Belongingness: a pivotal precursor to optimising the learning of nursing students in the clinical environment

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I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

(Signed) ……………………………………………….

      Tracy Levett-Jones

Dedication

This thesis is dedicated to the memory of my mother, Joy, whose firm belief in the power and potential of education inspired my academic journey. I wish I could have celebrated this milestone with her.

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My sincere thanks go to my supervisory "team": Professor Mary FitzGerald, who took the first steps of this journey with me and inspired me with her passion for research; Professor Judith Lathlean, whose belief in the value of this study, ongoing support and detailed critique has been a constant source of encouragement; Professor Margaret McMillan, who conversed with me in ways that continually challenged and clarified my thinking; and Doctor Isabel Higgins, whose critical feedback at important junctures was germane to this project.

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Abstract

The phenomenon of belongingness has intuitive appeal. Empirical literature from the disciplines of social science and psychology reveals that the need to belong exerts a powerful influence on cognitive processes, emotional patterns, behavioural responses, health and wellbeing, and that failure to satisfy this need can have devastating consequences. There are assertions that people who are deprived of belongingness are more likely to experience diminished self-esteem, increased stress and anxiety, depression, a decrease in general wellbeing and happiness, impaired cognition and an increase in affiliative behaviours, such as compliance and conformity. In the nursing literature, while there is paucity of studies about this salient issue, there are inferences that diminished belongingness may impede students' motivation for learning and influence the degree to which they are willing to conform rather than adopt a questioning approach to clinical practice. These findings are of concern to a profession that seeks to prepare innovative, confident, competent professionals with a commitment to self-directed learning; and they require careful investigation.

This study set out to identify the relationship between belongingness and the clinical placement experiences of pre-registration nursing students by measuring the extent to which students experience belongingness related to their clinical placements, and by exploring the factors that impact on and are consequences of that experience. Third-year students were recruited from two Australian universities—one in New South Wales and one in Queensland—and from one university in the south of England. This was a mixed-method case study where 362 students participated in an anonymous online survey termed the Belongingness Scale–Clinical Placement Experience (BES–CPE), and 18 of those students participated in in-depth semi-structured interviews.

The quantitative data from the survey were subjected to descriptive and inferential statistical analysis. In comparing the extent to which nursing students experience belongingness, it was determined that the mean BES–CPE scores of participants from the university in England were statistically higher than participants from either of the Australian universities. This finding may be partly explained by differences in the duration of clinical placements and the mentorship models in use at the three universities. Of the demographic variables analysed, previous or concurrent nursing experience, family

members with nursing experience, gender and country of birth were not a strong influence on students' experience of belongingness. The effects of age and English as a first language were less certain.

The qualitative interview data were thematically analysed. The experiences and perspectives of the participants from each of the three sites were remarkably similar in many respects. They described placement experiences that spanned a continuum from those that promoted a high degree of belongingness to those that provoked intense feelings of alienation. Belongingness was seen to be both a deeply personal and a contextually mediated experience. It was the interpersonal relationships forged with the registered nurses that students worked with on a day-to-day basis that exerted the single most important influence on their sense of belonging. However, students' sense of belonging was also influenced by a range of other individual, interpersonal, contextual and organisational factors.

A number of important consequences of belongingness were identified. These included affective consequences such as feeling safe, comfortable, satisfied and happy within the clinical environment. Belongingness was related to nursing students' self-concept, degree of self-efficacy, the extent to which they were willing to question or conform to poor practice, and their future career decisions. However, it was the relationship between belongingness and students' capacity and motivation for learning to nurse that emerged as a critical and recurring theme. Given that clinical placements are specifically designed to facilitate authentic learning opportunities, this is a significant finding that has repercussions at both the micro and macro levels.

By way of conclusion the practical implications of the study are brought to the foreground and made explicit through the presentation of the conceptual framework that emerged from the study. The Ascent to Competence conceptual framework applies a modified version of Maslow's hierarchy of needs to the clinical placement experience of nursing students, and sheds light on the challenges associated with the particular needs of students who are learning to nurse in contemporary practice environments.

Glossary of Terms

Abbreviation	Full term	Definition
AHWAC	Australia Health Workforce Advisory Committee	A committee formed in 2000 to oversee national level, government-initiated, health workforce planning in Australia, covering the nursing, midwifery and allied health workforces. It ceased to operate on 30 June 2006.
AIN	assistant in nursing	Sometimes referred to as trained care assistants, these staff work under the direct supervision and delegation of a RN. Some have Certificate II or III, others are undergraduate nursing students.
ANMC	Australian Nursing and Midwifery Council	The national body concerned with national competency standards and processes for the regulation of nursing in Australia.
EBL	enquiry-based learning	Working in small groups led by academic facilitators, students explore concepts of practice by examining a variety of scenarios and clinical case studies.
EN	enrolled nurse	A person whose name is entered on the register or role allocated to enrolled nurses.
HCW	healthcare worker	A variety of roles that denote unlicensed staff who care for clients / patients.

Abbreviation	Full term	Definition
LEF	Learning Environment Facilitator	RNs who are based in NHS Trusts and the independent sector to support mentors and manage practice-based learning issues.
NEB	Nurses' Education Board	A new statutory body, established in 1972. In 1974 it released the Nobel Report.
NG	new graduate nurse	Recently or newly qualified registered nurse.
NHS	National Health Service	UK system of public health care.
NMBNSW	Nurses and Midwives Board of New South Wales	Regulatory body for nurses and midwives in New South Wales.
NMC	Nursing and Midwifery Council	Regulatory body for nurses and midwives in the UK (previously United Kingdom Central Council for Nursing, Midwifery and Health Visiting, UKCC).
NORC	Nursing Organisations Representative Committee	A nursing group formed in 1974 with representatives drawn from all major nursing organisations.
NUM	nurse unit manager	A term used in Australia to denote the registered nurse manager responsible for a ward or unit. May be termed "sister" in the UK.
PBL	Problem-based learning	Students work together in small groups to define and addressed complex clinical problems or issues.

Abbreviation	Full term	Definition
PCT	Primary Care Trust	A component of the NHS. These trusts are responsible for assessing the health needs of the population in a specified region and commissioning services to meet those needs.
QNC	Queensland Nursing Council	Regulatory body for nurses and midwives In Queensland.
RN	registered nurse	A person whose name is entered on the register as having the authority to practice.
SDL	self-directed learning	A process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes (Knowles, 1975).
SHA	Strategic Health Authority	The link between the NHS and the Department of Health. These authorities are responsible for managing and setting the strategic direction of the NHS locally.
SPSS	Statistical Package for the Social Sciences	A widely used computer program for statistical analysis, data management and data documentation.
WDD	Workforce Development Directorate (previously termed Workforce Development Confederation)	The role of this organisation is to plan the NHS workforce, redesign work processes or jobs, commission education and training, and work with employers to implement good human resources practice. In particular, the WDD commissions nursing student numbers

Abbreviation	Full term	Definition
		depending on workforce projections and funds nursing education.
	mentor / preceptor	These terms are often used interchangeably to describe registered nurse clinicians who support and guide students (or newly qualified nurses) in clinical context. A "buddy" is a RN who works with students in a more informal capacity.

Glossary of Statistical Symbols and Terms

Symbol	Term	Description
α	alpha	The probability of rejecting a true null hypothesis.
	ANOVA	Analysis of Variance. A test of the statistical significance of the differences among the mean scores of two or more groups on one or more variables.
χ^2	chi-square test	Used to test if there are differences in a table by comparing the observed versus the expected values.
CI	confidence interval	Interval in which the true mean or proportion is expected to lie within a given confidence level.
r	correlation statistic	A statistic used to measure the level of association between two variables. Pearson's Product Moment Correlation is one of these statistics.
	Cronbach's alpha	The most common internal consistency measure, usually interpreted as the mean of all possible split-half coefficients.
df	Degrees of freedom	Value associated with a statistical test that is used to determine the level of significance; this value is dependent on the number of cases and/or number of samples utilised in the statistical test.
η^2	eta squared	Eta squared and partial eta squared are effect size measures for the association between a predictor and response variable.
η_p^2	partial eta squared	
F	F-statistic	The test used in ANOVA to determine if a predictor variable has a significant effect.
M	mean	The average of all scores reported in the sample or category.
p	probability value	The probability that a statistical result would occur by chance if a NULL hypothesis was true. A probability value less that .050 (i.e., $p < .050$) would suggest that the probability of obtaining observed scores would occur fewer than 5 out of 100 times by chance. Therefore, when probability values are less than .050, observed scores can be described as "significantly different" since there is a low likelihood of obtaining these observed scores by chance alone.
N	sample size	Total number in sample

Symbol	Term	Description
SD	standard deviation	A measure of the spread/dispersion of scores around the mean score.
n	sub-sample size	Total number in sub-sample
t	*t*-test statistic	A statistical test used to determine whether the difference between two sample means is significantly different. Two variations of this test have been utilised in this thesis: 1. *Independent Samples t-test:* compares the mean scores on a single variable from two different samples. 2. *Paired Samples t-test:* compares the mean difference of scores on a single sample.

Chapter 1

Introduction

1.1 Introduction

The ultimate goal of undergraduate nursing education is the development of efficacious, confident, competent professionals who have a healthy self-concept and a commitment to patient-centred care and self-directed learning. This thesis contends that the realisation of this goal is dependent upon the extent to which clinical placements promote and enhance nursing students' experience of belongingness.

There is widespread agreement that clinical learning is of central importance to nursing education. Although a theoretical and research-based education is vital for contemporary nursing, on its own it is not enough. Quality clinical placements are essential to becoming a competent professional nurse. The clinical environment provides an authentic context for nursing students to develop the knowledge, skills, attitudes and values of a registered nurse. Students have experiences on clinical placements that cannot realistically be provided in classrooms or simulated settings. While immersed in the "messiness" and complexity of practice, students have opportunities to communicate with patients and their families, observe and learn from role models and practise their skills under supervision. However, as academics and clinicians frequently point out, clinical placements are fraught with problems that are long-standing and multidimensional. Concerns related to the development of students' competence and confidence, and their preparedness or "fitness for practice" remain contentious issues. This thesis offers an alternative perspective on the challenges that surround clinical placements and student learning, a perspective that emerged from a study that set out to measure and explore nursing students' experience of belongingness.

In this introductory chapter, the terms belongingness and its antithesis, alienation, are defined in order to bring a preliminary understanding of the multidimensional nature of

these phenomena to the discussion. An overview of the literature covering the field of belongingness is presented as a background to the study, and knowledge gaps relating to nursing students' experience of belongingness are identified. A discussion then follows of how these knowledge gaps were used to conceptualise a study that sought to measure and explore the belongingness experiences of third-year nursing students from three universities, and how my own situatedness influenced the direction of the study. An outline of the study design is then presented. Finally, a brief synopsis of each chapter provides a structural map to the thesis.

1.2 The nature of belongingness

An important part of the human experience is the need to develop meaningful interpersonal relationships. The hypothesis that people are motivated to form and maintain interpersonal bonds is not new, of course. The words of the seventeenth-century poet John Donne (1952) remind us that "No man is an island, entire of itself", and over 60 years ago belongingness was posited by the oft-cited psychologist Abraham Maslow (1954) as a basic human need.

