and empathy is hindered if the patient does not perceive you the therapist as genuine, authentic or 'real' (Wyatt 2000; Wilkins 2003). Several writers have pointed to the importance of congruence in an educational context (Edwards and Richards 2002; Gillespie 2005; Cranton 2006; Conklin 2008) highlighting its importance in forming person-centred relationships.

Incorporating the elements of the SMI into my teaching provided a framework in which I could now form person-centred relationships with students. It had the effect of changing how I perceived myself as a teacher; I now considered myself to be an active facilitator of learning rather than a passive deliverer of information. Yet it was only when I began to share

what I was experiencing when teaching that I felt that my teaching was truly transformed. This awareness of self is what Cranton (2006:162) called as aspect of being authentic 'the expression of the genuine self in a community or with others in a relationship.' I found this the most difficult of the attitudes to adopt, especially when I felt that students were either not engaged in the process of learning or when they challenged my knowledge base; I was often tempted to return to strategies such as confrontation, warning and sarcasm in trying to engage students in learning, despite my previous experience of their use being less than positive. These strategies had emerged from a combination of other teachers' advice and my own experiences as a teacher and as a learner, and derived as far as I could tell from my own expectations of what a teacher should do, a so-called unexamined assumption (Brookfield 1995). When students asked me questions that I did not have the answer to I sometimes pretended to know because I felt that as a teacher it was expected that I should know everything about my subject, another assumption I had made about my role. When I tried to engage with a student (what Gillespie (2005:44) calls making a 'connection,') rather than maintaining what I considered to be a professional stance, the easier it got to appreciate and acknowledge the struggles of each student's attempt at learning. The impact of my effort to 'connect' seemed to be an increase in their appetite to learn.

This attitude was initially interpreted by me as a greater willingness to share with students my feelings about my clinical and teaching experiences. As I grew in confidence I became more 'congruent' in that I was more confident in being able to share with students what I was



experiencing at any given time ('being transparent') although at times this was (and still is) difficult, especially if I was feeling angry or frustrated. Nevertheless I did not interpret being congruent as being compelled to share all my feelings; being aware of what I was experiencing and then deciding if it was relevant to share it seemed sufficient. What did change was that I considered myself a more 'authentic' teacher when I tried to be congruent; this meant that I was more relaxed about making mistakes, owning up to not knowing, what Rogers et al (2014:72) called a 'willingness to be vulnerable.' My ability to 'be myself' and accept my imperfections varied greatly but when I did not try to 'put on an act' I felt much more relaxed when teaching. This 'integration of self into teaching' (Cranton 2006:196) grew primarily because the results were so positive; becoming more aware of what I was experiencing (accepting myself) made it much easier to deal with any anxiety I was feeling. Being less anxious made it easier to concentrate on the students who seemed to become more attentive and appeared to be listening much more intently to what was being said by myself and others. What seemed to be happening concurs with what Rogers (1969) predicted; allowing aspects of 'myself' into the teaching seemed to make it easier for students to become more confident about sharing their own clinical and learning experiences; being 'myself' was 'allowing' students to be their own authentic selves. Students also began to listen and take on board other contributions from other students. I believed my role here was to facilitate the discussion through asking questions, adding comments and developing different lines of thought aided by the provision of information and other resources. To my surprise, learning groups often formed to develop some of the ideas expressed with

little or no prompting. This enabled students to achieve what Rogers (1951:377-388) calls the 'goal of democratic education' which is for students to become creative, self-initiated, critically thinking individuals but who are also able to co-operate with each other.

## **Adult learning Theories**

The next section will consider the works of several adult learning theorists. Malcolm Knowles' andragogical theory of how adults learn (1980, 1984) will be reviewed as he follows in the tradition of Carl Rogers, claiming that forming collaborative, consensual relationships with students is the key to successful learning. A critical analysis of the theory of andragogy and its successor, Mezirow's theory of transformative learning (1975, 1991), then follows. These theories have change as their goal of learning but both acknowledge that there is no one definitive approach by which this can be achieved. The rationale for concentrating on these scholars is that they argue that examining our assumptions, values and attitudes about learning can lead to the creation of new ways of thinking and acting, a process that is hypothesised to occur when an adapted version of the SMI is used in teaching. A review of the effects of group size on student learning is included here since many nurse lecturers felt this constrained the effectiveness of student-centred teaching approaches. Andragogy is 'the art and science of helping adults learn' (Knowles 1980:42) and is contrasted with pedagogy, which is the way that Knowles (1980) argues that children learn. Fundamental assumptions about the nature of adult learning focus on the qualities inherent in the learner, the relationship between the learner and teacher, what is to be learnt and what motivates the adult to learn. Knowles (1980) described self-directed learning as a

characteristic of adult learners in which they are able to identify their own learning needs, set goals and identify the learning resources they need to achieve those goals. Adult learners are motivated to learn and this learning is normally associated with developing or acquiring new attitudes as well as new skills and knowledge. This concept of self-direction as a distinguishing feature of adult learning enjoys support from several scholars (Tough 1967; Candy 1991; Brookfield 1995; Billington 2007; McDonough 2013). Adult learning serves to create, develop and enrich social roles. Although external motivators do promote adult learning, Knowles (1980) argued that internal motivators such as a perceived increase in self-esteem, self-efficacy or confidence are more powerful in achieving this end. An andragogical approach is understood to be student-centred because it emphasises the needs of the individual and by doing so promotes autonomy and critical thinking. Although these assumptions about how adults learn have been adopted by many adult educators and indeed endorsed as desirable for nurse training since the 1980's (National Boards for England and Wales 1986), the evidence upon which they rest is controversial and argued by some to be largely anecdotal (Jarvis 1984; Davenport and Davenport 1985; Merriam and Caffarella 1991). Several authors have pointed to the few research studies that exist which explore the validity of andragogy (Hartree 1984; Davenport 1993; Merriam and Caffarella 1998) and therefore its central tenets about the way that adults learn remain relatively untested. Some have questioned whether Knowles' theory of how adults learn is in fact a theory at all (Davenport and Davenport 1985; Hartree 1984), whilst others have pointed out that many of his assumptions about how adults learn are not unique to adults

(Merriam et al 1996; Merriam 2001; Hanson 1996). For instance, Merriam (2001) states that many adults are motivated to learn by external factors such as keeping their jobs and maintaining their status. Moreover, some adult experiences can have a negative impact on learning (Merriam et al 1996). Misch (2002) considers the concept of motivation espoused by Knowles (1980, 1984) as too simplistic, since it ignores the role played by numerous biological, psychological, political, economic and contextual factors on its expression and effectiveness.

A review by Rachal (2002) into the research conducted on andragogy points out several major flaws in the methodologies of these studies. He points to several weaknesses such as a lack of randomisation of the experimental and control groups, and different operational definitions of the concept of andragogy. For example, most of the studies revealed that the students had little control over the content, assessment and evaluation of course material and no real consensus on what it means to be an adult learner. In addition, Rachal (2002) argues that the studies conducted into its efficacy so far have used methods of evaluation that do not adhere to the principles that are at the heart of this approach to teaching and learning. Others, notably Belenky et al. (1986), have specified that differences exist between the ways that men and women learn, not mentioned in andragogical theory.

Andragogy is an approach that advocates a new way of being with students, irrespective of age, in which insights from critical theory, person-centred therapy, transformative learning, phenomenology and feminist thinking have all made a contribution towards developing a stronger and more robust evidence base of teacher-learner effectiveness (Merriam

2001). For some though this is an incomplete theory of education because it fails to explore the social, political, cultural and economic factors that influence the development and sustainability of collaborative teacher-learner relationships, and the extent to which these collaborations can affect change (Brookfield 1995; Purdy 1995). This criticism is one that can be levelled at transformative learning and indeed MI and the SMI, since they have little to say on how social factors impact on the likelihood of collaboration and change. This emphasis on the promotion of collaborative relationships in education has been challenged on the basis that these relationships are incapable on their own of promoting real change for those who are powerless, and are a means by which the more dominant groups in society can maintain the status quo (Holloway and Penson 1987; Purdy 1995).

### **Transformative approaches to learning**

Transformative approaches to learning involve a critical examination of existing assumptions, attitudes, and beliefs in order to make these more open to change (Mezirow 1975, 2000). This is also a goal of person-centred approaches to education and of the counselling approach MI. Different strategies have been suggested that may promote this transformation of attitudes but, according to Cranton (2006), relationship formation is fundamental to the process. Mezirow's (1975) original theory has undergone several revisions by himself and others since its original conception; these are discussed in more depth below. Challenging assumptions about learning is also hypothesised to be important as a goal of teaching in the SMI and therefore these developments and their

applicability and relevance to its use will be discussed and critiqued.

Transformative learning is:

learning that transforms problematic frames of reference-sets of fixed assumptions and expectations (habits of mind, meaning perspectives, mind-sets) to make them more inclusive, discriminating, open, reflective, and emotionally able to change (Mezirow 2003:58-59).

Learning occurs when an alternative view is presented and the learner responds in such a way as to question unexamined assumptions and beliefs (Cranton 2006). Through a process of reflection, a revised set of beliefs, attitudes and values are created, which themselves are open to critical appraisal. For most supporters of this approach, reflecting on personal and professional experiences is an essential activity to achieve this transformation (Mezirow 2000; Cranton 2006).

### **Importance of reflection**

Critically reflecting on practice is considered an essential activity in nursing education and practice for enhancing and developing personal and professional learning (NMC 2002). All nurses are therefore required to keep and maintain a portfolio in which reflecting on previous experiences is a part of their personal and professional development. Numerous definitions of reflection exist but many authors agree that it involves generating new insight and understanding through a process of examining the feelings and thoughts associated with a past experience (Schon 1987; Gibbs 1988; Rolfe et al 2012). It is thought to occur in stages (Boud et al 1985; Johns 1995; Moon 2013). Critical reflection is one aspect of reflection in which

two major types of assumptions are examined:1 interests, [*so called*] hegemonic assumptions (Brookfield 1995:preface xiii).

Examples of these hegemonic assumptions from my own practice are that all adult learners are self-directed and that education is an apolitical activity. Others include my assumptions that group work is intrinsically a 'good thing' and that all students prefer me to talk about my own personal experiences. Transformative learning requires 'hunting for these assumptions' (Brookfield 1995:2) and involves the use of reflective skills to develop self-awareness. This gathering of information about whom we consider ourselves to be and how we operate and react to others, is undertaken knowing that this is achieved in the context of the social structures that affect how we live. Some authors cite this as the ultimate goal of adult education (Mezirow 1991, 2000; Dirx 1998; Cranton 2006).

Reflecting on experiences is hypothesized to be an important aspect of teaching in the SMI as a way of identifying and challenging assumptions about the self and others in relation to learning. Several scholars suggest that being reflective develops self-awareness and critical thinking, improves communication skills, enhances clinical competency and promotes changes to practice (Gibbs 1988; Atkins and Murphy 1993; Johns 1995; Bolton 2010).

### **Mezirow and the phases of Transformative Learning**

Mezirow's (1975) highly influential piece of research with 83 women returning to college in different parts of the USA after an interruption found that they all experienced several phases before they engaged with learning. The first stage involved disorientation which was followed by a period in which they came to re-evaluate through a process of reflection

their negative feelings associated with learning. This was then followed by feelings of recognition and warmth towards others in the same situation (a feeling of universality, one of Yalom's (1970) therapeutic factors said to exist in groups), with a subsequent emergence of a new perspective which incorporates new roles, new skills and new ways of feeling. Whenever assumptions are under scrutiny and found to be wanting then a transformation to a new perspective has occurred (Mezirow 1991). This perspective transformation is better understood by replacing the concept with the more detailed 'habits of mind' (Cranton 2006:22). This involves ways of seeing the world based on our background, experience, culture and personality which according to Mezirow (2003), remain largely unexamined by the self. This habit of mind is 'expressed as a point of view' (Cranton 2006:37). So a student nurse may believe in the value of individual effort and therefore feel that some health service users are in poverty because that is what they choose to do, which may have implications for the way that their care is subsequently organised and delivered. These habits of mind are often resistant to change unless an alternative is acknowledged and adopted. Critical reflection is one way to explore the assumptions, beliefs, feelings and values of these habits of mind (Mezirow 2000). It is an exercise in critical analysis. Yet involvement in the process does not guarantee transformative learning; what has to occur is change to these assumptions, values and beliefs.

Mezirow's (1991) conception of how transformative learning can be realised has been challenged from several perspectives. It is argued that his view of transformative learning gives too much emphasis to the cognitive aspects of the process (Dirkx 1997), and ignores social change



as a goal of adult education (Collard and Law, 1989). It undervalues the importance of relationship formation (Taylor 1997), and lacks analysis of how imbalances of power affect transformative learning (Hart 1990; Inglis 1997). It also neglects the impact that culture has on learning (Clark and Wilson 1991; Inglis 1997). Mezirow (2003) has responded to some of these criticisms by widening the definition of discourse to include emotions and interpersonal skills and claiming that through these aspects, individuals can change oppressive structures themselves.

Dirx (1997) argues that transformation involves both the emotions and the imagination. It is ultimately a way of *being* rather a process of *becoming* (Dirx 1998:11) echoing the emphasis that Rogers (1980) placed on the importance of the relational aspects of therapy and learning rather than on techniques to promote change. Given the person-centred credentials of the SMI, this widening of the concept of what is transformational is relevant to using the SMI to achieve this goal of transformation of the attitudes and values held by learners.

Being 'authentic' has the power to be transformative (Cranton and Carusetta 2004), because it helps to 'create honest and open relationships with students but it also serves as a model for learners working to define who they are' (Cranton 2006:115). This being authentic has many similarities to the person-centred principles of Carl Rogers and therefore the SMI. Cranton (2006) refers to a process similar to reciprocity, which Rogers (1980:116-117) argues is how patients, clients and students adopt the attitudes displayed by their therapists and teachers:

As the person is empathically heard, it becomes possible for him or her to listen more accurately to the flow of inner

experiencings. But as the person understands and prizes self, there is a development of a self more congruent with the experiencings. The person thus becoming more real, more genuine. These tendencies, the reciprocal of the therapist attitudes, means that the person is a more effective growth-enhancer for him or herself. There is a greater freedom to be the whole person that he or she inwardly is.

This being empathic with another person then allows them to develop their self-awareness (become more aware of their own feelings and thoughts). Being authentic (more self-aware) then is recognising the power of the self to transform the self and others (Buber 1961; Friere 1970; Cranton 2006). It is being supportive (Friere 1970; Cranton 2001), admitting that we are fallible (Palmer 2000), ensuring that there is a good match between how we behave and what we say (Brookfield 1990), and according to Heidegger 1962, cited in Mackey 2005) is to embrace our uniqueness in the face of constant societal pressure to reject it and conform. Being authentic then seems to be compatible with the elements that make up the SMI.

### **The effectiveness of Transformative Learning**

A review of the literature of transformative learning by Taylor in 2007 focussed on 41 studies undertaken from 1999 to 2005. Although the majority of these studies were qualitative in design, some recent research has used a mixed methods approach, incorporating scales and questionnaires into their methodologies as well as interviewing the participants. The majority of the studies reviewed by Taylor (2007) examined the attitudes necessary for transformative learning to take place,

whilst the more recent research focuses on the extent to which factors such as reflection, relationships and power imbalances were influential to its emergence, maintenance and development.

Instigating transformative learning through developing and maintaining relationships (Carter 2002) has found some support in the evidence base, particularly in the case of women (Mezirow's original work only included women in his sample). Factors such as trust, respect, self-disclosure, and an awareness of the distorting effects of power were found to be more likely to promote this change towards learning. A key component of aiding the transformative process is creating the necessary interpersonal, intrapersonal and environmental attitudes in which teachers and learners feel able to express themselves without fear of reprimand (Eisen 2001; Baumgartner 2002).

Robertson (1996) argues that teaching with a transformative approach to learning will necessitate a change in the dynamics of the teacher's relationship with learners from instructor to a facilitator of learning. He states that although there are similarities between counselling and the type of educational relationship required to promote a transformational learning experience, much more support and supervision is apparent in the former to deal with psychodynamic complexities that can arise in this kind of therapeutic alliance. He claims that in any relationship the psychological phenomena of transference and counter transference occur, which needs to be effectively managed. Transference in which the feelings, thoughts and aspirations of the learner from past relationships are projected on to current ones can be a significant factor in the healthiness or otherwise of the newly developing learner-teacher relationship. Likewise, with counter-

transference, the teacher can project past experiences and perceptions from other relationships with students onto those currently in education. Moreover, transformative learning is by definition a process in which old ways of thinking, feeling and behaving are revised in the light of new information; this process is usually an intense one and impacts on the dynamics of the teacher-learner relationship (Robertson 1996). Given this complexity of these relationships, many have called for adequate training and supervision to effectively deal with these difficult aspects (Daloz 1986; Roberson 1996; Taylor and Cranton 2012).

## **Class size and student-centred learning**

Although most of the teachers interviewed endorsed student-centred approaches to learning, they did have concerns that it was made much more difficult when class sizes were large. Traditional teaching, in which there is a one way flow of information delivered to a largely passive student audience, is associated with several problems such as poor attendance, low levels of engagement and student retention of knowledge (Robinson 1995; Wang 2007). An essential prerequisite for student-centred learning is the active involvement of the student in the process of learning (Prince 2004). This is usually understood to mean that there is an expectation that students not only get involved in activities but also engage in reflective practices (Smith and Cardaciotto 2011). Engaging students in the learning process seems to lead to improved outcomes such as increased motivation, more positive attitudes towards learning, higher grades, and an increased likelihood to retain concepts (Bleske-Rechek 2001; Hovelynck 2003; Yoder and Hochevar 2005).

Although large class sizes make engagement difficult to achieve (Michael 2007), some authors have pointed out that is worth pursuing, given the well-documented improvement in outcomes (Handelsman et al 2004; Smith et al 2005). One approach to this dilemma is to introduce small group activities into the larger lecture theatre thereby reducing traditional lecture time. The literature on its effectiveness however, is sparse. A study by Walker et al (2008) divided 500 first year US university students taking a 1 hour 15 min per week introductory biology course into two groups. The first group received a traditional lecture approach, although there were some quizzes included. The second 'active learning' group had lectures that lasted no longer than 15 minutes; the rest of the time (one hour) was filled with group work, some homework and quizzes. Both groups took multi-choice exams at the end of the course. The scores from the exams taken by the active learning group were statistically significantly higher compared to those in the traditional teaching group, although this difference was small. Students with poorer academic records seemed to have benefitted to a greater degree in the active learning group compared to the traditional group. Attendance was also found to be higher in the active learning group. However, confidence in the ability to discuss and think critically about scientific concepts was greater in the traditional group. Students were concerned that the active learning group did not provide them with the 'right answers.' When asked about teaching and learning the students emphasised that they thought of learning as a one way delivery of incontestable facts from 'expert' to 'novice.' Many students also felt they were not 'learning' in the active group because of the much reduced emphasis on presenting facts. There was, however, an acknowledgement

by the students that small groups could take away some of the fear associated with learning. The authors concluded that presenting lectures to large groups where the time is split evenly between a traditional approach to the delivery of information and group activities may be the best way forward.

## **Summary of findings from the literature**

Successful learning is a multiphase, complex process dependent on a wide range of cognitive, affective, behavioural and environmental factors which themselves are very much dependent on the way in which the teacher orientates, engages and subsequently treats his students. The literature on transformative learning comes to similar conclusions as the literature on MI concerning the importance of relationship building with people who are ambivalent about change. This change can be an increase in the confidence a student has in his or her ability to learn or how the behaviour of a health service user such as heavy drinking no longer seems to be giving the advantages it once did (Rogers 1969, 1983; Edwards et al 1977; Miller and Rollnick 2013).

'Connecting' with students enables learning (change) to thrive (Rogers 1980; Knowles 1980; Mezirow 2003; Cranton 2006). This connection facilitates positive self-regard, mutual respect, and being 'genuine' with students (Rogers 1959; Gillespie 2002). It also involves trust, (Brookfield 1997) compassion, being affirmational, showing caring and commitment, all of which are constantly evolving (Gillespie 2002, 2005). Connecting with students is either an end in itself or an essential prerequisite for change to occur in their behaviour (Rogers 1951).

Most of my teaching colleagues have felt that there is little to learn from therapies designed to address the complexity of issues surrounding change, presumably based on the observation that students are different from health service users. Yet many of the issues that face health service users and students are similar: for instance, both 'groups' are often apprehensive, worried, concerned or just curious about what the therapist or teacher will be 'like' and what kind of relationship they will have with him or her. Anxieties are commonplace about what is likely to happen during and after the therapy or teaching ends. It is also common for people to doubt their abilities to change or learn, and remain unconvinced that they have enough resources to acquire this new learning. Previous experiences of learning and/or trying to change are often littered with failure and can be a powerful indicator as to whether further change or learning is possible.

Although there is a broad consensus that engaging with a health service user requires the demonstration of the 'core' attitudes of congruence, UPR and empathy, established within the boundaries of a relationship, differences emerge as to whether this is enough on its own to instigate changes in behaviour. Therapists outside of the person-centred tradition largely advocate the use of techniques to supplement the 'core' attitudes of congruence, UPR and empathy but almost all agree that forming relationships in which the above attitudes are present are necessary before change can take place (Lazarus 1993; Miller and Rollnick 2002; Westbrook et al 2007).

The literature on the use of person-centred principles in both therapy and education suggests that an accepting, transparent, empathic self

seems to be able to energise the 'other' to adopt similar attitudes towards themselves. This 'movement' allows the possibility of a transformative process to take hold in which the examination of thoughts and feelings that previously had often provoked fear or avoidance can now take place, enabling change to proceed.

The SMI is a 'way of being' with health service users that fundamentally has much in common with the principles and practices of Rogers's person-centred approach. Yet as I have argued previously it goes further in that the inclusion of compassion (Miller and Rollnick 2013) strengthens the commitment to act in an empathic manner. A willingness to share what you are experiencing (being congruent or self-aware) is an essential part of the person-centred approach and my experiences of the benefits of being self-aware when teaching makes me believe that this should be added to the attitudes of the SMI in order to promote transformative learning. This change could be alternative ways of thinking about someone experiencing depression or drug addiction or it could be a change in attitude towards their own learning. When facilitation of learning does take place, its transformative power has the capacity to generate 'excitement beyond belief.' It has the ability to:

....free curiosity; to permit individuals to go charging off in new directions dictated by their own interests; to unleash the sense of enquiry; to open everything to questioning and exploration; to recognise that everything is in a process of *change* [emphasis added] (Rogers 1983:113).

It is argued that the possession of person-centred attitudes by practitioners promotes therapeutic change in health service users in



distress and has much to offer in helping people to learn (Rogers 1951, 1969; Cornelius-White 2007). An adaptation of the SMI for teaching is proposed which adds self-awareness to its existing components. This adaptation therefore contains the elements self-awareness, partnership, acceptance and evocation (SPACE). This has led to the development of a fundamental question that this research will hope to address.

## **Research questions**

I am using an adaptation to my teaching which I have called SPACE (self-awareness, partnership, acceptance, compassion and evocation). This means that when I am teaching I would form partnerships with students based on the display of the attitudes listed above (acceptance includes the construct empathy, see chapter 1). I was sure that this approach did produce students who were more engaged in their learning, but evidence to support (or refute) this conviction needed to be gathered. I also wanted to know that if students changed their perceptions of learning, would they subsequently be able to demonstrate self-awareness, acceptance and compassion to their patients and clients. These general ideas became a set of aims (see end of chapter one) and informed the literature review subsequently covered in chapter 2. A process of evaluating what the literature had to say along with my own clinical and teaching experience resulted in the emergence of the following research questions:

- 1) Can a teaching approach than incorporates the attitudes or values of Self-awareness, Partnership, Acceptance, Compassion and Evocation (an

adaptation of the Spirit of Motivational Interviewing) promote transformative learning?

Other questions that developed from this main question are as follows:-

2) Is teaching in the adapted version of the Spirit of Motivational Interviewing (Self-awareness, Partnership, Acceptance, Compassion and Evocation) linked to an increase in student empathy?

3) What are the similarities and differences between using this adapted version of the Spirit of Motivational Interviewing and the teaching practices adopted by my teaching colleagues?

# Chapter 3 - Methodology

## Action Research

When I replaced a way of working with alcohol dependent users that emphasised analysis and confrontation with a person-centred approach that focussed on collaboration, acceptance and empathy, two important changes emerged. The first was that patients and clients who used the service seemed more motivated to change. The second, and perhaps more surprising, was that the staff seemed much more optimistic concerning the possibilities that users of the service could change. This different way of working became known as the Spirit of Motivational Interviewing (Rollick and Miller 1995) which meant that nurses would now aim to establish person-centred relationships with problematic alcohol users that were based on partnership, acceptance, compassion and evocation (See chapter 1 for a full account of this 'way of being' with health service users (Miller and Rollnick 2002:34))

I therefore began to think that this may be the 'missing ingredient' from my teaching; learning would become easier for the student I reasoned, if I took the time to engage with the student experiencing difficulties with learning in much the same way as I engaged with health service users struggling to learn to overcome alcohol problems. However, finding a research method to investigate this was proving somewhat problematic, since it needed to fulfil certain conditions. I was already using the SMI in my teaching so I ideally needed a research approach or method that would be able to evaluate this change to practice. I wanted to capture the experience of teaching and learning using the SMI so interviewing students and staff seemed the most accessible and equally reliable way to achieve

this. However, using both qualitative and quantitative data can enhance understanding of the issues and therefore give a more complete picture of their complexity (Creswell 2013). I therefore decided to include quantitative as well as qualitative data, and choose to do this in the form of empathic questionnaires. Empathy was preferred over the other aspects of the SMI for two reasons. Firstly there is a greater body of research into its constituents and its effectiveness in producing change. Secondly it was chosen because reliable and valid questionnaires to measure aspects of the SMI apart from empathy are not readily available.

Action research (AR) is a research methodology that satisfies both aspects; its theoretical framework happily incorporates qualitative and quantitative approaches to data collection and its fundamental aim is to implement change in order to improve practitioner practice (Elliott 1991; Koshy et al 2010). There is some debate as to what constitutes AR (see below) and to what extent others should be involved, but a fundamental belief of AR is that human effort can overcome obstacles that prevent making things better. This chapter will therefore describe AR and its underlying theoretical framework, followed by a discussion of its advantages and disadvantages as a research approach. Details of demographic data on the students and staff that agreed to participate in the study are then followed by a section on what is understood by mixed methods research. A section on data collection tools, (including my thoughts and feelings as the interviewer) is then followed by a consideration of the issues relating to the construction of empathy questionnaires. Both questionnaires used in the research are described.

The final section includes a discussion of the study's ethical issues and ways to increase the reliability and validity of the data.

Action Research it is an activity that seeks to improve ways of working by identifying problems, imagining solutions, employing these new approaches, acquiring feedback to evaluate if these have succeeded. This feedback is then acted upon in order to change and further evaluate work practices in the light of these insights (Kemmis and McTaggart 2005). The whole process is expected to lead to a greater understanding and therefore an improved delivery of those strategies that make up your own practice (Stenhouse 1975; Whitehead 1989; McNiff 2002).

I wanted to change my practice because as outlined in chapter 1 and 2 the non-verbal language of the students coupled with end of module evaluations suggested that they were not fully engaged in the learning process. Having changed my approach to teaching, I needed to know how this had impacted on their learning. An AR approach to investigate my practice resonated because it has change at the heart of its process (Koshy et al 2010). Although I had introduced changes to the way I did teach (see chapter 1 and 2), the lack of any formal evaluation of these changes became one the drivers for this thesis. The process begins when as a teacher:

1. I experience a problem when some of my educational values are negated in my practice.
2. I imagine a solution to my problem.
3. I act in the direction of the solution.
4. I evaluate the outcomes of my action.
5. I modify my problems, ideas and actions in the light of these

evaluations (Whitehead 1985:98).

Whitehead (1985) believes that a problem in practice emerges because there are likely be times when there is conflict between the values held by a teacher and the actual practice of teaching in an educational institution. So for example, my belief that students all have different ways of learning is challenged if I lecture in a manner which makes assumptions about the similarity of their learning needs. I have been teaching for several years in a way that I think of as compatible with the SMI (albeit with the inclusion of self-awareness) and therefore it seemed important to collect the views of past as well as current students on their experiences of this teaching approach.

Action research is an orientation to conducting research that does not define a particular method or approach. Yet the approaches that are chosen to collect and analyse the data are inevitably influenced by the values and beliefs held by the researcher and these should be made explicit (Koshy et al 2010). Action Researchers would reject the notion that knowledge is exclusively '... objective and value free' (Brydon-Miller et al 2003:9), arguing that it is constructed by those that are part of that society. The ontological stance of AR would therefore construe reality as a social construct and not 'independent and external' (Koshy et al 2010:14).

Although several models of AR exist they all seek to improve practice through active participation in the process and by doing so, change it (Leitch and Day 2000; Koshy et al 2010). Lewin (1946:206) was the first to use the term 'Action Research' and described it as a series of steps 'each of which is composed of a circle of planning, action and fact-finding about the result of the action.' This cycle then repeats itself to constantly inform

practice. Kemmis and McTaggart (1988) emphasised the role of critical reflection in changing perspectives based on 'habits of mind' (Mezirow 2003:58) to one which is characterised by thinking critically (Mitchell et al 2009). This focus on shifting between reflection and action is theorised to lead to teachers gathering '... evidence from multiple sources to guide their practice to make informed decisions based on evidence' (Mitchell et al 2009:345).

### **Advantages and disadvantages of using AR**

Using AR is an approach that continually evaluates practice. It therefore has the ability to check that values such as compassion and care are incorporated into the practice of nurses. Other advantages of AR are that it is underpinned by a democratic philosophy, is cyclical in nature and contributes to the debate as to the nature of teaching and learning (Koshy et al 2010). Using a reflective approach to the practice of teaching acknowledges that teaching is largely an emotional experience (Hargreaves 1998). If that is the case then lasting change will be difficult if not impossible to achieve without the delivery of a teaching approach that validates the expression of these feelings, both on an individual and systemic level.

In contrast, concerns have been raised about the rigidity of some AR models, the prescriptive, almost evangelical zeal of some of its advocates (Gibson 1985; Hopkins 1993; McNiff 2002), issues regarding its reliability and validity, and philosophical and epistemological arguments about what constitutes 'real action research' (Zeichner 1993). In addition, the difficulties of gathering reliable data whilst still a practitioner has given rise

to concerns of the significant challenges that teachers may face when attempting to thoroughly examine their own practice (Somekh 2006).

## **Mixed methods research**

A mixed methods approach was chosen because this was considered to be able to represent a more complete picture of the complexity of the teaching approach under scrutiny (more details below).

Mixed methods research is understood here to mean:

the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study (Johnson and Onwuegbuzie (2004:17).

This pragmatic approach to 'truth' has its roots in the works of philosophers such as William James, John Dewey and more lately Richard Rorty. A pragmatic approach to research acknowledges that both qualitative and quantitative methods have much to say about the world we live in and therefore values both inductive and deductive reasoning and their different approaches to data collection and analysis (Denzin 1989). Ontological and epistemological differences are acknowledged and accepted; traditional dualisms about the above are rejected in favour of whether the approaches either help or hinder answering the research questions posed. The existence and importance of an objective world is accepted as much as the one perceived through the eyes and ears of a human being (Rocco et al 2003). A mixed methods research design does not reject conflicting theory about the nature of existence; it supports the view that knowledge is not a fixed identity but something that changes over time. It also believes truth is not absolute and is therefore susceptible



to and driven by change. A pragmatic approach to data gathering means philosophical stances are put to one side in order to generate solutions to problems that best mirror our own experiences (Cresswell 2013). This means that methods are adopted to collect information about the world to ascertain if they work to solve the problem encountered. If they do not work then they are discarded in favour of those that do. A practical, realistic approach to research therefore more closely matches the experience of being human (Morgan 2007; Feilzer 2010).

This approach is not however without controversy. Johnson and Onwuegbuzie (2004) argue that the different research traditions are just simply tools to collect data from different perspectives. Others such as Sale et al (2002) and Guba and Lincoln (1989), believe that the very different ontological and epistemological assumptions underpinning both approaches makes a 'marriage' of these methods impossible. One approach to dealing with concepts that have seemingly irreconcilable epistemological and ontological positions is to concentrate on the object of our concerns. This means questions are focussed on a consideration of the practical advantages of combining these approaches.

A growing number of researchers have adopted mixed methods designs especially in the last 25 years or so (Cresswell 2013), arguing that many of the arguments over the superiority of one research approach over another have become somewhat sterile. Momentum has been gathering to combine different approaches based on a rationale that it will only enhance research findings that would not been achievable if only one methodology had been used. This pragmatic tactic is no panacea; critics have pointed to issues such as what is really meant when concepts such as 'useful' and

'workable' are applied to mixed methods research designs and who the target audience is supposed to be (Mertens 2003). Many researchers are drawn to mixed methods research as a way of avoiding the debate that has been labelled by some as the 'paradigm wars' (Gage 1989:4). Yet there are others who are not convinced that pragmatism offers a solid enough philosophical stance to warrant the use of methods from 'the other side' (Sale et al 2002:18) and that mixed methods does not disguise the fact that the dominant ideology is still positivist (Giddens 2006).