The term *belongingness* has multiple meanings. While there is no agreed definition in the literature, there are several complementary definitions that reflect elements of the discipline from which they originated. Anant, one of the first to publish findings related to belongingness, defined it as "the experience of personal involvement (in a system or environment) to the extent that the individual feels himself [sic] to be an integral and indispensable part of that system" (Anant, 1966, p. 22). In undertaking a concept analysis of belongingness, Hagerty, Lynch-Sauer, Patusky, Bouwsema and Collier (1992, p. 173) identified two additional defining attributes of belongingness: valued involvement, or the experience of being valued, needed and accepted; and fit, that is, the person's perception that his or her values and characteristics articulate with or complement the system or environment. In a seminal work aimed at understanding what constitutes human need, Maslow (1987) reiterated these descriptions in his explanation of belongingness as the human need to be accepted, recognised, valued and appreciated by a group of other people. A similar but more comprehensive definition of belongingness is that developed by Somers (1999, p. 16), where the concept is defined as

the need to be and perception of being involved with others at differing interpersonal levels…which contributes to one's sense of connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared about, valued and respected by others), while providing reciprocal acceptance, caring and valuing to others.

The word belonging derives from the Old English word *gelang*, meaning dependent, or the Middle English word *bilongen*, which means long dependent (*American heritage dictionary of the English language*, 2000). These etymologies suggest the importance of relationships based on mutual trust and the security of knowing that one can depend upon the members of a group to which one is connected. The *Oxford English dictionary* (2006) uses the following expressions to define belonging:

- a feeling of security
- acceptance as a natural member or part
- membership of a group
- the happiness felt in a secure relationship, as in "with his classmates he felt a sense of belonging"
- to be in an appropriate situation or environment, as in "that plant belongs outdoors"
- to fit into a group naturally, as in "no matter what I did, I just didn't belong"
- to be a part of something else, as in "these blades belong to the food processor"
- to be proper, appropriate or suitable, as in "a napkin belongs at every place setting".

Belongingness, a noun, refers to the state or condition of belonging. Synonyms for belonging and belongingness include acceptance, affinity, association, attachment, fellowship, inclusion, rapport and relationship (Roget, 2006).

In order to fully appreciate belongingness its antithesis, alienation, must also be understood. Hajda (1961, pp. 758–759) defined alienation as "an individual's feeling of uneasiness or discomfort which reflects his [sic] exclusion or self exclusion from social and cultural participation". Alienation refers to rejection by one's peers and a sense of separation from the group (*Oxford English dictionary*, 2006). A person who is alienated senses that they are in a hostile or foreign place where they feel estranged, disaffected, isolated, separated, distanced and/or segregated from the group (Roget, 2006). Many of the words used here to describe alienation, and previously to define belongingness,

appear throughout the literature and are typical of the language used by students when describing their clinical placement experiences.

Although statements of definition serve to simplify and make general a phenomenon, this study sought to define belongingness through a detailed interpretation of nursing students' clinical placement experiences. Thus, the broad definition of belongingness that derived from analysis and interpretation of the study data was:

> A deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group. The experience of belongingness may evolve passively in response to the actions of the group to which one aspires to belong and/or actively through the actions initiated by the individual.

The way in which this definition emerged and the relevance of each descriptor within it will become apparent in the later chapters of the thesis as the qualitative data are explored.

1.3 Background to the study

The impetus for the study derived from a long-standing personal and professional interest in the clinical experiences of nursing students. Increasingly recognised as an important component of undergraduate education, clinical placements are nevertheless problematic and, for many students, pervaded by the sense that they are 'outsiders' or 'interlopers'. Over the years when students shared stories of their clinical placements with me they often made declarations such as "I don't fit in there…I just don't belong. I go home every day in tears" or, conversely, "On that ward I felt like part of the team, like I really belonged". My interactions with students in clinical and academic settings led me to wonder whether the notion of belongingness might have a role to play in explaining the clinical experiences of nursing students. During a study tour examining clinical placement models in Australia and the United Kingdom (UK), my interest in understanding how nursing students experience and conceptualise belongingness deepened. I became particularly interested in exploring the antecedents, attributes and consequences of belongingness, and whether these factors differed between cultures and contexts.

In an attempt to better understand the phenomenon of belongingness and assess its merit as a topic worthy of further investigation, I began to examine the literature. My attention first turned to the social science and psychology literature. The idea that the need to belong and be accepted is fundamental, driving much of human pursuit, activity and thinking, was proffered by Baumeister and Leary (1995). It was also suggested that a diminished sense of belonging can have deleterious emotional, psychological, physical and behavioural consequences (Twenge, Baumeister, Tice & Stucke, 2001). A broad range of empirical evidence proposed that people who are deprived of belongingness are more likely to experience stress, anxiety, depression, diminished self-esteem and impaired cognition (Baumeister & Tice, 1990; Baumeister, Twenge & Nuss, 2002; Hagerty & Williams, 1999; Lakin, 2003). They are also more likely to engage in affiliative behaviours, such as acquiescence and conformity (Clark, 1992). Additionally, deprivation of stable social relationships has been linked to an array of pathological consequences, with those who lack belongingness suffering higher levels of both somatic and psychosomatic illness (Baumeister & Leary, 1995). However, while the experience of belongingness was demonstrated to be an important and measurable construct, apart from experimental studies, substantive research into exploring the factors that enhance or detract from belongingness had not been undertaken. The findings from the literature were significant and convinced me that belongingness was a concept that should be further investigated.

The concept of belongingness has been inadequately explored in the nursing education literature. Even though many papers referred to the importance of students being accepted, welcomed and supported on clinical placements, few studies focused specifically on the experience of belonging. The methodologies employed by nurse researchers to examine and describe student experiences limited the amount and type of data collected, and resulted in a narrow and imprecise picture of students' experiences. While it seemed that there was an implicit assumption in the nursing literature that belonging was important to a positive clinical placement experience, few studies addressed the meaning or implications of belongingness. The specific ways in which clinical environments engender belongingness was not clear from the literature; neither were the short- or long-term consequences of this phenomenon, either for the individual or for the nursing profession.

While there was a paucity of studies about belongingness and nursing students in the literature, a number of pertinent issues were identified, although with little empirical evidence to support the discussion. Some authors (Turner, Davies, Beattie, Vickerstaff & Wilkinson, 2006; Walker, 2005) referred to the length of clinical placements as a key element in developing a sense of belonging, although there was no discussion of the manner in which this transpires. There were also claims in the nursing literature that some students conform to clinical practices, irrespective of whether they are "best practice", so as to be accepted into the nursing team and to belong (Bradby, 1990; Hart & Rotem, 1994; Hemmings, 1993; Tradewell, 1996). This is of significant concern to a profession that seeks to be innovative and forward thinking, and it is essential that this claim is more fully interrogated. The literature also referred to a potential relationship between belongingness and student learning. Nolan (1998) described how students' need to fit in and be accepted by staff was a preface to their active participation and learning. A number of authors proposed that the fear and anxiety experienced during the socialisation process may negatively affect student learning (Kleehammer, Hart & Fogel Keck, 1990; Lindop, 1999; Lo, 2002; Meisenhelder, 1987; Timmins & Kaliszer, 2002). This, coupled with the suggestion that social exclusion impedes cognition (Baumeister et al., 2002), has implications for the education of undergraduate nurses, and empirical research is required to explore this issue more fully.

1.4 Purpose and design of the study

To address some of the identified knowledge deficits, the following research questions, as they relate to third-year nursing students' clinical placement experiences, were posed:

1. To what extent do nursing students from three different universities experience belongingness?
2. Which of the following demographic variables influence nursing students' experience of belongingness?
   - Nursing experience, apart from that included in students' current nursing program
   - Family members with nursing experience
   - Gender
   - Age
   - Country of birth
   - English as a first language

3. What factors impact on nursing students' experience of belongingness?

4. What are the consequences of nursing students' experience of belongingness?

These questions provided the guiding parameters from which paradigmatic and methodological decisions were then made. In order to gain a deeper appreciation of belongingness, as well as a comparative perspective, a mixed method, multi-site, cross-national study was conceptualised. In designing a study that would generate the type of information required, a case study incorporating quantitative and qualitative methods was considered to be the most appropriate framework. Yin (2003) claims that case study is the preferred strategy when there is a desire to investigate a contemporary phenomenon and uncover the contextual conditions that may influence the phenomenon. A case study framework was in accord with a mixed-method approach, as it supports the use of more than one source of evidence and convergence of findings. The case study approach was also aligned with the theoretical perspective of pragmatism, a paradigm that appealed because of its capacity to move research beyond the boundaries and restrictions of a single paradigm towards theory construction tailored to fit particular practical situations (Doane, 2003). The tenets of pragmatism—that is, a commitment to what works in practice, appreciation of plurality, and the desire for integrated results—were considered fitting for this mixed-method case study.

Stake (1995) contends that a case study moves from "a foreshadowed" problem (a broad and general area of concern) to the identification of more specific issues, and then to the formation of potential assertions. Thus, a progressive focus was adopted for the case study, which followed an iterative sequence comprising:

- becoming knowledgeable about the literature and contexts of the study
- designing the study
- selecting the participants for the study
- undertaking the research and analysing the findings
- identifying some general principles and recurring themes that deepen the understanding of the phenomenon of belongingness and help to provide potential explanations for the issues raised
- development of recommendations for practice.

1.5 Study participants

Reflecting on the definitions of belongingness previously described, it becomes apparent that it is a deeply personal perception, which is felt or experienced differently by each individual. Whereas an attempt can be made to describe the defining features of belongingness and speculate about the potential antecedents and consequences of that experience, the only person who can verify that a sense of belonging is experienced—and in fact the real meaning of that personal experience—is the individual concerned. What this study sought was the perspectives of students themselves, as they were considered to be the foremost experts on their own experiences. This is in accord with Harr and Secord (1972) who proposed a "radical" approach to discovering why people acted, thought and felt the way they did—why not ask them? These authors reasoned that human acts and explanatory accounts of those acts came from the same source. Thus, because belongingness is a deeply personal experience and because I considered students to be the experts on their experiences, the study explored belongingness through their eyes.

1.6 Sample and data collection

Study participants were recruited from two Australian universities—one in New South Wales (NSW) and one in Queensland—and one university in the UK. These universities were selected for their differences as well as their similarities, as both factors were considered important to the purpose of the study. Although each university provides a three-year tertiary program as the requisite preparation for registration as a nurse, they differ in the duration and structure of the clinical placements provided, the clinical supervision models, and the variables of environment, curriculum, cohort size and student demographics. The UK site was of particular interest because it offered an opportunity to explore how a mentorship model of clinical supervision and extended clinical placements may impact belongingness.

Third-year students were seen as the best source for obtaining information about belongingness and clinical placements, as they had undertaken a range of clinical placements and it was reasonable to expect them to have at least some experience of belongingness and therefore be rich in the information relevant to the study.

As one of the primary goals of the study was to measure and compare the extent to which nursing students experience belongingness related to their clinical placements, the quantitative phase of the study required that an appropriate data collection instrument was either identified or developed. A range of instruments were sourced through the literature review but were rejected on the basis of their unsuitability to the current study. Although a number of instruments have been used to assess the quality of the clinical learning environment, for example Chan (2001) and Dunn and Burnett (1995), these instruments were not appropriate to the current study. This was because, even though the quality of the environment undoubtedly influences students' experience of belongingness, evaluating the clinical environment was not the intention of the study. Other tools have been developed to assess the degree to which people desire or need belongingness, affiliation or social relatedness, for example Schreindorfer, Leary and Keith's Need to Belong Scale (1996) and Hill's Interpersonal Orientation Scale (1987). Once again, these scales were not appropriate, as the study was being approached from the premise, grounded in the literature, that belongingness is a universal and fundamental human need. What was required was an instrument that specifically measured the extent to which people belong. Hagerty and Patusky's sense of belonging instrument (SOBI) (1995) was reviewed, and, although it has proven reliability, it is a global measure that assumes belongingness to be generally applicable and consistent across contexts. The instrument does not distinguish between belongingness specific to certain situations or environments, and fails to take into account that a person may simultaneously experience belongingness in one context but not in another. This limitation weakened its usefulness to the current study, which proposed to measure belongingness specific to the clinical environment. In Dissertation Abstracts International, a doctoral thesis by Marsha Somers was found where she had developed and validated an instrument termed the Belongingness Scale (BES) (Somers, 1999). This instrument was based on the work of Baumeister and Leary (1995). It measured belongingness specific to four different environments: (a) family, (b) friends, (c) work or school, and (d) neighbourhood/community. The subscale of work/school had a Cronbach's alpha coefficient of .94 in the reliability analysis and with minimal modification was deemed appropriate for the current study. The author's permission to use the scale was obtained, and the scale was subsequently developed into an anonymous, online survey, termed the Belongingness Scale–Clinical Placement Experience (BES–CPE)[1]. It is a 34-item self-report instrument that measures belongingness specific to the clinical

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[1] The BES–CPE instrument is fully described in Chapter 3 and a copy is provided as Appendix 1.

placement environment and consists of items that assess feelings, cognitions and behaviours. Three hundred and sixty-two students from the three sites participated in the survey. The results were analysed using Statistical Package for the Social Sciences (SPSS) (Version 13).

From those that completed the BES–CPE survey, a purposive sample of 18 students was recruited for the qualitative phase of the study. Semi-structured in-depth interviews provided a forum for the students to share meaningful and insightful stories of their experience of belongingness when on clinical placements. During data analysis and interpretation, the transcripts of the interviews were studied intensively and the main issues articulated by the participants were coded and clustered into themes that highlight the factors that impact belongingness and the consequences of that experience. Each theme revealed and explored the dimensions of belongingness as it relates to students' clinical placement experiences.

1.7 Chapter outline

1.7.1 Introduction

Chapter 1 provides an overview of the nature and defining features of belongingness and profiles the research project. A summary of the literature from the disciplines of psychology and social sciences is used to introduce the current state of knowledge regarding belongingness and, in particular, the fundamental and pervasive nature of the phenomenon. A review of the nursing literature suggests that, while a number of interesting points have been raised, conclusions have been limited by the paucity of current research focusing specifically on belongingness. The rationale for the study is then explained and the research questions posed. The questions emanated from a concern with current knowledge deficits about nursing students' experience of belongingness when on clinical placements, and from a commitment to use the understandings generated by the research to inform practice. An overview of the case study approach, the theoretical perspective of pragmatism and the mixed method design is then provided.

1.7.2 Literature review

A detailed review of the literature is provided in Chapter 2. It outlines the evolution of the concept of belongingness and its application in research over the last 60 years. The

defining features of the phenomenon, alluded to briefly in Chapter 1, are contextualised and expanded, and a range of studies from the fields of psychology, social science and nursing are critiqued. The review of literature from the social and psychological sciences suggests that belongingness may well be one of the most far-reaching and integrative constructs currently available for understanding human behaviour. This body of literature is persuasive and implies that the clinical placement experiences of nursing students may be better understood through the lens of belongingness. Although the nursing literature reviewed was limited in scope and approach, it nevertheless did shed some light on the potential implications of belongingness and confirmed the significance of the study. The chapter concludes by reiterating the purpose and direction of the research.

1.7.3 Research design

The research design and methods used to measure and explore nursing students' experience of belongingness are described in Chapter 3. The selection of pragmatism as a theoretical perspective and case study as a research framework are explained and justified in the first section of the chapter. An outline of the mixed-method approach is then provided. This section is divided into two sections. The first outlines the quantitative data collection phase of the study and the second section reviews the qualitative data collection phase. Each section provides explanations for the decisions surrounding:

- research participants
- research instruments
- research protocols and procedures
- data collection methods
- validity and reliability measures.

1.7.4 Context

In Chapter 4 the context of each of the three sites is outlined, as a prelude to the research findings presented in the following chapters. A brief historical overview of nursing in Australia and the UK is provided, as well as an outline of the contemporary healthcare, nursing workforce and educational issues in both countries. The location, curriculum framework and clinical placement models of each site are then discussed. This is a useful chapter as it gives the reader an insight into the social world of the participants and provides an understanding of the similarities and differences between the contexts described. Additionally, describing the context in this manner allows the reader to make a

judgment of the study's transferability, or the extent to which the study findings are relevant to and can fit into contexts outside of the study situation.

1.7.5 Quantitative results

Chapter 5 presents the results of the quantitative phase of the study, in which the first two research questions and the related hypotheses are addressed. The chapter begins by describing the demographic characteristics of the study sample and sub-samples. This links well to the previous chapter, as it builds upon the reader's understanding of the diversity and similarities between the three study sites. Research question 1 is addressed by the descriptive statistics of the BES-CPE items and comparison of the mean BES-CPE scores between sites. In research question 2, hypotheses 1–6 explore the demographic variables that influence belongingness. The statistical procedure(s) and results for analysis of each hypothesis are provided. The exploratory factor analysis employed to better understand the underlying dimensions of the BES-CPE and to ascertain its construct validity are then described. Finally, reliability measures of the BES-CPE and it subscales are discussed.

1.7.6 Qualitative findings

The qualitative findings are thematically analysed and discussed in Chapters 6, 7 and 8. The factors that influence nursing students' experience of belongingness (research question 3) are the focus of the discussion in Chapters 6 and 7, and the consequences of that experience (research question 4) are featured in Chapter 8. The stories told by the 18 interview participants created a rich and colourful tapestry that enabled a greater understanding of the multiple dimensions of belongingness. In these chapters, the perspectives of the interview participants are predominant. Numerous quotes from the transcripts have been included to allow the participants' voices to stand out and to enhance the credibility of the findings. Each of the participants recalled diverse clinical placement experiences that spanned the continuum from those that promoted a high degree of belongingness to those that engendered intense feelings of alienation. It was apparent from the students' accounts that belongingness is mediated by a range of individual, interpersonal, contextual and organisational factors. In these chapters, the relationship between belongingness and learning stands out as a critical and recurring theme.

1.7.7 Discussion

In Chapter 9 the findings from the quantitative and qualitative data analysis are interpreted and converged in order to better appreciate the phenomenon of belongingness and its implications for students, their patients and the nursing profession into which they are moving. The chapter is structured around each of the four research questions and its related hypothesis. Research questions 1 and 2 are informed by the findings from the quantitative and, where appropriate, qualitative data, as well as by the related literature. Research questions 3 and 4 are addressed by a montage that juxtaposes narratives of alienation and belongingness. The montage provides a framework that captures the phenomena of belongingness and alienation, in a way that may be only partially appreciated by other interpretive methods. It re-presents the themes from the qualitative data analysis and integrates them into coherent and meaningful narratives that focus on the broad contours of participants' stories. The participants' narratives are further illuminated and informed by reference to the relevant literature, and framed by my interpretative perspective.

1.7.8 Conceptual framework and conclusion

The final chapter of the dissertation focuses on the relevance of the research findings to practice by introducing the conceptual framework that emerged from the study. The Ascent to Competence conceptual framework applies a modified version of Maslow's (1987) theory of human motivation to the clinical placement experience of nursing students and sheds light on the challenges associated with the particular needs of students who are learning to nurse in contemporary practice environments. Recommendations for practice are included in and informed by the discussion surrounding the conceptual framework. Following on from the conceptual framework, the chapter draws to a close with an outline of my personal reflections on the study, a discussion of the strengths and weaknesses of the study, and recommendations for future research.

1.8 Conclusion

I introduced this chapter and this thesis by contending that the development of efficacious, confident, competent nursing graduates with a healthy self-concept and a commitment to patient-centred care and self-directed learning is closely linked to the degree to which clinical placements facilitate their experience of belongingness. I then provided an

introductory overview of the mixed-method, cross-national case study that allowed me to reach this conclusion and make this assertion with confidence. In this chapter the nature and defining features of belongingness have been described as a background to the study and the rationale for the study has been provided. The following chapter provides a comprehensive review of the literature surrounding belongingness. The potential implications of the phenomenon for nursing students and for the nursing profession are the central, unifying themes of that chapter.

Chapter 2

Literature Review

2.1 Introduction

The evolution of the concept of belongingness over the last 60 years and its application in research is the focus of the first section of this chapter. Through a critical review of studies drawn from the psychological and social science literature, the nature and defining characteristics of belongingness are explored. As an understanding of belongingness would not be complete without considering its antithesis, alienation, this concept is also discussed. This section of the literature review supports the idea that human beings are fundamentally and pervasively motivated by a need to belong. Links between belongingness and cognitive processes, emotional patterns, behavioural responses, health and wellbeing are evidenced. The review of literature from the social and psychological sciences presents a background to the subsequent review of the nursing literature by raising a number of questions about the applicability and relevance of the concept of belongingness to nursing students.

In the second part of this chapter the nursing literature is explored with a view to detailing the extent to which the existing body of knowledge addresses questions surrounding nursing students' experience of belongingness. Although the aim was to achieve a better general understanding of belongingness through a review of the literature, the super-ordinate question that dominated the review was: "What could this mean to nursing students, to their education and to the curriculum goals of developing competent and confident practitioners?" The nursing literature is limited in nature and scope; although many papers refer to the importance of students being accepted, welcomed and supported on clinical placements, few studies focus specifically on the experience of belonging. This chapter concludes by identifying the gaps that exist in the body of knowledge related to nursing students and their experience of belongingness while on clinical placements. The emergent research questions are then reviewed.

2.2 Search strategy

An extensive search of the electronic databases of those disciplines that have studied belongingness—namely social sciences, psychology and, to a lesser extent, nursing— was undertaken. The initial search strategy was limited to the keywords that comprise or are related to the definition of belongingness: that is, belonging, belongingness, sense of belonging, inclusion, connectedness, value, esteem, fit, acceptance and alienation. The terms nursing student, clinical placement and practice placements were then added. This search revealed few research studies linking belongingness, and its surrogate terms, to nursing students. It was therefore expanded to include beginning, novice, neophyte, pre-registration, pre-qualifying and new graduate nurse.

The objective of the search was to identify published (in peer-reviewed journals or reference books) and unpublished studies. The search for published papers from 1940 onwards included the electronic databases CINAHL, Journals@Ovid Full Text, Proquest, PSCHinfo, Medline, Expanded Academic, Embase and Current Contents. In addition, Dissertation Abstracts International and Proceedings First were searched to identify any unpublished research. In view of resource limitations, the search was restricted to reports in the English language. Papers identified in the reference lists of each report were searched manually. All titles and abstracts identified in the search were scanned to determine if they satisfied the inclusion criteria of an explicit consideration of belongingness or one of the related surrogate terms in the study design or discussion. The search process continued until new references ceased to emerge. Each study was reviewed for methodological quality and critically appraised.

2.2.1 Management of citations

During the review, papers were retrieved, organised by keyword and discipline, numbered and filed. When retrieval was complete, papers were read at least twice. The initial reading provided an overview of the paper. During the second reading, the papers were organised into themes: belongingness definitions, belongingness as a fundamental human need, the evolutionary basis of belongingness, belongingness as a theory of human relatedness, belongingness as a mental health concept, alienation (the antithesis of belongingness), conformity as a strategy to belong, fitting in, feeling valued, work satisfaction, I don't belong, outsider/insider and staff–student relationships.

EndNote software was used to manage the references as it was able to store and organise bibliographical references by numbering each citation.