The method(s) of data collection and analysis for this research were therefore selected on the basis of their appropriateness for the research questions formulated, following the 'real world' approach of Johnson and Onwuegbuzie (2004), mentioned above. A mixed methods study could also have the potential to capture a deeper understanding of the complexity of the various components of the Spirit of Motivational Interviewing (SMI), operating against a background of shifting environmental influences (Mezirow 1997; Miller and Rollnick 2013). A mixed methods approach has the advantage of providing a bridge between the two traditions (Streubert and Carpenter 2011) and has the potential to add rigour to the findings (Hammond 2005; Cresswell and Plano Clark 2007).

This research mixed different 'types' of participants (staff and students), and used different methods of data collection (interviews and questionnaires). This meant different methods of analysis were subsequently used (thematic analysis and statistical tests).

# Sampling

## **Students in the qualitative arm of the study**

Two continuous professional development (CPD) modules in substance misuse (SM) and dual diagnosis (DD) (those with a mental health and a substance misuse problem) began to take post-registration nursing students from 2003/4 at the University of Manchester School of Nursing, Midwifery and Social Work (UMSNMSW). Both modules can be taken towards obtaining a degree in Nursing or Professional Practice. This meant that by the time the research started in 2010 there were substantial numbers of students who had experiences of either one or both of the modules. In order to enrich the data the views of students over the lifespan of the modules were sought. Ethical approval was first sought and gained from both institutions (Manchester Metropolitan University and the University of Manchester) before letters asking if they would like to participate in the study were sent out to the students (see appendix 6). Then the same letters were sent out in September 2010 to 56 former SM and DD students. Some students were not contacted because they were not living in the UK or lived too far away to easily get to the university. All letters included an information sheet outlining the research proposal and a consent form.

Four students replied stating that would be willing to engage with the research project, a number I was disappointed with. Three of these students were white, Caucasian women between the ages of 22 and 38 and one black, African man aged 37. I would have probably received a better response if I had stated in their invitation letter that I would be willing to speak to them in or near their homes but a lack of time and

money to arrange this (some of the potential participants lived in different parts of the country) made this option unrealistic. I could have used online interviewing via email to overcome this problem but I lacked experience in this form of interviewing and there is also the disadvantage of not being able to pick up nonverbal cues compared to face-to-face interviewing. Arrangements were therefore made to interview them individually, for approximately one hour in the UMSNMSW using a list of questions I had prepared earlier (see appendix 4). Three more students replied saying they would have liked to be involved but could not due to other commitments. Why the majority of those contacted did not reply is hard to say. I wrote to them irrespective of the mark they received for the module(s) they attended. Students who received a lower mark than they expected may have felt uncomfortable or possibly resentful undertaking an interview with me, as I was the one who had marked their assignments. Other reasons for nonparticipation could include an unwillingness to be involved in research in the first place. The UMNMSW building where the research was to be conducted might also have negative associations for some of them.

Three male and three female students, age range 21-46 who had applied to be part of the February 2011 substance misuse cohort were contacted and all agreed to be interviewed. Arrangements were made to interview them individually for approximately the same time (one hour), asking the same set of questions, at the same venue (see appendix 4). The final number interviewed was ten students. Six were from the current cohort plus the four students who had agreed to participate from previous cohorts. Four of these 10 students had attended both SM and DD units, three of whom were current students. All of the students interviewed were qualified

nurses. Three of the students from the 2008 and 2009 cohorts who had agreed to participate were still undertaking studies towards their degree, which might explain their decision to join the research. The final sample size of 10 students was chosen on the basis of reading from the established research literature combined with discussion with others. I also gave some thought to whether this number would more than likely lead to no new information emerging concerning the issues raised by the research questions emerging (so called 'saturation'), especially if it contained students (which it did) who had completed the units in the recent past.

Of the 10 students interviewed seven were women with an average age of 35.1 years (see appendix 11). Five were mental health nurses and two were trained to be adult (general) nurses. The youngest had 3 years' experience as a qualified nurse and the oldest 24 years. The three men interviewed had an average age of 38.3 years and their experience as trained nurses varied from 5 years to 9 years. At the time of interview, four women had completed both the SM and DD modules between two and six years ago. Three men had already completed the DD module when interviewed and all were currently students on their second.

Eight of the 10 students who were interviewed were qualified, mental health trained nurses, four of whom were working on mental health wards in NHS hospitals at the time of the interviews. Three of these were males, two of whom were working on Psychiatric Intensive Care Units (PICU's) where health service users were often acutely ill. The third male mental health nurse was working nights on an acute ward for mental health problems. The other two adult trained nurses were female and working in accident and emergency departments.

## **Students in the quantitative arm of the study**

Consent and information forms were sent to all of the prospective students who were due to start the February 2011 substance module and again some 6 months later to students were due to start the same module one year later in February 2012. All of the students from both cohorts were asked (32 students in total) to participate and all agreed. However, I was concerned that asking the six students who were to be interviewed to then participate in the quantitative arm of the research may increase the possibility of a change in their behaviour simply because they were part of a study, the so called Hawthorne effect (Cresswell 2013). I therefore decided these students would not be included in this arm of the research.

This left 26 qualified nursing students who had agreed to participate, 18 from the first cohort and 8 from the second, 16 female and 10 male. The ages of these students were between 25 and 59, with a mean age of 42.3 years (see appendix 11). 14 (53.8%) students were mental health nurses whilst the other 12 (46.2%) were adult trained. The mean number of years qualified was 11.5, with a minimum of 4 years to a maximum of 23 years. 21 (80.8%) of the sample described themselves as white, whilst 19.2% came from one of three other ethnic groups. Three (5.7%) of the students described themselves as black African (two females and one male), one (1.9%) as a black Caribbean (female) and one female (1.9%) as a South East Asian.

All were asked to fill in two empathy questionnaires, the Helpful Responses Questionnaire (HRQ) (Miller et al 1991) and the Emotional Empathy Scale, (EES) (Caruso and Mayer 1998) prior to starting the SM module. They were then asked to fill in the same questionnaires on the last

day of the module. I distributed the questionnaires myself and asked the students to read the rubric attached to each (see appendix 1 and 2). After asking if there were any questions (there weren't any), I invited them to proceed. Time to complete the questionnaires ranged from 30 to 45 minutes. The questionnaires were collected by myself and prepared for analysis. Demographic data for the students who filled in these questionnaires is provided in appendix 12.

### **Teaching staff in the qualitative arm of the study**

Part of the research was to explore other teachers' experiences in teaching nursing students. The interviews also sought to explore their views between student-centred approaches to teaching and the establishment and subsequent demonstration of empathy in students under their tutelage.

Determining how many teachers would be sufficient to interview was calculated on the basis that I would stop when no new information from the data (saturation) seemed to be occurring. Although saturation is a concept that is used by many with the field as a criterion for determining sample sizes for qualitative research (Mason 2010), advice on actual numbers is rarely forthcoming. Different authors suggest different numbers, often linked to which type of qualitative research was being considered. In addition, most of these authors gave no rationale for their choices (Guest et al 2006). Since there appears to be little consensus regarding how many participants are required to achieve data saturation, I went ahead and asked nine nursing lecturers if they would be willing to be interviewed about the nature of their teaching. All agreed. Every staff member interviewed had a minimum of five years teaching experience, but

some teachers had over five times more than this. All of the teaching staff interviewed were qualified nurses and full time nursing lecturers, and with the exception of one, at the top of their grade. Eight were female and one male. All were white, with an average age of 43.4 years. Their experience as teachers varied from 5 years at the time of interview up to 30 years, with a mean of 14.8 years (see appendix 10). The teachers I asked to participate in this study were a mix of adult and mental health lecturers. They were chosen mainly on the basis of ease of access and availability, although I tried to select staff who I knew had different attitudes towards teaching and learning. This makes the way the teachers were selected a convenience sample but one that has also has elements of a purposive approach to sampling (Parahoo 2014; Robson 2011).

## **Ethical considerations of the Study**

Four principles guide the considerations of ethics in health care research. These are autonomy, non-maleficence, justice and beneficence (Beauchamp and Childress 2001; Grove et al 2014). Autonomy is understood as respect for choice; this 'allows' the individual to withdraw from the research at any time and a consent form which points this out was sent to every student in the study (see appendix 7). Given that I was the teacher as well as researcher of the students in the study means that a decision to withdraw could be more difficult than would normally be the case. I therefore pointed out at every available opportunity that I was aware of this potential dilemma and reassured participating students that there would be no repercussions if they made this decision. The second principle of non-maleficence means no harm should occur to the participants. This condition was met by engaging in a person-centred



manner, building trust, and respecting the right of the participants to answer the questions in any way they wished. It also meant being aware and responding appropriately to any sensitive issues that may arise. Providing details of the research methods and the rationale in the form of an information leaflet to would-be participants addressed this principle. It was also made clear that the information collected would not be used in any detrimental manner. This principle extends to the collection, storage and access to data. Issues such as the anonymity, confidentiality and dissemination of data have to be considered including awareness of legal protections such as the Data Protection Act, 1998 (Moule and Goodman, 2014). The names given in this thesis to both the students and the staff are pseudonyms in order that confidentiality and anonymity can be maintained. Access to the data is password protected and stored on my own personal laptop. The third principle is an obligation on the part of the researcher to ensure that the research is directed towards the benefit of others. This would mean ensuring that the findings are widely disseminated. This would entail sharing them with my colleagues and attending conferences to share them with others, and then seeking out relevant nursing and educational journals in order to publish these same findings. One of the reasons for undertaking this research was the hope that it would shed some light on helping to improve the student experiences of learning by enabling them to learn SMI consistent skills. The fourth principle, justice, is conceptualised as ensuring that equal access and opportunity is given to all who would wish to participate in the research irrespective of race, religion, age, sex or class. This principle enshrines the idea of fairness and this was achieved throughout the

research by making sure that the sampling procedure was transparent and inclusive. It also meant that the interests of participants take precedence over any other issues. This principle also applies to issues regarding data, in which all views must be represented. If ethical issues or perhaps more accurately ethical tensions do arise during a research study then being mindful that informed consent is not a single event but an ongoing process is essential. This meant that the original advice, information on the consent form and any other aspects of the study were raised as a topic for discussion at regular intervals during the study.

A second aspect of conducting this research is to adopt a reflexive approach towards my own actions. I was mindful at all times of the key ethical principles to do no harm, to convey respect to the individuals in the study and to issues concerning storage of information gleaned about the participants. To behave in an ethical manner is enshrined not only in my own professional code of conduct (NMC 2015) but also through the advice and guidelines issued by the Health Research Authority, both universities and by the Royal College of Nursing. The principle of doing no harm and being respectful to the individuals I interviewed is to acknowledge the collaborative nature of the person-centred interviews. These are understood to mean using the skills of open questioning, making affirmations, reflecting, summarising, clarifying and on occasions probing, whilst at the same time making sure that the autonomy and dignity of the participant was maintained. All of the interviews were conducted in this style but there is a real possibility that my novice status as a researcher left some worries and concerns that were not acknowledged and left unexplored by myself. I had no awareness of any ethical tensions arising

during the study but the power imbalance present in interviews does little to increase awareness of this process.

I acknowledged and tried to interpret nonverbal signs to give me indications if what I was saying was causing some stress for the interviewee. Sometimes it became necessary because of this to change the wording and timing of the questions because of feelings that some difficulties were arising in the interview. For example, it was clear that one student was becoming distressed when asked to describe her experiences of undertaking the SM module since she had difficulties with another member of the cohort who she felt was regularly discounting what she said. I judged that this student needed some reassurance and some attempt at validating her experiences, after which she appeared to regain her composure. I decided to go straight to the question about what a lecturer could do to help with the process of learning rather than focus on examining her beliefs and attitudes (see appendix 4). To do no harm could be interpreted as making sure that the participants did not feel that what they said was ignored, disregarded or misinterpreted during the study. I may also have inadvertently brought up issues that the participants may have preferred not to discuss; although I did not feel that this occurred there is no way of knowing that this was entirely true.

Power issues are ever present when a researcher conducts an interview but greater complex arises when existing unequal relationships such as those between teacher and student (Donalek 2005) are involved. Students may feel that they are obliged to give the answer that they think the lecturer wants to hear. Inequality in the distribution of power between researcher and participants needs to be acknowledged by and strategies

put into effect to minimise its impact. Establishing relationships in which the interviewees feel safe to tell their stories is the key to managing issues in which student don't feel able to share how they really feel (Murray 2003). One way to help to reduce this influence is by implementing practices that ensure that students are protected from harm. Stating that you are available to discuss the data and any implications at mutually agreed times can be reassuring to participants. In addition, giving written information about how the data is collected, stored and eventually disseminated can also help empower those interviewed. Informing all of the interviewees that the information gathered was available at any time for them to check for accuracy and interpretation was also an important step in aiming to reduce these power imbalances.

## **Data tools and analysis**

Interviews and empathy questionnaires were the data tools of choice. What follows is a rationale for their use, a description of their characteristics, and a consideration of their evidence bases.

### **Interviews**

The rationale for choosing interviews as a data collection method lies with its unlimited potential, especially so for unstructured and semi-structured interviews (Parahoo 2014). Skilled questioning can create opportunities for the interviewee to give views on the topic under scrutiny in a setting without fear or pressure from others. This approach best suited my research questions which ask both student and teachers to explore their thoughts and feelings about the nature of their learning and teaching. Structured interviews were rejected on the basis that their very nature would not allow for further elaboration (Parahoo 2014) and because they

are in many ways similar to questionnaires, albeit the information is obtained verbally (Robson 2011). Unstructured interviews do 'allow' both interviewer and interviewee the opportunity to explore any line of enquiry but can often stray into areas that have little to do with the focus of the research, and were subsequently rejected because of this tendency. Semi-structured interviews were chosen because the interviewer can probe answers and follow different lines of enquiry based on the responses from participants as with unstructured interviews, yet still have a structure that focusses the interviewer and interviewee on the research questions (Silverman 2011). Interviewing teaching staff and students led me to add and modify my list of prepared questions depending on the responses I received. This flexibility offers the possibility of an exploration of the interviewee's verbal and nonverbal responses, a distinct advantage of the interview over questionnaires. Yet this greater flexibility to modify your questions does require some skill, expertise and stamina on the part of the interviewer (Robson 2011). A face-to-face interview also gives the participants the opportunity to clear up any ambiguities or confusion, should it arise. The process can best be described as a collaborative interviewing approach in which the 'core' attitudes of empathy, genuineness and UPR are present (Kvale and Brinkmann 2009). The aim is to establish a rapport in which these attitudes are present in order for participants to feel safe to tell their stories when interviewed (Murray 2003).

### **Description and definition**

Kvale (1996:14) states that an interview is:

An interchange of views between two or more people on a topic of mutual interest, sees the centrality of human interaction for knowledge production, and emphasizes the social situatedness of research data.

This view of interviewing perceives it as a collaborative, multi-phased event (Whiting 2008). These phases are building rapport, exploration, cooperation, participation and termination. Building rapport involves the use of person-centred skills such as empathic responding and attending, followed by the use of open questions as a means to explore some of the issues (Rubin and Rubin 2011). The interview questions (see appendices 4 and 5) were designed to explore student and staff attitudes, beliefs and values regarding learning and teaching. My role as the interviewer was to encourage further elaboration and expansion of what the respondents said. The primary skills I used to achieve this end in addition to those mentioned above were clarifying and summarising, the same skills I would use when speaking to a patient or student. Participants often showed a substantial amount of apprehension at the start of an interview and the use of these skills can increase mutual trust, an essential requirement for participants to feel safe enough to share their thoughts and feelings (Price 2002). Using a person-centred approach gave opportunities for both participants and the interviewer to share their stories. This reciprocity is thought to enhance the quality of the data obtained (Rubin and Rubin 2011).

In developing these questions, I was mindful to avoid using ones that were too long or questions that steered the interviewee to answer in a particular way. All of the questions were of the open variety, in which further exploration of what the participant said could be developed and which encouraged the display of feelings (Whiting 2008). Questions were

read and reread to increase familiarity and reduced the tendency for the interview to become stilted. The first question was deliberately broad as a way of reducing any discomfort or anxiety that the participant might be feeling on the initial encounter. The final list of questions was revised after several drafts in order to increase the possibility of fluency.

All of the interviews of staff and students were conducted between September 2010 and March 2011. The interviews were recorded on a digital device and were emailed to a transcription service. This was done principally in order to save time. All participants were informed by email some three weeks later than they have all been completed and that they could contact me either through email, by phone or in person in order to verify the accuracy of the transcriptions. No students or staff however, requested to see them. I did cross-check that the information obtained from the transcription service was an accurate representation of the voice recordings taken from both the students and teaching staff.

### **Issues in interviewing**

Several issues arise with interviews not least the extent to which the extraction and interpretation of the data obtained only has relevancy to the time and place to when the interviews actually occurred (Morgan 2007; Robson 2011). Some authors however, would claim that there is much that is relevant and therefore transferable from data collected in this way to other populations of students, especially when issues as broad and as fundamental as learning are under scrutiny (Guba and Lincoln 1989; Morse and Field 1995). Moreover, the extent to which the nature of the relationship established between the interviewer and the respondents affects the gathering and interpretation of the data is of fundamental

importance and is therefore a prime issue for consideration. Nunkoosing (2005) claims that power differentials exist in all human exchanges. In order to avoid the possibility of exploitation during the interview, he urges that the interviewer needs to be constantly aware of the changing nature of self, and the other identities (for example, race, gender, teacher, nurse) presented when an exchange takes place. The interviewer needs to give '...full expression to the emotional lives that these stories recreate' (Nunkoosing 2005:705). Providing a climate in which interviewees feel welcomed and encouraged to share can be problematic, especially given the claim that it allows the researcher to 'democratise power relations' (Karnieli-Miller 2009:280) between researcher and participant. Kvale (2006) claims that interviewing in a person-centred manner has manipulative potential pointing out that forming this type of relationship does not ensure a redistribution of power towards the interviewee. Several aspects of interviews are different from person-centred relationships in that it is the researcher who sets the agenda, formulates and asks the questions, decides when to initiate and stop the conversation and controls the interpretation of the data. The likelihood that the students I interviewed might be tempted to tell me what I wanted to hear may have been increased by the inclusion of current students who had not yet had their essays and presentations assessed by me. Given that power imbalances already exist between a student and a lecturer (Brookfield 1995; Cranton 2006), interviews would more than likely exacerbate this effect. When research interviews take place it can alter this existing unequal distribution of power between a teacher and student (Holloway and Wheeler 2013; Robson 2011). Power imbalances can be shifted in favour of the



interviewee if the interview setting is chosen by them (Elwood and Martin 2000). However, as previously mentioned, this innovation was rejected in this study on financial grounds.

The major problem most authors cite concerning interviews focusses on the time they take to organise and undertake, and the time taken to transcribe the data (Holloway and Freshwater 2007; Robson 2011). The whole process did take longer than I thought it would. If I was to repeat this research I would consider the feasibility of using focus groups, although their limitations are well documented (Jayasekara 2012).

It is possible that my inexperience of research interviewing led to some restriction and/or curtailment of the data collected although this could have been compensated by my clinical experience of forming person-centred relationships. During the interviews, I was aware of mixed feelings towards my interviewees: although I wanted them to feel free to answer the questions in any way that they saw fit, I was also aware that I was anxious that they answered the questions in such a way that would reinforce my thoughts and feelings as about what was important in instigating change. This ambivalence permeated most of the interviews and this manifested itself in experiencing moments of anxiety whenever some respondents decided to talk about issues that I thought were not relevant. I wanted them to answer in a particular way and quickly realized that I was blaming my questions for what I thought was a 'poor' answer. Some respondents clearly wanted to get some other issues 'off their chests.' These 'difficulties' centred around support for the forthcoming assignment and problems experienced with their last one, interpersonal difficulties with previous lecturers and current/past peers, and finally difficulties at work. Those

students seemed glad of the opportunity to use some of the time in this way. It does suggest that more contact time to discuss some of these important issues is required, at least for some students.

### **Reliability and validity of the interview data**

To minimise accusations of bias the interview data were subjected to procedures that are designed to ascertain its reliability and validity/trustworthiness. The qualitative data in this thesis used the criteria set out by Lincoln and Guba (1985) to ascertain its trustworthiness. This is deemed to have been achieved if it meets the requirements of four criteria: -credibility, dependability, confirmability and transferability.

Credibility is establishing how believable the findings are. The most important way that this can be achieved is by checking the accuracy of the data with the original participants, so called 'member checking.' This extends to any interpretations made of the data. This can take place at any stage of the study. Students were regularly invited to check via email the transcriptions of their interview and the accuracy of the interpretations made of the data. No students elected to take up this option. It could be that the students felt my interpretations were satisfactory. A more likely explanation is that they felt that they couldn't challenge them even if they disagreed because of my position as their teacher in relation to them as student.

The use of well-established methods of collecting and analysing the data establishes credibility (Shenton 2004). The interview is a standard procedure for the collection of people's perceptions of the subject in question, but the information can be perceived as suspect if participants are asked leading questions. Creating the atmosphere in which people feel

safe to talk freely and honestly can be achieved by using communication techniques such as active listening, open questions, reflection and summarising during the interviews. Immersing oneself as much as possible in the culture, preferably before the data is obtained (Morse and Field 1995; Shenton 2004) enhances credibility. Teaching in higher education for 20 years enabled me to feel reasonably confident about meeting this condition, but lecturers will always remain outsiders to the intricacies and complexities of student culture. However, regular discussion and exploration of the research with supervisors, other academics and students went some way to meeting this condition. Triangulation can enhance the credibility of the study through acquiring data from different sources and from different times (Denzin 1989). I therefore interviewed staff from different fields of nursing (adult and mental health) and former as well as current students. A detailed description of all aspects of the research process promotes credibility; the more detail provided (the 'thicker' the description) the more likely the findings can be evaluated to determine their applicability to other people in other settings. Issues of dependability were met by supplying sufficient detail in order that others could repeat the research. Since this detail has already been provided in this thesis to meet the criterion for confirmability it should, as Lincoln and Guba (1985) argue, be sufficient to meet issues with regard to dependability.

Confirmability is a process by which the findings are assessed to determine whether any bias has been introduced into the study. This is achieved when conditions are met regarding credibility, dependability and transferability (Guba and Lincoln 1989). This study met this condition by supplying clear information and rationales for all of the decisions made in

the study. Transferability refers to the extent to which the findings can be applied to other settings and depends on their similarities. Providing enough information so that others can judge its transferability can meet this condition (Guba and Lincoln 1989).

## **Qualitative data analysis: identification of the themes**

Thematic analysis is a method of organising, describing and interpreting data and can be used irrespective of the theoretical perspectives of the researcher (Braun and Clarke 2006). One of its great strengths therefore is its flexibility. There appears to be no consensus on how it should be undertaken, nor any 'hard' evidence of one approach enjoying superiority over another (Boyatzis 1998; Attride-Stirling, 2001). Several methods are in use, from checking the data for similar words and expressions to analysing every sentence to identify 'hidden meanings.' Nevertheless, these themes and subthemes must represent the 'whole story' (Braun and Clarke 2006). A theme is understood to mean the 'conceptual linking of expressions' but Ryan and Bernard point out that the term is somewhat 'fuzzy' (2003:87-88). A theme is:

... something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (Braun and Clarke 2006:82).

Ryan and Bernard (2003) note that different authors have used different words to describe an expression of a theme such as 'categories' (Glasser and Strauss (1967), 'codes' or 'chunks' (Miles and Huberman 1994), 'data bits' or 'labels' (Dey 1993). The term 'theme' will be used rather than the

alternatives mentioned because it is in common usage and therefore understood by people from different fields (Ryan and Bernard 2003).

A theme then is primarily created from a concept or expression that reoccurs when the data is scrutinised (Boyatzis 1998). When trying to develop themes/codes, five questions should be asked:

- What is going on?
- What are people doing?
- What is the person saying?
- What do these actions and statements take for granted?
- How do structure and context serve to support, maintain, impede or change these actions and statements? (Charmaz 2003:94-95).

This approach to the development of themes was found to be useful. Ryan and Bernard's (2003:87) advice that you know when a theme has emerged when you can answer the question 'what is this expression an example of' was also applied to the data sets.

This process began with a thorough reading of each typed transcript in order to get a sense of what the data was 'saying' overall, resisting the temptation to plunge straight in order to identify individual themes (Pope et al 2000). A re-reading then followed, but this time a 'text box' facility in Microsoft® Word 2010 was created in the margin of each page of transcript in which I could add words or phrases that seemed to explain/summarise what each segment of the data meant (see appendix 8). Any key words were also highlighted at this stage. These were then colour coded in order that I could initially cross-reference similarities, differences and anything of note/interest within the interviews. All of the interview transcripts were read closely and on reading again, themes were added to the margins in

an attempt to explain what was happening/what was not happening (Bryman 2008). Any unusual comment/ phrases or change in attitudes, emotions or behaviour towards learning were also noted as were any repetitions of key words or phrases. Inevitably, the themes that did finally emerge were a product of what I thought I saw in the data plus the influence of my own values, my philosophical and theoretical orientation, attitudes, and knowledge base. Re-reading the data sets again added more themes, especially when ideas of my own concerning what I understood the data to mean were included. Some of the respondents identified different aspects of the same theme, which lead to the creation of subthemes. Further readings concentrated on responses that I had expected, and which did not subsequently materialise. This consideration of so-called 'missing data' can generate new insights (Ryan and Bernard 2003). Finally, consideration was then given to how the respondent answers were influenced by issues such as gender, professional, cultural and ethnic perspectives. Several themes were initially identified from the student and the staff interviews. Themes were then checked for similarities and/or repetition and whether merging could take place. Some arose that had a theoretical context and the research questions were influential in this regard. It was clear that themes could be further organised into subthemes (see table 2 below).

Table 2. Final themes and subthemes extracted from the data

Data source	Theme	Subtheme
Students	Engagement	Self-awareness
		Developing empathy
		Learning from others
	Learning	Self-efficacy
		Environment
		Nature of change

Teaching staff	Engagement	Teaching as engagement
		Engagement as the giving of self
		Engagement as role modelling
	Learning from others	
	Group size	
	Dynamics of change	

## **Quantitative design and empathy questionnaires**

Several quantitative designs were under scrutiny and after much deliberation, a decision was made to use the pretest-posttest approach. The pretest-posttest design involves measuring the dependent variable (in this case empathy) of a sample of students at two different points in time to determine whether an intervention (in this case the module) had produced any change (Watson et al 2008). A major criticism of a pretest-posttest design is the lack of a control group, which raises concerns about the reliability and validity of the data (Creswell 2013). Using a control or comparison group establishes a baseline so that any changes witnessed in the 'experimental' group, would be more likely than not due to the intervention rather than other 'extraneous variables,' such as life events or/and time. For example, the very act of taking a 'test' on empathy raises its profile and may encourage students to want to examine the issues in more depth. Some may read articles on empathy, the SMI or MI, watch a programme about empathy, go to a conference about either of the above and so on. In addition, both of these courses are part-time and all of the students were working in various clinical settings where empathy approaches were use to a lesser or greater extent, which could have influenced the result. Taking the same questionnaires the second time usually leads to improved scores anyway, due to familiarisation not just

with the environment and the teacher but with the 'test' itself (Parahoo 2014). In the case of the current research comparing one group of students who received the module with an MI teaching approach could be compared to another group of similar students who were taught the same module but with a 'standard' teaching style, (one in which the emphasis is on information dissemination). Any difference in subsequent empathy scores (if this was the dependent variable to be measured) could more than likely be attributed to the teaching approach than to anything else (provided it reached statistical significance). Be that as it may, this option was dismissed as too difficult and time consuming to arrange at the time. It would need a comparable group to be taught by myself in this 'standard' teaching approach all of which was not really achievable given that I had been teaching using SPACE (self-awareness, partnership, acceptance, compassion and evocation) for some considerable time. Moreover, I would have to teach both groups at the same time and there is no evidence there would be sufficient demand for the course to provide two cohorts of students. Comparing SPACE with a 'standard' approach from another teacher would introduce too many confounding variables. Despite this lack of a control group, there are some authors who believe that a pretest-posttest design is capable of indicating whether change has taken place when an intervention has been applied (Watson et al 2008; Parahoo 2014). Therefore a decision was made to adopt it.

Deciding on which ingredients to focus on and measure when a partnership or collaboration has the hallmarks of engagement is never easy. Nevertheless, there is a general consensus that a display of empathy is a sign of collaborative forces operating within a therapeutic relationship



(White 1997; Egan 2009). The easiest and most convenient way to measure this with whole cohorts of students is to use empathy questionnaires.

Although several standardised empathy questionnaires already exist, there is little consensus about their efficacy and effectiveness (Yu and Kirk 2008), due largely to a lack of agreement of a definition and therefore what its components are (Jolliffe and Farrington 2004). Given this lack of consensus, a questionnaire that measured empathy from a different theoretical framework than the HRQ was employed, because using different data instruments is thought to strengthen the reliability of the construct (Denzin 1989). The HRQ (Miller et al 1991) was chosen primarily because it was devised by the originator of Motivational Interviewing (MI) and secondly because its scenario based questions allows participants to provide a more considered response, one that can be scored to ascertain the depth of reflective listening. The second questionnaire, the EES (Caruso and Meyer 1998) was chosen because of its emphasis on the emotional aspects of empathy, advocated by several scholars (Mehrabian and Epstein 1972; Mehrabian et al 1988; Holm 1996; Spreng et al 2013).

Some authors prefer to conceptualise empathy as a demonstration of the skill of reflective listening (Gordon 1970; Miller and Rollnick 2002), which is the focus of the HRQ (Miller et al 1991). The HRQ (Miller et al 1991) presents scenarios that require the participant to respond in ways that Carl Rogers and others would more than likely understand as being empathic (Rogers 1957, 1980; Truax and Carhuff 1967; Miller 1991, 1992). This is achieved by rating responses to six scenarios according to the depth of reflection (see appendix 1). Each response is scored from 1 to 5, with

higher scores given to reflections that revealed greater 'depth.' If a response in the HRQ includes one of the twelve 'roadblocks' to communication such as arguing, analysing, warning or giving advice (Gordon 1970, see appendix 3) and no reflection, the response is given a 1. A score of 2 contains a reflection but also a 'roadblock.' A reflection that repeats what is said is given a 3. A response that is a reflection but paraphrases the scenario and/or is given some added meaning scores a 4, and finally a reflection scores a 5 that adds feeling or uses metaphor to describe what is happening.

The use of two investigators to score the data obtained can enhance the reliability of the data (Denzin 1989). Appraising the depth of reflective responses to the scenarios in the HRQ requires some expertise, and therefore an experienced clinician familiar with using reflective statements in practice was chosen as the second scorer in addition to myself. No training was given to the second investigator, since she was chosen on the basis of 15 years' experience working as a trained nurse with health service users experiencing addiction problems. A test to check the interrater reliability between the scores obtained from the two investigators used on the HRQ was undertaken in order to check their consistency. There is no single method that is deemed superior to undertake this (Hallgren 2012). Computing Pearsons' product moment reliability coefficients ( $r$ ) for each item, (6 in all) of the HRQ and comparing the scores is one way to achieve this. These scores ranged from .47 to .72 (all  $p < .05$ ). The interrater reliability for the sum of the scores for each participant ( $N=26$ ) was 0.54 ( $p < .01$ ). Landis and Koch (1977) and Altman (1991) state that this level of agreement between the two scorers can only be described as moderate.

Conversely, Fleiss (1981) argues that values between 0.4 and 0.75 can be interpreted as fair to good. Yet this interpretation of the data is somewhat arbitrary since none of the above authors provide any justification for their assertions. The scores do suggest though that consistency of scoring between the investigators could be improved through the implementation of a training programme.

Given the lack of consensus about the most effective way to measure empathy, a second questionnaire that adopted a different theoretical framework to the HRQ was employed, because using different data instruments is thought to strengthen the reliability of a construct (Denzin 1989). It employs a Likert scale of 1-5. 1 equates to strongly agree and 5 equates to strongly disagree (see appendix 2). The questionnaire is divided into four categories that emphasises the emotional aspects of the construct. They were labelled as Suffering (items 3, 5, 6, 8, 12, 18, 24, and 28), Positive Sharing (items 14, 22, 23, 29, 30), Responsive Crying (1, 20 and 25) Emotional Attention (4, 9, 13 and 27) and finally Emotional Contagion (items 11 and 17).

Six of the items were reverse scored prior to analysis because they were negatively worded (see appendix 2). These reverse score items have a long tradition in questionnaire design and are included in order to reduce acquiescence and extreme response bias, so that respondents pay more attention to the items they are reading (Anastasi 1982). Yet there are criticisms of this strategy in that it can lower the internal reliability of the questionnaire (Stewart and Frye 2004) and lead to problems with the way the categories are structured (Pilotte and Gable 1990; Barnette 2000).

### **Advantages and Disadvantages of Questionnaires**

Questionnaires have several advantages; they are easy to use, relatively quick to fill in, can be used with large samples, allow time for the respondent to consider an answer, contain data that is quantifiable, can be made anonymous and finally can be standardised. Consequentially, they can be reliable and valid instruments (Parahoo 2014; Robson 2011). Deciding which of the many available to use though was much more problematic since the disadvantages are well known. Response rates if posted tend to be low and they often fail to capture more than just a cursory notion of what is wanted by the researcher. Some of the questions may not be answered because the respondents are unwilling to do so, or are not clear about what is being asked. If too many questions are posed, participants may 'rush' some of the answers, others may not contain their real opinion, fearing that it may be deemed unacceptable or 'wrong.' The responses to the questions asked often tells little about the context and culture of the person who fills it in. It therefore becomes paramount to decide on which questions to use, how they are worded, how many to use and the order that they come in (Polit and Beck 2009; Robson 2011).

The use of a scenario-based questionnaire in which the respondent has to actively create an empathic statement is considered preferable to the 'passive' Likert scales of many of the questionnaires used to measure this construct, since self-rating is often confounded with ideas of social desirability. These scale-based questionnaires are designed to detect how empathic the person thinks and feels they are and this is one of their major weaknesses. Recent data has upheld this view, highlighting shortcomings in many of these currently available 'static' questionnaires (Lietz et al 2011). Even those empathy questionnaires that have been used more

often than others have not been able to consistently demonstrate that high scores on a scale translates into becoming more empathic with health service users, indicating that their reliability is somewhat questionable (Polit and Beck 2009; Robson 2011). Despite these shortcomings, Likert based scales are still the most common approach used for detecting and measuring the presence of empathy (Holloway and Wheeler 2013).

# **Reliability and Validity of the quantitative data**

## **Reliability**

Reliability is understood as the degree to which an instrument measures the construct under scrutiny the same way with the same people each time it is used (Robson 2012). Internal consistency is an accurate measure of the reliability of a research instrument and is a measure of the extent to which each of the items on the scale is measuring the same construct. A widely used measure of this internal consistency of scales and questionnaires is Cronbach's alpha coefficient, which measures the correlations between the different items on the test under scrutiny. It is calculated as a number between 0 and 1 and the higher the estimate of reliability (the closer the score gets to one) the more the items on the questionnaire or scale are correlated to each other and the lower the result can be attributable to error (Tavakol and Dennick 2011). The alpha coefficient of the EES (Caruso and Meyer 1998) is high, with a reported figure of .88. The current study used the same statistical test via the aid of the Statistical Package for the Social Sciences (SPSS) to check the reliability of this questionnaire and computed a value of .90. The internal consistency of the HRQ was analysed using the same statistical test and resulted in a figure of .89, the same as that of the authors (Miller et al) calculated in 1991. An internal consistency coefficient of .7 is regarded as acceptable by most authorities (DeVellis 2003).

## **Validity**

SPSS was used to calculate correlations in order to explore the strength and direction of the relationship between continuous variables. The data collected from both questionnaires is non-parametric (the numbers used for both questionnaires have order but the differences between them are not of same magnitude). The appropriate statistical test is the Spearman rho test. It measures the strength of association between two variables, in this case whether attendance at a substance misuse module increases the demonstration of empathy. Validity is a measure of whether a data collection tool accurately measures what it is supposed to measure (Moule and Goodman 2014). There are three types of validity measures; content, criterion and construct. Content validity is concerned with the extent to which the instrument in question was able to collect all aspects or interpretations of that construct; one way to achieve this is to get expert opinion when constructing the instrument. Using established questionnaires that already have high reliability and validity is one way to meet this condition. For example, the HRQ (Miller et al 1991) was based on an empathy scale devised by Truax and Carhuff (1967), an empathy questionnaire that enjoyed regular use and was known for its reliability. Criterion-related validity is comparing results from two different methods. This was met in this study by using two questionnaires. Two types exist, concurrent validity and predictive. Concurrent validity is the extent to which correlated outcomes are achieved when both questionnaires are administered at the same time. Predictive validity is the ability of the questionnaire to indicate differences between current and future measures of the concept.

Construct validity involves making a judgment as to whether the instrument is measuring what it says it is measuring. Even though both questionnaires conceptualise and measure empathy in different ways, their descriptions of its elements remain within accepted definitions of the construct (Yu and Kirk 2008).

## **Quantitative data**

Data obtained from the empathy questionnaires was entered into the statistical package SPSS in order to detect the strength and direction of the relationship between my teaching approach and the students' experience of empathy. Different tests are available depending on whether the data are considered to fulfil the requirements of being parametric or non-parametric. This data are more likely to meet the conditions of being nonparametric. When this is the case, the Spearman correlation coefficient or rho test is recommended by SPSS for use in detecting the strength of association between two variables. The value of rho varies between plus one and minus one with plus signifying a perfect positive correlation between the two variables and minus one signifying a perfect negative one. This test was applied to the findings from both empathy questionnaires, the EES (Caruso and Meyer 1998) and the HRQ (Miller et al 1991). No correlation was found between the age of the students and their ability to display empathy.

The Wilcoxon Signed Rank Test statistic is the appropriate non-parametric test to detect if different scores from the same participants reach statistical significance. The difference between pre-test and post-test scores obtained from the EES and those obtained from a mean of both



investigator scores on each of the 6 items of the HRQ were therefore subjected to analysis.

## **Conclusion**

This chapter argued for the use of Action Research (AR) as a methodology to collect the data for this thesis. This is because AR's goal of evaluating changes in practice in order to improve that practice shares similar goals to the research questions (see chapter 2).

A mixed methods approach was used for data collection because it can achieve a more complete understanding of the issues than just using either quantitative or qualitative methods. The essential characteristics of the students and staff invited to undertake the research were then described in order to give the reader some basic knowledge of the respective samples. Ethical principles and consent were explained and duly noted. I hoped that using a mixed methods approach would deepen my understanding as to whether forming person-centred relationships when I taught influenced changes in students' attitudes towards their learning and whether this change resulted in changes to the way they formed relationships with their patients and clients.

Both data collection instruments (interviews and the two questionnaires) were then described, followed by a section on their strengths and weaknesses. The main strength of semi-structured interviews is that they are able to explore individual responses issues within a framework of set questions that was used with all of the participants. Despite their limitations both empathy questionnaires are reliable and valid instruments and are sufficiently different to add to the credibility of the study. The next chapter will discuss the findings of the data in detail.

# Chapter 4 - Data analysis

## Introduction

In the late 1990's I became aware that my perspectives towards teaching and learning were beginning to change, due largely to the introduction of an adapted version of the Spirit of Motivation Interviewing (SMI) into my teaching practice. This SMI is a set of principles which guides the formation of person-centred relationships with patients and clients, considered essential in order for the practice of the counselling approach Motivational Interviewing (MI) to take place (Miller and Rollnick 2013). However, I found that my teaching became more effective when I adapted the SMI to form an approach to teaching which I have called SPACE. It has five components; self-awareness, partnership, acceptance, compassion and evocation (see chapter 1 for a full account of this approach). Using SPACE had two goals; firstly it was used as a means to form person-centred relationships with students in order to increase the possibility that their attitudes towards learning would be enhanced. The second objective was that if this transformation of attitudes occurred, the students would be more able to adopt the values associated with caring such as empathy and compassion and by so doing improve their nursing practice.

All of these themes and subthemes presented in this chapter emerged from a process which is described in detail in chapter 2. In summary, it involved highlighting key words and phrases from the interviews on what helped and what hindered their learning, and then revising and reinterpreting this data in the light of new insights obtained from several re-readings. A similar process took place for the staff interviews but with an emphasis on what they thought they did when teaching to promote

learning. The responses from the students will be discussed and analysed before those from the nurse teaching staff.

## **Qualitative Theme: Engagement**

### **Subtheme: Self-awareness**

When the student data was analysed a major theme to emerge in relation to their learning was engagement. All of the students felt that their interest and enthusiasm to learn were increased when teachers made efforts to engage with them. Engagement is understood as the ability to form collaborative relationships based on acceptance and compassion. Collaboration means acknowledging that students have valuable knowledge that can help in their learning. Compassion requires the demonstration of empathy.

Without self awareness, however, it is difficult to imagine acceptance and empathy being effective in forming relationships. My experience of using the SMI in teaching felt that it needed the addition of self-awareness to make it more applicable to teaching. It is understood to mean become aware of your own attitudes, values and beliefs in order that they can serve as a guide for your own behaviour (Cook 1999).

Louise, one of the students who had undertaken both of the modules states:

I think you've got to make it a bit more fun and obviously you've got take it seriously, but you can be a bit light hearted and learning can be fun. It's not about sitting in a classroom and somebody sort of just dictating, otherwise you think I might just as well get the essay question and go off and researched the subject myself and just put an essay in.

Here Louise implies that learning is enhanced when some kind of relationship between the teacher and the student emerges, and suggests it is much more than the acquisition of facts. She is also offering a challenge to the conventional methods and emotional expectations of teachers and teaching when learning take place. She clearly states that teaching in a 'neutral manner' in which there is no consideration of the nature of the individual people who are learning would be pointless. She is arguing that teaching should be about engagement and that means that the whole experience doesn't have to be solemn but should acknowledge other emotions.

She goes on to say:

...you were quite honest in what you knew and what you didn't know... you sort of tapped into us into looking more in depth into the subject, kind of going a bit deeper into the subject, explaining the myths and the kind of things and there was that kind of openness in terms of you're very open about the subject. Where you didn't have a clue you said well, I don't know how... but some of these things have helped and some of these...sharing your experience with us.

This display of 'realness' is being self-aware. This self-awareness manifests itself in different ways, one of which is not pretending to know things when you do not. It seems that my attempt at being 'transparent' made it easier for her to 'connect' to me which in turn made it easier for Louise to be able to examine the complexity of the issues. The willingness and capacity of Louise to learn seemed to increase only when she had been

exposed by my willingness to 'be myself,' (self-aware) the first component of SPACE.

Reagan, a student, voices her opinions on the value of becoming more self-aware and its implications for practice:

...if I come across to people in an arrogant way, they will fire that back at me. It's like a mirror image, so it's having that level of self-awareness to be able to sit and think, 'Well if I behave in a way that's professional and kind and considerate of that person and they're still being aggressive, it's not about me. It's about them. Well it's like if say, for instance, if you walk in anywhere and you can speak to somebody and they're really... if I'm feeling rubbish and I speak to somebody in a rubbish manner, they will generate that back to me so it's like a mirror image. And that's what I'm trying to work on. So if I – I sound a bit iffy now – but if send out messages of being quite... of being kind and considerate, and trying to give people the benefit of the doubt, then I hope that they will show that back to me. Does that make sense?

Besides providing an example of reciprocity, the above passage also rather eloquently points out that adopting a critical, self-reflective approach to practice is capable not only of increasing self-awareness, but also begin the process of transforming one's attitudes values and beliefs. Reagan states she has changed significantly in the way she would treat dual diagnosis and substance-misusing health service users compared to the way she treated them in the past. This change has been brought about by learning more about herself, (a goal of teaching in the SMI) rather than learning through the acquisition of facts and/or technical skills. It is

impossible to say that this change in her attitudes was a direct result of the substance misuse course but she feels it has at least been something of a catalyst. Her reflective comments in the next section indicate that the module has started a process in which her ways of thinking about drug users are beginning to shift:

Because I feel I have changed with practice because I've learnt more. I changed how I am with patients because I look a bit more and I know and I understand and I feel that helps me to help them and personally I just feel learning has helped me as a person to understand more about them. It becomes where... where like... say for instance the people... before the course, I was aware that there were individuals but when you're in A&E you do have a tendency to think, 'They're here again. They need...' and almost that kind of frustration and, 'Oh well. They've taken...' Like watching my own stereotyping of people when they take overdoses, my attitude towards them is, 'Well that's not going to work. Let's give them a list of what really works.' And... Yes. I noticed how judgmental I can be, and I didn't like that in myself. So in order to address that I had to look at why I was being so judgmental and usually, for me, if I'm angry or defensive or judgmental it's usually due to fear, so quite frightened of what I didn't know, so therefore it has them put on a front of either defensive or angry, or frustrated.

Reagan does not like what she sees in herself when her self-awareness is raised. Whenever substance users came into A and E she realises that it triggered a host of negative emotions and judgments about this group of individuals. She describes how she was quick to come up with definitive

statements about drug users 'here we go again' '*they need,*' 'I know what will work.' Reagan acknowledges that what lies behind her judgmental attitudes towards people who have overdosed on drugs is fear, which then triggers negative emotions in her health service users. She then goes into more detail as to how the module has affected her attitudes:

I'd say it's opened my mind up even more [*the module*]. I try to have an open mind today and then it opened my mind up a lot more to the different levels of psychiatric needs that patients have. It's not just about the addiction itself. There's personality disorders and all sorts of stuff I don't have any idea about. Yes. I mean it's taking on board that... my dad suffers with depression but I don't really understand it, and because I don't understand it I've had a tendency to go, 'Tsk. Just get on with it. What's the problem? Why aren't you doing...?' So for me it's having a deeper awareness that it's not all as I think it should be, that my...there's a lot more to it than what meets the eye. It's the complexity of everything that people go through, what they're bringing to the table..., but it's really just trying to take the person just for who they are.

The key word here that Regan uses is 'complexity.' She found herself advocating 'quick fix' solutions to problems through a lack of understanding that far from being simple, many addiction and mental health problems are linked to and perpetuated by a network of interrelated spiritual, psychological, social and physical factors. Change came about through a module in which students are encouraged to tell their stories, to reflect on practice. In the safety afforded by a non-judgemental climate created and fostered within the classroom, Regan is encouraged to develop her



awareness of self, through creating a climate where her comments will not be judged. Reagan has shifted her perspective from seeing a person as a set of symptoms which needs 'fixing' to a person who has complex problems or as she puts it, to seeing the person 'as they are.'

What Reagan is doing here is resisting the temptation to implement the 'righting reflex' (Miller and Rollnick 2002:6). This righting reflex is a desire of many health care workers to give advice and put people on the 'right' course of action. However, it fails to acknowledge that many drug users are ambivalent about their use, in which the user is aware of both sides of the argument for change and for not changing. The righting reflex adopts the 'good side' ('change' side) of the argument but fails to acknowledge the 'bad side' ('remain the same' side). When a worker adopts this 'righting reflex' (you need to quit using drugs) the risk is that the patient will adopt the opposite view (I don't think so). Seeing the whole person makes it easier for her to reject the 'righting reflex' as a health care strategy. Through incorporating self-awareness in my teaching I was prepared to share my feelings and thoughts with my students. Allowing others to 'see' what you are experiencing gives permission for students to examine their own thoughts and feelings about themselves and in relation to the topic at hand.

## **Subtheme: Developing Empathy**

All of the students held the view before the start of the module that being empathic was an essential way of communicating with all health service users as a way to show respect, develop trust and deliver compassionate care. Here three student views are presented in which the value of empathy is described. Two of them point to the teaching in the modules as empathy based. Empathy is an essential aspect of acceptance (as described in the SMI), which is the third component of SPACE.

Martin shared his everyday experiences of working as a staff nurse on a Psychiatric Intensive Care unit (PICU) and points out the centrality of being empathic when communicating with patients:

A lot of my job is supervision [*many employers require senior nurses to supervise junior staff*] and explaining empathy that I know they know [*here Martin is referring to staff*] but reminding them of empathy during supervision because confrontations are not acceptable in that kind of environment, but are commonplace unfortunately.

It appears that nursing staff are sometimes confrontational with the patients because they do not seem to appreciate how much time and effort they have put into their care:

I can tell you why [*confrontation occurs*] the staff nurses that I supervise say it is, they say it is because they put everything into taking care of their patients, their care planning and the paperwork...and then when a patient, I don't know, argues back, that sounds terrible, or causes confrontation or doesn't do something you ask of them, or disobeys a house rule shall we

say...they take it quite personally the staff nurses do because of the time they put into the health service users, when that respect isn't given back they take it personally. I think people who do not remind themselves of empathy do treat health service users disrespectfully. If you don't do empathy then [you are] more likely to be confrontational.

Martin is clearly not condoning the behaviour of his staff but is trying to understand/justify in relation to its context. Yet he does state that confrontation is not an acceptable intervention and the way to change it is to become more empathic. He seems to be arguing here for more empathy training. He perceives empathy and confrontation as opposites and the way to reduce confrontational approaches is to make an effort to listen, understand and communicate that understanding to another.

He goes on to say being more empathic is not innate but can be learnt:

I think... and ...yeah I think empathy is reinforced and teachable yeah I think it is... [*that empathy is teachable*] by discussing, by scenarios, just examples of using empathy.

He also points out that the modules could be reframed as 'Empathy Training':

Quite a lot of it's back to back, [*he did the 2 modules consecutively*] and it's definitely given me a boost as it were, a boost of empathy if that exists. I mean I did substance misuse and dual diagnosis back to back so I suppose I was going through empathy training.

The point about his exposure to what he calls 'empathy training' is that empathy was not timetabled as such as a session, discussed in any great depth or provided as 'information;' 30 minutes out of a possible 48 hours

of teaching was given over to the discussion of the concept, approximately 1% of the teaching time. It was not taught to any great extent yet he felt it could have been reframed as training in the use of empathy. Empathy training without referring to content suggests a link to process and this was demonstrated by *how* [my italics] I was teaching. The way I related to them as students emphasised attitudes such as empathy, respect, compassion and trust and is the way I want students to relate to their patients and clients. Experiencing a process whereby a teacher tries hard to listen and not judge (showing acceptance) often creates the conditions through a process of reciprocity where it becomes easier for the student to listen and not judge the experiences of others. The conditions of feeling 'cared for' provided by the teacher are also the same conditions which encourage the possibility of attitudinal change to occur, the first stage of transformative learning (Mezirow 2000). In essence the teacher is role modelling empathy and as a 'way of being' with another.

Bahir is a 33 year old male student who clearly states in this passage the value of being empathic with health service users:

I think empathy forms the platform of the relationship that you form with patients. If you're not going to show empathy why would people be interested in working with you? To me, that is the most important principal that students will display that will make the other person want to work with you.

Empathy is viewed here as occupying a central role in forming relationships. Forming person-centred relationships is a prerequisite for change to take place in a patient's, and according to Rogers (1980), student behaviour. Bahir compares and contrasts relationships with and

without empathy, pointing out that if you want to set up a working alliance with health service users then empathy must be present. The alternative is presented quite starkly; no empathy, no working alliance (relationship) and therefore no change to the problem behaviour. No working alliance means that the possibility of change is diminished. The statements from Bahir about the importance of empathy have implications for teaching using SPACE because setting up an empathic relationship is considered essential to teach in this style.

Veronica, a 36 year old student who had undertaken both modules, reveals her views on empathy.

I think they [*nurse educators*] have to show it themselves, with the students. Because to stand there and say we need to empathise with our health service users, but not actually show it. You had a guest speaker in and I probably didn't play nicely. Purely because I found the speaker quite big headed and to be honest I found him quite arrogant and very I've done this and I've done that, and I've done this. When you've gotten 10 years under your belt as well, it's like I've got more than you mate. And there was no empathy from that person.

Veronica states that when she is exposed to understanding and concern from another, the more likely the response from herself will be similar, an example of reciprocity. She then goes on to make the point that the teacher has to show empathy with the students if there is to be any chance that they will subsequently show it with health service users. The importance of this statement cannot be underestimated since she is clearly saying it is not enough to talk about the usefulness of empathy you have to

*demonstrate* it [my italics]. Demonstrating empathy is a definition of compassion (Miller and Rollnick 2013) and an element of SPACE. However, if it is not shown to someone then the response can be abrupt and dismissive. This passage reveals how Veronica's experience of a lack of empathy displayed from the guest speaker gave rise to some powerful negative emotions. It may have interfered with her learning.

She goes on to say that it would be difficult for her to believe that he could be empathic with his health service users:

We all got the impression he was climbing a greasy pole, which is fine if that is your choice of career however, I certainly wouldn't rate him as a drugs worker, because there was no empathy. It was all me, and I don't think you can do this line of work if you can't give that little bit. I think as nurses we come at it from a different line, I work with a lot of social workers and certain things are very different, but I think that's part of the training. I've never trained as a social worker, I don't know. But I think certainly as a nurse I've nursed someone and then they've died, and you've dealt with the family and then you've gone out of the room and you cried like a baby. And I think nurses have more of that sort of side. He didn't show that side at all...but it comes back to the empathy as well, if you're showing empathy you are going to have feelings, views and opinions and emotions.

She clearly states the importance of being able to be empathic to be an effective worker but also seems to be saying that to be effective as a teacher empathy is required because it allows other people to get a glimpse of a the 'real you.' She believes the empathy is not something you can

switch on and off and is a 'way of being,' a phrase used to describe the SMI (Miller and Rollnick 2002:34).

When the same student was asked to describe an empathic teaching style she says it is a:

Willingness to listen and that wonderful phrase 'actively listening' as opposed to 'dissing' comments. But also maintaining a control. Because if for example a patient is one of mine is either kicking off down there or sobbing, I need to show empathy, but remain in control. Certainly, for the first few sessions... But to actually be an empathic lecturer you need to keep that control, and I think certainly at the beginning and as the course... and I think for you yourself as a lecturer, and you... because every group of students you get must be quite... the dynamics in it vary week to week and group to group. And that needs to be managed.

Veronica seems to be advocating empathy especially for health service users but is not sure about its value for teaching students, without the notion of 'control.' This control seems to refer to managing the dynamics of a group of students without which she arguably fears people will say and or do things they might regret. Teaching using SPACE would mean that the teacher shows willingness to being open and transparent to what happens in the group. This process would have to be managed but showing care and concern, acknowledging and encouraging the emotional aspects of communication and developing self-awareness through sharing and reflecting on clinical practice increases the possibility of change (Gillespie 2002).

Bahir spoke rather eloquently and at some length on the importance of empathy when treating health service users:

... I don't see how you can work in a field with health service users when you're not empathic, otherwise people will feel not wanted. It's not wasting time. When you're going to talk to people you should show that genuine kind of interest in them, and feel that that person...empathy is living the distress that patient is living. If you're not able to live that distress and see things from their perspective...inevitably you're unable to accept that person as an individual and accept them with their problems and their shortcomings.

Bahir goes on to say that without empathy collaboration is difficult, if not impossible, and collaboration makes the difference between working and not being able to work with a client; it conveys to the client the notion that through empathic responding 'I am trying to understand how the world seems to you.'

This emphasis on forming relationships is the second component of SPACE (partnerships). The strategies outlined above by Bahir are employed so engagement and then 'working with' the patient can proceed. This working with is increasingly the likelihood of change. There is little here that could not also be applied to working with students as revealed in the following passage:

I find that it makes all the difference in practice in forming a strategic alliance with the client. Once you've displayed and shown empathy with the client then you're able to work with that client because the client feels wanted. He feels he's being listened to. He



feels at least there is someone who is genuinely wanting to help me or genuinely interested in what I'm going to say or saying to them. And you can reflect that back to the client. All the aspects of the interviewing process, like reflective listening and reflecting and everything, all that, you are genuinely wanting to get things from the client that I'm getting what you're saying.

Bahir claims that empathy is the 'way in' before you can treat a client. He points to the value of a client feeling they have been 'listened to' and that showing empathy makes them feel 'wanted.' The alliance formed *precedes* treatment. It is undertaken because treatment (changes to behaviour) is more likely to be successful if undertaken in an attempt at engagement (forming an alliance) has taken place. Bahir points to the value of reflective listening (a hallmark of MI) as a technique which aids and supports this engagement. The same outcome is seen when using SPACE; changes in student behaviour towards learning are much more achievable if the initial concern of the teacher towards the student is characterised by the use of person-centred engagement strategies.

Larry pointed out that the beginning of his nurse training was notable for the lack of an empathic response from his teachers which made learning difficult. He felt that his recent experiences of learning had been enabling in that they had the capability of validating him as a person, achieved by having his views listened to and openly debated:

Well I think, the approach at that time was, not necessarily in the mental health side, but certainly in the first year, when we did a lot of the general stuff, it was very factual and...it wasn't very inclusive really ...'These are the facts. End of. Dump these on you.' I think

the good thing about these past two modules [*dual diagnosis and substance misuse*] I've done is, there has been encouragement of debate on the issues, you know, so it's quite inclusive really. It makes you feel a bit more like your views are listened to I think so, yes, because like I say it makes you feel valued and listened to. And you might not feel that in work, you know what I mean?

His experience of university as one in which he is 'valued and listened to' is compared and contrasted with his experiences of the workplace. Teaching using SPACE includes showing acceptance, a part of which is being affirmational. Being affirmational is acknowledging a person's strengths and showing respect, a process that is enhanced through listening. Whether he is likely to replicate this behaviour with his own patients is difficult to say with any certainty but given its reciprocal nature it is more likely to happen than not.

### **An analysis of the findings from 2 empathy questionnaires**

The next section will now consider further data obtained concerning the use of SPACE to develop empathy in students. These quantitative data were obtained from two questionnaires given to students before they started the module and when the taught part had ended, some 8 weeks later (see chapter 3 for further details).

There is some debate as to whether the ability to display empathy is related to age and experience and to what extent is it a teachable skill. The majority of nurses in this sample had many years' experience and therefore establishing whether there was a link between age and empathy may have repercussions for training. Using the Spearman's Rank Order Correlation Test, there were no statistically significant correlations between age and

empathy scores on the HRQ from both investigators before and after the training. Similarly, there were no statistically significant correlations between age and empathy scores from the EES questionnaire.

The Wilcoxon signed rank test is a non-parametric statistical test used for comparing scores from the same participants. When this test was used, no significant differences between empathy score for males and females was found in both data sets. It seems then that age and gender are not significant factors to enhance the potential for students to acquire the skills necessary to be empathic.

Table 3. Empathy scores on the EES

	<b>N</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Standard Deviation</b>
<b>Pretest</b>	26	82.00	110.00	99.8	7.59
<b>Posttest</b>	26	103.00	148.00	122.19	12.66

The difference between pre-test and post-test scores obtained from the EES and those obtained from a mean of both investigator scores on each of the 6 items of the HRQ were analysed using the SPSS statistical package. The interrater reliability for the sum of the scores for each participant (N=26) was 0.54 ( $p < .01$ ).

Landis and Koch (1977) and Altman (1991) state that this level of agreement between the two scorers or raters can only be described as moderate. It is more reliable to have 2 raters than one but the moderate level of agreement found in this research between the raters is a cause for concern. I assumed that using a clinician of 15 years experience working with people with alcohol problems as the other scorer besides myself would lead to a greater level of consistency between the scores than was actually the case. Attendance at a training course is therefore recommended as a means to increase the consistency between different raters.

The appropriate test to detect if the differences between the scores pre-test and post test scores reach significance (assuming the data is nonparametric, see chapter 3 for a fuller account of this construct) is the Wilcoxon Signed Rank Test statistic.

Table 4. Mean Empathy scores on the HRQ

Item on the HRQ	Before training n=26.		After training n=26.	
	Scorer 1	Scorer 2	Scorer 1	Scorer 2
1	1	1.08	1.08	1.38
2	1	1	1.08	1.31
3	1	1	1.12	1.38
4	1	1.08	1.12	1.42
5	1	1	1.08	1.42
6	1	1	1.12	1.36

Scores from the Likert scale on the EES were also collated and both sets of data were then subjected to analysis using the statistical package SPSS. The analysis seeks to determine if training had an effect on levels of empathy as measured by the HRQ and the EES.

A Wilcoxon signed rank test revealed a statistically significant increase in empathy after the substance use module on both questionnaires (The HRQ,  $z = -3.83$ ,  $p < 0.001$ ) (EES,  $z = -4.00$ ,  $p < 0.001$ ). Both effect sizes were large; HRQ ( $r = .75$ ), EES ( $r = .55$ ).

These figures reveal that when students attended a substance misuse module, highly significant improvements in empathy as measured on both the HRQ and the EES were achieved. Person-centred care is a requirement in nursing (NMC 2015) and empathy is an essential component of person-centred approaches to care and teaching. Empathy is theorised to be a part of acceptance in the SMI (Miller and Rollnick 2013) and acceptance is part of SPACE (self-awareness, partnership, acceptance, compassion and evocation). Teaching in this manner tries to sense what the student is thinking and feeling and communicates in a way that feeds this back to the student ('being empathic'). This experience of being accepted and cared for by another increases the likelihood of the student caring for themselves (reciprocity). This increased sense of liking oneself makes it more likely that this style of communicating will therefore be used in other transactions. Empathy is a strategy of engagement and what the data shows is that it can contribute to change (transformation) in the attitudes of the students towards learning, one of my research questions.

### **Subtheme: Learning from others**

Forming partnerships with students and showing the attitudes of acceptance and compassion recognises that students possess knowledge and experience that can enhance learning. The SPACE approach to teaching would use strategies to access this resource. This is contrasted with a traditional, teacher-centred approach to teaching in which students

are expected to be quiet and take notes (see below for a fuller description of this type of teaching). The data suggests that learning was enhanced when the students could listen, respond and critically self-reflect on what others in the group had to say about their own clinical practice. Encouraging the students to get to know each other's professional and social identities is part of the SPACE approach. Exploring and reflecting on how students relate to others is useful material for discussion on how to relate to people with substance use problems.

Louise was an enthusiastic supporter of this approach:

..... it's good to hear other people's experiences and it's fascinating hearing other people's roles. I think was it on one of ours [*the Dual Diagnosis module*] when there was somebody [*one of the other students*] going to set up a business or something with the drugs. They were really interesting, and I think we had general nurses [*other students who attended the module*] who worked with the stimulants. Yes, it was really interesting to learn about other experiences with people.

Bahir was keen to embrace a teaching approach that emphasised the importance of reflection on clinical practice as a tool to learn. He thought that the teaching sessions encouraged him not only to speak about his own practice (reflect) but listen to the stories from others including the teacher:

You are more reflective on your own practice and your experiences and when you've been in practice and from your resources teaching this module what people tell you, those experiences that you've shared with us which other students shared with you are more...it's

like you come into university and there's this pool of knowledge that you've gained, that you are able to share with us.

Sandra felt much the same:

Because as well you can bounce ideas off other people, because we do get all very... I've worked in substance misuse for over ten years now, I'm a general nurse by trade, it's nice to get the feedback off another nurse in another group saying... and you can bounce ideas off each other and maybe this is why, and this is why we actually prefer you guys [*mental health nurses, seen as more expert in this role*] to do this policy [*here she means guidelines for prescribing*]. If you get a patient who's on methadone and it's the weekend and you can't guarantee what... this is why we say only give 10mls of [*in*] our protocol [*some health service users are observed taking methadone, a heroin substitute which does not make dependent users feel 'high.'* This is initiated because community nurses typically work Monday to Friday and therefore they are unable to undertake this at the weekend. The concern is that for some health service users if they get their normal dose unsupervised then they may try to sell it in order to get a drug which will give them a 'high' such as heroin] so that we know when you're discharging them they've not come out going yes party time, they've just upped me by another 50mls. And that sort of thing.

Here Sandra is pointing to the frustration many drug workers feel when individuals in health care organisations do not follow the guidelines and/or protocols issued by notable bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Department of Health (DH). 'Giving

permission' to the students to share their knowledge encourages the process of networking with others. So using the above scenario as an example, a discussion would then be encouraged to explore what needs to be done to move towards a more consistent approach to the treatment of drug users. The process of encouraging the sharing of stories followed by an exploration of the relevance of those experiences can only aid this process and is an example of using self-awareness, the first component of SPACE. When I shared my feelings and thoughts about a clinical experience it seemed to encourage the students to share theirs. This process of sharing and exploring clinical stories often led me to generate further insights.

Penny felt that all of the students on the module were encouraged to say what they thought and importantly she did not feel they were being judged:

I think with this course in particular you are able to say your views, can't you? I mean sometimes you could see people wanting to say things and they stop themselves. It was like, oh I can't say that. It's like when people say they smoke but they won't ever say that they've taken drugs years ago. It doesn't have to be like that now but people wouldn't say it [*normally*]. I think more so in this course you can say how you feel about certain things and with it being a small group people don't seem to judge, there were more people that actually might agree and go, oh yeah, I feel like that.

Telling these stories encouraged openness and honesty which appeared to lead to new understandings about others and about themselves.



Yeah, especially to each other because you learn a lot from other people from their experiences and it is nice because I think it was Andy [*one of the students but not his real name*] said you could come to the unit, you know, and have a look round and things like that and we were like, oh God, you know. Things like that, it's nice when people offer, you know, and if you were in a big group that wouldn't happen.

Here is another extract on the same theme from Larry, one of the students:

I think the dynamics...there was a lot of learning from each other ... because I was saying with the dual diagnosis [*module*] there was more than just mental health nurses, [*mental health nurses were in the majority*] but with substance misuse you find that like having general nurses interested in substance misuse, they deal with this, people learning from their perspective. It's very interesting where their interests lie and how they deal with these patients that come through. [*The student is pointing out here that most of the students on the DD module were mental health trained whereas the substance misuse module attracts both mental health and adult trained nurses. Having adult trained nurses provided the students with different but useful perspectives on how to treat drug users*].

When students were asked if this telling of personal stories about clinical situation was not part of my role all disagreed. This exchange below is typical:

Me: If I encourage and enhance those stories is that detracting from what I'm there to do?

Student: No, because I think that comes back to right at the beginning on the attitudes and values. And anything that can improve all of us, that's got to be beneficial for the patient ultimately, whether they're in with a DVT [*deep vein thrombosis*] or whatever.