2.3 Belongingness in psychology and social science

2.3.1 Belongingness—a fundamental human need

The well-known and oft-cited psychologist Abraham Maslow originally posited a motivational hierarchy with five sets of goals or needs—physiological, safety and security, belonging and acceptance, self-esteem and self-actualisation (Maslow, 1954). He later expanded the hierarchy to include cognitive needs (the need to know, understand and explore); aesthetic needs (the need for symmetry, order and beauty) and transcendence (the need to help others find self-fulfilment and realise their potential) (Maslow, 1971; Maslow & Lowery, 1998). Maslow, in a seminal work aimed at understanding what constitutes human need, theorised that unless each stage of the needs hierarchy is met, people will be unable to focus successfully on the needs of the next level. In terms of belongingness, according to Maslow (1954, p. 89):

> If both the physiological needs and the safety needs are fairly well gratified, there will emerge the…belongingness needs…Now the person will hunger for affectionate relations with people in general, namely, for a place in his [sic] group, and will strive with great intensity to achieve this goal.

However, Maslow's theory was accompanied neither by original data nor review of previous findings. Maslow (1987) himself admitted that while his theory conformed to known facts—clinical, observational and experimental—it was derived mostly from clinical experience. In a more recently published edition of selected writings, Maslow is quoted as having said that his motivational theory should, "stand or fall, not so much on facts currently available or evidence presented, as upon researches yet to be done" (Maslow, 2000, p. 253).

Following on from the work of Maslow, Baumeister and Leary (1995) proposed that despite frequent, speculative assertions that people have a need to belong, the belongingness hypothesis required critical evaluation in the light of empirical evidence. Through an extensive review of empirical literature from social and personality psychology, these authors tested the hypothesis that a need to belong is a fundamental human motivation and that human beings have a pervasive drive to form and maintain lasting, positive and significant interpersonal relationships.

Baumeister and Leary proposed that a fundamental motivation should: (a) produce effects readily under all but adverse conditions; (b) have affective consequences; (c) direct cognitive processing; (d) when thwarted, lead to ill effects (such as on health or adjustment); (e) elicit goal-oriented behaviour designed to satisfy it; (f) be universal in the sense of applying to all people; (g) not be derivative of other motives; (h) affect a broad variety of behaviours; and (i) have implications that go beyond immediate psychological functioning. Each of these was addressed separately in Baumeister and Leary's study by critical evaluation of both the literature that supported and the literature that refuted each criterion.

Baumeister and Leary (1995, p. 501) concluded that existing evidence does support the hypothesis that the need to belong is a universal, strong, fundamental and extremely pervasive human motivation. Specifically, the need to belong seems to be apparent, to some degree, in humans from all cultures and may even have an evolutionary basis (an issue discussed in more detail in Section 2.3.2). Most people form social bonds across a wide variety of situations and in a range of diverse environments (for example: family, friends, work, school and community) relatively easily, and at times find these bonds difficult to break. At the affective level, increases in belongingness are related to positive affect, and decreases related to negative affect. The need to belong may also influence cognition, as people devote a considerable amount of time and effort processing and attempting to understand interpersonal relationships, particularly when those relationships do not fulfil their need to belong. At the behavioural level, the absence of meaningful interpersonal relationships leads to an increase in behaviours such as unquestioning agreement with another person's decision, acquiescence or modification of behaviour. Aversive reactions to a loss of belongingness include stress, behavioural or psychological pathology, somatic and psychosomatic illness, maladjustment, decreased general wellbeing, and feelings of alienation; and positive effects are linked to happiness, reduced anxiety and attribution of meaningful involvement. Baumeister and Leary concluded by proposing that the need to belong can provide a point of departure for understanding a great deal of the existing literature regarding human interpersonal behaviour.

Baumeister and Leary's (1995) summary of the evidence related to belonging is quite convincing, and on close inspection the counterexamples reviewed did not refute their hypothesis. It seems clear that there is a universal desire to develop and maintain stable, fulfilling interpersonal relationships and that the consequences of not belonging

are significant. Previous and subsequent research by Baumeister and his colleagues has underpinned and strengthened support for these conclusions. The findings from these studies are briefly described below.

Based on the assumption that the need to belong is a basic and powerful motivation and the proposal that people are be likely to feel emotional distress when that urge is thwarted (Baumeister & Leary, 1995), a series of experimental studies was undertaken that focused on the effects of social exclusion. This research found social exclusion to be a significant cause of anxiety (Baumeister & Tice, 1990), and it was proffered that the anxiety produced by being excluded produces a short-term impairment in cognitive functioning and mediates a reduction in intelligent thought (Baumeister, Twenge & Nuss, 2002). These experimental studies also concluded that rejection by social groups causes an increase in aggressive behaviour (Twenge, Baumeister, Tice & Stucke, 2001) and derogation of the rejecters (Bourgeois & Leary, 2001). Likewise, there is an increase in self-defeating behaviours (Twenge, Baumeister, DeWall, Ciarocco & Bartels, in press) and a decrease in self-esteem and prosocial behaviour when belongingness needs are not met (Leary, Cottrell & Phillips, 2001; Miller, 1991). These findings should be read with caution, however, as experimental approaches that examine the concept of belongingness can be problematic, in that in trying to isolate variables they tend to exclude the social context within which people operate.

In line with Baumeister and Leary's (1995) work, Somers (1999, p. 16), defined belongingness as

> the need to be and perception of being involved with others at differing interpersonal levels…which contributes to one's sense of connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared about, valued and respected by others), while providing reciprocal acceptance, caring and valuing to others.

As part of her doctoral studies, Somers developed and undertook a preliminary psychometric analysis of a measurement instrument, grounded in the theoretical framework of Baumeister and Leary and designed to assess belongingness in four distinct interpersonal environments: (a) family, (b) friends, (c) work/school and (d) neighbourhood/community. This instrument was termed the Belongingness Scale (BES). Consistent with her definition of belongingness, Somers postulated that belongingness is composed of two basic components that are not mutually exclusive: (a) feeling connected to and accepted by others, and having a sense of fitting in; and (b) feeling cared about, valued, respected and held in esteem by others. Items representing each of these components were included in the BES. Items were also

written to indicate that belongingness relates to and influences affective consequences, cognitive processing and a broad variety of goal-oriented behaviours. In accordance with Baumeister and Leary's notion that belongingness is composed of reciprocal interactions, Somers proposed that belongingness operates in a two-way fashion, and thus items were included that implied either a passive/receiving state, an active/giving state, or a neutral state.

Exploratory Factor Analysis supported the proposed environmental model as predicted. Results of the study provided preliminary evidence for construct validity acquired through scale comparisons. Specifically, the BES showed significant correlations in expected directions with measures of social support, self-esteem and loneliness. Gender differences emerged, with women scoring significantly higher than men, and racial differences were identified in which white Americans scored higher than African Americans and Hispanics. The proposal that belongingness is comprised of connectedness/esteem and active/passive components was not tested as part of this study. The development and validation of the BES are discussed more fully in Chapter 3, where the modification and use of this instrument for the purpose of the current study are outlined.

2.3.2 The evolutionary basis of belongingness

The universality of a motivation like belongingness indicates the likelihood of an evolutionary basis. According to most evolutionary psychology and anthropological perspectives, earlier societies lived in environments in which individuals who were on their own found it difficult to survive and successfully reproduce (Buss & Kendrick, 1998; Coon, 1946; Johanson & Edgar, 1996). The environment of evolutionary adaptation was complex and difficult to navigate, and individuals were forced to rely on other group members to complete necessary survival activities such as locating and securing food sources and shelter, defending against predators, and reproducing and raising offspring (Lakin, 2003; Somers, 1999). The groups in which most early humans lived became the locus of many of these important behavioural activities (Lewin, 1993; Poirier & McKee, 1999). Individuals who were cooperative and able to maintain harmonious group relationships were more likely to continue to be included in the group and were therefore at an evolutionary advantage (Lakin, 2003; Lewin, 1993; Poirier & McKee, 1999). Individuals who were excluded were less likely to survive. This may explain why people tend to avoid exclusion from groups and have developed a strong need to belong.

2.3.3 Belongingness as a mental health concept

As one of the first to publish findings related to belongingness and mental health, Anant (1966) posited that belongingness is the missing conceptual link in understanding mental health and mental illness from a relationship/interactional perspective. In an early paper, he wrote that belongingness implies recognition and acceptance of a person by the members of a group. Anant (1966, p. 22) defined belongingness as a "sense of personal involvement (in a social system) to the extent that the person feels himself [sic] to be an indispensable and integral part of that system".

In the 1960s, Anant published reports of two studies in which the relationship between belongingness, anxiety and self-sufficiency were examined (Anant, 1967, 1969). In the first study Anant proposed that when people are placed in strange situations, with a lack of clarity about what to do, where to go or who to talk to, they are likely to become anxious. However, a person who is an integral part of a social system—that is, the person who belongs—will feel more secure and at ease than a person who does not belong and feels alienated. Anant (1967) further suggested that people who belong are more self-sufficient and capable of taking care of themselves. This study was conducted with 47 nursing students (33 females and 14 males) from a general hospital in Canada. Their mean age was 18.9 years. Three tests were used, Anant's Sense of Belongingness Questionnaire, Bernreuter's Self-Sufficiency Scale and Willoughby's Personality Schedule (a measure of anxiety). The results of this study supported an inverse relationship between belongingness and anxiety, but did not support the positive relationship between belongingness and self-sufficiency. However, it should be noted that the published report contains no information on the validity or reliability measures for the study instruments, an issue that detracts from the strength of Anant's findings.

In Anant's (1969) next published study the relationships between belongingness, anxiety and self-sufficiency were again examined. The sample consisted of college students from four traditional caste groups in India (132 males and 6 females) with a mean age of 26.2 years. The three tests used in the previous study were again employed: Anant's Sense of Belongingness Questionnaire, Bernreuter's Self-Sufficiency Scale and Willoughby's Personality Schedule. The findings demonstrated that the mean belongingness score of these groups was lower than that of the Canadian sample previously described, and the mean self-sufficiency score

significantly higher. The correlations between the three variables of belongingness, anxiety and self-sufficiency were apparent, but lower than in the Canadian sample. Anant had proposed that the higher caste group, ostensibly free from anxiety and concerns about basic physiological needs, should show higher correlations among the three variables. This contention was supported. Once again, concerns related to the validity and reliability of the study instruments limit the interpretation of the findings.

2.3.4 Belongingness as a theory of human relatedness

Hagerty and a group of like-minded colleagues have amassed a wide body of literature on the concept of belonging as it relates to human relatedness, psychosocial functioning and mental health. In order to develop a body of research on a defined topic, it is not unusual to begin by exploring if and how the concept was defined by previous researchers, and the various theoretical perspectives used to describe the concept. Hagerty et al.'s research into belonging began in 1992 with a concept analysis of sense of belonging (Hagerty, Lynch-Sauer, Patusky, Bouwsema & Collier, 1992). This analysis determined that sense of belonging was a concept that had not been adequately researched in social science, psychology or psychiatric nursing practice, and that it was different from more frequently discussed concepts such as loneliness, alienation and social support. Using a concept analysis strategy proposed by Walker and Avant (1988), these authors presented a detailed description of the concept that evolved from a series of inductive and deductive strategies. Over a period of two years, clinical case studies were developed based on clinical observations, small-group interviews conducted with psychiatric nurses, and a series of four focus groups undertaken with individuals having no previous psychiatric treatment history. Subsequently, an integrative literature review was conducted to synthesise information pertaining to belonging and human relatedness. Analysis of the accumulated data from all the activities underpinned the conceptualisation of sense of belonging and human relatedness.