An examination of attitudes and values is just as important as the acquisition of knowledge because it aids the treatment of health service users through the process of reciprocity (Muetzel 1988). This is important because it implies that teaching using this adaptation of the spirit of MI in teaching is one way of transmitting values of self-awareness, partnership, empathy, compassion and being non-judgmental, all part of the standards required by the body that registers and monitors the conduct of qualified nurses, the Nursing and Midwifery Council (NMC).

Bahir also points out that reflecting on clinical practice (via the telling of stories) was encouraged in the sessions and how it led to a greater appreciation of the contribution made by non-mental health nurses to 'his' client group:

Yeah, you're encouraged to reflect on their practice and to bring on their own experiences to us, and that in itself is mind altering. And how much sometimes...it brings me as well to talk about my own experiences and it's kind of more...because sometimes there's a shift in blame for...like oh, the adult nurses, you guys don't do this and the other...but there was more bringing together the disciplines for the greater good of the client.'

What these students are highlighting is that the teaching encouraged them to talk about themselves as a source of learning and knowledge that

seemed to benefit others. These examples are testament to an approach that emphasises that each member of the group is a rich source of learning, provided that relationships based on acceptance and compassion are created and allowed to flourish.

## **Theme: Student Learning**

### **Subtheme: Student Self-efficacy**

All of the students interviewed had views on what helped to enhance student learning. These opinions have been split into three subthemes. The first concerns the students' thoughts and feelings about the importance of confidence (self-efficacy). The second is the impact the environment makes on this learning and finally is the relationship between learning and change. The data revealed occasions when poor marks and/or negative feedback from recent academic endeavours raised anxiety levels of some of the students and undermined confidence more so than 'failures' from the past. Yet, it was clear that although some negative experiences of learning happened a long time ago they still had the power to undermine self-efficacy and become a self-fulfilling prophecy. One student talked about 'not being good' at essays based on one previous module. The more confident students seemed to be the more motivated and less prone to experience high anxiety levels than those with less confidence.

Reagan attended the substance misuse unit because she said that she was 'fed up' with the negative comments she was getting from her colleagues about substance users and did not want to end up 'like them, all twisted and bitter.' She also points out that she has major doubts about her ability to learn because of an experience she had when she was a child in primary school:

It was maths, and the teacher... I was trying to... I was really good with sums and this one particular day she said to me... she gave me a sum and I couldn't do it quick enough and then she put me in the corner of the room, my head down. So then there's a lot of shame attached to not being quick enough, not knowing.

She felt that she needs to win the approval of a teacher early on, otherwise this lingering fear of not being 'good enough' resurfaces and interferes with her ability to learn, especially when she is put under stress.

Another student (Susan) felt that returning to learning after a long gap when she left school was the problem:

Yeah. I think I was alright at school. I think it's because I left it so long before I started again. I think that's where my fear comes from. I enjoy learning. I think, it's not actually...what's the right word...I think it's just my lack of confidence. I don't think it's actually I struggle with learning, I think I just lack a bit of confidence.

Here Susan is somewhat hesitant when she is asked about the influence of experiences of learning. She mentions 'fear' arising out of 'leaving it so long.' This implies that learning is a struggle although she says 'she just lacks a bit of confidence.' This and other stories from students indicate that their confidence to overcome learning obstacles is somewhat fragile and that a significant factor that influences their learning is the way the teacher 'operates.' This concept of 'operating' contains attributes such as enthusiasm and knowledge but also contains issues around confidence. Confidence grew when students felt that the teachers believed in their

abilities to learn. Penny cites a lack of confidence about her ability to learn, not helped by her previous experience of undertaking a unit at this university:

Although I like doing it and I like coming to university, it can be quite challenging, because like I say, I didn't enjoy my last course. I don't know. I think it's just...I'm not a very confident person anyway and think it's a bit different when you're at work because you've got a uniform on, haven't you, and you have that different confidence, but I think I can do the work but academically I think I struggle. Learning is scary.

The experiences of learning have made her come to the conclusion that the problem is *her* [my italics] rather than entertain the possibility it might be due to factors such as the extent to which the teacher used strategies to engage, how the information was delivered, the amount of participation 'allowed' in the lecture and so on. She describes two types of confidence both of which are important but not equal in value. There is the confidence to do your job well, which she suggests is made easier because of the 'uniform.' The confidence to be 'good' at learning requires you to be confident as a *person*, which is clearly not how she feels. Her lack of confidence that she alludes to comes right after describing her last academic course. She seems to have considered the confidence gained from working as an adult nurse as inferior to that needed to be successful at academic tasks, even though working in Accident and Emergency (A and E) is acknowledged to be one of the busiest and most anxiety provoking areas of the NHS:

So I was a bit reluctant and then when I came like I really enjoyed it and I told a lot of my colleagues, oh go on that one, [*the substance misuse module*] you know. It helps. But I think you do, you change as a person anyway and you get more confident and then towards the end of the course you do feel a lot more confidence in the way you are.

Creating a climate in which the student perceives that you care is a feature of acceptance, the third component of SPACE. Trusting in students and creating a climate of warmth and acceptance gives the student the confidence (self-efficacy) to believe in their ability to learn and therefore change.

### **Subtheme: Environment**

The atmosphere created in the setting where the teaching was taking place was deemed important to the learning of the students interviewed. When asked about what else helps her learning the student Susan mentioned a 'relaxed atmosphere':

Because I think if you're more relaxed it's easier to take in information and learn better. Discussion is okay, yeah, because it's more, well, a bit more, far more relaxed and that makes it easier.

Edith agreed that the atmosphere created by the teacher was crucial as to how easy learning occurred:

...It's approachability, probably, isn't it? If you chat about other things, normal things, other than just that, so, everybody's in that relaxed atmosphere where they feel they can chat..... how at ease you feel with somebody and if someone's just very, very serious,

very just to the point of what they do, you already feel a little bit like you're in a classroom...

Approachability was again highlighted as important to creating a 'relaxed atmosphere'

According to Martin:

...the atmosphere was relaxed and so everybody was more willing to make it an interactive experience rather than you talking to us saying this is how you engage with patients

Edith's comments on the kind of 'environment' that is conducive to learning are germane here:

An atmosphere that you don't feel judged in, somewhere where you're made to feel you can state your opinions, without looking stupid, without looking foolish.... [*an environment in which*] if you did make a bit of an error and say something wrong in a group that's, kind of, you know, you just laugh about it, it wouldn't be something that would bother you, you wouldn't sit there thinking, oh God, I wish I'd never spoke now.

Penny's comments are similar; part of creating the right environment for learning is relating to students as autonomous, worthwhile human beings, all aspects of the acceptance component of using SPACE in teaching.

...I think you have got to be able to be approachable and relaxed, haven't you, in the sense of...oh, I can't ask [the teacher] that, you know, because he might think I'm stupid, and I don't have that on this course at all.

Creating an environment which feels safe to share your feelings about learning is essential if new perspectives are to take hold. This climate can be facilitated through engaging with students in a way that demonstrates self-awareness, partnership, acceptance, compassion and evocation.

### **Subtheme: The Nature of Change**

The relationship between teaching and change (research question 1) is explored in this theme. Bahir thought a transformation of some of his assumptions, attitudes and values occurred when he moved from seeing substance-using people as a uniform group to one comprising of unique individuals, a process that occurred whilst attending the module:

Before, myself included, we saw them as people who were timewasters. Some people get fed up with them as people who were time wasting, wasting services, wasting resources. Yeah, a nuisance. People that can't be helped because they use substances therefore there was that blame culture kind of thing, it's their fault.'

Bahir goes on to suggest that the major reason why mental health staff stigmatise another group (those with personality disorders) is that the individuals with this problem have a tendency to complain, something that most mental health service users do not do. This should be an opportunity he argues, for staff to re-examine these attitudes in order to maximise recovery. The key to this perspective change occurred when the staff began to see drug users and/or mental health users as unique individuals rather than members of a group who are regularly subjected to stigmatisation and stereotyping. Behaviours such as lecturing, warning, threatening and criticising are easier to justify if all the drug-using



individuals are perceived to have the same (stigmatised) group characteristics:

... I think, to be honest with you, sometimes professionals...it's like I would give you an example, someone who has got personality disorder and at the same time they're using substances. That kind of blows the...I think the frustration from the staff has been in the management of this client group when they've used substances while they're impassioned, whereby when somebody's intoxicated, for instance, and they become aggressive or more vocal they begin to be able to express themselves, how they feel the services are treating them. What is frustrating is they are being honest about the way they are treated by services and they are telling us exactly how we treat them, and probably as professionals they're sort of mirroring our views how we treat them. And they reflect those views, the way services treat them, very, very strongly and just exactly, the truth sometimes that they tell about how they have been treated by professionals and services and that kind of brings to the fore that you should examine the way you treat people. .... before I had the same attitude, the same negativity in terms of...but now I'm more attentive and more accepting of their problems instead of trying to be to the person you mustn't drink, you mustn't do this.

It seems that Bahir is saying that the teaching was at least partially responsible for a transformation of his attitudes. A fundamental tenet of teaching in this relational style is to engage. Engagement accepts that individuals are unique. Once this has been experienced it is easier to accept

that drug users are individuals who have problems rather than stereotypical views of drug users per se.

Edith felt that the module helped her to be more empathic:

More patient, more empathic, yes. It makes you want to do your job better, you want to be a better nurse. I want to be able to do my job good. I am not saying I'm bad now, but I want to be able to work with people and make them feel better... and yes definitely you feel like you're more confident, or feel like you can do your job better, and I can help people more and give them extra input.

Martin underwent a similar process during the modules in that he began to re-evaluate many of his assumptions about treatment for patient with acute mental health problems:

...It's certainly changed me in how I've identified the need for treatment in dual diagnosis and substance misuse. It's...I mean you always know it's there and, you know, certainly on the PICU [*psychiatric intensive care unit*] nine out of ten patients sometimes have a dual diagnosis and our forensics prove some of the figures. And then you can identify the lack of work that's been done with this client group so maybe...it's certainly made me more aware of the issue and the lack of work that's been done as frightening as that is, but...so yeah I suppose certainly more insightful into the needs of them.

When asked whether it is carried over to the workplace the same student has no hesitation in answering in the affirmative:

Yeah, absolutely. I can see the benefits in working with them for anybody. Empathic style of teaching, well I think with substance

misuse there's such a...and dual diagnosis I think it's such a big part of it, empathy that it's... I mean I'm more aware of empathy since post reg training..... empathy can be transferable to anything, if you understand what it means I'm confident it can be transferred to any clinical group.

Emma felt that her exposure to both units had produced a dramatic change in the way she now perceives and treats health service users:

Definitely, as a professional, maybe not so much as a person, it's not changed what's in me, but, it's definitely changed me as a professional, because, it's changed how I do things, changed how I react to things and how I evaluate myself. So, the biggest change is in the way I do, rather than the way I think.

What these students share is a change in perspective initiated by a teaching approach that allowed them to examine their current perspectives and revise them in the light of new experiences. This is a definition of Mezirow's (2000) transformative learning. It seems then that teaching using SPACE is a means by which the phases associated with transformative learning can take place.

My final research question concerns the similarities and differences between using SPACE in teaching and the approaches adopted by other teaching staff in my institution. Interviewing lecturers was therefore justified in order to seek their views on what promoted change to the attitudes and values of student towards learning and what impact this change would have on their attitudes and values towards health service users. As far as I knew, none of the teachers were using SPACE in their teaching but many would describe themselves as advocates of a person-

centred approach to care. I therefore wanted to know the similarities and differences between their approach to teaching and mine.

## **Theme: Engagement**

All of the staff interviewed felt that engagement was an important part of their role as a teacher. None of my prepared questions in the staff interviews asked about engagement or its importance. Despite this, several teachers referred to its significance during the interviews.

### **Subtheme: Teaching as Engagement**

Teaching is engagement (Helen). But I suppose my first aim [of teaching] is engagement.... Just to try and develop that sort of relationship with them where they are wanting to hear what I've got to say' (Lana). In regard to teaching my hope would be to get them engaged, get them interested (Jackie). Teaching is enabling them to learn (Joyce). You can connect with one or two, and you can tell that you've connected with one or two, because the ones that you've connected with hang on to every word that you're saying, and you can see it. And there's some that you don't connect with ever for some reason (Debbie).

What is clear from the data is that engagement is seen as an essential component of teaching by my colleagues and is achieved by forming relationships or partnerships with students, the first element of the SPACE approach. What follows is different opinions on how this could be achieved and what the lecturers interviewed considered the barriers were to prevent or thwart them from achieving this goal.

### **Subtheme: Engagement as the giving of self**

Engagement is involvement of 'you' by 'you' in teaching (Debbie). You're [*there*] for want of a... your human-ness. Not your lecture-ship (Margaret). Yeah [*connection is*] dialogue, discussion, analysis of situations, practices, feelings, thoughts, all of those emotional aspects of a person I think. Tuning into those (Helen). I think you can't teach without giving of yourself (Lana).

All of the teachers interviewed were able to articulate what this connection meant and although there were differences of emphasis, all were united in feeling it was about the 'giving of self.' This 'giving of self' is self-awareness, the addition element to the spirit of MI to form the acronym SPACE (self-awareness, partnership, acceptance compassion and evocation). According to Helen, if this did not occur the lecture would be mechanical and students would switch off:

If I was to go in and deliver a straightforward lecture I would hazard a guess that after so many minutes people would maybe, if it was purely theoretical they would switch off.

This 'straightforward' lecture is understood by Helen as meaning the delivery of information without 'giving.'

This is a PowerPoint, this is the objectives of the session, we're going to go da, da, da, da, I'm going to give you this information, I'm going to hint that you need to go away and read a bit more around it. But that's the sum total of what I'm going to give.

She goes on to explain what this 'giving' means:

So in essence by trying to engage with people you're actually expanding that interaction, you're expanding that repertoire of

things that you can deliver. So by interjecting a bit of humour, interjecting previous experiences, asking the audience for some interaction back, entering into dialogue, even things like movement around an arena, speaking to people on a personal level, all of that draws out different experiences from people.

Helen stresses the importance of engagement when she goes on to say:

...I always feel that if you engage with something and whether that's emotionally or intellectually, if you engage with something then your brain is more open to what's going on. Also try to engage them by using bits of video and bits of telly that they might have watched or whatever, so I watch telly a lot and I try to record bits of things that I think might act as some kind of trigger or whatever. Soap operas are great for that and what have you. I draw on things that may have been on the telly or whatever in discussions, I say did you see this, did you see that. Some of them have seen, so I am trying to engage individuals in conversation at different times.

Most felt that the responsibility for establishing a rapport with students was the teachers but some felt that the learner had to 'play ball' as well. Joyce, an adult nurse teacher with over 25 years' experience was no different to the rest of the staff in that the establishment of this connection was important but differed in that she had a clear idea of the responsibilities for both teacher and student. She felt that as a teacher you had a responsibility to prepare yourself before the lecture or seminar began. This meant making sure you were up-to-date with the knowledge that you wanted to share. It also meant being aware of your need to be confident. In order to increase their capacity to learn, lecturers must

ensure their delivery is enthusiastic and passionate, otherwise you risk losing the interest of students. This fits in well with Colin's view that performance is an important element of teaching.

A third aspect of connecting to students is understood by Joyce to mean that she wants the students to enjoy the experience. This is important for her because 'students will learn if they are not frightened.'

Debbie thought that connecting to students had five aspects:-

I think with students, you've got to be professional, but you've got to be approachable, you've got to be friendly, you've got to demonstrate that you've got knowledge and understanding and empathy, and all of those skills that are required in nursing. I often say that when I came into teaching I swapped my patients for students, and it does feel a little bit like that.

Debbie is promoting the use of role modelling to demonstrate values here. She also felt that 'If students like you, if they think you're credible then they will more likely learn'. In my experience this process is accelerated if the teacher allows the student to 'see' aspects of the person who is doing the lecture. This 'seeing' is another way of 'being yourself' (being self-aware), the added aspect to the SMI to form SPACE. Margaret makes the point that personal students (ones that were allocated to a lecturer and who would tend to see on a regular basis albeit for 'pastoral' care rather than academic guidance), will always listen and engage more than others in a large lecture theatre, because they 'know' you more. This knowing comes in different forms but it involves sharing your experiences not only as a teacher but as person. Taking this risk of 'allowing' students to glimpse aspects of yourself aids the building of person-centred

relationships which this research seems to show leads to an increase in the appetite of students to learn. Teaching in a style that incorporates SPACE is a way to build these relationships.

### **Subtheme: Engagement as role modelling**

Debbie is adamant that showing positive regard to students is an essential prerequisite to connect. Yet, she tries to link what happens in the classroom or lecture theatre with behaviour towards health service users:

Sometimes, I have to point that out to students and say, you know, you're not demonstrating positive regard to me, if you do that when you're with your patient they can see that you were thinking about something else, or you're writing when, you're not demonstrating positive regard to them.

According to Stephanie, the emphasis in the lecture theatre or teaching situation should be on the similarities between all of us as human beings rather than the differences, remarking that the emphasis on difference can be the cause of problems:

So to try and break down the protection that people... Like I'm a nurse and you're different from me because you're the patient. So I always try and bash that one down, it's like we're all just people. .... I think you get the bad care when people don't see the patients as equivalent to themselves.

Debbie believes that this value is an important part of the 'way of being' with students:

'Okay, I think, as a teacher, we should be portraying the types of qualities that we would expect of them when they're nursing for somebody.'



She goes on to say that given the considerable research evidence that supports the notion that people learn by observing what others do, it is therefore crucial nurse teachers demonstrate the behaviours that want to be seen used with health service users. Role modelling behaviours that you want students to adopt is much easier when attempts have been made to engage with them. When students experience being treated with care and compassion they are much more likely to engage and then transmit these values to health service users. Being treated in this manner is characteristic of teaching using SPACE.

## **Subtheme: Learning from students**

And what I'm trying to do, I see learning as the students, it's their property, only they can do it. Teaching I see as something that offers the student some help in that learning (Colin). So are teaching and learning the same thing? Well they are for me because I learn off the students all the time (Stephanie). Yes teaching is a relationship isn't it? It's a relationship with the people who you're teaching, it's not just me doing it too, it's more of a two way thing (Helen).

Several of the lecturers pointed out that forming relationships with students is fundamental if teaching and learning is to occur. Learning is much more than acquiring information, it is feeling confident enough to challenge your own values and assumptions. Most of those interviewed felt that teachers had a responsibility to role-model the kind of behaviour they would expect from students towards health service users. For example, in order for students to become more empathic towards health service users, it would require that lecturers model this behaviour and communicate in an empathic manner towards students.

Debbie puts this succinctly by saying:

'For my role, yes, because the students, for me, are a group of, they're my caseload now.'

Louise is keen to employ teaching strategies that breakdown the barriers between teacher and student:

Okay, well increasingly I move away from, if you like, I'm the teacher they're the student to we're all people and we've got something to learn from each other and we're all coming from

varying backgrounds and levels of life experience etcetera. So I suppose I find myself much more in tune with some of the Eastern philosophies of education where you learn alongside each other.'

Lana describes the experience of teaching in language that Carl Rogers would no doubt approve of 'On a kind of a journey together.'

This does not mean that responsibility for teaching/learning is equally shared between teacher and student. Lana makes it clear that she understands the metaphor to mean that directing and guidance is often required in order for students to maximise their learning opportunities, and this must come from the teacher. The SMI can be used as an approach to motivating change where the onus is clearly on the therapist to initiate and develop a relationship based on mutual trust and empathic understanding with the patient. Likewise the responsibility for forming relationships with students is clearly the teachers. Teaching using SPACE is unambiguous in stating that relationships should be formed by teachers with students which are characterised by being affirmational, non-judgemental, empathic and compassionate.

### **Subtheme: Size of group**

Connecting with students was something all of the lecturers interviewed strived for but found more difficult as the size of the group grew. Almost all of the lecturers found that teaching in large groups (300 plus) was very difficult since it was not really teaching as they understood it. The major problem was the relational aspects which were extremely challenging to achieve in large groups. Many felt that when the numbers exceeded about 40, engagement became problematic. As Margaret puts it (a nurse teacher with over 25 years' experience in teaching) there is:

An element of crowd control because there are groups, small groups within those large groups who are not going to engage. And so my role with them is to make sure that they know that I am aware of them, because they often sit at the back, but to make sure that they know I am aware of them, by trying to do some group work within a large group, but it's incredibly difficult.

Colin is experimenting by trying to put the elements that work in small groups into large groups which he argues is 'difficult but not impossible.' According to him, an adult nurse teacher with approximately 12 years' experience of teaching:

Something that I do which I used to always do as a lecturer because anatomy and physiology appears to be a lecture but now for pain, anatomy and physiology, which is my speciality, I do it as a workshop irrespective of the size of the group and within that what I ask the students to do is think back to times at which they've last hurt themselves and then we explore that, so within the large group I get them thinking individually and then I get them talking about it in groups of probably in twos and then we build up to larger and larger groups that we then sort of, they all have the capability or the chance to bring their ideas to the main group. I'm very conscious of the fact that a lot of them don't.

Here he is sabotaging the traditional structure of the lecture to make it more interactive. Yet, although he accepts that many will not be able to or do not wish to participate he seems determined to continue with this experiment. What Colin is doing here is trying to engage with students, a fundamental principle of teaching using the SPACE approach. He

acknowledges that small groups are much easier to engage and proceeds to split the large group into smaller factions. His interaction enables him to give something of himself (a feature of SPACE) yet at the same time he accepts that many students will not wish to participate (being non-judgmental, a part of acceptance, the third element in SPACE).

Stephanie, a mental health nurse lecturer is relatively inexperienced (and is quick to point it out), felt that teaching in large groups was 'pretty pointless' other than when you wanted to specifically deliver information such as the anatomy of the heart or the Mental Health Act. She felt strongly that in lectures where the numbers were large (300 plus) she was: '...singing and dancing there and I don't know if any of its going in.'

She also adds that in lecture theatres with large numbers of students:

It's more difficult to get them to speak up, apart from the keen-ies (*enthusiastic students*) at the front that dominate everything.

Again, what she is alluding to is a common complaint; if teaching is establishing relationships with students then doing 'it' in large lecture theatres is not teaching. Most of the teachers interviewed said that this lecturing has some uses but many were sceptical that it achieved very much. Stephanie points to the fact that many of the students would not be able to say anything anyway because of the large numbers:

So the one at the back you can't engage with because it's too humiliating for them to have to speak in front of the whole group.

Some of the teachers had come up with ways of overcoming the problems they encountered with these large numbers that managed to embrace some aspects of person-centred engagement philosophy that was much easier to establish in small groups. These range from creating

minigroups (buzz groups) within the large group, introducing activities such as quizzes that got the students involved to an acceptance of the fact that some of the students were not going to engage. All of the teachers interviewed emphasised the relational aspects of teaching in which establishing some kind of connection with students was essential if learning was to take place. Getting in touch with their 'human-ness' was how Margaret described it, another way of stating the self-awareness acceptance elements of SPACE.

Lana was also eager to point out that learning does not have to be done in an atmosphere of total seriousness- she will often say 'let's have some fun.' An adult nursing teacher with over 30 years' experience she felt there were similarities between parenting and teaching. Yet she was at pains to say teaching was not about being parental in the sense of controlling but parental in the sense of enabling. It was:

Nurturing I mean as a parent your role is to nurture, support, encourage, develop, educate, enable, that person to go out and be a competent, responsible grown-up.

The students' reactions to this relationship building are interesting, since according to Lana they can look at you and think you are a 'bit barmy'.

### **Subtheme: The dynamics of change**

All of the lecturers interviewed agreed that learning meant change and that change in attitudes towards health service users was a legitimate aspiration of teaching. Yet, all of the staff interviewed also thought that you would not be able to detect changes in the attitudes of students as a direct result of teaching, unless the students themselves shared that

openly with you. Several lecturers stated that it did not matter whether change was due to any strategies employed by the teacher so long as it occurred. Yet they were united in their belief that teaching approaches that didn't put the formation of relationships with students as a primary concern were less likely to initiate change in attitudes towards learning and therefore to changes towards health service users. For instance, Louise states that promoting change in attitudes towards learning needs participation by the student:

Anything that means the student has to play a significant part in the process.

Stephanie feels change can come from a variety of sources beside herself:

Student change comes from everybody not necessarily my teaching. It can come from each other yeah. Somebody could have decided to stop drinking couldn't they and therefore they're slightly less hung-over, it could be nothing to do with me. Or they suddenly... well anything yeah. It could be a thousand things that are not me.

For Margaret change without engagement is impossible:

Yes, that is the first thing, and if you haven't engaged the student, then the change won't occur.

Helen feels that teaching is more than information giving:

Teaching isn't in my opinion just about delivering knowledge, it's about that whole process of I suppose engagement and sharing and dialogue, and communication.

As far as Jackie is concerned engagement is essential because it prepares the ground to challenge students:

In regard to teaching my hope would be to get them engaged, get them interested, and I think to...what can I say erm...spark, yes spark and I think really to challenge them in a gentle way but to...yeah just to challenge them in a gentle way, to really erm...well it's to engage and to challenge them to think about what they think they already know.

It seems then that the nurse lecturers staff was in agreement about the importance of engagement in teaching and that this must come before any changes in attitudes, values and beliefs can take place. When engaging with students it was important for teachers to be themselves, be nonjudgemental and be willing to learn from others. There was overwhelming support for an empathic, interpersonal style with students, all aspects of teaching found when teaching in a way that I have labelled SPACE.

None of the staff were aware that I was using the SPACE approach in my teaching but many knew that I felt strongly about the importance of engaging students in the learning process. Many would probably label my teaching as 'student centred.' Although there are similarities between the approaches used by many of the staff interviewed and the SPACE approach, there are several differences and these will be discussed in the next chapter.



## **Chapter 5 - Discussion and conclusions**

This chapter will begin by discussing the findings from the data and then proceed to compare and contrast them with those from the established literature. This is followed by a section that summarises these findings followed by some deliberations on the limitations of the study. Implications of these findings for educational policy, practice and research are then considered, followed by a section of recommendations for future research. This is followed by a section that consists of some reflections on the use of an Action Research approach to this study. The final section highlights the contribution the findings from this thesis have made to the existing body of knowledge.

### **SPACE and transformative learning**

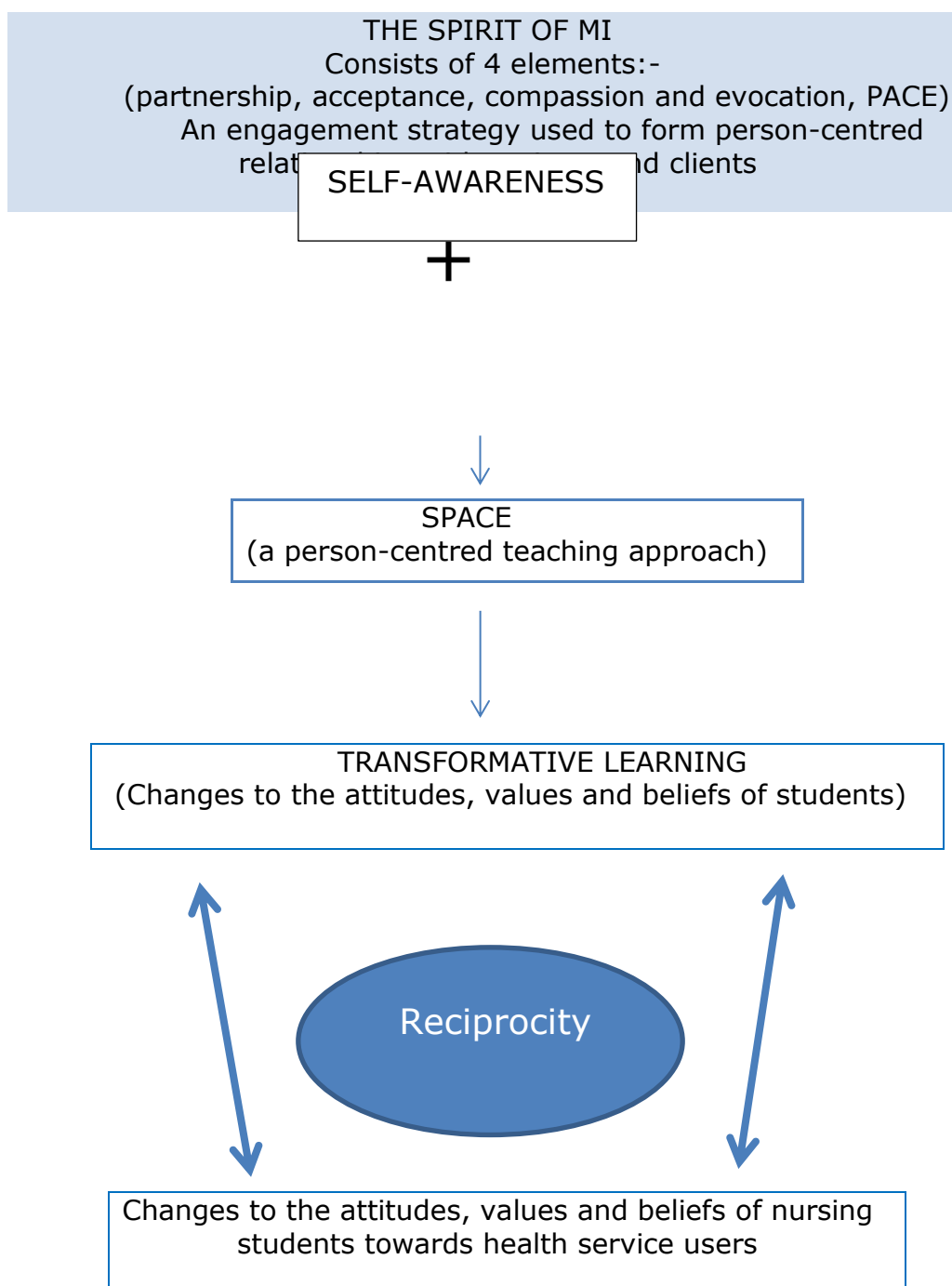
The Spirit of Motivational Interviewing (SMI) is a set of person-centred attitudes or principles that provide a guide as to how to engage with patients and clients. It consists of four components: partnership, acceptance, compassion and evocation (PACE). When I introduced this approach to the treatment of alcohol problems, two major benefits emerged. Firstly, patient relapse rates significantly reduced and secondly staff became much more optimistic about their patients' chances of success in making changes to their drinking behaviour (see chapter 1 for a full account).

When I left my clinical practice to start teaching nursing students, it became clear that many students were experiencing difficulties in learning. I therefore thought that using the same person-centred elements that were successful in being instrumental in changing patient behaviour might also enjoy similar success in changing the behaviour of students towards

learning. I therefore began to incorporate the SMI into my teaching. However, I seemed to have more success in engaging with students when I tried to replace the professional front of being a 'teacher' with a willingness to share what I thinking and feeling when I was teaching. The addition of self-awareness to form SPACE (Self awareness, Partnership, Acceptance, Compassion and Evocation) therefore became my adaptation of the SMI for the purposes of teaching in a person-centred manner.

My first research question considered the relationship between using SPACE, learning and change. Transformative learning is understood as the kind of learning that produces permanent change (Mezirow 1991; Cranton 2006). This is achieved through a process in which present attitudes, values and beliefs are revised in the light of new information, and the data confirmed that using SPACE in teaching is one way to achieve this. This change of attitude towards the self is thought to be a precursor to change in attitudes and subsequent behaviour towards others (see table 5).

Table 5. The origins of SPACE and how it can promote transformative learning



Most of the students interviewed stated that their experience of attending the substance misuse module and/or the dual diagnosis module did result in changes to their attitudes towards learning. Some students claimed that exposure to the module had also changed their practice. For

example, several of the students interviewed stated that the substance misuse module helped them to examine their attitudes towards drug users, realising that many of the assumptions they made were based on stereotypes about people who took drugs. This led to an exploration in class of how these views and attitudes shaped how my students engaged and subsequently treated their health service users.

A critical reflective approach as outlined above is supported in the literature as a way to start the process of transformative learning (Brookfield 1995, Mezirow 2000). Yet undergoing a process in which unexamined perspectives are subjected to the full glare of critical reflection is challenging and fraught with difficulties. Many of these attitudes, values and beliefs are an intricate part of who we perceive ourselves to be. Being aware that there is a need to amend perspectives that are unhelpful and discriminating is not usually enough to lead to feeling confident about changing, since this often entails a step(s) into the unknown. One student referred to learning experiences that had happened a long time ago but nevertheless were still able to generate feelings of shame and of 'not being quick enough.' Another felt that her confidence was undermined in her last course by 'not knowing enough' leading her to say that 'learning is scary.' 'Breaking out of our frameworks of interpretation' (Cranton 2006:65) requires both teachers and students to provide feedback that challenges these perspectives but also ensures that they receive adequate support throughout this anxiety provoking process (Brookfield 1995).

## **Teaching and Self-awareness**

Rogers (1980) consistently argued throughout his writings that within the confines of forming a relationship, three attitudes needed to be present for change to occur in another person; congruence, acceptance and empathic understanding. Learning is enhanced (changed) when a teacher is 'congruent' in their relationships with students (Rogers 1961:287). Congruence is an attempt to be cognisant of what I am experiencing and then communicating this experience; it is being aware of the feelings and thoughts that I have when I teach and being willing to share them. This desire by the teacher to be seen as a 'real' person with likes and dislikes is crucial in the person-centred approach. According to Rogers (1980), it would be difficult to imagine forming authentic relationships with students without the teacher attempting to be congruent. The work of Carusetta and Cranton developed this idea of being 'authentic.' It is:

being genuine, showing consistency between values and actions, relating to others in such a way as to encourage their authenticity, and living a critical life (Cranton and Carusetta 2004:7).

Living a 'critical life' is developing self-awareness through an examination of the assumptions that much of practice is based upon; demonstrating acceptance and compassion is hypothesised to promote authenticity (change) in others (Rogers 1980). Most of the lecturers interviewed felt that their most effective and satisfying experiences of teaching had this quality of being authentic, that it to say when they were able to be supportive to students through developing relationships with them in which they were able to be 'themselves.' Being authentic was not possible if students were not seen as individuals, a finding supported in the literature

(Cranton 2006). However, many teachers felt that this was very difficult to achieve when teaching large groups.

Although most of the lecturers equated good teaching with feeling able to share aspects of themselves, none of the teachers were able to clarify how this aspect (self-awareness) could be developed or enhanced. Moreover, none of the teachers interviewed linked being self-aware to how relationships with students could be developed and maintained. None of the teachers were also able to explain how 'revealing' the self was connected to learning. Although I know some teachers do use clinical stories as part of their teaching approach, none of my interviewees provided examples as how this would enhance student learning.

Reflecting on practice enables nurses to learn and maintain the professional standards associated with that practice (Atkins and Murphy 1993) and is a requirement in order to maintain safe practice (NMC 2015). None of the teachers interviewed mentioned the role of reflection and its relationship to self-awareness. Being reflective is deemed to raise self-awareness which is necessary in order to be able to reflect (Freshwater and Stickley 2004). There was also no mention of reflection by the teachers interviewed as an instrument in achieving a change in attitudes and values. Moreover, none of the teachers pointed out a change in attitudes and values as a goal of their teaching. Being critically reflective involves challenging assumptions (Brookfield 1995; Johns 2007). As I noted in chapter 1, an example from my own teaching would be an identification and subsequent examination of the assumption that learning is unidirectional, moving from teacher to student. On reflection, it became clear to me this was clearly not the case but the problem was how to

acknowledge it; my hesitation was partly due my belief of 'teacher as expert.' I also experienced some fear over whether my 'authority' would be compromised if I admitted that the students knew more than I did.

### **Partners in learning**

The data from teachers and students support the view that creating an atmosphere in which barriers to learning can be tackled was best achieved through forming relationships with students, and this relationship needs to be built on person-centred principles as formulated by Rogers (1957, 1961). Rogers (1980) was unswerving in his belief that the same ingredients used in relationships that produce change in patients and clients should also be used to promote changes in how students learn. Partnership is also an essential component of the SMI, the person-centred approach to engaging with health service users (Rollnick and Miller 1995). Research on student-centred approaches supports the notion that students become more effective learners when they are equal partners in the process of learning (Rogers 1961, 1980; Gibbs 1988; Cornelius-White 2007). Students reported a greater satisfaction with the quality of the teaching and the learning environment when an entire university changed over to a student-centred approach to teaching and learning (Kember 2009).

Since SPACE is a teaching adaptation of the SMI it was theorised to be able to change attitudes of students towards learning and subsequently change their attitudes towards health service users, a finding that was confirmed in this study. Both students and teachers were united in their belief that forming partnerships (the second aspect of SPACE) built on self-awareness, trust, respect, empathy and compassion were essential if

teaching and learning were to thrive. All of the teachers were unanimous in feeling that effective teaching was an active process in which engaging and motivating the student to participate fully in the process of learning was the goal, rather than just the imparting of information. 'Good' teaching was an activity that had to acknowledge and address the relational aspects of the process if it was to succeed, and many lecturers who were interviewed talked at length about how you would go about this.

Some of the nurse teachers interviewed were of the opinion that if you did not seek to engage with students then what you were doing, whilst it could be important could not be conceptualised as teaching; most held the view that conceptualising teaching as predominantly an activity that is solely concerned with imparting information was missing its *raison d'être*. The comments from Colin (one of the nurse lecturers) were typical when he says that teaching and learning are inextricably linked 'I see [*teaching*] as something that offers the student some help in that learning'. Students as well as staff were also consistent in stating that learning was much more difficult if engagement with the teacher was troublesome. Although many staff agreed that the much larger numbers that they were now expected to 'teach' made engagement difficult, no one thought that it was impossible. However, most teachers thought that different strategies needed to be employed in order to make this happen. When questioned, all lecturers thought that fostering positive attitudes towards learning was the 'business' of lecturers.

Yet the data also suggest that in order for attitudinal change to take place it needs to be undertaken in an affirmative, non-judgmental climate if students are not to feel embarrassed, frightened or guilty of divulging



what may be perceived by them and others as weaknesses. The SPACE approach to teaching may have great potential, because it seems to offer real benefits to both students and teachers. It appears to be capable of connecting or reconnecting students to positive experiences when learning something new, whilst at the same time it seems to enhance, boost and enrich the experience of teachers trying to teach, because of its attempt to be relational.

However, although the teachers were aware that forming partnerships enhanced their teaching and facilitated the learning of students, few of the teachers interviewed were able to articulate the process or skills required by which they would be able to accomplish this goal. This is important because establishing a person-centred relationship in which students are treated as partners in their quest to learn has the advantage that it make change easier to achieve; being treated as less important than the teacher seems to make change to a host of educational outcomes such as better grades, absenteeism and less anxiety about learning harder to achieve (Cornelius-White 2007, see chapter 2 for a fuller discussion).

### **Teaching and acceptance**

When I showed an attitude of acceptance (the third component of SPACE) to students, it seemed to make it easier for them to accept themselves; accepting themselves seemed to make it easier to accept others and therefore change (Rogers 1980). Creating this climate of acceptance seemed to transform the learning experience; there seemed to be a much greater willingness for students to engage and share their own knowledge and experiences with each other.

Many of the lecturers accepted that forming relationships with students and being willing to share aspects of yourself enhanced their teaching. In spite of this there was no recognition by those teachers interviewed that the attitude of acceptance had value in their teaching and/or that it was significant as a way to promote change. Although some lecturers did acknowledge that the experience and knowledge of students could be a useful resource to enhance their learning potential, few could provide any details as to how this would be achieved and/or used strategies to include this in their teaching.

The student data clearly show that some students had feelings of fear and shame, and embarrassment when allowed to freely discuss their worries and concerns about learning. Demonstrating the attitude of acceptance by the teacher creates a safe climate in which all of the students can discuss the issues that undermine their ability to learn, without concerns that they will be ridiculed or made to feel inadequate.

### **Teaching and Compassion**

Compassion is the fourth component of SPACE and is understood as deliberately acting in such a way that conveys being empathic (Peters 2006); compassion and empathy and therefore intimately related. However, a lack of current instruments to measure compassion means that a discussion of compassion is for all intent and purposes of this thesis a discussion of empathy. My second research question sought to find out whether using SPACE led to an increase in student empathy and positively affect their practice. The module was rated 'high in empathy' by several of the students, and the findings from the two empathy questionnaires employed in this research show a statistically significant increase in the

empathy scores of 26 students, despite using less than 1% of the teaching time available for specifically giving information about empathy. It is a requirement by the professional body that regulates nursing in the UK that all qualified nurses are able to communicate empathically (NMC 2015). The literature on the use of empathy in teaching has showed positive results for a whole range of outcomes, especially if student perceptions of what they experienced are taken into account (O'Neill and McMahon 2005; Cornelius-White 2007).

The data suggest that most of the teachers were teaching in a way that could be described as 'student-centred' although few used this term. This is understood here to mean forming person-centred relationships with students in which an examination of attitudes towards learning can take place. Both students and teachers contrasted this approach with the more traditional aspects of learning such as knowledge acquisition and information gathering, which usually gave rise to much student concern and anxiety. Even though there were some students who could not point to specific incidents that had undermined their belief in their ability to learn, all but one of the 10 students interviewed said that they were apprehensive and somewhat intimidated at the prospect of learning. Students felt their most memorable learning experiences were when they felt validated and supported. Adopting an empathic approach in which the emphasis is on trying to understand rather than judge the student provides the climate in which they could 'relax' and 'be themselves.' Being 'themselves' allows them to learn more effectively (Rogers 1980), a part of which is being encouraged to examine their own attitudes, beliefs and values through the stories they tell and the feedback they received from

others in the group. Part of being a 'connected teacher' (Gillespie 2002:571) is being compassionate. This is when teachers show evidence of:

an awareness and responsiveness to students and their intent to understand student perspectives, acknowledge students as individuals and support learning experiences.

## **Person-centred attitudes, evocation and change**

Accepting that students have the resources to change and that the job of the teacher is to use strategies that bring these forth fulfils the last element of SPACE, evocation. Students are regarded as the experts on themselves (Rogers 1980). Being ambivalent about change is normal (Miller and Rollnick 2002) and reasons for changing and not changing will already lie within the student. Acknowledging the difficulties around change and summarising both sides of the argument is a strategy that can tip the balance in favour of change and is often used when undertaking MI (Miller and Rollnick 2013). The data support the use of employing strategies which encourage students to share their clinical and learning experience. This activity flourished when the teacher demonstrated acceptance (an aspect of SPACE) and encouraged other students to be acceptant towards others. Demonstrating acceptance is part of caring (Griffiths et al 2012) and demonstrating caring to students by teachers is considered essential in order for them to subsequently care for health service users (Diekelmann 1990; Paterson and Crawford 1994). Acknowledging and validating individual experience through communicating an attitude of acceptance is therefore a powerful motivator

to learn in itself; the message that their own experience has value enhances students' confidence and self-esteem. Because using SPACE is participatory, affirmational and empathic, the stories of students are heard not just by the teachers but by other students.

The data from the teachers show that the extent to which the teachers engaged with students largely determined if the experience of teaching was satisfactory. A successful session for those teachers interviewed varied in detail but all of the teachers agreed that the teaching needed to be constructed so that that the students were actively involved in the process of learning. Using SPACE is by definition adopting a participatory style of teaching, since one of its strategies is to engage and elicit stories from students about their learning. Engaging has the tendency to validate the student experience and consequently moves the student away from a dependent relationship with the teacher towards a more collaborative one. Once this has been achieved, the conditions have been created for change/transformation to take place.

My overarching research question considers whether using SPACE in teaching can stimulate transformative learning, in which conditions are created where what students currently think and feel about themselves is subject to analysis and change. The teaching approach that is SPACE is theorised to be able to encourage the changes required that would constitute transformative learning. Using SPACE as a teaching approach maintains that many of the assumptions made about health service users when a nurse/therapist uses the elements of the SMI to form a relationship with a patient can be made when a teacher forms a relationship with a student. For example, this model of teaching supports the belief that the

person is intrinsically worthwhile and should not be judged. Emphasising a person's strengths rather than weaknesses is also a feature of this approach as is the belief that students already possess all of the resources they need to change. The role of the teacher then is to engage and act in an empathic, compassionate way towards the student based on the belief that students will tap into their own resources to change.

These students are then in a position to actively learn from others. This process is reinforced through the teacher managing the group processes and produces a climate that is participatory, democratic, supportive and autonomous. Using SPACE in teaching respects the right of students to make decisions about their learning and the teacher as change agent needs to have faith in that process. For instance, this would mean in practical terms that the knowledge they wanted to learn would not be predetermined but would be open to discussion and debate as would the methods of delivery. Perceptions of how their learning was progressing would be explored on a regular basis.

Using the SPACE approach in teaching requires that group dynamics are acknowledged and managed. This would mean reinforcing and developing some elements of the stories shared by students. As one student commented '...allowing discussion is good for teaching – [*you*] get to know how others operate.'

## **Is the use of SPACE relevant for teaching large groups?**

When SPACE is used in teaching, it utilises the power of modelling desirable behaviours. The extent to which role modelling is successful depends on several factors. Examples would include how the student

perceives how useful the behaviour is going to be, how motivated the student is and how confident the students feel in their ability to execute this behaviour. However, what seems crucial is the quality of the relationship between teacher and student as to how successful or otherwise the role modelling will ultimately be (Bandura 1977, 1986; 2002; Davies 1993). Many of the students felt that this was a decisive factor as to whether their learning was enjoyable or not. Although speaking directly to all students is not really feasible other than in small groups, the act of personalising the way that teaching is executed using SPACE means it must take place in a non-judgmental and growth promoting atmosphere.

Given that this research was conducted with students who were not taught in groups of more than 25, there are concerns that this approach may have little relevance to teaching in the much larger groups (approximately 400) often seen in university lecture theatres. A practical approach to the problem of big groups used by one of the teachers interviewed was to divide them into smaller groups which then feed back into the larger group. It seemed that he did manage to increase engagement in the process more than the traditional lecture approach. Using SPACE seeks to transmit values associated with nurturing and compassion. Attempts made by me on other occasions to relate to individuals within big groups using person-centred attitudes were not always successful but I always sensed that the students appreciated the effort I was making to be inclusive, respectful, empathic and non-judgmental when responding to their comments. When these values are perceived to be within reach of most of the student body it makes it easier for students to kick-start their own transformative journey (Cranton 2006).

When I used SPACE in smaller groups, it was easy to see that many of the students adopted a more empathic way of communicating with each other. When this occurred, the students interviewed felt more learning took place. As one student put it, comments were allowed 'to land;' the perspectives of others were not dismissed but respected and debated. Also the nature of the learning was different; they listened to other people's views and opinions on their client groups and how they went about implementing care. This awareness of how 'others operate' has transformative potential because it illuminates one's own attitudes and value judgements. The quantitative research data show that being empathic with students led to an increased likelihood that they would be more empathic. If each member of the student group is encouraged to listen to others and respond empathically, it is more likely that a climate is created in which people can feel safe to consider alternatives, since empathic responses has the power to enable change (Rogers 1980). These alternative perspectives are egocentric; individual students feel able to discuss and debate their issues with learning and/or teaching and/or caring. This process increases the chances of transformative learning change occurring, since it decreases the sense that it remains exclusively a personal struggle (Cranton 2006).

## **Learning as 'connecting' with the teacher**

Forming a 'connection' with nursing students in which the teacher presents an 'authentic self' enhances student motivation to learn (Gillespie 2005). Similar conclusions have been drawn from educational research conducted in the fields of nurse adult education and schools (Handelsman 2004; Cranton 2006; Cornelius-White 2007).



'Connection' here has several components but there was a consensus from the students interviewed that it included attempts made by the teacher 'to see how it is to be a student.' All students felt that in order to be effective the teacher needed to engage; this meant that it was the responsibility of the teachers to form relationships with them, but ones in which they were treated as equals, shown respect, and were focussed on their needs. The nature of this connection varied, with several students acknowledging that different teachers had different styles but teaching/learning approaches in which they were encouraged to discuss their thoughts, feelings, beliefs and attitudes were more memorable and ultimately more satisfying. They valued a process that made it possible to learn from other students through a combination of listening, responding, clarifying, challenging and supporting each other's experiences. Creating and maintaining an environment in which the emphasis is on empathic responding and one in which values such as respect, dignity, self-direction, independence, achievement, loyalty and security flourish is enabling, gives students the confidence to tackle the issues around learning.

## **Transformation through the telling of stories**

Creating an environment in which nursing students are encouraged to discuss and examine their education and clinical experiences can lead to new ways of thinking, feeling and acting about their educational and clinical practice (Ironsides 2005). This discourse has the potential to challenge many of their educational and clinical assumptions that often underpin student nurse learning and is therefore capable of transforming their attitudes about that learning (Mezirow 2000).

Teaching as validating student experiences through the telling of their stories is able to create a safe learning environment where the assumptions, beliefs and attitudes of students can be stated, examined and challenged by others within the group without fear or guilt. This approach is not easy, but one that is worth the effort given that the rewards are significant for both teacher and students.

If sufficient attention is not given to developing partnerships with students then change is much harder to achieve. Using SPACE is effective in forming relationships with students and in encouraging students to tell their stories. The initial reaction from most students was surprise at being encouraged to talk about themselves, their clinical practice and their learning experiences to date but focussing on their experiences was evaluated as worthwhile. Using skills normally associated with person-centred counselling such as open questions, affirmations and reflective listening creates a trusting environment in which the student feels more able to discuss the impact of significant experiences. Creating a safe place where often powerful feelings can be heard is difficult but important since their voicing and elaboration often leads to cathartic responses. Subsequent debate and exploration of aspects of these stories is encouraged by the teacher in the group, focussing on wider cognitive, attitudinal and emotional components.

Mezirow's (1991, 1997) transformative learning theory suggests that an individual is not always aware of their attitudes, values and assumptions and as a result are largely 'hidden from view.' However they can be brought into full awareness and can be changed through a process of critical reflection (Brookfield 1995). Cranton (2006) agrees with both

findings, arguing that there are several ways to achieve this change of perspective. However Cranton (2006) goes on to point out that forming authentic relationships in which the teacher is self-aware, aware of others and engages in critical reflection on practice is essential to the process of supporting transformative learning. The use of SPACE meets the criteria for this construct. SPACE can therefore be understood as a teaching approach that promotes authenticity and therefore transformative learning.

One student said that the module was one in which there was a 'lot of discussion which gave her a 'different perspective on things,' an indication that transformative learning has taken place (Mezirow 2000). Another student said that through this process he felt 'valued and listened to' which he said he 'didn't always feel at work.' Here the student is clearly pointing out that this approach to teaching increased his sense of being validated, that what he says matters. Since he pointed out that this is not always the case at work then it is possible that these negative values and attitudes are then transmitted to health service users. Another student pointed out the transformative nature of the module:

it's a life changing kind of experience in terms of the attitudes that we as professionals sometimes hold regarding the people with a 'dual diagnosis' (those health service users with a mental health and substance misuse problem).

Some of the teachers interviewed argued that responding empathically would take too long and that they may 'laugh at you' (Colin). However, responding empathically to a student story often leads to rich rewards relatively quickly. Students generally trust this new 'regimen' if it is clear

that the teacher is being authentic (caring and treating students as individuals). Confidence grows in individuals within the group that it is 'ok' to discuss personal fears and anxieties associated with change. Process takes over from content. Once a student has taken the plunge to speak, it is commonplace for others to follow.

Using the SPACE approach in teaching encourages disclosure due in some part to members of the group feeling increasingly safe to talk about what is preventing them from embracing change/learning. The group then becomes a safe place to listen, consider and share their perspectives. Adopting the non-judgmental stance of the teacher allows students to consider the validity of other viewpoints. One student pointed out that being accepted in the classroom is likely to lead to an orientation towards clients that holds similar views and values. Clearly then being validated in a classroom can have important repercussions for the way health care service users are treated by staff.

Emphasising what one of the teachers interviewed called the 'humanness' of teaching is an approach that is able to confront many of the practices and actions that stifle learning. Traditional teaching approaches emphasise the establishment and maintenance of a professional gap between teacher and student. Teaching using SPACE in contrast gives a template for change to occur through establishing a connection between a teacher and student (see above). This connection has emotional as well as cognitive components. As one student remarked:

I think with this course in particular you are able to say your views, aren't you? ... people don't seem to judge, there were more people that actually might agree and go, oh yeah, I feel like that.

Teaching in this manner allows the identification of processes normally witnessed in therapeutic groups to flourish (Yalom and Leszcz 2005). Yalom (1970) identified several therapeutic factors that operate in groups such as the instillation of hope, universality, altruism, group cohesiveness and imitative behaviour. A teacher using SPACE would benefit from an awareness of group dynamics in their drive to engage students with learning. Individuals in groups learn from each other as well as the teacher; role modelling desirable behaviours enhances confidence (self-efficacy).

## **Reflections on student participation**

Assuming that all students will enjoy participating in learning is making assumptions; some students clearly enjoyed the process of discussing their stories more than others. Many of the lecturers interviewed were acutely aware that increasing participation can often mean that one or two voices dominate to the exclusion of others. It was important also to accept that some students were clearly in a greater state of readiness for this than others. Many suggested that their aim was to get more students actively involved in the process of learning but struggling with how to achieve this. Contributing to democratic discussion is not something that many students have experience of and it was clear that some teachers had anxieties concerning the wisdom of this approach. Although power cannot be eliminated in the relationships between teachers and students acknowledging that it does exist and incorporating it into being 'authentic' with students tends to lessen its corrupting effects (Cranton 2006). Being authentic is 'helping students to learn, caring for students, engaging in dialogue and being aware of exercising power' (Cranton and Carusetta 2004:113) and according to the same authors capable of triggering

transformative learning in students. Much of what are considered to be elements of being person-centred are also elements of SPACE. The student data presented in this thesis suggest that SPACE promotes transformative learning, through a change to their attitudes and perspectives, resulting in changes to how they engage with their patients and clients.

## **How different is SPACE to other nurse education practices?**

The third research question concerns the similarities and differences between the use of SPACE and the teaching approaches of other nurse teachers. The teachers interviewed all thought that even though they believed that a teaching approach that had forming relationships at its centre was superior to other approaches, big groups (more than 40) made this very difficult to adopt. Some lecturers mentioned 'being overwhelmed' and losing 'control' when they were expected to teach these large numbers. Keeping control was considered important for some of the teachers and using an approach based on forming relationships clearly threatened this. Others thought that a teaching style based on forming relationships was impossible with big groups and abandoned it altogether. Some however were trying to adapt their teaching to avoid losing the interpersonal aspects because they thought that the benefits were significant and potentially far-reaching. Few of the teachers perceived their teaching to be participatory in which strategies are used to elicit a student dialogue. However, using SPACE is by definition a participatory form of teaching and therefore many of its strategies are focused on involving the student in teaching and learning. When I am being open, demonstrating acceptance and developing empathic, authentic connections to students it not only

appreciably changes the dynamic between teacher and student, but also between student and student. Initial reactions to this approach can be somewhat daunting; when some students witness a lecture in which a lecturer asks open questions/reflects/shares personal experiences what follows is often a period of silence in which they are trying to figure out what is exactly going on. I often feel that students are somewhat suspicious when I as lecturer try to include them in the teaching and learning, especially at the beginning of a teaching session. Participation is not usually an option given to students, especially in large groups. Although some students do not appear to respond most do; the effort of trying to connect to students often causes a 'disturbance' when I try to engage with them. The data from the student interviews suggest that there is some anxiety that they will be 'picked' on by a lecturer who clearly wants students to participate. This quickly dissipates when it becomes clear that when they do participate they will not be judged. What is undoubtedly true is that it takes students by surprise because previous experience tells them that lecturers usually communicate with students in a manner that elevates the teacher to the position as the authority, often resulting in communication that is patronising or dismissive or sometimes both. If teachers try to reach out to students in a way that their 'humanness' is allowed to express itself, then the response is overwhelmingly positive and learning can get a foothold.

Responding to student stories will sometimes involve asking others to reduce the level of background noise so that the student telling the story can be heard. Listening and reflecting back in order to check that what I have understood is what a student was trying to convey is unusual in a

lecture theatre. Yet I have found that behaving this way with a student is a much more powerful technique to change behaviour than simply providing a list on a PowerPoint® slide of how you want them to behave when they are with health service users. To do this effectively needs a reasonably quiet lecture theatre, a challenge for most lecturers, most of the time. Somewhat counterintuitively, initiating a dialogue in this manner tends to do just that; it is much more effective in getting students to listen than exhorting or pleading with them to be quiet. If it works then it is because the student sees you as making a genuine attempt to try and connect with a person or persons in a group irrespective of its size.

Role modelling can change attitudes and behaviour (Bandura 1977; Lunenberg 2007). Person-centred approaches are hypothesised to do this through a process of reciprocity (Rogers 1980; Muetzel 1988), acknowledged when using SPACE in teaching. This approach also has the potential to energise students who suddenly are aware that they might be expected to participate rather than remain passive, a state that many not unnaturally adopt when in a lecture hall that contains 300 or more. Speaking to individuals within a group this large is not easy but not impossible; experimenting by breaking down this large group into smaller, 'buzz' groups is one approach that has been used by a couple of the lecturers interviewed.

All of the lecturers thought that addressing individuals within these groups and role modelling a collaborative approach to that person is enabling to most students. It did not result in any of them thinking that this approach was not worthwhile if they failed to connect with some



students. It acknowledges the students as a working group in their own right but focuses on the individuals in that same group.

## **Summary of findings from the data**

Using a teaching style that is compatible with the SPACE approach enables teachers to engage and demonstrate respect through the establishment of a relationship based on partnership in the process of learning. This relationship is characterised by an empathic, non-judgemental, compassionate and affirmational approach to the learning of students. Research over several decades into the efficacy of person-centred teaching has consistently shown improvements to a wide range of learning outcomes in different schools, both here in the UK and the rest of the western world (Cornelius-White 2007).

Some of the student data indicate that the teaching on the modules they attended was able to change their attitudes and subsequent behaviour towards how they perceived learning, other students and their own health service users, all features of transformative learning. The data also shows that the students scored higher on two different measures of empathy when they finished the module compared to when they started; that is, they became more empathic by the end of the module. The lecturers interviewed in this study taught in a way that did show some similarities to the use of SPACE. However, there were several differences. Although the majority of the lecturers felt that good teaching was synonymous with being able to 'be themselves' little was forthcoming about how this was understood or how it could be developed in their teaching. Although all of the lecturers agreed that relationships should be formed with students and that part of their role was to facilitate their learning, none thought that the

communication style should be based on elements within the person-centred approach, such as empathy and acceptance. Colin thought that he learnt from the students all of the time as did several of the other lecturers. He strongly felt that his job as a teacher was to facilitate the learning of students but his view was not shared by all. Compassion was not mentioned at all by the lecturers in their discussion of teaching and learning, despite 'compassionate care' appearing repeatedly in the NMC 2010 standards for pre-registration nursing education document. Many of the lecturers thought that role modelling standards and values was an important part of their teaching but felt that large groups made this an almost impossible task.

Using the SPACE adaptation to my teaching created an inclusive environment which tries to balance the experience and expertise of others within the group. It recognises that individuals can make a difference to the learning needs of others; it states that you are not alone and what you witness is seeing others learn. It can provide inspiration for others; it is clear that more students want to listen and learn now in my classroom because they participate in 'hushing' some of the others students. This can have a snowball effect in which the students effectively create the conditions for listening to take place for the majority.

## **Limitations of the study**

Several limitations are inherent in the way that this research was conducted making it difficult to draw any firm conclusions about how generalizable these findings are to other populations. Issues arose concerning the sample size and sampling methods employed, the research design, the methodology, the data collection methods and the way the data

were analysed. 10 students and 9 staff were interviewed for the qualitative arm of the research. How these sample sizes were determined was largely a result of a consideration of several aspects of this research. I wanted as many diverse opinions as possible but was also conscious that how much time these interviews would take, given that I was sole researcher working in a full time job as a nurse lecturer. Advice was also taken from others as to an 'adequate' number of participants. As a neophyte researcher I was mindful that the scope of this research is limited to some extent by the constraints imposed by the intended qualification. The small sample size also reflected my wish for the interviews to reveal how the participants thought and felt about person-centred approaches in education, an approach which might result in sacrificing breadth for depth.

In addition, the research was conducted in only one university, based on data collected and analysed from just one researcher (myself). Any interpretations of the data are therefore open to accusations of bias based on undisclosed assumptions and an enthusiasm for MI as an approach, which may have had the potential to blind me to other interpretations of the data. However I was aware of this as a potential problem which did have the tendency to increase my resistance to interpreting the data in this manner. In addition, what helped to keep me aware of this potential problem was that I had regularly informed the students in the study that the data was open to all of them to scrutinise the data whenever they felt the need. The pretest-posttest design of the quantitative part of this study is able to detect differences attributable to an intervention, but does have potential issues with attributing causality to the increases found in the students' empathy scores. So called threats to the internal validity of the

design can arise in this instance due to what can happen in time between the two data collection points (see chapter 3 for more detail).

Delivering empathic care is a requirement to remain on the Nursing and Midwifery Council's (NMC 2015) register and so students filling in the empathy questionnaires may well have rated themselves 'higher' on a scale than would otherwise be the case. This would be easier to achieve when circling a number on a Likert scale of the EES (Caruso and Meyer 1998) rather than the empathic responses required for the scenario-based Helpful Responses Questionnaire, HRQ (Miller et al 1991), but nevertheless this aspirational aspect of perceiving yourself as an empathy based carer is still capable of skewing the result. Miller and Rollnick (2013) have argued that because of these shortcomings with questionnaires, direct observation using a manual to witness and record instances of someone using the elements of the SMI and MI with others is a much more reliable method to ascertain whether the skills of engagement and change are in evidence. This approach was considered for this research project, but the major difficulty associated with using observation was the time and the expense it would take to organise, notwithstanding the training and competency issues concerned with the use of manuals and/or protocols.

The way that students and staff were recruited for this study is best described as a convenience sample, although it did bear some hallmarks of purposive sampling (see chapter 3 for a fuller discussion). Chosen because of its ease of access and low cost, there is no way of knowing for certain how representative the sample is and therefore to what extent the findings can be generalised to other students. On the other hand, it seems

unlikely that the concerns about learning found in this sample of students are unique to students studying nursing.

Whether the findings from this research on using SPACE in classes of 20 can be generalised to pre-registration nursing students who are usually taught in groups of 300-400 is difficult to answer, although there is a growing body of literature on the applicability of person-centred approaches in lectures with large numbers (O'Neill and McMahon 2005; Biggs 2011).

This study derives its understanding of the intervention SPACE from how the terms that make up the acronym are used in the established literature. Yet in the same literature, there is a lack of a consensus on how constructs such as 'empathy,' 'self-awareness,' 'partnership,' 'collaboration,' 'acceptance' and 'compassion' are understood as well as the aforementioned differences of opinions as to what 'student-centred' means. Given the lack of a consistent definition of these constructs it would be prudent to be cautious in attempting to generalise the findings from this study to student nurses in general and to students on other courses.

However in spite of these potential shortcomings, the qualitative data from both students and staff showed that the display of empathy was valued by both sets of participants. The quantitative data also showed a rise in the presentation of empathy by students at the end of the module compared to its beginning. Although there are different definitions of what person-centred means the students had a shared understanding of this construct and valued its use in their learning. All were unanimous on its importance in forming person-centred relationships with health care users.

## **Implications of the findings**

Contrary to what I expected, the data revealed that students and teachers that I interviewed had similar views on teaching and learning. Both groups for instance supported the importance of the teacher as a self-aware facilitator of learning. They also agreed that the teacher needed to engage with the student if learning was to be effective. Both groups also thought that engagement should be undertaken in a non-judgemental and compassionate manner. Many schools and universities would claim that their approach is student-centred. Yet as pointed out in chapter 2, scholars such as Fielding (2009) warns would-be advocates of student-centred approaches to proceed with caution, arguing that it is often used to attract students to a teaching method that bears little resemblance to what advocates of person-centred approaches would consider are the essential characteristics of a student-centred approach. Although there are limitations to generalising these findings to other groups of students especially in large groups (see above), the worries and concerns expressed by the learners in this sample had little to do with the subject matter in hand but with learning per se. If this is the case and if further research did indeed corroborate these findings then it would provide further evidence that SPACE can be used as a teaching approach to engage with all students, irrespective of which subject they are studying. In addition, the data from some of the students suggest that the SPACE teaching approach can promote a fundamental change in students' attitudes towards how they engage with health service users. If this finding is replicated by further research then SPACE may have the potential to transform learning through establishing and developing a person-centred approach to health service users, which as already stated, is a requirement of the regulatory body for

nurses, the Nursing and Midwifery Council (NMC 2015). Likewise, if it was to be adopted by all nursing teachers as a way of teaching professional values then it would be *through* the way they engage with students rather than the delivery of information *about* the way they should engage with health service users.

It is my intention to present these findings to both pre-registration and post registration nursing degree programme committees of the institution I work for, since they have substantial influence over the way that their respective programmes are delivered. The present pre-registration curriculum is currently under review and the intention is to try and influence the way that professional values are taught by submitting these findings to the various curriculum sub-committees that already exist.

Funding for further research could be sought either from the small grants available from my own institution's educational research committee or from other national funding streams. Disseminating the findings could be achieved by publishing the results in reputable educational and nursing journals as well as presenting them at conferences organised within and outside of my own school of nursing. Adopting an action research approach to this research means that there are responsibilities on the individual to constantly adapt their practice but it also means that the institution needs to be willing to give the necessary training and support to teachers to implement this change to practice. It also requires that the institution accepts that it needs to work towards a culture that embraces and acts upon the dynamism that using an action research particularly brings to evaluating and changing the practice of its teaching staff.

The data show no correlation between age, experience and the ability to display empathy and therefore it can be taught to all preregistration nurses. Given that many of the positive findings of the use of person-centred approach in therapy have been replicated in schools (Cornelius-White 2007), there are sufficient grounds to recommend the development of measures that detect whether or not a teacher adopts a person-centred relationship based on self-awareness, partnership, acceptance, compassion and evocation in their teaching.