The defining attributes of belonging were identified by Hagerty et al. (1992, p. 173) as: (1) the person's experience of being valued, needed, or important with respect to other people, groups, objects, organisations, environments or spiritual dimensions; and (2) the person's experience of fit or congruence with other people, groups, organisations or environments through shared or complementary characteristics. The proposed antecedents of belonging, or those incidents that must occur before the existence of the concept, were the person's (1) energy for involvement, (2) potential and desire for meaningful involvement, and (3) potential for shared or complementary characteristics

or values. Consequences are incidents that occur as a result of the concept. Identification of consequences allowed the researchers to begin examining relationships between the proposed concept and resultant incidents. The proposed consequences to sense of belonging included: (1) psychological, social, spiritual, or physical involvement; (2) the attribution of meaningfulness to that involvement; and (3) fortification or laying down of a fundamental foundation for emotional and behavioural responses. Identification of model, related, borderline and invented cases—a strategy proposed by Walker and Avant (1988)—was used to illustrate the concept more fully. The final definition of belonging derived by Hagerty et al. was (1992, p. 173) "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of the system or environment".

The analysis represented an initial effort to develop conceptual foundations for ongoing work into the concept of belonging as an important phenomenon of human relatedness, with Hagerty et al. (1992) concluding that sense of belonging also has important applicability for clinical use with psychiatric clients. The concept analysis went some way towards analysing the concept of belonging, but, as the authors acknowledged, further refinement, development and testing of empirical measures, and theory generation was required before its clinical applicability could be assessed.

Following on from the initial concept analysis, Hagerty, Lynch-Sauer, Patusky and Bouwsema (1993) developed a theoretical framework that encapsulated sense of belonging as one of the social processes that contribute to human relatedness. The authors' goals were to develop a framework from which to better understand, assess and intervene with clients experiencing difficulties in relatedness. Using the data elicited while undertaking the concept analysis previously described, a theory of human relatedness was developed. The core construct of the theory is relatedness which is defined by the authors as a "functional, behavioral system rooted in early attachment behaviours and patterns" (Hagerty et al., 1993, p. 292). It includes the individual's level of involvement with other people, groups and environments and the concurrent level of comfort associated with that involvement. That is, while relatedness can be experienced as comfortable and anxiety-reducing, it can also be experienced as uncomfortable and anxiety-producing. This is understood by clarification of the four states of relatedness:

- Connectedness occurs when a person is actively involved with another in a manner that produces a sense of comfort, wellbeing and anxiety reduction.

- Disconnectedness is experienced when a person is not actively involved with others and the lack of involvement results in discomfort, anxiety and a lack of a sense of wellbeing. This has been closely linked to estrangement and alienation.

- Parallelism occurs when a person's lack of involvement is comfortable and results in an enhanced sense of wellbeing. This may be a state whereby physical and emotional replenishment occurs.

- Enmeshment is experienced when a person's involvement with another is such that they feel trapped or confined and this causes them discomfort and anxiety. A lack of a sense of self is described as one of the dynamics of enmeshment by Hagerty et al. (1992, p. 173).

With regard to the four states of relatedness, Hagerty et al. (1993) identified four major processes involved in promoting relatedness states. These include sense of belonging, reciprocity, mutuality and synchrony. Foremost among these is sense of belonging, defined as "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of the system or environment" (Hagerty et al., 1992, p. 173). Reciprocity was defined as the individual's perception that their involvement in an equitable exchange with another is accompanied by a sense of complementarity. Mutuality is the experience of shared commonalities in visions, goals, characteristics or values, including shared acceptance of differences. Synchrony, the fourth process, is described as the person's experience of congruence between their internal rhythms and external interactions with others. Hagerty et al. (1993) proposed that a person's experience of connectedness in a particular relationship is dependent upon the extent to which they also experience belonging, reciprocity, mutuality and synchrony.

As the theory emerged, the following basic assumptions were identified:
- Human growth and development occur within the context of relatedness.
- People ascribe meaning to their experiences and this is influenced by their sense of self.
- People are capable of pro-actively changing their relatedness experiences.
- An important component of wellbeing is the affective realm.
- Relatedness is a universal phenomenon, but its expression is individualistic.
- People are capable of experiencing both choice and responsibility in their relatedness experiences.

- People experience sensitive periods, during which interventions can influence the nature of the relatedness.

While this framework provided the basis for researching the behaviours of mental health clients, hypothesising beyond these initial assumptions required additional theoretical and descriptive work.

Building on the work of the concept analysis (Hagerty et al., 1992) and theory development (Hagerty et al., 1993), Hagerty and Patusky (1995) next sought to develop and psychometrically test a self-report instrument designed to measure sense of belonging in adults. The definition of belonging derived from initial concept analysis (Hagerty et al., 1992, p. 173), that is, "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of the system or environment"; and the defining attributes of (a) valued involvement and (b) fit provided the conceptual basis for development of what was called the Sense of Belonging Instrument (SOBI). Using the definition and its related attributes, instrument items were generated to reflect the psychological experiences of sense of belonging and its antecedents. Items were developed from a number of sources, including the author's clinical experience, and the data that underpinned the initial concept analysis.

Content analysis of the instrument was assessed by a panel of seven experts who were asked to rate the extent to which the items were clear and relevant to the definition of sense of belonging. The experts were also invited to suggest additional items to ensure that the concept was adequately tapped. Psychometric testing of the SOBI occurred with three sample groups located in the United States. The first was a sample of 379 community college students chosen for the heterogeneous mix of students and ease of access. The second group was a sample of 31 clients diagnosed with major depression. This group was included because the researcher's clinical experience had suggested that interpersonal relationships and feeling connected are difficult when a person is depressed. A revised 27-item version of the instrument was subsequently tested with a group of 37 retired Roman Catholic nuns, selected because it was anticipated that this group would score significantly higher than either of the other groups.

Three methods were used to examine construct validity of the SOBI: contrasted groups, factor analysis and comparisons with other measures. Factor analysis yielded a two-factor solution that explained 37 per cent of the variance in the set of items. Two

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factor subscales were devised that supported the theoretical components of the construct, with the first scale (SOBI-P) representing the psychological experience of belonging and the second scale (SOBI-A) representing the antecedents.

It had been hypothesised that the depressed group would score significantly lower on the SOBI than the student group, and that the nuns would score higher. The hypothesis was supported. The differences of the means between each of the three sample groups on both the SOBI-P and SOBI-A scores in the hypothesised directions suggest that the instruments have the ability to differentiate between high and low levels of belonging and its antecedents.

The third method used to assess construct validity of the instrument was the extent to which SOBI-P and SOBI-A correlated with other measures of sense of belonging or similar concepts. Since no other known measure of sense of belonging was available, student's scores on the SOBI-P and SOBI-A were correlated with measures of loneliness, reciprocity and social support. Loneliness was measured by the Revised UCLA Loneliness Scale (RULS) (Russell, Peplau & Cutrona, 1980). Two scales of the Interpersonal Relationships Inventory (IRI) were used to measure social support and reciprocity (Tilden, Nelson & May, 1990). Scores on the SOBI correlated with measures of loneliness, reciprocity and social support in hypothesised directions, that is positively with reciprocity and social support, and negatively with loneliness. Reliability of the SOBI-P and SOBI-A was evaluated with Cronbach's alpha[1] for each of the three groups and found to be satisfactory. Thus, support was demonstrated for the validity and reliability of the SOBI-P, although the internal consistency of the SOBI-A was lower in all groups.

In a study by Hagerty, Williams, Coyne and Early (1996), the validity of the proposition that sense of belonging is an element of psychological functioning was further examined. The goal of this study was to more fully explicate sense of belonging by addressing two research questions: (1) what are the relationships and differences between men's and women's personal characteristics and sense of belonging; and (2) what are the relationships and differences between men's and women's psychological and social functioning and sense of belonging? The study sample consisted of the 379 community college students used in previously described study. The instruments employed were the SOBI-P and SOBI-A (Hagerty & Patusky, 1995), as well as

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[1] A glossary of the statistical symbols and terms used in this thesis is provided on pp. xvi–xx.

measures of social support, conflict, loneliness, depression and anxiety. Validity and reliability of the instruments was cited. No statistical significance was identified between belonging, gender and either age, marital status or education. For women there was a significant difference for income on both the SOBI-P and SOBI-A. Those whose household incomes were more than US$40,000 per year scored higher on both measures. For men a significant difference for religious preferences was identified by scores on the SOPI-P, but not on the SOBI-A. There were no significant differences for either gender between group mean scores of any of the ethnic groups on SOBI-P or SOBI-A. Higher scores of belonging and its antecedents were associated with more perceived social support for both genders. With respect to psychological functioning, lower scores on the SOBI-P were related to loneliness, depression, anxiety, a history of psychiatric treatment, and suicidal thinking and attempts. These relationships were higher in women than men, although significant for both genders.

The results of this study provide further support for the theoretical development and validity of the SOBI-P. Although both measures performed as hypothesised with indicators of psychological and social functioning, relationships with the study variables and SOBI-A were weaker, reflecting the need for further refinement of the scale. This study contributed to the literature on belonging by providing further understanding of the parameters and conditions under which sense of belonging operates and how it influences, and is influenced by, cognition, affect and behaviour.

A number of studies have been undertaken by Hagerty et al. to determine the relationship between sense of belonging and depression. These studies examined factors such as the effects of sense of belonging, social support, conflict and loneliness on depression (Hagerty & Williams, 1999); sense of belonging as a buffer against depressive symptoms (Sargent, Williams, Hagerty, Lynch-Sauer & Hoyle, 2002); chronic stress, sense of belonging, and depression among survivors of traumatic brain injury (Hagerty, Williams, Kirsch & Gillespie, 2002); and the impact of belonging and social support on stress and depression in individuals with depression (Choenarom, Williams & Hagerty, 2005). Each of these studies attested to the strong relationship between belonging and depression.

The Hagerty-Patusky Sense of Belonging Instrument has also been used by other researchers to examine the relationship between belonging and a diverse range of variables. For example, Kissane and McLaren (2006) investigated sense of belonging as a predictor of reasons for living in older adults, and described how a higher sense of

belonging was indicative of reasons to live, survival and coping skills in a sample of 104 elderly people aged 61–95 years. Winter-Collins and McDaniel (2000) explored the relationship between sense of belonging and job satisfaction in 95 graduate nurses using a modified version of the Hagerty-Patusky Sense of Belonging Instrument (SOBI) and McCloskey-Mueller's Satisfaction Scale (Mueller & McCloskey 1990 . This study will be detailed more fully in Section 2.4.2. Both of these studies have contributed to the literature on belongingness and, by using the Hagerty-Patusky Sense of Belonging Instrument across different groups, have continued to support evidence of the instrument's psychometric integrity.

It should be noted that the Hagerty-Patusky Sense of Belonging Instrument is a global measure that assumes belongingness to be generally applicable and consistent across contexts. The instrument does not distinguish between belongingness specific to certain situations or environments and fails to take into account that a person may simultaneously experience belongingness within one context but not in another. For example, a person may feel that they are accepted and valued within their family structure but may not experience that same sense of belonging in their work or school environment. This is an important limitation that weakens the utility and applicability of the instrument for the study of belongingness specific to a particular environment.

2.3.5 Alienation—the antithesis of belongingness

A discussion of belongingness is not complete without consideration of its antithesis, alienation. Hajda (1961, pp. 758–759) defined alienation as

> an individual's feeling of uneasiness or discomfort which reflects his [sic] exclusion or self exclusion from social and cultural participation…it is a social phenomenon [that] cannot be understood apart from its opposite, the feeling of belonging.