## **Recommendations for future research**

Although the use of empathy questionnaires did reveal statistically higher levels of empathy that reached statistical significance at the end of the module compared to that measured at the start, it is difficult to ignore several shortcomings attributed to the use of empathy questionnaires (Lietz et al 2011). Perhaps the most important of these concerns is the fact that achieving a high score appears to bear little relation to the actual display of empathy (Miller and Rollnick 2013; see chapter 3). The literature seems to indicate that direct observations or health care users' perceptions of empathy are more accurate than the rating of the therapist (Elliott et al 2011; Moyers and Miller 2013). If I were to undertake this research again I would therefore either replace questionnaires with an instrument that measures all of the aspects of SPACE, or use direct observation and health care user interviews. I would persevere with semi-structured interviews since I felt this approach gave me the depth of response that did justice to the complexity of the concepts under scrutiny. I would also focus more on aspects of SPACE that tend to be less well formulated such as compassion and evocation. SPACE could be a template for ensuring the delivery of



person-centred approaches in schools, provided scales to measure its presence could be devised. Scales have been designed to measure the presence and frequency of empathy in a therapeutic setting when analysing audio recordings (Moyers et al 2005) and presumably this could be used or adapted for use in an educational setting.

Attempting to replicate the results by investigating the use of SPACE in its effectiveness in transforming the learning of pre-registration nursing students would be the logical next step. This could then be followed by using the approach in university departments other than nursing and then in different universities. Setting up trials where SPACE could be compared to other more traditional approaches to teaching would also be worthwhile pursuing. Each of the components of SPACE is amenable to being learnt and therefore SPACE has great potential as a systematic approach to the training of person-centred skills in teaching. This could potentially be important since as far as I am aware there are no established training programmes for the acquisition of the skills and attitudes necessary to be competent in using person-centred approaches when teaching. It is not known what level of expertise is needed in the various components of SPACE to effect a transformation in student learning and so investigations into this aspect would be worthwhile also.

The role that emotions play in using SPACE and subsequent change needs clarification as does what strategies are best suited to maintain change after it has taken place. Further research into which components of SPACE and in what 'amounts' are considered essential to foster transformative learning would be worth pursuing. Finally research into the part that social factors play in the likelihood of any individual being able to

embrace change to their attitudes concerning learning could also reap rewards.

## **Reflections on using an Action Research approach**

After contemplating the use of several methodological approaches to this study, Action Research (AR) seemed to me to offer the most appropriate theoretical and philosophical framework to evaluate the changes I had introduced to the way I was teaching student nurses. I felt that AR's repeating cycles of 'planning, acting, observing and reflecting' (Zuber-Skerritt 1994:47) gives me the framework to maintain high standards in my practice. Critically reflecting on what I understand when I mean by teaching and learning enables me to become more aware of my practice. An AR approach then encourages the application of strategies for improvement but crucially at my own pace and in my own time. End of module evaluations are a compulsory part of the teaching at my institution. I was aware that using an AR framework however meant that my practice was continually under the gaze of evaluation and change, a process that proved to be exhausting at times. It did have the advantage though of forging closer links between theory and practice since the AR process required that I needed to regularly retrieved literature about teaching and learning.

AR encourages exploration and critical reflection of existing practice (Whitehead 1983); here was a research approach that emphasised change but also at the same time gave some legitimacy to my current experiences as a teacher. AR feels like a research approach that trusts teachers to reveal insights that could become the basis for changes to their practice

based on their observations. The use of AR therefore felt somewhat empowering. The inclusion of a critical reflective element in AR gave me some confidence in using the approach since I was familiar with this practice as it is a requirement for all nurses by the NMC (2002, 2008) to be reflective practitioners. Engaging with an action research approach also made me more aware that practice does not take place in a vacuum; it highlighted that institutions may need to change also to achieve the improvements needed (Schostak 1992). My findings were not just restricted to the acquisition of knowledge that in some way legitimised what I was doing when teaching. Framing the interviews of teaching staff within an AR approach with its emphasis on community increased my sense of wanting to work with those that shared similar ideals to me. The teacher as the prime mover in evaluating and changing practice fits an action research (AR) perspective, since it reinforces the view that practice can be improved through individual effort alone. Using AR has however, created some problems. The focus on reflecting and subsequently changing my practice did increase my sense of control over the whole process, but as already mentioned, it also raised my awareness that the organisation may need to change in order to be able to accommodate the implementation of improvements to practice. For example, it became clear that many of the lecturers felt that the effectiveness of transmitting values required by the nursing profession such as acceptance and compassion are most effectively achieved when class sizes are small. However, the reality is the class sizes for teaching nursing students are going in the opposite direction. Although my initial reaction to this impasse was one of increasing frustration and powerlessness over changes that are necessary but I am unable to effect,

AR does give you the impetus to look for alternative solutions such as the use of seminars to discuss these issues in the depth required. However, the prospect of offering your practice to the constant glare of a never-ending process of inspection and revision did at times reinforce the notion that your practice can never be good enough, with this constant emphasis on change.

It is my intention to continue to use and develop the SPACE approach in teaching pre and post-registration students. Given that I also intend to apply the principles of action research with its emphasis on perpetual cycles of practice, reflection and evaluation of that practice (McNiff 2002), I will need to consider in the light of this research that the SPACE approach may have to be adapted to be as effective in large groups. One consideration is to use an approach that has been successful and mentioned in the data from one of my colleagues. This involved breaking large group of students into smaller ones who then discuss and feed back to the whole group.

One of the major advantages of using action research is that you can constantly refine practice so that it more closely complements the values, beliefs and attitudes I hold about my practice. Although I have been using SPACE for some time and am steadfast in my belief of its credentials as a student-centred approach to teaching, I still decide without any consultation on the aims and objectives of the substance misuse and the dual diagnosis module, the length and content of the sessions and how it is assessed. I still stand at the front of the class and 'lecture.' There are changes I could make which would move the way the teaching is organised to a more student-centred, active learning approach (Honey and Mumford

1982), which I think would have the advantage of enhancing the student-centred nature of the use of SPACE. I could give more control over to the students as to what they want to learn; for example, groups could be formed either by myself or by the students in order to encourage them to work on different projects in relation to substance misuse/dual diagnosis in which they could then feed back to the whole group. Further decisions about what to investigate could then be taken by the group as the module proceeds. Although the university insists that there has to be a summative assessment of the module, I could discuss with the students whether alternatives to the present 2,500 word assignment would be more useful to their learning.

## **Contributions to knowledge**

This study makes three contributions to the debate about learning and change in nursing students. Firstly, the student data indicate that enhancing attitudinal change in nursing students towards learning can be achieved if the clinical engagement strategy known as the Spirit of Motivational Interviewing (SMI) (Partnership, Acceptance, Compassion And Evocation) is adapted for the purposes of teaching to include the construct self-awareness and therefore become SPACE (Self-awareness, Partnership, Acceptance, Compassion and Evocation). Secondly, the qualitative data from interviewing teachers and students suggest that they have similar views and beliefs about the nature of teaching and learning. Nevertheless, there were substantial differences between the way I and the other teachers went about the practice of teaching. My practice is increasingly driven by a need to not be afraid to consider sharing with the student what I am experiencing at any given moment when I teach: this

means resisting the temptation to hide beneath a professional façade. There is evidence that before acceptance and compassion can be effective in establishing relationships with students, teachers need to demonstrate this self-awareness (Wilkins 2003). This is a finding that I have confirmed in my own teaching; students are more likely to acknowledge and accept me as a non-judgemental, empathic and compassionate teacher when I am prepared to be 'myself' (self aware) in front of students.

The use of SPACE puts an emphasis on being self-aware when I am teaching. This is understood to mean that I try to be aware of what my feelings and thoughts are at any one time when I am in front of a class or lecture room full of students. The rationale for this approach is that when I try to accept myself as I am at any given moment, imperfections and all, I feel I become a much more effective teacher. This attempt at accepting myself (becoming self-aware, the first component of SPACE) is a crucial stage in change: '...the curious paradox is that when I learn to accept myself as I am, then I change' (Rogers 1961:17). This is important because attempting to be 'real' with myself means I am more likely to enter into 'real' relationships with the students in front of me. A distinguishing feature of this attempt at forming 'real' relationships with students is that I try very hard to accept and not judge their feelings towards me. Often this means encouraging students to voice their concerns about the subject at hand and accepting common feelings of fear and apprehension about the learning they are about to embark on. Acceptance (the second component of SPACE) brings about change in myself and through a process of reciprocity, in others. Accepting others means prizing their individuality, an emphasis on focussing on a person's strengths rather than their

weaknesses, and communicating and behaving in an empathic and compassionate manner. It also entails a fundamental belief that the person has the potential they need to change (learn). This means the task of the teacher is to facilitate the process of encouraging students to access this 'potential.' This approach also acknowledges the teacher as resource; my task is to share my knowledge and experience as a way to encourage the sharing of the students' knowledge and experience. This sharing of knowledge and experience provides the climate to re-examine attitudes and values towards their learning that have been less than helpful. Exposure to attitudes within SPACE such as self-awareness, collaboration, respect, trust, empathic understanding and acceptance seems to promote a change in the attitudes of students, a transforming learning experience (Cranton 2006). Some of the students then went on to state they adopted these attitudes when they formed relationships with patients and clients. Using SPACE is therefore able to promote a transformative learning experience.

Finally, the data obtained from two empathy questionnaires taken by students show an increase in empathy that was statistically significant. Teaching about empathy took less than 1% of the time dedicated on the modules to teaching. In spite of this, empathy was used throughout the units as a way of communicating with students and therefore this increase in empathy scores is theorised to have occurred as a result of an empathic way of communication when teaching and learning from students.

# **Chapter 6-Final Thoughts**

## **Introduction**

During the process of conducting and writing up this piece of research I realised that several issues were emerging that needed further reflection. This final chapter will therefore examine and critically reflect on my assumptions, thoughts and feelings about the whole research process, including how I conducted the research. It will also include highlighting the rationale and the strengths and weaknesses for my choice of sampling procedure, sample size, the person-centred approach to learning, research design, mixed methods, and the use of action research as a methodology. It will also critically examine the concept of engagement, given that several views were expressed about what this was understood to be and its importance in teaching. The final section of the chapter will discuss how using action research in further studies into the use of self-awareness, partnership, acceptance, compassion and evocation (SPACE) in teaching could be achieved, with the aim of improving the practice of teaching.

## **Participants**

This research study interviewed both teachers and students. My research came to the conclusion that values such as care and compassion can be role-modelled to students through exposure to the SPACE approach to teaching. Some students stated that it had then subsequently changed the way they engaged with their patients and clients. A priority for further research on the applicability of SPACE in teaching would therefore be focussing on what health service users thought and felt about the care they



received from those students who were exposed to the SPACE approach to teaching.

## **The sampling procedure**

My original intentions were always to ask former as well as current students to participate in this research on the basis that since I had been using this approach for some time, gaining the views of former and current students would add credibility to the study's findings. However, I only received 4 replies from 56 former students contacted and two of these still were studying units to obtain their degree in Nursing and/or Professional Practice. The other two students could have received 'good' marks from me for their essays (I did not check this) and so it is possible this is why they decided to accept the invitation to to be part of the study. The other six students were all current students on a unit in which I was also their assessor as well as their teacher and they still had to submit their essays. Moreover, the 26 students in the quantitative arm of the study had also to hand in their essays to be marked by myself. The almost universal positive comments about the use of SPACE in teaching from the student data could therefore have been influenced by these characteristics of the sample and may well not be representative of the student body of nurses as a whole. It would therefore be unwise on the basis of these findings to generalise about the applicability of the SPACE approach to all nurses and indeed to students on other courses.

## **Sample characteristics**

### **Sample size**

Several of the lecturers when interviewed felt that group size was an important restricting factor on engaging with, and being able to role model the transmission of values such as compassion, empathy and respect. All of these values are central to the concept of caring. The advice that sample size in qualitative research should be determined by the point at which no new data emerges (saturation) (Glazer and Strauss 1967), is often the starting point for qualitative researchers to make a decision concerning this aspect. However, factors such as the expertise of the researcher, the nature of the topic and the heterogeneity of the population under scrutiny, the types of data collected, and the availability of resources can all affect saturation (Morse 2000; Ritchie 2003). Bowen (2008) makes the point that how saturation is achieved is rarely stated by researchers. Advice on actual numbers in qualitative research is hard to find, with different authors suggesting ranges between 5 and 60 (Morse 1995; Ritchie et al 2003; Charmaz 2006), depending it seems on the type of qualitative research undertaken. However, given that my research study only interviewed 10 students and 9 lecturers it would be worthwhile repeating this research with a larger sample size of students. People who want to become nurses can choose either to become an Adult, Child, Learning Disability or Mental Health nurse. As a Mental Health nurse myself I would prefer to develop this research initially into this field of nursing. The pre-registration mental health student nurse cohort at the University of Manchester, School of Midwifery and Social Work is currently fixed at 70 and this would therefore

be ideal, using the guidelines mentioned above, to recruit a sample of between 20 and 50.

### **Making the sample more representative**

Some students who were contacted for this piece of research were unable to come to the university to be interviewed face to face, mostly because of the distance involved. I was not able to provide funds either for myself to go to their homes or to pay the travelling expenses for them to come to the university. But as mentioned in chapter 3, there is also evidence that students would be more forthcoming if they could conduct the interviews in the comfort of their own accommodation or indeed in a neutral space. The use of 'skype' and/or 'facetime' is a recent innovation that can help to overcome these problems.

Widening the sample characteristics of the students would increase confidence in the credibility of the data (Lincoln and Guba 1985) and therefore further research could use a student sample that focussed on preregistration nurses. It could include a mix of 1st, 2nd and 3rd years. Including Adult nurses (current cohort is approximately 300 per year) may make it more representative of the nurses who start their training and go on to achieve qualification. This may need a change of method of data collection (focus groups instead of interviews) but the use of quantitative methods such as questionnaires has been ruled out (see below).

### **Research design**

The original research could be described as a mixed methods, single case, action research design and on reflection further research might not include a quantitative element. I decided to use a quantitative research approach initially because I thought it would enhance the credibility of my

qualitative findings. I had originally wanted to use a quantitative measure of other aspects of the Spirit of Motivational Interviewing (SMI) but the only measure of any of the constructs that make up the SMI that had a degree of reliability and validity was empathy. This difficulty in finding quantitative ways to measure the other aspects beside empathy in SPACE was one of the reasons as to why I thought that using 2 empathy questionnaires would further enhance the credibility of the findings. Another reason not to pursue a mixed methods design is that using empathy questionnaires (the only realistic option), is only measuring less than 20% of the SPACE construct.

In addition, questions have been raised about the validity of using questionnaires to detect empathy (Miller and Rollnick 2009). Direct observation of attitudes such as empathy and compassion is therefore recommended by some, through the use of measures such as the Motivational Interviewing Treatment Integrity Code (MITI) (Moyers et al 2005) and the Behavioural Change Counselling Index (BECCI) (Lane et al 2005). THE MITI is a scale scored by observers that has two parts. It first of all measures the therapists use of the components of the SMI interview, (usually in the form of a tape), using a 5-point Likert scale. Secondly it asks observers to rate the use of aspects of MI such as open questions and the type of reflection (simple or complex). The BECCI also uses a 5-point Likert scale to measure 11 items, such as the amount of empathy displayed and the extent to which the focus of the conversation between helper and patient is focussed on the subject of behaviour change. In spite of this, there are very few studies that have revealed what students and health care users have experienced when a therapist is empathic, collaborative,

caring and compassionate. It is this author's opinion that determining whether the SPACE approach to teaching can transform students' attitudes towards their patients and clients must also include the views, opinions, thoughts and feelings of the health service users that are exposed to the students who have been taught using the SPACE approach.

## **Data Collection**

An essential element of the SPACE approach to teaching is that it is delivered in an empathic style, a feature that found some justification from the findings from the quantitative arm of the study. The empathy scores of 26 students who filled in 2 empathy questionnaires were found to be higher by a statistically significant amount at the end of the module compared to the beginning (please see chapter 4 for a fuller discussion). However, empathy is only one aspect of the construct SPACE and therefore if questionnaires are to be retained in future research then ideally one would need to be one devised that could embrace all of the constructs of SPACE. Creating questionnaires that have high reliability and validity are time consuming and difficult to do (Rattray and Jones 2007) and on reflection, arguably this time would be better utilised by using an exclusively qualitative approach to the collection of data. A variety of methods would be considered for further qualitative research besides one to one, face to face interviews. These could include focus groups, reflective diaries, field notes, notes from meetings and so on (see below for further details).

# Engagement

Trowler (2010:3) offers this definition of engagement:

The interaction between the time, effort and other relevant resources invested by both students and their institutions intended to optimise the student experience and enhance the learning outcomes and development of students and the performance, and reputation of the institution.

She goes on to say that 'the value of [*student*] engagement is no longer questioned' (Trowler 2010:9). Despite this assertion, when I came to review the literature on engagement it was clear that there is little consensus on what the term means. For instance, Kahu (2014) identifies 4 different perspectives of engagement; the behavioural, which focusses on what the teacher can do to be effective, the psychological, which emphasises the processes that go on inside an individual, the context, which embraces the sociocultural process and the holistic perspective, which attempts to integrate all of the previous interpretations. Most studies on engagement failed to define the term, with some using it interchangeably with motivation and values (Jimerson et al 2003). Most of the data collected from these studies were from student surveys, which arguably don't adequately capture the dynamic aspect of engagement. They also failed to identify which aspect of engagement was being measured (Roth et al 1996). Moreover, many of these studies failed to point out where the engagement took place or with whom (Furlong et al 2003).

The use of the holistic definition of engagement outlined above means accepting that engagement is influenced by the social context in which it

takes place. This may offer an explanation as to why some students were easier to engage than others. When I reflect on the kind of student that I found it easiest to engage with, it is hard to escape the feeling that many of these had similar profiles, culture and outlooks to myself. In other words, these student nurses were mostly white and came from predominately working class backgrounds. They seemed to think and feel in similar ways to myself. The aspirations of these students also seemed similar with most of them believing that through education, they could escape the low expectations often attributed to being a member of the working class. One of my unexamined assumptions about teaching is that all students irrespective of gender, race and background would respond positively when I tried to engage with them and gave them 'permission' to state their own thoughts and feelings. Some students however seemed to become disengaged from learning when I used the SPACE approach. I can only speculate as to the reasons why this might be happening but it is possible that SPACE challenges some of the expectations that some students have about their role and that of the teachers.

For some students being passive is what a student does; the use of SPACE requires that students participate regardless of their feelings and thoughts. My reluctance to accept any understanding of my role other than as a facilitator of learning, could make them less willing to participate rather than more. Some of the difficulties of engaging with students I felt were due to different expectations of what it means to be a teacher with some students clearly wanting a teacher to teach in the traditional manner (lecturing - in which I do most if not all of the talking to a largely passive, silent, student audience). The use of SPACE purports to be culture-free and

that may well be one of its limitations. I noticed that some students from other cultures especially found it difficult when I tried to treat them as an equal and encouraged them to speak freely. This may be due to cultural and social expectations of what it means to be a teacher and what it means to be a student.

The key limitations of the psychological perspective of the concept of engagement centre on a lack of definition and differentiation between the dimensions. Clear definitions of the construct of engagement is essential for shared understanding, but Jimerson et al's (2003) review shows that 31 of the 45 papers scrutinised did not define the term clearly. In addition, not only is there considerable overlap with previously studied constructs such as motivation, learning and values but also these problems of definition have led to inconsistencies in measurement.

### **Limitations of the person-centred approach**

Rogers argues that when the attitudes of congruence (self-awareness), Unconditional Positive Regard (UPR) and empathy are offered by the teacher or therapist within the confines of a collaborative relationship, change will ensue. He clearly stated that these were all that were needed; they were 'necessary and sufficient' (Rogers 1957:101). No techniques were required to instigate change. The necessity and sufficiency of these attitudes has been a constant source of disagreement both within the person-centred tradition and from those that advocate other approaches such as Cognitive-Behavioural Therapy (Westbrook et al 2007) and Motivational Interviewing (Miller and Rollnick 2013) (see chapter 2 for a fuller discussion).



Difficulties also arise because there are no accepted, consistent definitions for congruence, UPR and empathy. Indeed Rogers himself uses different words to describe all three (see chapter 2). Rogers's beliefs about what it means to be human have been a constant source of debate and controversy. For instance, a fundamental tenet of person-centred therapy is that human beings possess an innate desire to fulfil their potential, an assumption that is impossible to prove. Ryan (1995) asserts that human beings are more characterised by inconsistency. Quinn (1993) argues that Rogers's view of people as continually moving towards optimum growth provided the right psychological conditions are present is over-optimistic and a simplistic explanation of what it is to be human. Brown and Smart (1991) have argued that the personality develops through a system of rewards and punishments from society at large rather than from any innate tendency to fulfil potential. Moreover, person-centred therapy ignores that people are shaped by powerful social and cultural forces that affect their ability to take opportunities to develop and thrive as an individual (Kensit 2000). Many behavioural psychologists have consistently argued that many people with mental health problems lack the skills necessary to cope with the demands of modern life and therefore need to be taught these (Westbrook et al 2007). Rogers also fails to acknowledge sufficiently the influence of the environment on behaviour.

Person-centred therapy does not diagnose or offer any techniques (Thorne and Sanders 2012). Moreover, because there are no strategies, it has to rely on the expertise of the individual therapist or teacher for its effectiveness, making it difficult if not impossible to deliver a consistent approach. Cognitive-Behavioural Therapists would argue that Rogers does

not pay enough attention to the role that thinking has on subsequent behaviour (Beck 1976). Some have also argued that providing an accepting environment and empathising with a person who is clearly dysfunctional could be construed as irresponsible and could be described as neglect. This would contravene the duty of care of nurses, a legal requirement (Cox 2010). Mearns and Thorne (2007) suggest that person-centred approaches are more a product of the time, background and experience of its originator, Carl Rogers. They depict him as a middle class, North American man who reflects a culture that emphasises the importance and supremacy of individual effort over other more social approaches to the resolution of problems. Mearns and Thorne (2007) go on to argue that person-centred approaches have less success in cultures such as the Japanese, because of their belief in the supremacy of the group over the individual in solving the issues within society.

## **The potential of Action Research to further develop the SPACE approach to teaching**

No one definition of Action Research (AR) exists but it focuses on those activities that seek to improve practice and involves repeating cycles of planning, acting, observing and reflecting (Kemmis and McTaggart 2000). The spiral nature of the whole process means that the researchers and participants increase the likelihood of expanding their understanding of the experience. One of the strengths of AR is that it can incorporate different perspectives and knowledge bases (Reason and Bradbury 2008). AR is a 'call for engagement with people in collaborative relationships, opening new 'communicative spaces' in which dialogue and development can flourish' (Reason and Bradbury 2008:3). It is characterised by a need for

'better understanding, participation, improvement, reform, problem solving, a step by step process, modification, and theory building' (Koshy 2011:10).

In my research I worked alone, but AR does give the opportunity to work collaboratively not just with participants, but with other researchers. The findings from the staff interviews suggested that many lecturers have similar views about the nature of teaching and forming an action research group of like-minded individuals would be a first step in future research. So the intention of any future study would be to widen significantly the participants to include a whole range of individuals from the local community who have an interest in the teaching of nursing students.

In my original research, I included nurse lecturers as well as students. When I reflect on over 20 years of teaching it is clear that there have been significant contributions from many others, all of who could be considered for future involvement in research on the applicability and usefulness of a SPACE approach to teaching. I have often asked health care users to come and talk to discuss their experiences of treatment with student nurses. I have arranged for different clinicians such as nurses, doctors, social workers and occupational therapists working in many different settings to share their knowledge and experiences with a student audience. Pre-registration nursing students spent 50% of their time in university and 50% of their time in hospital and community settings. When they arrive at their clinical placement, each student is appointed a mentor. Since 2001 in England, Practice Education Facilitators (PEF's) have been appointed by each Health Care Trust to help, guide and support mentors and other staff to ensure that the students achieve their outcomes for that particular

placement. Administrators and programme managers have views and opinions about student learning, as do members of the public. Therefore in order to increase the participatory element of action research, future research into SPACE would benefit from recruiting participants from a wide range of people whose attitudes, values and beliefs impact on the teaching of students. This could include clinicians, PEF's, administrators, other lecturers, pre-registration and post-registration students and members of the public, all of which have opinions on the teaching of student nurses. Data could be collected using a variety of methods such as interviews, focus groups, minutes and notes from meetings, reflective diaries, and emails. Emerging themes would then be identified, discussed and explored using the same kind of coding methods used in my research (see chapter 4 for a full discussion).

## **Conclusion**

This chapter has critically analysed some of the issues regarding the students who agreed to join this study. It has also challenged some of the theoretical assumptions concerning person-centred approaches and the notion of engagement. Finally, there are some reflections on how using action research approaches in future research could enhance and improve the practice of the use of SPACE in the teaching of both student and qualified nurses.

## **References**

Altman, D.G. (1990). *Practical statistics for medical research*. London: Chapman and Hall.

- Akinsanya, J.A. (1987). 'The life sciences in nursing: development of a theoretical model.' *Journal of Advanced Nursing*, 12(3) pp. 267-274.
- Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M. and Fulcher, L. (2003). 'Client commitment language during motivational interviewing predicts drug use outcomes.' *Journal of Consulting and Clinical Psychology*, 71(5) pp. 862-878.
- Anastasi, A. (1982). *Psychological testing*. 5th ed., New York: Macmillan.
- Apocada, T.R. and Longabaugh, R. (2009). 'Mechanisms of change in motivational interviewing: a review and preliminary evaluation of the evidence.' *Addiction*, (104) pp. 705-715.
- Aspy, D. N. and Roebuck, F. N. (1972). 'An investigation of the relationship between student levels of cognitive functioning and the teacher's classroom behaviour.' *Journal of Educational Research*, 65 pp. 365-368.
- Aspy, D. N. and Roebuck, F. N. (1975). 'The relationship of teacher-offered conditions of meaning to behaviors described by Flanders' interaction analysis.' *Education*, 95, pp. 216-222.
- Atack, L., Comacu, M., Kenny, R., LaBelle, N. and Miller, D. (2000). 'Student and staff relationships in a clinical practice model: impact on learning.' *Journal of Nursing Education*, 39(9) pp. 387-392.
- Athay, A.H. (1974). 'The relationship between empathy, warmth and genuineness and client rated improvement.' *Dissertation Abstracts International*, 34(7-A), 3976.
- Atkins, S and Murphy, K (1993). 'Reflection: A review of the literature.' *Journal of Advanced Nursing*, 18, pp. 1188-1192.
- Attride-Stirling, J. (2001). 'Thematic networks: an analytic tool for qualitative research.' *Qualitative research*, 1(3) pp. 385-405.
- Baer, J. S., Beadnell, B., Garrett, S. B., Hartzler, B., Wells, E. A. and Peterson, P. L. (2008). 'Adolescent change language within a brief motivational intervention and substance use outcomes.' *Psychology of Addictive Behaviors*, (22), pp. 570-575.
- Baldwin, A., Mills, J., Birks, M. and Budden, L. (2014). 'Role modeling in undergraduate nursing education: An integrative literature review.' *Nurse education today*, 34(6) pp. 18-26.
- Baldwin, M. (2013). *The use of self in therapy*. London: Routledge.
- Baldwin, S. A., Wampold, B. E., and Imel, Z. E. (2007). 'Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance.' *Journal of Consulting and Clinical Psychology*, (75) pp. 842-852.

- Bandura, A. (1977). 'Self-efficacy: Toward a Unifying Theory of Behavioral Change.' *Psychological Review*, 84(2) pp. 191-215.
- Bandura, A. (1982). 'Self-efficacy mechanism in human agency.' *American Psychologist*, 37, pp. 122-147.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. New Jersey: Prentice Hall.
- Bandura, A. (1991). Social cognitive theory of self-regulation. *Organizational Behaviour and Human Decision Processes*, 50, pp. 248-287.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Bandura, A. (2006). 'Towards a Psychology of Human Agency.' *Perspectives on Psychological Science*, 1, pp. 164-180.
- Barrett-Lennard, G.T. (1986). 'The relationship inventory now: Issues and advances.' In Greenberg, L.S. and Pinsof, W.W. (eds.) *The psychotherapeutic process a research handbook*. New York: Guilford press.
- Barnette, J.J. (2000). 'Effects of Stem and Likert response option reversals on survey internal consistency: ' if you feel the need, there is a better alternative to using those negatively worded stems.' *Educational and Psychological Measurement*, 60(3) pp. 361-370.
- Bassin, A. (1975). 'Different strokes for different folks: A defence of confrontation tactics in psychotherapy.' *The Counselling Psychologist*, 5 (3) pp. 128-130.
- Baumgartner, L. M. (2002). 'Living and Learning with HIV/AIDS: Transformational Tales Continued.' *Adult Education Quarterly*, 53, pp. 44-70.
- Beck, A.T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York. International University Press.
- Beauchamp, T.L. and Childress, J.F. (2001). *Principles of biomedical ethics*. USA: Oxford University Press.
- Belenky, M. F. Clinch, B. M. Coldberaer, N. R. and Tarule, I. M. (1986). *Women's ways of knowing the development of self voice and mind*. New York: Basic Books.
- Bien, T.H., Miller, W.R. and Tonigan, J.S (1993). 'Brief interventions for alcohol problems: a review.' *Addiction*, 88(3) pp. 315-336.
- Biggs, J.B. (2011). *Teaching for quality learning at university: What the student does*. UK: McGraw-Hill Education.
- Billington, D. (2007). Seven characteristics of adult education/adult learning. [Online] [Accessed on 10/2/2013] <http://education.jhu.edu/PD/newhorizons/lifelonglearning/workplace/articles/characteristics>.
- Birch, S.H. and Ladd, G.W. (1997). 'The teacher-child relationship and children's early school adjustment.' *Journal of School Psychology*, 35, pp. 61-79.

- Bleske-Rechek, A. L. (2001). 'Obedience, conformity, and social roles: Active learning in a large introductory psychology class.' *Teaching of Psychology*, 28, pp. 260-262.
- Bolton, G. (2010). *Reflective Practice, Writing and Professional Development*. 3rd ed., California: Sage.
- Boud, D. Keogh R. and Walker, D (1985). *Reflection: Turning Experience into Learning*. London: Kogan Page.
- Boyatzis, R. (1998). *Transforming Qualitative Information: Thematic and Code Development*. Thousand Oaks, CA: Sage.
- Bowen, G.A., (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative research*, 8(1), pp.137-152.
- Bozarth, J. D. (1998). *Person-centred therapy: A revolutionary paradigm*. UK: PCCS Books.
- Brandes, D and Ginnis, P. (1986). *A guide to student-centred learning*. UK: Nelson Thornes.
- Braun, V. and Clarke, V. (2006). 'Using thematic analysis in psychology.' *Qualitative Research in Psychology*, 3, pp. 77-102.
- Brookfield, S. (1990). *The Skilful Teacher*. San Francisco: Jossey-Bass.
- Brookfield, S.D. (1995). *Becoming a critically reflective teacher*. San Francisco: Jossey-Bass.
- Brown, J.D. and Smart, S., (1991). The self and social conduct: Linking self-representations to prosocial behavior. *Journal of Personality and Social Psychology*, 60(3), p.368.
- Brydon-Miller, M. and Greenwood, D. (2003). 'Why action research?' *Action Research*, 1(1) pp. 9-28.
- Bryman, A. (2008). *Social Research Methods*. 3rd ed., Oxford: Oxford University Press.
- Bryson, C. and Hand, L. (2007). 'The role of engagement in inspiring teaching and learning.' *Innovations in education and teaching international*, 44(4) pp. 349-362.
- Buber, M. (1961). *Between man and man*. London: Fontana.
- Bulman, C. and Schulz, S. (eds.) (2013). *Reflective Practice in Nursing*. 5th ed., Oxford: Wiley Blackwell.
- Burke, B.L., Arkowitz, H. and Menchola, M. (2003). 'The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials.' *Journal of Consulting and Clinical Psychology*, 71, pp. 843-861.
- Burnard, P. (1999). 'Carl Rogers and postmodernism: Challenges in nursing and health sciences.' *Nursing and Health Sciences*, 1(4) pp. 241-247.

- Grove, S.K., Gray, J.R. and Burns, N. (2014). *Understanding Nursing Research: Building an Evidence-Based Practice*. USA: Elsevier Health Sciences.
- Candy, P. C. (1991). *Self-Direction for Lifelong Learning*. San Francisco: Jossey-Bass.
- Carr, G. (2007). 'Changes in nurse education: being a nurse teacher.' *Nurse Education Today*, 27, pp. 893–899.
- Carter, T. J. (2002). 'The Importance of Talk to Midcareer Women's Development: A Collaborative Inquiry.' *The Journal of Business Communication*, 39 pp. 55–91.
- Caruso, D. R. and Mayer, J. D. (1998). 'A Measure of Emotional Empathy for Adolescents and Adults.' *Unpublished manuscript*, pp. 713-726.
- Charmaz, K. (2003). 'Grounded theory: Obejectivist and constructivist methods.' *In* Denzin, N.K. and Lincoln, Y.K. (eds.) *Strategies of qualitative inquiry*. 2nd ed., London: Sage.
- Charmaz, K ( 2006). *Constructing grounded theory: A practical guide through qualitative research*. London: Sage
- Chhuon, V. and Wallace, T. L. (2014). 'Creating Connectedness Through Being Known Fulfilling the Need to Belong in US High Schools.' *Youth and Society*, 46(3) pp. 379-40.
- Clark, M.C. and Wilson, A.L. (1991). 'Context and rationality in Mezirow's theory of transformational learning.' *Adult Education Quarterly*, 41, pp. 75-91.
- Cohen, J. (1988). Set correlation and contingency tables. *Applied Psychological Measurement*, 12(4), pp. 425-434.
- Cialdini, R.B. (2007). 'Descriptive social norms as underappreciated sources of social control.' *Psychometrika*, 72(2), pp. 263-268.
- Collard, S. and Law, M. (1989). 'The limits of perspective transformation: A critique of Mezirow's Theory.' *Adult Education Quarterly*, 39, pp. 99-107.
- Conklin, H.G. (2008). 'Modeling compassion in critical, justice-oriented teacher education.' *Harvard Educational Review*, 78(4) pp. 652-674.
- Cornelius-White, J. (2007). 'Learner-Centered Student relationships are effective: A Meta-Analysis.' *Review of Educational Research*, 77(1) pp. 113–143.
- Cowan, D.T., Norman, I. and Coopamah, V.P. (2005). 'Competence in nursing practice: a controversial concept—a focused review of literature.' *Nurse education today*, 25(5) pp. 355-36.
- Craft, J., Hudson, P., Plenderleith, M., Wirihana, L. and Gordon, C. (2013). 'Commencing nursing students' perceptions and anxiety of bioscience.' *Nurse education today*, 33(11) pp. 1399-1405.



- Cox, C., (2010). Legal responsibility and accountability: Chris Cox looks at risk management and accountability issues for nurses, especially those undertaking extended roles. *Nursing management*, 17(3), pp.18-20.
- Cranton, P. (2001). *Becoming an authentic teacher in higher education*. Florida: Krieger Press.
- Cranton, P. (2006). *Understanding and Promoting Transformative learning. A Guide for Educators of Adults*. 2nd ed., USA: Jossey-Bass.
- Cranton, P. and Carusetta, E. (2004). 'Perspectives on Authenticity in Teaching.' *Adult Education Quarterly*, 55, pp. 5–22.
- Crawford, P., Gilbert, P., Gilbert, J., Gale, C. and Harvey, K. (2013). 'The language of compassion in acute mental health care.' *Qualitative Health Research*, pp. 1-9.
- Creswell, J. and Plano Clark, V.L. (2007). *Designing and Conducting Mixed Methods Research*. Thousand Oaks, California: Sage.
- Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. London: Sage.
- Curtin, S. and Trace, A. (2013). 'Exploring motivational interviewing and its philosophical alignment to an undergraduate behavioural science programme in dentistry.' *European Journal of Dental Education*, 17, pp. 83–87.
- Daloz, L. A. (1986). *Effective teaching and mentoring: Realizing the transformational power of adult learning experiences*. San Francisco: Jossey-Bass.
- Davenport, J. and Davenport, J. A. (1985). 'A chronology and analysis of the andragogy debate.' *Adult Education Quarterly*, 35(3) pp. 152-159.
- Davies, E. (1993). 'Clinical role modelling: uncovering hidden knowledge.' *Journal of Advanced Nursing*, 18(4) pp. 627–636.
- Denzin, N.K. (1989). *The Research Act: A Theoretical Introduction to Sociological Methods*. 3rd ed., New Jersey: Prentice Hall.
- Department of Health (2012). *Compassion in Practice Nursing, Midwifery and Care Staff: Our Vision and Strategy*. London: Department of Health.
- Department of Health (2014). *Compassion in Practice: Two Years On*. London: Department of Health.
- DeVellis, R.F. (2003). *Scale development*. Thousand Oaks, CA: Sage.
- Dewey, J. (1916). *Democracy and Education. An introduction to the philosophy of education*. New York: Free Press.
- Dey, I. (1993). *Qualitative Data Analysis: A User-friendly Guide for Social Scientists*. New York: Routledge.
- Diekelmann, N. (1990). 'Nursing education: Caring, dialogue, and practice.' *Journal of Nursing Education*, 29(7), pp. 300-305.

- Dirkx, J. (1997). 'Nurturing the Soul in Adult Learning' In Cranton, P. (ed.) *Transformative Learning in Action: Insights from Practice. New Directions in Adult and Continuing Education*, no. 74. San Francisco: Jossey-Bass.
- Dirkx, J.M. (1998). 'Transformative learning theory in the practice of adult education: An overview.' *PAACE journal of lifelong learning*, 7, pp. 1-14.
- Dirkx, J. (2008). 'The meaning and role of emotions in adult learning.' *New Directions for Adult and Continuing Education*, 120, pp. 7-18.
- Dryden, W. (1990). *Rational emotive counselling in action*. London: Sage.
- Donaldson, J.H. and Carter, D. (2005). 'The value of role modelling: Perceptions of undergraduate and diploma nursing (adult) students.' *Nurse Education in Practice*, 5, pp. 353-359.
- Donalek, J.G. (2005). 'The interview in qualitative research.' *Urologic Nursing*, 25(2), p.124.
- Dunne, K., Sullivan, K. and Kernohan, G. (2005). 'Palliative care for patients with cancer: district nurses' experiences.' *Journal of Advanced Nursing*, 50(4) pp. 372-380.
- Eckroth-Bucher, M. (2010). 'Self-awareness: A review and analysis of a basic nursing concept.' *Advances in Nursing Science*, 33(4) pp. 297-309.
- Edwards, G., Orford, J., Egert, S., Guthrie, S., Hawker, A., Hensman, C., Mitcheson, M., Oppenheimer, E. and Taylor, C. (1977). 'Alcoholism: a controlled trial of 'treatment' and 'advice.' *Journal of Studies on Alcohol*, 38(5), pp. 1004-1031.
- Edwards, J.B. and Richards, A. (2002). 'Relational teaching: A view of relational teaching in social work education.' *Journal of Teaching in Social Work*, 22(1/2), pp. 33-48.
- Egan, G. (2009). *The skilled helper: A problem management and opportunity development approach to helping*. 9<sup>th</sup> ed., US: Brooks /Cole.
- Eisen, M. J. (2001). 'Peer-based Professional Development Viewed through the Lens of Transformative Learning.' *Holistic Nursing Practice*, 16, pp. 30-42.
- Elbaz, F. (1992). 'Hope, attentiveness and daring for difference. The moral voice of teaching.' *Teaching and Teacher education*, 8 (5) pp. 421-432.
- Elliott, R, Bohart, A C, Watson, and J. C. Greenberg. (2011). 'Empathy.' *Psychotherapy*, 48(1) pp. 43-49.
- Elliott, R and Freire, B. (2009). 'Empirical support for person-centred/experiential psychotherapies: meta-analysis update 2008.' Paper presented at SPR (UK) Ravenscar research Conference 2009, Ravenscar, 14/03/09 - 16/03/09.
- Ellis, A. (1973). *Humanistic psychotherapy: The rational-emotive approach*. New York: McGraw-Hill.

- Elwood, S.A. and Martin, D.G. (2000). 'Placing" interviews: location and scales of power in qualitative research.' *The Professional Geographer*, 52(4) pp. 649-65.
- Farber, B.A. and Doolin, E.M. (2011). 'Positive regard.' *Psychotherapy*, 48(1), p.58
- Feilzer, M. Y. (2010). 'Doing mixed methods research pragmatically: Implications for the rediscovery of pragmatism as a research paradigm.' *Journal of Mixed Methods Research*, 4, pp. 6-16.
- Felstead, I. (2013). 'Role modelling and students' professional development.' *British Journal of Nursing*, 22 (4) pp. 223-22.
- Fine, M. (1991). *Framing dropouts: Notes on the politics of an urban high school*. New York: State University of New York Press.
- Fielding, M. (2009). Interrogating Student Voice: Pre-Occupations, Purposes and Possibilities. In Daniels, H. Lauder, H. and Porter, J. (eds.) *Educational Theories, Cultures and Learning: A Critical Perspective*. pp. 101-116. London: Routledge.
- Finfgeld-Connett, D. (2008). 'Meta-synthesis of caring in nursing.' *Journal of Clinical Nursing*, 17, pp. 196-204.
- Fleiss, J.L. (1981). *Statistical methods for rates and proportions*. New York: John Wiley and Sons.
- Fook, J., White, S., and Gardner, F. (2006). 'Critical reflection: a review of contemporary literature and understandings.' *Critical reflection in health and social care*, pp. 3-20.
- Forsyth, D. (2009). *Group dynamics*. US. Cengage Learning.
- Foster, K. C. (2008). 'The transformative potential of teacher care as described by students in a higher education access initiative.' *Education and Urban Society*, 41(104) pp. 104-126.
- Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery office.
- Fraser, B. J., Wahlberg, H. J., Welch, W. W., and Hattie, J. A. (1987). 'Syntheses of educational productivity research.' *International Journal of Educational Research*, 11, pp. 144-252.
- Freshwater, D. and Stickley, T. (2004). 'The heart of the art: emotional intelligence in nurse education.' *Nursing Inquiry*, 11(2) pp.91-98.
- Fretz, B. R. (1966). 'Postural movements in a counseling diad.' *Journal of Counseling Psychology*, 13(3) pp. 335-43.
- Friedel, J.M. and Treagust, D.F. (2005). 'Learning bioscience in nursing education: perceptions of the intended and the prescribed curriculum.' *Learning in Health and Social Care*, 4(4) pp. 203-216.
- Friere, P. (1970). *Pedagogy of the oppressed*. UK: Penguin.

- Furlong, M.J., Whipple, A.D., Jean, G.S., Simental, J., Soliz, A. and Punthuna, S., (2003). Multiple contexts of school engagement: Moving toward a unifying framework for educational research and practice. *The California School Psychologist*, 8(1), pp.99-113.
- Gage, N. (1989). 'The paradigm wars and their aftermath: A historical sketch of research and teaching since 1989.' *Educational Research*, 18, pp. 4-10.
- Gibbs, G. (1988). *Learning by Doing: A guide to teaching and learning methods*. Further Education Unit. Oxford: Oxford Polytechnic.
- Gibson, R. (1985). 'Critical times for Action Research.' *Cambridge Journal of Education* 15, pp. 59-64.
- Giddens, A. (2006). *Sociology*. 5<sup>th</sup> ed., Cambridge: Polity Press.
- Gilbert, P. (2009). 'Introducing compassion-focused therapy.' *Advances in Psychiatric Treatment*, 15(3) pp. 199-208.
- Gillespie, M. (2002). 'Student-teacher connection in clinical nursing education.' *Journal of Advanced Nursing*, 3(6) pp. 566-576.
- Gillespie, M. (2005). 'Student-teacher connection: a place of possibility.' *Journal of Advanced Nursing*, 52, pp. 211-219.
- Glaser, B. G. and A. Strauss. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Goldbeck, R. (1997). 'Denial in physical illness.' *Journal in Psychosomatic Research*, 43 (6) pp. 575-593.
- Goldstein, L.S. (2003). *Reclaiming Caring in Teaching and Teacher Education*. Oxford: Peter Lang.
- Goldstein, H. and Blatchford, P. (1998). 'Class Size and Educational Achievement: a review of methodology with particular reference to study design.' *British Educational Research Journal*, 24, pp. 255-268.
- Gordon, T. (1970). *Parent Effectiveness Training*. New York: Plume.
- Griffiths, J, Speed, S, Horne, M, and Keeley, P. (2012). 'A caring professional attitude. What health service users and carers seek in graduate nurses and the challenge for educators.' *Nurse Education Today*, 32(2) pp. 121-127.
- Guba, E.G. and Lincoln, Y.G. (1989). *Fourth generation evaluation*. Newbury Park: Sage.
- Guest, G., Bunce, A. and Johnson, L. (2006). 'How many interviews are enough? An experiment with data saturation and variability.' *Field methods*, 18(1) pp. 59-82.
- Jarvis, P. (1984). 'Andragogy. A sign of the times.' *Studies in the Education of Adults*, 16, pp. 32-38.

Johnson, V. E. (1986). *Intervention: How to help someone who doesn't want help*. Center City, MN: Hazelden.

Jordan, S., Davies, S. and Green, B. (1999). 'The biosciences in the pre-registration nursing curriculum: staff and students' perceptions of difficulties and relevance.' *Nurse education today*, 19 (3) pp. 215-226.

Hallgren, K.A. (2012). 'Computing inter-rater reliability for observational data: an overview and tutorial.' *Tutorials in quantitative methods for psychology*, 8(1), p. 23.

Hibbard, J.H., Mahoney, E.R., Stock, R. and Tusler, M. (2007). 'Do increases in patient activation result in improved self-management behaviors?' *Health Services Research* 42,(4) pp. 1443-1663.

Hammond, C. (2005). 'The wider benefits of adult learning: An illustration of the advantages of multi-method research.' *International Journal of Social Research Methodology*, 8(3) pp. 239-255.

Handelsman, J. (2004). 'Scientific teaching.' *Science*, 304, pp. 521-522.

Hart, M. (1990). 'Critical theory and beyond: Further perspectives on emancipatory education.' *Adult Education Quarterly*, 40, pp. 125-138.

Harden, R. M. and Crosby, J. R. (2000). AMEE Education Guide No 20: 'The good teacher is more than a lecturer – the twelve roles of the teacher.' *Medical Teacher*, 22(4) pp. 334-34.

Hargreaves, A. (1998). 'The emotional practice of teaching.' *Teaching and Teacher Education*, 14 (1998), pp. 835–85.

Haugh, S. (1998). 'Congruence: A confusion of language.' *Person-Centered Practice*, 6(1) pp. 44-50.

Hettema, J. Steele, J. and Miller, W. R. (2005). 'Motivational interviewing.' *Annual Review of Clinical Psychology*, (1) pp. 91-111.

Holloway, I and Freshwater, D. (2007). *Narrative Research in Nursing*. Oxford: Blackwell Publishing.

Holloway, L. and Penson, J. (1987). 'Nurse education and social control.' *Nurse Education Today*, 7, pp. 235-241.

Holloway, I. and Wheeler, S. (2013). *Qualitative research in nursing and healthcare*. USA: John Wiley and Sons.

Holm.U (1996). 'The Affect Reading Scale: a method of measuring prerequisites for empathy.' *Scandinavian Journal of Educational Research*, 40, pp. 239–253.

Honey, P and Mumford, A. (1982). *Manual of learning styles*. London: P Honey.

Hopkins, D. (1993). *A Teachers' Guide to Classroom Research*. 2nd ed., Buckingham, UK: Open University Press.

- Hopton, J. (1997). 'Towards a critical theory of mental health nursing.' *Journal of Advanced Nursing*, 25, pp. 492-500.
- Hovelynck, J. (2003). 'Moving active learning forward.' *The Journal of Experiential Education*, 26 (1) pp. 1-7.
- Huba, M.E. and Freed, J.E. (2000). 'Learner centered assessment on college campuses: Shifting the focus from teaching to learning.' *Community College Journal of Research and Practice*, 24(9) pp. 759-766.
- Inglis, T. (1997). 'Empowerment and emancipation.' *Adult Education Quarterly*, 48(1), pp. 3-17.
- Irving, P. and Dickinson, D. (2004). 'Empathy: Towards a conceptual framework for health professionals.' *International Journal of Healthcare Quality Assurance*, 17(4/5) pp. 212-220.
- Jayasekara, R.S. (2012). Focus groups in nursing research: methodological perspectives. *Nursing outlook*, 60(6), pp. 411-416.
- Jellinek, E.M. (1960). *The Disease Concept of Alcoholism*. New Haven: Hillhouse.
- Johns, C (1995). 'The Value of Reflective practice for Nursing.' *Journal of Clinical Nursing*, 4, pp. 23-60.
- Jimerson, S.R., Campos, E. and Greif, J.L., (2003). Toward an understanding of definitions and measures of school engagement and related terms. *The California School Psychologist*, 8(1), pp.7-27.
- Johnson, J. and Pratt, D.D. (1998). 'The apprenticeship perspective: Modelling ways of being.' *Five perspectives on teaching in adult and higher education*, pp. 83-103.
- Johnson, R.B. and Onwuegbuzie, A.J. (2004). 'Mixed Methods Research: A Research Paradigm Whose Time Has Come.' *Educational Researcher*, 33(7) pp. 14-26.
- Johnson, V. E. (1986). *Intervention: How to help someone who doesn't want help*. Center City, MN: Hazelden.
- Jolliffe, D. and Farrington, D. (2004). 'Empathy and offending: a systematic review.' *Aggression and violent behaviour*, 9 (5) pp. 441-476.
- Jordan, S., Davies, S. and Green, B. (1999). 'The biosciences in the pre-registration nursing curriculum: staff and students' perceptions of difficulties and relevance.' *Nurse education today*, 19(3), pp. 215-226.
- Kahu, E.R., (2013). Framing student engagement in higher education. *Studies in higher education*, 38(5), pp.758-773.
- Karnieli-Miller, O., Strier, R. and Pessach, L. (2009). 'Power relations in qualitative research.' *Qualitative health research*, 19(2), pp. 279-289.

- Karno, M.P. and Longabaugh, R. (2005). 'An examination of how therapist directiveness interacts with patient anger and reactance to predict alcohol use.' *Journal of Studies in Alcohol*, 66, pp. 825-832.
- Kember, D. (1997). 'A reconceptualisation of the research into university academics conceptions of teaching.' *Learning and Instruction*, 7 (3) pp. 255-275.
- Kemmis, S. and McTaggart, R. (2005). 'Communicative action and the public sphere.' *The Sage handbook of qualitative research*, 3, pp. 559-603.
- Kensit, D.A., (2000). Rogerian theory: A critique of the effectiveness of pure client-centred therapy. *Counselling Psychology Quarterly*, 13(4), pp. 345-351.
- Kirschenbaum, H and Jourdan, A (2005). 'The current status of Carl Rogers and the Person-centred approach.' *Psychotherapy: Theory, Research, Practice, Training*, 42, (1) pp, 37-51.
- Knight, K. M., McGowan, L., Dickens, C. and Bundy, C. (2006). 'A systematic review of motivational interviewing in physical health care settings.' *British Journal of Health Psychology*, 11(2) pp. 319-332.
- Kolden, G., Klein, M.H., Wang, C. and Austin, S. (2011). 'Congruence/genuineness'. *Psychotherapy*, 48(1) pp. 65-7.
- Kondrat, M. E. (1999). 'Who is the self in self-aware: Professional self-awareness from a critical theory perspective.' *Social Service Review*, 73(4) pp. 451-477.
- Knowles, M. S. (1980). *The modern practice of adult education: From pedagogy to andragogy*. Chicago: Association Press.
- Knowles, M. (1984). *The adult learner: A neglected species*. 3rd ed., Houston: Gulf Publishing.
- Kohut, H. (1978). 'The psychoanalyst in the community of scholars' In Ornstein, P.H. (ed.) *The search for self. Selected Writings of H. Kohut*. New York: International Universities Press.
- Koshy, V., Waterman, H. and Koshy, E. (2010). *Action Research in Healthcare*. London: Sage.
- Kunyk, D. and Olson, J.K. (2001). 'Clarification of conceptualisations of empathy.' *Journal of Advanced Nursing*, 35(3) pp. 317-325.
- Kvale, S. (2006). 'Dominance through interviews and dialogues.' *Qualitative inquiry*, 12(3), pp. 480-500.
- Kvale, S. and Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. London: Sage.
- Lane, C., Huws-Thomas, M., Hood, K., Rollnick, S., Edwards, K, and Robling, M. (2005). 'Measuring adaptations of motivational interviewing: The development and validation of the Behaviour Change Counselling Index (BECCI).' *Patient Education and Counselling* 56(2) pp. 166-73.

- Land, D. (1996). 'Partial views.' in Hutterer, R. Pawlowsky, G. Schmid, P.F. and Stipsits, R. (eds.) *Client-centered and Experiential Psychotherapy: A Paradigm in Motion*. Frankfurt: Peter Lang.
- Landis, J.R. and Koch, G.G. (1977). 'An application of hierarchical kappa-type statistics in the assessment of majority agreement among multiple observers.' *Biometrics*, pp. 363-374.
- Lewin, K. (1946). 'Action Research and Minority Problems.' *Journal of Social Issues*, 2(4) pp. 34-46.
- Lietaer, G. (1984). 'Unconditional positive regard: a controversial basic attitude in client-centered therapy.' In Levant, R.F. and Shlein, J.M. (eds.) *Client-Centered Therapy and the Person-Centered Approach: New Directions in Theory, Research and Practice*. New York: Praeger.
- Leitch, R. and Day, C. (2000). 'Action research and reflective practice: towards a holistic view.' *Educational Action Research*, 8 (1) pp. 179-193.
- Lietz, C.A., Gerdes, K.E., Sun, F., Geiger, J.M., Wagaman, M.A. and Segal, E.A. (2011). 'The Empathy Assessment Index (EAI): A Confirmatory Factor Analysis of a Multidimensional Model of Empathy.' *Journal of the Society for Social Work and Research*, 2 (2) pp. 104-124.
- Lincoln, Y.S. and Guba, E.G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.
- Loughran, J. and Berry, A. (2005). 'Modelling by teacher educators.' *Teaching and teacher education*, 21(2) pp. 193-203.
- Lundahl, B., Moleni, T., Burke, B. L., Butters, R., Tollefson, D., Butler, C. and Rollnick, S. (2013). 'Motivational interviewing in medical care settings: a systematic review and meta-analysis of randomized controlled trials.' *Patient education and counseling*, 93(2) pp.157-168.
- Lunenberg, M., Korthagen, F. and Swennen, A. (2007). 'The teacher educator as a role model.' *Teaching and teacher education*, 23(5) pp. 586-601.
- Madson, M.B., Loignon, A. C. and Lane, C. (2009). 'Training in motivational interviewing: a systematic review.' *Journal of Substance Abuse Treatment*, 36, pp. 101-10.
- Maben, J., Latter, S. and Clark, J.M. (2007). 'The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study.' *Nursing Inquiry*, 14(2) pp. 99-113.
- Mackey, S. (2005). 'Phenomenological nursing research: methodological insights derived from Heidegger's interpretive phenomenology.' *International Journal of Nursing studies*, 42(2) pp. 179-186.
- Maslow, A.H. (1954). *Motivation and Personality*. New York: Harper and Row.



- Maslow, A.H. (1968). *Towards a psychology of being*. 2nd ed., New York: Van Nostrand Reinhold.
- Mason, M. (2010). 'Sample size and saturation in PhD studies using qualitative interviews.' *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 11 (3).
- McDonough, D. (2013). 'Similarities and Differences between Adult and Child Learners as Participants in the Natural Learning Process.' *Psychology*, (4), pp. 345-348.
- McCambridge, J. and Strang, J. (2004). 'The efficacy of single session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: results from a multi-site cluster randomized trial.' *Addiction*, 99(1) pp. 39-52.
- McKee, G. (2002). 'Why is biological science difficult for first-year nursing students?' *Nurse Education Today*, 22(3) pp. 251-257.
- McLean, C. (2012). 'The yellow brick road: A values based curriculum model.' *Nurse education in practice*, 12(3) pp. 159-163.
- McNiff, J. (2002). *Action Research: Principles and Practice*. London: Routledge.
- Meece, J.L., Herman, P. and McCombs, B.L. (2003). 'Relations of learner-centered teaching practices to adolescents' achievement goals.' *International Journal of Educational Research*, 39(4) pp. 457-475.
- Mearns, D. and Thorne, B. (2007). *Person-centred counselling in action*. 3rd ed., London: Sage Publications.
- Mehrabian, A. and Epstein, N. (1972). 'A measure of Emotional Empathy.' *Journal of Personality*, 40, pp. 535-538.
- Mehrabian, A., Young, A.L. and Sato, S.(1988). Emotional empathy and associated individual differences. *Current Psychology*, 7(3), pp. 221-240.
- Melnick, B and Pierce, R.M. (1971). Client evaluation of therapist strength and positive-negative evaluation as related to client dynamics, objective ratings of competency and outcome. *Journal of Clinical Psychology*, 27, pp. 408-11.
- Merriam, S. B., Mott, V. W. and Lee, M. (1996). 'Learning That Comes from the Negative Interpretation of Life Experience.' *Studies in Continuing Education*, 18(1) pp. 1-23.
- Merriam, S. and Caffarella, R. (1998). *Learning in Adulthood. A comprehensive guide*. San Francisco: Jossey-Bass.
- Merriam, S. B. (ed.) (2001). *The new update on adult learning theory*. New Directions for Adult and Continuing Education, San Francisco: Jossey-Bass.
- Mertens, D. M. (2003). 'Mixed methods and the politics of human re-search: The transformative-emancipatory perspective.' *In* Tashakkori, A. and Teddlie, C. (eds.)

- Handbook of mixed methods in social and behavioural research*. Thousand Oaks, CA: Sage.
- Mezirow, J. (1975). *Education for perspective transformation: Women's re-entry programs in community colleges*. New York: Centre for Adult Education, Teachers College, Columbia University.
- Mezirow, J. (1991). *Transformative Dimensions of Adult Learning*. San Francisco CA: Jossey-Bass.
- Mezirow, J. (1997). 'Transformative learning: Theory to practice.' In Cranton, P. (ed.) *Transformative learning in action: Insights from practice. New directions for adult and continuing education*, No.74, San Francisco: Jossey-Bass.
- Mezirow, J. (2000). 'Learning to think like an adult.' In Mezirow, J. (ed.) *Learning as Transformation: Critical Perspectives on a Theory in Progress*. San Francisco: Jossey-Bass.
- Mezirow, J. (2003). 'Transformative Learning as Discourse.' *Journal of Transformative Education*, 1(1) pp. 58-63.
- Michael, J. (2007). 'Faculty perceptions about barriers to active learning.' *College Teaching*, 55, pp. 42-47.
- Miller, W.R., Hedrick, K.E. and Orlofsky, D.R. (1991). 'The Helpful Responses Questionnaire: A procedure for measuring therapeutic empathy.' *Journal of Clinical Psychology*, 47, pp. 444-448.
- Miller, W.R. and Hester, S (1995). *The Handbook of Alcohol Treatment Approaches: Effective Alternatives*. Boston: Allyn and Bacon.
- Miller, W.R. and Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*. 2nd ed., New York: Guilford Press.
- Miller, W.R. and Rollnick, S. (2013). *Motivational Interviewing: Helping people change*. 3rd ed., New York: Guilford Press.
- Miller, W.R. and Rose, G.S. (2009). 'Toward a theory of Motivational Interviewing.' *American Psychologist*, 64, pp. 527-537.
- Miles, M.B. and Huberman, M. (1994). *Qualitative Data Analysis: A Sourcebook of New Methods*. Beverly Hills, CA: Sage.
- Milligan, F. (1997). 'In defence of andragogy part 2. An educational process consistent with modern nursing aims.' *Nurse Education Today*, 17, pp. 487-493.
- Misch, D.A. (2002). 'Andragogy and Medical Education: Are Medical Students Internally Motivated to Learn?' *Advances in Health Sciences Education*, 7, pp. 153-160.
- Mitchell, K. M., Bozarth, J. D. and Krauft, C. C. (1977). A reappraisal of the therapeutic effectiveness of accurate empathy, non-possessive warmth, and

- genuineness. In Gurman, A.S. and Razing, A.M. (eds.) *Effective Psychotherapy*. New York: Pergamon Press.
- Mitchell, S.N., Reilly, R.C. and Logue, M.E. (2009). 'Benefits of collaborative action research for the beginning teacher.' *Teaching and Teacher Education*, 25, pp. 344–349.
- Morgan, D. L. (2007). 'Combining Qualitative and Quantitative Methods Paradigms Lost and Pragmatism Regained: Methodological Implications of.' *Journal of Mixed Methods Research*, 1, p. 48.
- Morse, J. and Field, P. (1995). *Qualitative Research for Health Professionals*. Thousand Oaks, USA: Sage.
- Morse, J.M., 2000. Determining sample size. *Qualitative health research*, 10(1), pp.3-5.
- Moon, J.A. (2013). *Reflection in learning and professional development: Theory and practice*. London: Routledge.
- Morse, J., Anderson, G., O'Brien, B., and Solberg, S. (1992). 'Beyond empathy: expanding expressions of caring.' *Journal of Advanced Nursing*, 17, pp. 809–821.
- Moyers, T.B., Martin, T., Manuel, J.K., Hendrickson, S.M. and Miller, W.R. (2005). 'Assessing competence in the use of motivational interviewing.' *Journal of substance abuse treatment*, 28(1) pp.19-26.
- Moyers, T. B., and Houck, J. (2011). 'Combining Motivational Interviewing with cognitive behavioral treatments for substance abuse: Lessons from the COMBINE Research Project'. *Cognitive and Behavioral Practice*, 18(1), pp. 38-45.
- Moyers, T.B., Martin, T., Manuel, J.K., Hendrickson, S.M.L. and Miller, W.R. (2005). 'Assessing competence in the use of motivational interviewing.' *Journal of Substance Abuse Treatment*, 28, pp. 19–2.
- Moule, P and Goddman, M (2014). *Nursing Research: An introduction*. California: Sage.
- Moyers, T.B. and Miller, W.R. (2013). 'Is low therapist empathy toxic?' *Psychology of Addictive Behaviors*, 27(3) pp. 878.
- Muetzel, P.A. (1988). Therapeutic nursing-Theory, Issues and Practice. In McMahon, R. and Pearson, A. *Nursing as Therapy*. Cheltenham: Stanley Thornes, pp. 1-20.
- Murdock, T.B. (1999). 'The social context of risk: Status and motivational predictors of alienation in middle school'. *Journal of educational psychology*, 91(1) p. 62.
- Murray, M. (2003). 'Narrative psychology.' In Smith, J.A. (ed.) *Qualitative psychology: A practical guide to research methods*. 2nd ed., London: Sage.

- National Boards For England and Wales (1986). Syllabus of Training 1982: Professional Register-Part 3 (Registered Mental Nurse). London: English National Board.
- Noddings, N. (2005). *The challenge to care in schools: An alternative approach to education*. 2nd ed., New York: Teachers College Press.
- Nunkoosing, K. (2005). 'The problems with interviews.' *Qualitative health research*, 15(5) pp. 698-706.
- Nursing and Midwifery Council (2002). *Code of Professional Conduct*. London: NMC.
- Nursing and Midwifery Council (2007). *Nursing Midwifery Council Circular 07/2007*.
- Nursing and Midwifery Council (2008). *The Code-Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.
- Nursing and Midwifery Council (2010). *Nursing and Midwifery Council Standards for Pre-registration Nursing Education*. London: NMC.
- Nursing and Midwifery Council (2015). *The code: professional standards of practice and behaviour for nurses and midwives*. London: NMC.
- Nussbaum, M. (1996). 'Compassion: The basic social emotion.' *Social Philosophy and Policy Foundation*, 13(1) pp. 27-58.
- O'Driscoll, M.F., Allan, H.T. and Smith, P.A. (2010). 'Still looking for leadership—Who is responsible for student nurses' learning in practice?' *Nurse Education Today*, 30(3), pp. 212-217.
- O'Hara, M. (2003). 'Cultivating Consciousness Carl R. Rogers's Person-Centered Group Process as Transformative Androgogy.' *Journal of Transformative Education*, 1(1) pp. 64-79.
- O'Neill, G. and McMahon, T. (2005). 'Student-centred learning: what does it mean for students and lecturers?'; In O'Neill, G., Moore, S. and McMullin, B. (eds.) *Emerging issues in the practice of university learning and teaching*. Dublin: AISHE.
- Orlinsky, D. E., and Howard, K. I. (1978). 'The relation of process to outcome in psychotherapy.' In Garfield, S. and Bergin, A. (eds). *Handbook of psychotherapy and behavior change*, 2nd ed., New York: Wiley.
- Orlinsky, D. E., and Howard, K. I. (1986). Process and outcome in psychotherapy. In S Garfield, S. and Bergin, A. (eds). *Handbook of psychotherapy and behavior change*, 3rd ed., New York: Wiley.
- Palmer, P. (2000). *Let your life speak: Listening for the voice of vocation*. San Francisco: Jossey-Bass.
- Parahoo, K. (2014). *Nursing research: principles, process and issues*. 3<sup>rd</sup> ed., New York Palgrave Macmillan.

- Paterson, B. and Crawford, M. (1994). 'Caring in nursing education: An analysis.' *Journal of Advanced Nursing*, 19(1), pp. 164-173.
- Peters, M.A. (2006). 'Compassion: An Investigation into the Experience of Nursing Faculty.' *International Journal for Human Caring*, 10(3).
- Pilotte, W. J. and Gable, R. K. (1990). 'The impact of positive and negative item stems on the validity of a computer anxiety scale.' *Educational and Psychological Measurement*, 50, pp. 603-610.
- Polit, D. F. and Beck, C.T. (2009). *Essentials of nursing research; Methods, Appraisal and utilisation*. London: Lippicot Williams.
- Pope, C., Ziebland, S. and Mays, N. (2000). Analysing qualitative data. *British Medical Journal*, 320(7227) pp. 114-116.
- Price, B. (2002). 'Laddered questions and qualitative data research interviews.' *Journal of Advanced Nursing*, 37(3) pp. 273-281.
- Prince, M. (2004). 'Does active learning work? A review of the research.' *Journal of Engineering Education*, 93(3) pp. 223-31.
- Purdy, M. (1995). 'Humanist ideology and nurse education 1. 'Humanist educational theory.' *Nurse Education Today*, 17, pp. 192-195.
- Reason, P. and Bradbury, H., (2008). *The SAGE handbook of action research: Participative inquiry and practice*. Sage: London
- Rachal, J. (2002). 'Andragogy's detectives: a critique of the present and a proposal for the future.' *Adult education quarterly*, 52(3) pp. 210-227.
- Rattray, J. and Jones, M.C., 2007. Essential elements of questionnaire design and development. *Journal of clinical nursing*, 16(2), pp.234-243.
- Rautalinko, E., Lisper, H.O., Ekehammar, B. (2007). 'Reflective listening in counseling: effects of training time and evaluator social skills.' *American Journal of Psychotherapy* 61, pp. 191-209.
- Reniers, R.L., Corcoran, R., Drake, R., Shryane, N.M. and Völlm, B. A. (2011). 'The QCAE: A questionnaire of cognitive and affective empathy.' *Journal of personality assessment*, 93(1) pp. 84-95.
- Reynolds, W. J. and Scott, B. (1999). 'Empathy: a crucial component of the helping relationship.' *Journal of Psychiatric and Mental Health Nursing*, 6, pp. 363-370.
- Ritchie, J., Spencer, L. and O'Connor, W. (2003). *Carrying out qualitative analysis. Qualitative research practice: A guide for social science students and researchers*. London: Sage.
- Robertson, D. (1996). 'Facilitating Transformative Learning: Attending to the Dynamics of the Educational helping Relationship.' *Adult Education Quarterly*, 47, pp. 41-53.