Hajda further suggested that alienation varies in scope and intensity. For some it may be restricted to specific social situations or contexts, while for others the experience may be more far reaching. It may be a sporadic feeling, arising from specific encounters and events, or it may be an intense and enduring feeling perpetuated by the individual's self-concept, or their perception of how they are viewed by others. Additionally, Hajda proposed that alienation is related to the extent to which a person's values, beliefs and norms correspond to those of the particular group with which he or she is associated. Individuals are motivated by a desire to avoid alienation and to foster inclusion. Hajda suggests that people's attempts to avoid being alienated and to enhance their chance of inclusion within defined groups may lead to unquestioning

acceptance of group norms, compliance with existing traditions, and latent conservatism. Against this backdrop Hajda set out to explore 2360 US-born graduate students' experiences of alienation. Four sample groups—termed alienated intellectuals, integrated intellectuals, alienated non-intellectuals and integrated non-intellectuals—were surveyed. Each group was classified by their different social profile, values orientations, group affiliations, attachments and commitments. Responses to questions on the survey yielded a picture of graduate students' self-conceptions, views and feelings related to alienation and belonging. Hajda concluded that alienation is not inevitable, but individualistic, contextually mediated and connected to perceived social support structures, including peer support. Additionally, for the participants in this study, alienation was related to anxiety, insomnia, depression, lack of motivation, lack of direction and loss of appetite.

Dean (1961) adds to the discussion of alienation by suggesting that it is has three major components: powerlessness, normlessness and social isolation. Powerlessness refers to a lack of control over events and feeling helpless to be able to influence or change those events. Normlessness refers to the absence of values and group norms that give purpose or direction to life, resulting in hopeless disorientation. The third component, social isolation, refers to rejection by a person's peers and a sense of separation from the group.

As part of his doctoral dissertation, Dean constructed and psychometrically tested a scale to determine what empirical relationships existed between the three components of alienation and the variables of occupation, education, income, age and community. The random study sample comprised 433 individuals, who completed an anonymous survey consisting of 24 items. The results of the study indicated that the correlation coefficients between the subscales of powerlessness, normlessness and social isolation were statistically significant, suggesting that it is feasible to consider the subscales as belonging to the same general concept. However, the correlation coefficients between alienation and occupation, education, income, age and community were uniformly of such low magnitude that it was not possible to predict the degree of alienation from the score on any of the five social correlates measured. Dean concluded that the results of the study pointed to the fact that alienation is not a personality trait but a situation-relevant variable. He argued that a person may experience alienation in one context but belong in another. The results of the study, while interesting, presented an initial attempt to explore the concept of alienation but required further investigation.

2.3.6 Conformity as a strategy to belong

A behavioural consequence of diminished belongingness is said to be an increase in affiliative behaviours, such as unquestioning agreement with another person's decision, acquiescence, modification of behaviour, or engaging in negative behaviours sanctioned by group members (Baumeister & Leary, 1995; Clark, 1992; Lakin, 2003; Williams & Sommer, 1997). Group conformity may be viewed in the context of enhancing one's chances of inclusion in groups (Mooreland & Levine, 1989). In exploring the concept of belonging as it relates to adolescents, Clark (1992) proposed that gangs and other adolescent subcultures provide the sense of belonging that may be absent in homes, schools and communities. To be alienated is to lack a sense of belonging, to feel cut off from family, friends, school or work. Members of some groups are pressured to commit criminal acts ranging from vandalism to terrorism in order to be accepted by, and to demonstrate commitment to, a group (Breitman, 1991). Although the antisocial behaviour typical of gangs and other adolescent subcultures may at first glance be regarded as a potential counterargument for the belongingness hypothesis (because antisocial behaviour alienates others), it is readily apparent that belongingness has close ties to it (Clark, 1992). Gangs and other adolescent subcultures may offer what is lacking in the adolescent's life: companionship, loyalty, identity, status and belongingness. The price of membership is usually total conformity and commitment to the group. It is also no accident that people seem most likely to be prejudiced against members of groups that they aspire to join but to which they have little or no opportunity to belong (Meindl & Lerner, 1984).

2.3.7 Summary of the psychological and social science literature

The review of literature from the disciplines of social science and psychology supports the idea that human beings are social creatures and that the need to belong and be accepted is fundamental, driving much of human pursuit, activity and thinking (Baumeister & Leary, 1995). In turn, the converse of social exclusion can be devastating (Twenge et al., 2001). There is a broad range of literature that details the importance of belonging, as well as the deleterious emotional, psychological, physical and behavioural consequences of having this need thwarted (Anant, 1966; Hagerty et al., 1992; Maslow, 1987; Somers, 1999). Empirical evidence suggests that people who are deprived of belongingness can experience diminished self-esteem, increased stress and anxiety, depression, a decrease in general wellbeing and happiness, impaired cognition (Baumeister & Tice, 1990; Baumeister et al., 2002; Hagerty & Williams, 1999; Lakin, 2003), and an increase in affiliative behaviours, such as

compliance, or engagement in negative behaviours sanctioned by group members (Clark, 1992).

Baumeister and Leary (1995, p. 514) go as far as to suggest that the desire for interpersonal attachment may well be one of the most far-reaching and integrative constructs currently available to understand human behaviour. However, while the experience of belongingness has been demonstrated to be a measurable construct, substantive research into exploring the factors that enhance or detract from a sense of belonging is yet to be undertaken.

The overview of literature from the social and psychological sciences presents a background to further study, provides a springboard for an extensive but focused search of the nursing literature, and raises a number of important questions. The most pertinent questions to this study are: with regard to the clinical placement, to what degree do nursing students experience belongingness, and what factors impact upon and are consequences of that experience? Thus, the review now turns to an exploration of the nursing literature to determine whether the existing body of knowledge sheds light on these questions.

2.4 Belongingness in nursing education

There is widespread agreement that clinical placement experiences are central to nursing education and that they are crucial to the consolidation of student learning (Clare, White, Edwards & van Loon, 2002). It is clear, however, that clinical placements represent a very challenging component of nursing education. For many students, clinical placement experiences are difficult and stressful, typified by feelings of alienation and fear of making mistakes (Levett-Jones & Bourgeois, 2007; Lo, 2002; Timmins & Kaliszer, 2002). The last decade has seen a plethora of reports that provide evidence of the longstanding and multidimensional nature of the problems that surround clinical placements, (Clare, Edwards, Brown & White, 2003; Council of Deans and Heads of UK University Faculties for Nursing Midwifery and Health Visiting, 1998; Department of Health, 1999, 2000; FitzGerald et al., 2001; Heath, Duncan, Lowe & Macri, 2002; Johnson & Preston, 2001; Peach, 1999; Senate Report, 2002). One way of exploring these problems and reconceptualising nursing students' clinical experiences is through the lens of belongingness. However, while the idea of belonging has intuitive appeal, nursing literature provides little clarity regarding belongingness, particularly as it relates to nursing students. The use of the terms *sense of belonging*

and *belongingness*, while commonplace, have not been adequately explored. In fact, the majority of authors do not go beyond providing descriptive accounts of the importance of belonging and little attention is paid to defining or clarifying the concept or to delineating the interrelationships that exist between belongingness and nurses. Few studies address the multidimensional factors that impact on belongingness; fewer still consider the consequences. In this review a relatively small number of nursing studies satisfied the inclusion criteria of a clear consideration of belongingness or one of the related terms in the study design and discussion. An overview of these studies is now presented before a summary of the main issues and a review of the state of knowledge regarding nursing students' experience of belongingness.

2.4.1 Fitting in

Champion, Ambler and Keatinge (1998) undertook a study to clarify beginning registered nurses' and experienced nurses' perceptions of the process of fitting in and to investigate what supports and inhibits that process during the first year of employment. This was a small, local study in a semi-metropolitan hospital in New South Wales, Australia. The approach was qualitative, with data collected through semi-structured interviews and focus groups in which critical incident and nominal group techniques were used. Data were analysed using content and thematic analysis. Beginning practitioners and experienced practitioners participated in the study. Of the 198 experienced practitioners invited to participate, 8 participated in the interviews and 6 in the focus group. Thirty-four beginning practitioners were invited to participate in the study; 7 participated in interviews, and 4 in the focus group.

The diversity and wide range of comments made while working towards a definition of fitting in prevented a concise definition of the phenomena from being developed. In attempting to reach a common understanding of the term fitting in, some participants described the expected behaviours and attributes of beginning practitioners who fitted in (for example: competent, works well, not too self-conscious or self-critical); others described aspects of interpersonal relationships that underpin the fitting-in process (for example, both sides giving mutual respect). Fitting in was also described as a process (for example, learning to work as part of the team or getting along with the staff). The responses from the experienced practitioners seeking to define fitting in contrasted significantly from those of the beginning practitioners. The experienced practitioners placed a great deal of the responsibility for fitting in on the beginning practitioners; they were expected to have clinical competence, good communication skills, an awareness of status (as a beginner), be open to learning and able to get on well with other

members of the team. Experienced practitioners also expected the beginners to do what was required of them and to conform to what was currently done in the unit. The dichotomy between the perspectives of beginning and experienced practitioners demonstrated a lack of mutual understanding and was identified by Champion et al. (1998) as a potential barrier to fitting in.

In terms of identifying the factors that impact upon the process of fitting in, contrasting opinions between the beginning practitioners and experienced practitioners was again apparent. Beginning practitioners identified factors that contributed to their being accepted and supported as key to fitting in. They considered being appreciated, recognised and accepted as a person and as a colleague to be essential to feeling like one of the team. Experienced practitioners indicated that they expected beginning practitioners to engage in a number of specific behaviours if they wanted to fit in. These included asking for advice, offering to help others, picking things up easily, and getting their work done.

When exploring factors that detracted from fitting in, beginning practitioners cited non-acceptance and lack of support as key, although they often blamed themselves and rated "making mistakes" and "a lack of interest" as those behaviours most likely to contribute to their not fitting in. These participants also appeared to accept with resignation their "place" in the healthcare environment, rarely retaliating when criticised and believing that they had to "take the punches to start with" (Champion et al., 1998, p. 31). Experienced practitioners identified not being valued, welcomed or nurtured as detrimental to beginning practitioners being able to fit in, but added that not offering help to their colleagues, being unreliable and poor performance were equally important.

Contextual factors that impacted upon fitting in for beginning practitioners was whether or not they were given an adequate orientation and supernumerary time, provided with a consistent mentor or given adequate educator support, although these issues were not explored in any detail. Both the experienced and the beginning practitioners commented on the role of the university in preparing beginning practitioners to fit in to the workplace. Positive comments included the adequacy of the beginning practitioners' clinical ability, but typically negative comments focused on the inadequate duration of clinical placements and being supported by facilitators instead of learning to manage independently.

This study sheds some light on the process of fitting in. However, the sample size makes any conclusions tentative at best. As it was a pilot study, the limited financial resources meant that it was limited to, and reflected the experiences of, beginning and experienced practitioners in one context only. Additionally, the consequences of not fitting in were poorly articulated.

In a grounded theory project that used in-depth interviews, diary accounts and telephone conversations, fitting in was once again a dominate theme (Hemmings, 1993). This study explored the socialisation and acculturation experiences of six beginning registered nurses who had completed a three-year pre-registration Diploma in Applied Science (Nursing) program and were commencing employment at a rural base hospital in Australia. The purpose of the study was to provide an in-depth and systematic analysis of the everyday experiences of a group of beginning registered nurses during the first months of their employment, and to derive from this an analysis of the processes involved in the transition from nursing student to practising registered nurse.