- Robinson, R. D. (1995). *Helping adults learn and change*. Wisconsin: Omnibook C.
- Robson, C. (2011). *Real World Research*. 3rd ed., Oxford: Blackwell.
- Rogers, C. (1951). *Client-centered Therapy: Its Current Practice, Implications and Theory*. London: Constable.
- Rogers, C.R. (1957). 'The necessary and sufficient conditions of therapeutic personality change.' *Journal of Consulting and Clinical Psychology*, 21: 95-103.
- Rogers, C.R. (1959). 'Significant Learning in Therapy and in Education.' *Educational Leadership*, 16, pp. 232-242.
- Rogers, C. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable.
- Rogers, C. (1969). *Freedom to Learn: A View of What Education Might Become*. Columbus, Ohio: Charles Merrill.
- Rogers, C. (1975). 'Empathic: an unappreciated way of being.' *The Counselling psychologist*, 5 (2) pp. 2-11.
- Rogers, C. R. (1983). *Freedom to Learn for the '80s*. Columbus, Ohio: Charles Merrill.
- Rogers, C.R., Lyon, HC and Tausch, R. (2014). *Becoming an effective teacher*. Abingdon: Routledge.
- Rollnick, S and Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23, pp. 325-334.
- Rorty, R (1999). *Philosophy and Social Hope*. London: Penguin Books.
- Rosengren, D. B. (2009). *Building motivational interviewing skills: A practitioner workbook*. New York: Guilford Press.
- Rubin, H.J. and Rubin, I.S. (2011). *Qualitative interviewing: The art of hearing data*. 3rd ed., London: Sage.
- Rocco, T. S., Bliss, L. A., Gallagher, S., and Perez-Prado, A. (2003). 'Taking the next step: Mixed methods research in organizational systems.' *Information Technology, Learning and Performance Journal*, 21(1) pp. 19-29.
- Rolfe, G., (2012). 'Fast food for thought: How to survive and thrive in the corporate university.' *Nurse education today*, 32(7), pp. 732-736.
- Roth, J., Damico, S.B. and Newmann, F., 1996. Continuing the Bifurcation of Affect and Cognition. *Curriculum Inquiry*, 26, (1) pp. 89-99.
- Rubak, S., Sandbæk, A., Lauritzen, T. and Christensen, B. (2005). 'Motivational interviewing: a systematic review and meta-analysis.' *The British Journal of General Practice*, 55 (513) pp.305-312.
- Ryan, R.M., (1995). Psychological needs and the facilitation of integrative processes. *Journal of personality*, 63(3), pp.397-427.

- Ryan, G.W. and Bernard, H.R. (2003). 'Techniques to Identify Themes', *Field Methods*, 15(1) pp. 85-109.
- Sale, J. E. Lohfeld, L. H. and Brazil, K. (2002). 'Revisiting the Quantitative-Qualitative Debate: Implications for Mixed-Methods Research', *Quality and Quantity*, 36, pp. 43-53.
- Schostak, J. (1999). 'Action research and the point instant of change.' *Educational Action Research*, 7(3) pp. 399-417.
- Scott, E.S., Engelke, M.K. and Swanson, M. (2008). 'New graduate nurse transitioning: necessary or nice?' *Applied Nursing Research*, 21(2) pp. 75-83.
- Scott, M.J. (2009). *Simple effective Cognitive Behaviour Therapy. A practitioner's guide*. London: Routledge.
- Sexton, T.L. and Whiston, S.C. (1994). 'The Status of the Counseling Relationship An Empirical Review, Theoretical Implications, and Research Directions.' *The Counseling Psychologist*, 22(1) pp. 6-78.
- Shenton, A.K. (2004). 'Strategies for ensuring trustworthiness in qualitative research projects.' *Education for information*, 22(2) pp. 63-75.
- Silverman, D. (2011). *Qualitative Research*. 3rd ed., California: Sage.
- Smith, C.V. and Cardaciotto, L. (2012). 'Is active learning like broccoli? Student perceptions of active learning in large lecture classes.' *Journal of the Scholarship of Teaching and Learning*, 11(1) pp. 53-61.
- Smith, K.A., Sheppard, S.D., Johnson, D.W. and Johnson, R.T. (2005). 'Pedagogies of engagement: Classroom-based practices.' *Journal of Engineering Education*, 94(1) pp. 87-101.
- Snyder, C.R. (1994). *Psychology of Hope: You can get there from here*. New York: Free Press.
- Somekh, B. (2006). *Action Research: A methodology for Change and Development*. Maidenhead: Open University Press.
- Speziale, H.S., Streubert, H.J. and Carpenter, D.R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative*. USA: Lippincott, Williams and Wilkins.
- Spreng, R.N., McKinnon, M.C., Mar, R.A. and Levine, B.(2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures. *Journal of personality assessment*, 91(1), pp. 62-71.
- Stables, F.R. and Sloane, R.B. (1976). 'Truax factors, speech characteristics and therapeutic outcome.' *Journal of Nervous and Mental Disease*, 163, pp. 135-140.
- Stenhouse, L. (1975). *An introduction to curriculum research and development*. London: Heinemann Educational Books.

- Stewart, T. J. and Frye, A. W. (2004). 'Investigating the use of negatively-phrased survey items in medical education settings: Common wisdom or common mistake?' *Academic Medicine*, 79(10) pp. S18–S20.
- Sunderland, M. (2003). *Helping Children with Low Self Esteem*. Milton Keynes: Speechmark publishing.
- Tausch, R. (1978). 'Facilitative dimensions in interpersonal relations: verifying the theoretical assumptions of Carl Rogers.' *College Student Journal*, 12 (1) pp. 2-11.
- Taylor, E. W. (1997). 'Building upon the theoretical debate: A critical review of the empirical studies of Mezirow's transformative learning theory.' *Adult Education Quarterly*, 418, pp. 34-59.
- Tavakol, M. and Dennick, R. (2011). 'Making sense of Cronbach's alpha.' *International Journal of Medical Education*, 2, p. 53.
- Taylor, E.W. (2007). 'An update of transformative learning theory: A critical review of the empirical research (1999–2005).' *International Journal of Lifelong Education*, 26(2) pp. 173-191.
- Taylor, E.W. and Cranton, P. (2012). *The Handbook of Transformative Learning: Theory, Research, and Practice*. San Francisco: Wiley and Sons.
- Thorne, B. and Sanders, P., (2012). *Carl Rogers*. London: Sage.
- Tiebout, H. (1953). 'Surrender versus Compliance in Therapy, with Special Reference to Alcoholism.' *Quarterly Journal of Studies on Alcohol*. pp. 58–68. Reprinted in Harry Tiebout: *The Collected Writings*.
- Tough, A. (1967). *Learning without a teacher: A study of tasks and assistance during adult self-teaching*. Toronto: Ontario Institute for Studies in Education.
- Truax, C and Carkhuff, R. (1967). *Toward effective counselling and psychotherapy*. Chicago: Aldine Publishing Company.
- Tudor, K. and Worrall, M. (1994). 'Congruence reconsidered.' *British Journal of Guidance and Counselling*, 22(2), pp. 197-206.
- Tudor, K and Worrall, M. (2006). *Person-centred therapy: A Clinical Philosophy*. London: Routledge.
- Trowler, V., (2010). Student engagement literature review. *The Higher Education Academy*, 11, pp.1-15.
- Von Dietze, E, and Orb, A. (2000). 'Compassionate care: a moral dimension of nursing.' *Nursing Inquiry*, 7(3) pp. 166-174.
- Walker, J. D., Cotner, S. H., Baepler, P. M., and Decker, M. D. (2008). 'A Delicate Balance: Integrating Active Learning into a Large Lecture Course.' *C.B.E. Life Sciences Education*, 7(4), pp. 361–367.



- Wang, T.P. (2007). 'The comparison of the difficulties between cooperative learning and traditional teaching methods in college English teachers.' *The Journal of Human Resource and Adult Learning*, 3(2) pp. 23-30.
- Watson, R., Stimpson, A., Topping, A. and Porock, D. (2002). 'Clinical competence assessment in nursing: a systematic review of the literature.' *Journal of Advanced Nursing*, 39(5) pp. 421-431.
- Watson, R. (2006). 'Is there a role for higher education in preparing nurses?' *Nurse Education Today*, 26, pp. 622-626.
- Watson, R. McKenna, H. Cowman, S. and Keady, J. (2008). *Nursing research Designs and methods*. USA: Churchill Livingstone.
- Watkins, M.J. (2000). 'Competency for nursing practice.' *Journal of Clinical Nursing*, 9 (3) pp. 338-346.
- Westbrook, D. Kennerley, H. and Kirk J. (2007). *An introduction to Cognitive Behaviour Therapy: Skills and Applications*. London: Sage Publications.
- Wharrad, H.J., Allcock, N. and Chapple, M. (1994). 'A survey of the teaching and learning of biological sciences on undergraduate nursing courses.' *Nurse Education Today*, 14(6), pp. 436-442.
- White, S.J. (1997). 'Empathy: a literature review and concept analysis,' *Journal of Clinical Nursing*, 6, pp. 253-257.
- Whitehead, J. (1985). An analysis of an individual's educational development: the basis for personally oriented action research, in Shipman, M. (ed.) *Educational Research: Principles, Policies and Practice*. London: The Falmer Press.
- Whitehead, J. (1989). 'Creating a Living Educational Theory from Questions of the Kind How do I Improve my Practice?' *Cambridge Journal of Education*, 19 (1), pp. 41-52.
- Whiting, L.S. (2008). 'Semi-structured interviews: guidance for novice researchers.' *Nursing Standard*, 22(23), pp. 35-40.
- Wilkins, P. (2003). *Person-Centred Therapy in Focus*. Sage: London.
- Winskill, R. (2000). 'Is competency based training/education useful for workplace training.' *Contemporary Nurse*, 9 (2) pp. 115-119.
- Wright, H. (1989). *Group work Perspectives and Practice*. Oxford: Scutari Press.
- Wyatt, G. (2000). 'The multifaceted nature of congruence within the therapeutic relationship.' *The Person-Centered Journal*, 7 (1) pp. 52-68.
- Yalom, I. (1970). *The theory and Practice of Group Psychotherapy*. New York: Basic Books.
- Yahne, C.E. and Miller, W. R. (1999). 'Evoking Hope.' In Miller, W.R. (ed) *Integrating spirituality into treatment: Resources for practitioners*. US: American Psychological Association pp. 217-233.

- Yalom, I. and Leszcz, D. M. (2005). *The theory and practice of group psychotherapy*. 5th ed., New York: Basic Books.
- Yu, J and Kirk, M. (2008). 'Evaluation of empathy measurement tools in nursing: a systematic review.' *Journal of Advanced Nursing*, 65(9) pp. 1790–1806.
- Yoder, J. D., and Hochevar, C. M. (2005). 'Encouraging active learning can improve students' performance on examinations.' *Teaching of Psychology*, 32, pp, 91–95.
- Zeichner, K. (1993). 'Traditions of practice in U.S: pre-service teacher education programs.' *Teaching and Teacher Education*, 9(1) pp. 1-13.
- Zimmerman, B.J. and Schunk, D.H. (eds.) (2001). *Self-regulated learning and academic achievement. Theoretical perspectives*. Hillsdale, NJ: Erlbaum.
- Zuber-Skerritt, O. (1994). *Professional development in higher education: A theoretical framework for action research*. Psychology Press: UK.

# Appendices

## Appendix 1. Helpful Responses Questionnaire, HRQ (Miller et al 1991)

The Helpful Responses Questionnaire (HRQ) consists of **six** paragraphs that simulate communications from individuals with specific concerns. After each paragraph, a space is provided for the respondent to write a helping response.

The following six paragraphs are things that a person might say to you. For each paragraph imagine that someone you know is talking to you and explaining a problem that he or she is having. You want to help by saying the right thing. Think about each paragraph as if you were really in the situation, with that person talking to you. In each case write the **next thing** that you would say if you wanted to be helpful.

Write only one or two sentences for each situation. Please print or write clearly.

1. A 41-year-old woman says to you: 'Last night Joe got really drunk and he came home late and we had a big fight. He yelled at me and I yelled back and then he hit me really hard! He broke a window and the TV set, too! It was like he was crazy. I just don't know what to do!'

2. A 36-year-old man tells you: 'My neighbour is really a pain. He's always over here bothering us or borrowing things that he never returns. Sometimes he calls us late at night after we've gone to bed and I really feel like telling him to get lost.'

3. A 15-year-old girl tells you: 'I'm really mixed up. A lot of my friends, they stay out real late and do things their parents don't know about. They always want me to come along and I don't want them to think I'm weird or something, but I don't know what would happen if I went along either.'

4. A 35-year-old parent says: 'My Maria is a good girl. She's never been in trouble, but I worry about her. Lately she wants to stay out later and later and sometimes I don't know where she is. She just had her ears pierced without asking me! And some of the friends she brings home-well I've told her again and again to stay away from that kind. They're no good for her, but she won't listen.'

5. A 43-year-old man says: 'I really feel awful. Last night I got drunk again and I don't even remember what I did. This morning I found out that the screen of the television is busted and I think I probably did it, but my wife isn't talking to me. I don't think I'm an alcoholic, you know, because I can go for weeks without drinking. But this has got to change.'

6. A 59-year-old unemployed teacher tells you: 'My life just doesn't seem worth living any more. I'm a lousy father. I can't get a job. Nothing good ever happens to me. Everything I try to do turns rotten. Sometimes I wonder whether it's worth it.'

## Appendix 2. Emotional Empathy Scale (EES) (Caruso and Mayer 1998).

		Strongly Disagree	1	2	3	4	5	Strongly Agree
1.	I feel like crying when watching a sad movie.		1	2	3	4	5	
2.	Certain pieces of music can really move me.		1	2	3	4	5	
3.	Seeing a hurt animal by the side of the road is very upsetting.		1	2	3	4	5	
4.	I don't give others' feelings much thought.		1	2	3	4	5	
5.	It makes me happy when I see people being nice to each other.		1	2	3	4	5	
6.	The suffering of others deeply disturbs me.		1	2	3	4	5	
7.	I always try to tune in to the feelings of those around me.		1	2	3	4	5	
8.	I get very upset when I see a young child who is being treated meanly.		1	2	3	4	5	
9.	Too much is made of the suffering of pets or animals.		1	2	3	4	5	
10.	If someone is upset I get upset, too.		1	2	3	4	5	
11.	When I'm with other people who are laughing I join in.		1	2	3	4	5	
12.	It makes me mad to see someone treated unjustly.		1	2	3	4	5	
13.	I rarely take notice when people treat each other warmly.		1	2	3	4	5	
14.	I feel happy when I see people laughing and enjoying themselves.		1	2	3	4	5	
15.	It's easy for me to get carried away by other people's emotions.		1	2	3	4	5	
16.	My feelings are my own and don't reflect how others feel.		1	2	3	4	5	
17.	If a crowd gets excited about something so do I.		1	2	3	4	5	
18.	I feel good when I help someone out or do something nice for someone.		1	2	3	4	5	
19.	I feel deeply for others.		1	2	3	4	5	
20.	I don't cry easily.		1	2	3	4	5	
21.	I feel other people's pain.		1	2	3	4	5	
22.	Seeing other people smile makes me smile.		1	2	3	4	5	
23.	Being around happy people makes me feel happy, too.		1	2	3	4	5	
24.	TV or news stories about injured or sick children greatly upset me.		1	2	3	4	5	
25.	I cry at sad parts of the books I read.		1	2	3	4	5	
26.	Being around people who are depressed brings my mood down.		1	2	3	4	5	
27.	I find it annoying when people cry in public.		1	2	3	4	5	
28.	It hurts to see another person in pain.		1	2	3	4	5	
29.	I get a warm feeling for someone if I see them helping another person.		1	2	3	4	5	
30.	I feel other people's joy.		1	2	3	4	5	

## **Appendix 3.** Gordon's (1970) 12 roadblocks to effective listening

1. Ordering, directing
2. Warning, threatening
3. Giving advice, making suggestions, providing solutions
4. Persuading with logic, arguing, lecturing
5. Moralizing, preaching
6. Judging, criticizing, blaming
7. Agreeing, praising
8. Shaming, ridiculing,
9. Interpreting, analysing
10. Reasoning, sympathizing
11. Questioning, probing
12. Withdrawing, distracting, changing the subject

## **Appendix 4. Interview questions to students**

1. Please describe your experience(s) of undertaking the substance misuse unit or the dual diagnosis unit or both.
2. Is an examination of your personal attitudes, beliefs, values and behaviour an important component of taking the unit (s)?
3. What would help you to develop relationships and the ways that you work with health service users?
4. How could a lecturer help with this process?
5. Have you had any experiences that led you to question your attitudes, beliefs, values and behaviour towards substance use/dual diagnosis clients and health service users?
6. Being empathic is considered by many to be essential in forming therapeutic alliances with health service users. Do you think the teacher should adopt an empathic style with students to help with this?
7. Did the unit change your attitudes beliefs values or behaviour towards substance users and if so in what way?
8. Has the unit changed you as a person or as a professional or both?

## **Appendix 5. Interview questions to teaching staff**

1. What do you aim to achieve when teaching students?
2. Is it possible to change students' attitudes, beliefs, values and behaviour towards health service users through the ways that we teach?
3. Are there teaching approaches that are more likely to produce a change in the beliefs, attitudes, values and behaviour of students?
4. To what extent do you believe that forming relationships with students when teaching is important if change is to be achieved?
5. What elements of a learning environment foster change in attitudes, beliefs, values and behaviour do you think?
6. How would you know if a change in a student had taken place as a result of your teaching as opposed to anything else?
7. To what extent do you think emotions play in learning and the process of change?
8. To what extent are problems that a student faces at the time of teaching an issue in relation to learning and change?



## **Appendix 6.** Information leaflet sent to students

Title of study: Teaching nursing students using an adaptation of the SMI: an Action Research-case study.

Dear Student,

My name is John Vernon and I work as a lecturer at the University of Manchester School of Nursing, Midwifery and Social Work. I am currently undertaking a Doctorate in Education and in order to proceed I need to carry out some research. I am therefore interested in whether you would be willing to participate in a research study. The study will try to find out whether teaching in a style that is consistent with the principles of Motivational Interviewing is more likely to increase the likelihood of students being more empathic with health service users. If this is shown to be the case then this research could have implications for the way the future teaching and training is conducted.

You have been contacted because you have either completed or are about to start the Continuous Professional Development Professional Practice in Dual Diagnosis or Substance Misuse units.

If you are a former student I would like to interview you for an hour either in your home or at the university, whichever best suits you. If you wish to be interviewed at the university then measures will be taken to ensure that you will not be out of pocket and your expenses will be paid. I will ask you questions about the teaching used when you did either or both of the units. The information will be recorded and then transcribed by myself although I may get some professional help with this. Current students will be asked to fill in two questionnaires before they start and when they finish the module.

All of the information will be stored on one computer than can only be accessed by myself and will remain strictly confidential. The project is expected to take 2 years to complete after which all of the information will be stored safely and kept in an encrypted form.

Participation is entirely voluntary and no questions will be asked if you decide to leave the study at any time. If you do decide that you would like to participate then please fill in the consent form and return it to me via email if possible within 3 weeks of receiving this later. If you would rather send the completed approval form then please return the consent from to me the above address.

If you decide that you would rather not be part of this study then I would like to thank you for taking the time to read this.

Yours sincerely,

John Vernon

## Appendix 7. Consent Form

Title of project: Teaching nursing students using an adaptation of the Spirit of Motivational Interviewing: an Action Research-case study.

Name of Researcher: John Vernon

Contact details: Email: [John.Vernon@manchester.ac.uk](mailto:John.Vernon@manchester.ac.uk)

Telephone: 0161306784

Please will you read these statements and tick the boxes if you agree.

I confirm that I have read and understood the information sheet and know what the research study is asking me to do

I have been given a chance to look at the information sheet and ask any questions before I join the study

I can choose to leave the study at any time and no reasons will be needed to be given

Any information that could possible identify me will not be published

I agree to any interviews being audio recorded

I agree to take part in the study

## Appendix 8. Excerpt from a student transcription

R: Yeah. I mean, I've only got a low case load, anyway, I've only got about twelve, so, it's not been applicable to everybody, but, there's two, in particular, that it's worked really well with and it has genuinely changed the way I work with people.

I: Ah! Tell me more about that.

R: Well, just, I suppose, in the past, it was more, you know, we've lost a couple of clients on our team, through substance misuse and alcohol issues, so, kind of, you know, it raises your anxieties, a bit, and I always worked hard to try to get people to change, but, the approach I was using was a bit more heavy handed, a bit more trying to persuade people, because, I was anxious and I thought they're really going to die, they really need to do this, do that and they need to get the alcohol team and I was, kind of, more, right, come on, yeah, we'll do the call together, here's my phone, you know, you make the call, because, these will be the consequences, out of, you know, worry for people.

I: Yeah. So, some of it was about your own anxieties.

R: Yes, definitely. And more that, you know, I felt, as a nurse, that I should, sort of, try to make them to make the right decisions to help themselves, but, in doing that, I think, looking back, sometimes, it caused people to, maybe,

Talking about change

through doing the unit

reflection

Transformation

through exposure to  
the module

be more defensive or to feel that you're putting the pressure on and for them to more avoid it and, maybe, not talk about it all.

I: And, what effect did that have on you?

R: Just frustration.

I: Mm, yeah.

R: Because, it's, like, butting your head, I mean, why can't they see, you know, and nothing's going to get better, everything's going to get worse and why can't they see, you know, the change would benefit them, so you end up in that, sort of, and, then, you're having the same conversation and a lot of similar conversations, time and time and time again, with people and, I thought, I'd go away leaving them something to think about and, then, we'd still be, kind of, at the same point and, sometimes, as well, things I noticed, people who had been, maybe, drinking heavily and they managed to cut back a little bit and, then, I find out they're drinking heavily again and, then, you know, the reason they'd not wanted to tell me is, because, you know, I didn't want to disappoint, I didn't want to let you down, I didn't want to disappoint you and, you know, I was looking at myself and thinking, there's something in my interactions is making them feel that they're letting me down and stopping them being able to be totally open and honest about what they are doing.

I: Right.

R: Not that I judged them, but, that I'd be disappointed in them, so, it's a form of judging someone, isn't it?

I: Mm. So, you seem to be saying that a lot of your, well, some of the exposure to the training and content of the module made you re-examine the way you work with your clients.

R: Definitely. I took a lot of steps back, I was always, kind of, a lot more rushed with it and trying to get things done, as quickly as I could, and it made me take a huge step back and think, you know, this doesn't matter if this takes, you know, I'm working with these people for years, you know, I've got a lot of time and we can touch on bits, pick up on bits, leave it when it needs leaving, return to it, and it really just made me look at myself, a little bit, and how I was doing things and it did make a difference to how people reacted to me.

I: Well, that's interesting, because, the next question I've got, really, is an examination of your personal attitudes, beliefs, values and behaviour, an important component of doing the unit. Now, I mean, I don't know whether it was before you went in, but, it seems like that's, kind of, happened, anyway.

R: Yeah.

I: Just tell me a little bit more about that, if you can, about...you, kind of, sound like you changed the...well, at least you changed the way that you approach clients.

R: Yeah.

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THE WAY SHE RELATES  
EITHER INCREASES OR  
DECREASES LIKELIHOOD  
OF CHANGE

TRANSFORMATION OF  
PERSP[ECTIVE

I: Because, you felt, what, that this has a potential to work?

R: Yeah, definitely. And, it puts it over, I think, by putting the control a little bit over with them, because, it was more my ideas before, you know, because, you know, I can see a load of ways of working around this, I can see several options that can help you, so, I'm going to sit and tell you about that and instead of doing that, it made me more, you know, the control is over to them, more, to sit and think about what changes and, sometimes, the changes they wanted to make would be a lot smaller than the things I would, ideally, like, but, that was, you know, to go with that, we'd have that as a start.

I: Sounds like you passed some of it over to the client.

R: Definitely, yeah.

I: Was that easy?

R: It was after, I suppose, you don't...unless you're reflecting and evaluating what you have done, you don't always take the time to step back, do you, to think about why things are how they are and I just think, you know, they don't want to change would be the conclusion that, maybe, you've drawn.

I: So, it allowed you to be self reflective.

R: Definitely. And, it wasn't hard, once I looked back and learnt about the principles and looked back at some

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of my attempts, then, I could say, oh, God, yeah, I'm arguing a point and I'm causing them to, then, say, oh, well you'd feel like this, you'd drink every day if you had this, that and that happen and this happen, you know, and I was causing those reactions. So, it wasn't hard, once I could see that, it was, like, a bit of a penny dropping, oh God, yeah, that's me, you know, I've done that.

I: A light bulb.

R: You know, I've been doing that, yeah.

I: I mean, you, kind of, think, you're saying that it was, mostly, good, the changes, any downsides to this different approach?

R: No, not that I can think of, no.

I: Mmhmm.



## Appendix 9. Timetables for the modules dual diagnosis and substance misuse.

### Dual diagnosis

<i>Date</i>	<i>10.00 – 10.30am</i>	<i>11.00 – 12.00mid.</i>	<i>12– 1pm</i>	<i>1.00 – 4.00pm</i>	
<b>28th September 2011</b> <i>Rm 2.324</i> <i>Jean McF</i>	Welcome and Introductions  <i>John Vernon</i>	Course Unit Guide Assessment Guidelines  <i>John Vernon</i>	LUNCH	<b>Anita Gill 1-1.30 Blackboard 1.30-4</b> Definitions, Prevalence, Concepts and Models of Dual Diagnosis <i>John Vernon</i>	
<b>5<sup>th</sup> Octob</b> <i>Room 2.325</i> <i>Jean McF</i>	Use and Misuse of Substances I  <i>John Vernon</i>		LUNCH	Use and Misuse of Substances  <i>John Vernon</i>	
<b>12<sup>th</sup> October</b> <i>Room 2.324</i> <i>Jean McF</i>	Use and Misuse of Substances 3  <i>John Vernon</i>		LUNCH	Use and misuse of substances 4  <i>John Vernon</i>	
<b>19<sup>th</sup> October</b> <i>Room2.324Jean McF</i>	Overview of Mental health problems  <i>Ian Wilson</i>		LUNCH	Assessment and evidence based interventions in dual diagnosis  <i>Ian Wilson</i>	
<b>26<sup>th</sup> October</b> <i>Room 2.324</i> <i>Jean McF</i>	Motivational Interviewing I Engagement and Change  <i>John Vernon</i>		LUNCH	Motivational Interviewing II Modifications with Dual Diagnosis Service Users  <i>John Vernon</i>	
<b>2 weeks reading time</b>					
<b>16<sup>th</sup> November</b> <i>Room 2.324</i> <i>Jean McF</i>	Pharmacological Approaches to working with Dual Diagnosis Service Users  <i>John Vernon</i>		LUNCH	CBT approaches to working with Dual Diagnosis Service Users  <i>John Vernon</i>	
<b>23<sup>rd</sup> November</b> <i>Room 2.325</i> <i>Jean McF</i>	Brief Interventions in Alcohol Use  <i>Maria O'Brien</i>		LUNCH	<b>Case studies</b>  <i>John Vernon</i>	
<b>30<sup>th</sup> November</b> <i>Room 2.325</i> <i>Jean McF</i>	Relapse Prevention Strategies with Dual Diagnosis Service Users  <i>Ian Wilson</i>		LUNCH	<b>1.00 – 1.30pm</b> Assignment Issues  <i>John Vernon</i>	<b>1.30pm-300pm</b> Evaluation of the Course Unit  <i>John Vernon</i>
<b>7<sup>th</sup> December</b> <i>Room 2.325</i> <i>Jean McF</i>	<b>STUDENT PRESENTATIONS</b> <i>(John Vernon, Emma Cooper)</i>				

## **Substance misuse**

DATE	10.00 - 11.00	11-12	12-1	1-4	
2nd February 2011 Room 4.209	Welcome and Introduction John Vernon/ Mandy Beck	Introduction to Blackboard and Online Submission Tim Walton	Lunch	1.00 – 3.30  Attitudes, Values and Beliefs of Substance Users  John Vernon	
9th February 2011 Room 4.209	Effects of Substances I  John Vernon		Lunch	Effects of Substances II  John Vernon	
16th February 2011 Room 4.209	Concepts, Models and Theories of Drug Use  John Vernon		Lunch	History Taking: Assessing the Substance Using Patient/Client  John Vernon	
23rd February 2011 Room 4.209	Motivational Interviewing I Engaging with Service Users  John Vernon		Lunch	Motivational Interviewing II Towards Action  John Vernon	
2nd March 2011 Room 4.209	10.00–11.00  Brief Interventions in Alcohol Use Maria O’Brien, Community Alcohol Nurse	11.00-12.00  Assignment Issues  John Vernon	Lunch	1.00-3.00  Management of Overdose  John Vernon	
2 Weeks Reading Time					
23rd March 2011 Room 4.209	Pharmacological Approaches to Alcohol Dependence  John Vernon		Lunch	Dual Diagnosis Assessment, Interventions and New Challenges  Ian Wilson	
30th March 2011 Room 4.209	CBT and Substance Misuse  John Vernon		Lunch	Tutorials  John Vernon	
6th April 2011 Room 4.209	Relapse Prevention Strategies used in Substance Misuse  John Vernon		Lunch	1.00 – 2.30pm  Treatment Care Pathways in an Inpatient alcohol and drug Unit  Team Leader, Kenyon House	3.00 – 4.00pm  Evaluation of the Course Unit  John Vernon

## Appendix 10. Demographic data from 9 nurse lecturer interviews.

Gender	Age	Ethnicity	Years experience as a nurse lecturer	Adult or mental health lecturer
female	38	white	5	Adult
female	43	white	10	Adult
female	55	white	30	Mental Health
female	46	white	12	Adult
female	43	white	10	Adult
female	32	white	6	Adult
female	40	white	13	Mental Health
female	44	white	12	Adult
male	52	white	9	Adult

## Appendix 11. Demographic data from 10 student interviews.

Key: A and E-Accident and Emergency; CMHT Community Mental Health Team;

PICU-Psychiatric Intensive Care Unit; DD-dual diagnosis; SM-substance misuse

Gender	Age	Years qualified	Ethnicity	Adult Trained (A) mental health trained (MH)	Where working when interviewed	Module(s) attended
Female	44	23	White	MH	Older peoples services	DD, SM
Female	38	14	White	A	A and E	SM
Female	32	3	White	A	A and E	SM
Female	54	24	White	MH	CMHT	DD, SM
Female	41	18	White	MH	Tranquilliser withdrawal	DD
Female	37	13	White	MH	CMHT	DD
Female	46	16	White	MH	CMHT	SM
Male	29	5	White	MH	PICU	DD, SM
Male	44	9	White	MH	PICU	DD, SM
Male	42	8	Black African	MH	Hospital ward	DD, SM

## Appendix 12. Demographic data from 26 students who completed two empathy questionnaires: the \*HRQ and the \*EES.

\*The HRQ, Helpful Responses Questionnaire (Miller et al 1991).

\*\*The EES, Emotional Empathy Scale (Caruso and Mayer 1998).

Gender	Age	Ethnicity	Mental Health nurse (MH) Adult nurse (A)	Years experience
Female	31	White	MH	6
Female	47	Black African	MH	12
Female	48	White	MH	9
Female	33	White	A	8
Female	51	White	A	22
Female	54	White	A	16
Female	28	White	A	7
Female	25	White	A	4
Female	29	White	A	8
Female	32	White	A	10
Female	28	White	MH	5
Female	41	Pakistani	MH	18
Female	46	Black African	MH	16
Female	53	Black African	MH	23
Female	59	White	MH	21
Female	25	Black Carribean	MH	4
Male	26	White	A	5
Male	44	White	A	9
Male	35	White	MH	6
Male	28	White	A	7
Male	35	White	A	13
Male	33	White	A	11
Male	53	White	A	19
Male	28	White	A	6
Male	57	White	MH	22
Male	44	White	MH	20
Male	43	White	A	21
Male	45	White	A	23