Hemmings (1993) found that the participants focused largely on being integrated into the particular ethos of the ward and hospital environment and that integration occurred when graduates learnt and applied the knowledge and behaviours appropriate to a particular ward culture. The participants stated that they quickly learnt that the best way to fit in and be accepted by the team was to comply with established practices and work routines similar to those used by other nurses on the ward. As integration occurred, it did not always involve a passive acceptance of the prevailing culture, nor did it always result in complete acquiescence to the views and behaviours of colleagues. At times the beginning nurses questioned the practices and attitudes of the registered nurses they worked with but, although there was some resistance to ward cultures, their criticisms were rarely voiced. Conflict sometimes became intense when their ideas were at odds with those of their colleagues. The distress surrounding these confrontations often led the participants to experience emotional and/or physical reactions—for example, crying, headache and insomnia.

Although compliance was identified as a strategy used by many of the participants to fit in, the potential consequences of compliance and acquiescence, and the factors that made a difference between those who conformed and those who resisted, were largely overlooked in the reported findings. Additionally, although the study claims to be a grounded theory project, there is no evidence of theoretical sampling and the

representativeness of the participants is not discussed. The context of the study is not described and this, together with the small sample size and localised nature of the study, prevents the reader from making a judgment about the applicability of the study's findings to another context.

2.4.2 Work satisfaction

In a quantitative study, Winter-Collins and McDaniel (2000) explored the relationship between sense of belonging and job satisfaction in graduate nurses using a modified version of the Hagerty-Patusky Sense of Belonging Instrument (SOBI) (Hagerty & Patusky, 1995) and McCloskey-Mueller's Satisfaction Scale (Mueller & McCloskey, 1990), including the eight subscales of interaction opportunities, praise, control, co-workers, schedule, extrinsic rewards, professional opportunities and balance. Both instruments have been examined for construct validity. The modified version of the Sense of Belonging Instrument had a Cronbach's alpha coefficient of 0.86 in the reliability analysis. The incentive for the study arose from the authors' contention that new graduate nurses leave positions at higher rates that experienced nurses.

Graduates who took the state board examination between January 1996 and January 1997 were randomly selected from an Indiana health professions bureau mailing list of graduates. An anonymous survey was mailed to 250 graduates. Of these, 107 replied and 95 met the specified criterion, that is, any registered nurse who had received their licence within the previous 18 months. This gave a response rate of 38 per cent.

Sense of belonging ranged from 1.9 to 3.5 on a 4-point scale, with a mean of 2.9. Low scores equalled low sense of belonging, high scores represent a greater sense of belonging. Total satisfaction ranged from 1.9 to 4.5 on a 5-point scale, with a mean of 3.5. Low scores indicated low satisfaction and high scores were associated with higher levels of satisfaction. There was little variation in mean sense of belonging across work settings; however, it was the highest in home health and obstetrics, and lowest in operating theatres. Total satisfaction was also highest in home health and lowest in operating theatres.

A Pearson r was used to determine relationships between sense of belonging, job satisfaction and satisfaction subscales. Significant correlation with sense of belonging existed with interaction opportunities ($p = .001$, $r = .33$), praise ($p = .000$, $r = .38$), control ($p = .001$, $r = .35$), co-workers ($p = .001$, $r = .33$), and schedule ($p = .006$, $r = .28$). The relationships between sense of belonging, extrinsic rewards ($r = .20$) and

professional opportunities (r = .21) were significant but the magnitude was very low. The relationship between balance (r = .06) and sense of belonging was not significant. The strongest relationship was between sense of belonging and new graduate total satisfaction (p = .000, r = .40). Winter-Collins and McDaniel (2000) concluded that a strong sense of belonging is associated with a graduate's satisfaction in his or her job, and further suggested that the quality of interactions with co-workers is pivotal to graduates' sense of belonging. The results of the study support the need for a nurturing environment for new graduate nurses.

The relationship between belongingness and job satisfaction seems quite convincing, although the low response rate weakens any statistical findings. In studies such as this, respondents may differ from non-respondents in character or attitudes. Those participants with strong views about their own experiences are more likely to respond, although the degree to which this occurred in this study and the variables involved cannot be ascertained. The instrument used to examine graduates' sense of belonging was a modification of the Hagerty-Patusky Sense of Belonging Instrument (SOBI) (1995). However, the manner in which the instrument was modified and the extent of the modification was not described in the study. This detracts from the study's strength. Additionally, apart from the variable of work satisfaction, the potential consequences of belonging or not belonging were not explored.

2.4.3 I don't belong

In an interpretive study undertaken by Nolan (1998), the theme *I don't belong* was described. This study sought to understand the clinical learning experiences of undergraduate nursing students by focusing on how students thought, acted and reflected on their clinical experiences. Convenience sampling was undertaken. Six second-year students were interviewed during their two-week medical-surgical placement in a private hospital. The researcher was their clinical supervisor. Data were collected in hourly post-clinical conferences in which students were asked to describe and interpret a moment of the day that stood out for them. Additional data were collected from informal discussions and observations of the students during the placement. The three emergent themes were: *I don't belong*; *doing and practising— progress at last*; and *transitions in thinking*.

In the theme *I don't belong* students described their need to fit in and be accepted by staff as a preface to their active participation and learning. The fear and anxiety associated with the new environment was seen to affect learning negatively. Nolan

contends that while students were familiarising themselves with the new settings, routines and staff, the need to fit in and be accepted dominated their thoughts. Until students felt accepted, learning could not proceed, as fitting-in took up most of their time and energy. Students began to feel more comfortable as time passed and once they knew the routine. Until that time, they felt that their contributions were not appreciated and that they were "in the way".

Feelings of inadequacy affected students' experiences, as did their relationships with registered staff. One student commented, "It's not the hospital or the patients; it's usually the staff that make your placement good or bad" (Nolan, 1998, p. 625). Conformity was seen to be a matter of survival. Students felt safe from criticism by doing it "the hospital way" and chose to keep quiet rather than challenge staff. Keeping a low profile and not asking too many questions were strategies used by students to fit in, two methods that also reduced their learning opportunities.

Nolan concluded that her study strengthens the argument for exposing students to fewer clinical venues and maximising the length of placements, suggesting that short placements and the unfamiliarity of new settings limit the students' feelings of inclusion in the nursing team and their capacity to engage in quality learning. Additionally, she contends that the fear and anxiety experienced during the socialisation process negatively affects student learning. These results should be considered carefully, as they raise important issues for the education of undergraduate nurses. However, this project was another small single-site study of a cohort of students located in North Queensland. In terms of transferability of findings, the study does not provide sufficient detail of the context to make it possible for the reader to determine whether the findings are relevant to other situations. Additionally, ethical concerns regarding the fiduciary relationship that existed between the research participants and their clinical supervisor/researcher, and the potential for violation of that relationship, were not addressed in the paper.

In a study of undergraduate nursing students conducted at another Australian university, Hart and Rotem (1994) reported on a research project designed to identify the attributes of clinical settings that support clinical learning. Thirty students were interviewed using a semi-structured format. The students were in their final semester of study. In 30-minute interviews students were asked to describe their best clinical learning experience and were then asked questions about that experience. Data were

organised under the headings of autonomy and recognition, job satisfaction, role clarity, opportunities for learning, quality of supervision and peer support.

The category of peer support elicited the most comments from students. In this category, issues of acceptance and belonging were recurring. One student commented, "If the staff accept you then you will feel comfortable about asking questions and if you can ask questions you won't make a mistake" (Hart & Rotem, 1994, p. 31). While some students in this study had been welcomed and afforded opportunities to engage with nursing staff in ways that promoted their sense of belonging, others felt that staff were often reluctant to work with them. One student stated, "I don't know why they don't want to help…as soon as they found out I was a student they couldn't be bothered with me" (Hart & Rotem, 1994, p. 31). For many students, their relationships with the nurses they worked with on the ward were more important in terms of learning and belonging than their relationship with their clinical supervisor/lecturer.

In order to be accepted into the clinical setting some students made a calculated decision to conform to the culture and practice of the ward setting, commenting that "you're accepted if you show a willingness to conform. I doubt you'd be accepted if you went in as a radical" (Hart & Rotem, 1994, p. 31). Other students felt that a questioning approach was not valued by nursing staff and learned to accept rather than challenge clinical practices.

Students specifically commented that the length of time spent on a ward influenced their sense of belonging, and frequently described their uncertainty when placed in clinical contexts for short periods of time. They suggested that it takes at least three weeks to feel comfortable. One student commented,

> By the third week you develop a sense of belonging; you feel like part of the team and understand staff nuances. Staff put more effort into you when they know you are going to stay for at least three weeks. (Hart & Rotem, 1994, p. 29)

Students also attributed feeling like one of the team to being busy, and feeling as if they had made a significant contribution.

Hart and Rotem concluded by emphasising that positive relationships with ward staff were pivotal to students' sense of belonging. However, similarly to Nolan's study, Hart and Rotem's findings are limited by the fact that the study was conducted in a single

site where clinical placements were undertaken only in small rural hospitals, and once again the context is not described in enough detail to allow for transferability to be determined. Nevertheless, the findings of both studies emphasise the crucial nature of belonging to students' placement experiences and raise important issues.

2.4.4 Feeling valued

In an extensive mixed methods study combining questionnaires, interviews and focus groups, Brodie et al. (2005) investigated the complex matrix of experiences and perceptions that influences a student's choice of employer, once qualified. The study was located in two universities in London. In the first phase of the study, first-, second- and third-year nursing students and recently qualified nurses who had graduated in the previous last 12 months, were invited to complete a 13-page questionnaire with closed and open questions. In total, 2845 questionnaires were posted to potential participants; 650 were returned giving a response rate of 22.8 per cent. The second phase of the study involved focus group discussions (n = 7) with pre-registration nursing students, and 15–20 minute semi-structured telephone interviews with recently qualified nurses (n = 30). Interviewees were randomly selected from university records. The quantitative data were entered into SPSS so that descriptive and inferential statistics could be generated and thus provide a contextual backdrop to the qualitative analysis. Interview transcripts were coded and analysed using NVivo. The analysis did not seek to compare across the two universities, as preliminary analysis highlighted few attitudinal differences between students of the different academic institutions.

The quantitative data from the study highlighted "feeling valued as a member of staff" to be the most important factor in employment decision-making. The qualitative analysis of focus group discussions and interviews reiterated the importance of this factor. Specifically, it was feeling valued, recognised and appreciated by members of the nursing team that underpinned students' career decisions. One student commented, "I would like a place where I am welcome, used and appreciated…having a feeling that I will be valued as a member of the staff…are important to me" (Brodie et al., 2005, p. 1873). Team cohesion and colleague support were identified as important components of feeling valued. Staff interactions and interpersonal relationships influenced the students' perceptions of the ward environment. Another student reflected,

> Looking back, placements where I was supported and felt like part of the team are where I would chose to work, certainly not areas where I went reluctantly each day and wards which physically reduced me to tears. (Brodie et al., 2005, p. 1873)

Second in importance to feeling valued was the quality of patient care as a determinant of participants' employment decisions. Brodie et al. (2005) assert that environments with perceived poor standards of care impact negatively on student's placement experiences and to their desire to be part of the team. Staff shortages were also seen as detrimental to quality patient care and to students' feelings of team cohesion, "I would not go back there for forty thousand pound a year…the ward is just so busy…I think it is dangerous for patients" (Brodie et al., 2005, p. 1874).

A number of other important factors related to recruitment were addressed in this study. Sequentially, feeling valued was followed by: quality of patient care, opportunities to gain clinical experience, team atmosphere, attitudes towards students, and educational opportunities. This review has focused on those factors that relate only to students being valued, included and welcomed as a part of the nursing team. Brodie et al. (2005) caution that students' perceptions of hospitals are often formed through their first-hand experiences of clinical placements. They add that healthcare institutions need to take a longer and more strategic perspective and recognise that the attitudes of current students may shape the future viability of their institutions.

While this study is informative in many respects, it is noteworthy that the response rate of 22.8 per cent and the failure to provide evidence of the sample's representativeness weaken the statistical findings and limit generalisation. Additionally, the development of the quantitative data collective instrument used by Brodie et al. (2005) was not described, neither were the psychometric integrity of the instrument or tests of validity or reliability included. These omissions detract from the strength of the findings.

2.4.5 Outsider/insider

In a doctoral thesis (Kiger, 1992) and later in a related paper (Kiger, 1993), Kiger describes the findings from a qualitative study of 24 Scottish nursing students that sought to explore nursing students' changing images of nursing from the commencement of their training to its completion. In this study, three rounds of interviews were conducted with each student during their three-year training. Analysis revealed five major themes in students' initial images: pictures of nursing, the good nurse, what nursing entails, occupational labels for nursing, and being a student/becoming a nurse.

The need to feel accepted as part of the team was equated with the desire for belonging, and this was identified by Kiger (1993) as a constant theme in the interview data. Students often rejected the idea of working in particular clinical contexts when they finished their training because of the way that staff attitudes or behaviours impacted upon their sense of belonging. This related to the treatment of both the patients and students. These were environments in which students reported feeling disillusioned and distressed. Some students engaged in extenuation, and rationalised or excused the behaviours of the nursing staff rather than challenging it. To challenge was seen as upsetting the status quo and likely to undermine any chance of acceptance by staff.

Throughout the interviews, staff attitudes figured prominently in determining the quality of the students' clinical experience. A feature that underlay many of the students' accounts was the notion of insider/outsider status. They stated or implied that they "became a nurse" as they moved from being an outsider to an insider. However, students felt that for much of the time they were straddling the border between being an insider and an outsider as they struggled with the sense of strangeness and fear of the unknown. To a large extent students' ability to cross the border between insider and outsider was determined by the nurses they worked with, termed "good staff" and "bad staff" by Kiger. Good staff were identified as friendly, welcoming, supportive of students and providers of quality patient care. They acknowledged students, oriented them, introduced them to other staff members, learned and used their names and included them in the ward activities. Bad staff treated students impersonally, were unwelcoming and unfriendly, excluded students, gave negative feedback and no praise, and did not acknowledge students' learning needs. From the students' perspective it was the bad staff that constituted the most difficult aspect of clinical nursing. Additionally, extended clinical experience in one clinical setting with good staff support, regardless of the type of clinical nursing, was preferred by students to several shorter clinical placements. It was identified that the interpersonal relationships formed in extended placements were crucial to students' experience of belonging.

Kiger notes a number of limitations to her study. She acknowledges that the sample may have been slightly skewed in that the majority of the participants were enrolled in the mental handicap branch of the diploma. Additionally, all but one of the students were Scottish, representing a relatively monocultural group. Nevertheless, as this was a qualitative study, the aim was not to provide grounds for generalisation, but to

present ways of understanding student nurses' images of nursing. In this respect the study was illuminative.

2.4.6 Staff–student relationships

A study using mixed methods was undertaken by Dunn and Hansford (1997) to identify factors that characterise students' perceptions of the clinical learning environment. The convenience sample consisted of 229 second- and third-year undergraduate nursing students enrolled in a Queensland university. Quantitative and qualitative methods were used for the purposes of triangulation and complementarity. The study used the Clinical Learning Environment Scale (CLES) (Dunn & Burnett, 1995), a 23-item instrument with the subscales of staff–students relationships, nurse manager commitment, patient relationships, interpersonal relationships and student satisfaction. The instrument had been previously tested and was shown to have face validity and construct validity. Reliability coefficients for the subscales ranged from high ($r = .85$) to marginal ($r = .70$). Quantitative data were analysed using SPSS.

Qualitative data were collected through focus group interviews. Theoretical sampling was undertaken to include students from units that had previously been shown to have extremely good or extremely poor clinical learning environments. Participants were from public and private hospitals and a variety of patient care specialties. During the focus groups, students were asked to describe their impressions of their unit as a clinical learning environment. Qualitative data were analysed thematically.

In this review, it is the category of staff–student relationships that will be discussed. It was suggested that interpersonal relationships in the clinical setting played a significant role in students' perceptions of the clinical learning environment. Registered nurses were seen as the gatekeepers and guides to students' learning and the students' most important form of support (Dunn & Hansford, 1997). Quantitative data analysis highlighted the importance of the willingness of registered nurses to engage in a teaching relationship and to accept the student as a learner with a legitimate role on the team. Qualitative data showed that the attitudes and behaviours of nursing staff were pivotal to students' learning experiences. These included the warmth and rapport demonstrated by nurses, and their willingness to engage in teaching. While the quantitative data indicated that students' satisfaction with their learning environment is an outcome of the positive learning environment, the qualitative data demonstrated a more proactive perspective, indicating that students were, to some extent, also responsible for their own learning experiences.

This was an extensive study, the results of which have been only briefly outlined here. The mixed methods approach elicited a range of perspectives and provided a compelling view of the clinical learning environment from the perspectives of students. The CLES (Dunn & Burnett, 1995) was still a relatively new construct at the time and requires further testing to determine its validity and reliability with other populations. The representativeness of the study sample could not be adequately assessed, as the size and demographic characteristics of the population were not provided in the paper. Additionally, the response rate was not specified. These factors to some extent limit the conclusions that can be drawn from the study.

2.4.7 Summary of the nursing literature

The domain of staff-students relationships, as part of fitting in, has been researched for a number of decades, yet problems continue to be encountered. Likewise, discussions related to the importance of creating nurturing, supportive and welcoming clinical environments are neither new nor surprising. The specific ways in which clinical environments engender and enhance belongingness are less clear, as are the short- and long-term consequences of this phenomenon, both for the individual and for the nursing profession. While there is a paucity of studies in the literature about the salient issue of belongingness and nursing students, a number of pertinent issues have been identified, albeit with little empirical evidence to support the discussion. In addition to those factors previously identified in the review of the psychosocial and social science literature, the nursing literature suggests that there may be a relationship between students' experience of belongingness and: (a) the length of clinical placements, (b) conformity to and unquestioning acceptance of clinical practices, and (c) learning on clinical placements. These issues are briefly summarised at this point.

The debates about how the duration of clinical placements impacts on students' experiences are ongoing, but inconclusive. Two recently published papers describing innovative nursing curricula and clinical placement models (Turner, Davies, Beattie, Vickerstaff & Wilkinson, 2006; Walker, 2005) refer to the length of clinical placements as a key element in developing a sense of belonging. Yet in these papers, as in most of the nursing literature reviewed, the authors did not define or describe what they meant by belonging, and the processes by which the length of placements enhances belonging were not explored. While there appears to be an implicit assumption that there is a direct relationship between length of clinical placements and belongingness, at this stage this is speculative and warrants further investigation (Levett-Jones,

Lathlean, Maguire & McMillan, 2007). In both Australia and the UK the duration of clinical placements is an oft-debated issue (Clare et al., 2003; Mallaber & Turner, 2006). These arguments should be informed by sound research rather than somewhat spurious arguments. To date, research that would adequately inform this debate has not been undertaken (Clare et al., 2002).

There are assertions in the nursing literature that some students conform to clinical practices, irrespective of whether they are best-practice, so as to be accepted into the nursing team (Bradby, 1990; Goh & Watt, 2003; Hart & Rotem, 1994; Hemmings, 1993; Tradewell, 1996). Rather than conformity, subservience, uniformity and compliance, the focus of nursing education has shifted, and fostering individuality and originality of thought, while maintaining a commitment to teamwork, is paramount. Questioning, assertive practitioners are an asset to a profession that seeks to be innovative and forward-thinking. Thus, it is imperative that there is better understanding of the strategy of unquestioning compliance by students as a means of enhancing their acceptance and inclusion by the nursing team. Furthermore, in an era when quality care is paramount, and competency (or fitness for practice) is an ongoing area of debate, the inference that for many students the need to fit in (by not challenging or questioning) takes precedence over the quality of care they provide and the level of competency they achieve (Bradby, 1990; Levett-Jones & Bourgeois, 2007) merits investigation. Further empirical research is required to examine the subtle interplay of factors that influence nursing students' attitudes and behaviours in relation to their need to belong and how this is enacted in practice.

It is important to consider the relationship between belongingness and student learning, although admittedly this is an aspect that is infrequently discussed in the nursing literature. Stress, anxiety, depression and reduced self-esteem—consequences said to derive from, among other factors, a diminished sense of belonging—are reported by some authors to impede learning (Begley & White, 2003; Crawford & Kiger, 1998; Kleehammer, Hart & Fogel Keck, 1990; Lindop, 1999; Lo, 2002; Meisenhelder, 1987; Nolan, 1998; Timmins & Kaliszer, 2002). This, coupled with the suggestion that social exclusion impedes cognition (Baumeister et al., 2002), has significant implications for nursing students and their clinical practice, and for the profession as a whole. Given that the clinical learning environment is where students are expected to develop clinical and professional competency by *learning* to nurse, there needs to be a greater understanding of the impact of diminished belongingness on students' clinical learning (Levett-Jones et al., 2007). Furthermore, research of

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students' capacity and motivation for learning in clinical environments should consider factors that constrain and facilitate self-directed as opposed to passive learning.

2.5 Conclusion

This review has established the importance of belongingness as a dimension of human relatedness and demonstrated that it is an issue worthy of further investigation. While the concept of belongingness has intuitive appeal, the empirical literature from the disciplines of social science and psychology has confirmed that the need to belong has deep roots in evolutionary history and exerts a powerful impact on contemporary human psychological processes (Baumeister & Leary, 1995; Baumeister et al., 2002). Failure to satisfy this need can have devastating consequences for psychological wellbeing (Twenge et al., 2001), and ostracism, rejection, and other forms of social exclusion can be highly aversive (Baumeister & Tice, 1990).

The nursing literature reviewed in this chapter sheds some light on nursing students' experience of belongingness when on clinical placements, although there is a paucity of research about this salient issue. It seems reasonable to assume that belongingness is crucial to a positive clinical placement experience. However there is little understanding of the demographic, organisational, contextual, interpersonal or individual factors that impact on students' experience of belongingness, and even less understanding of the consequences of belongingness. Furthermore, the methodologies employed by researchers to date have often imposed restrictions on the amount and type of data collected, resulting in a fragmented and somewhat sketchy picture of students' experiences. There has been a failure by researchers to tap the complexities of the everyday experiences of students in a way that brings understanding and clarity to the multiple dimensions of belongingness.

In order to more fully understand the relationship between students' experience of belongingness and clinical placements, and how that experience affects the individual as well as the profession, at micro and macro levels, further research is required. Moreover, the means to enhance students' sense of belonging should become the focus of research that is persuasive, because the evidence is grounded in practice exemplars. Research that explores the impact of clinical placements on student's belongingness experience would be illuminative and go some way towards filling the gap that exists in the literature. Thus, this study sets out to address some of the knowledge deficits by examining the extent to which nursing students experience

belongingness, and the factors that impact on and are consequences of belongingness.

The following chapter discusses the research design that frames the study. It presents the theoretical perspective and methods employed to address the research questions and the rationale for each methodological decision.

Chapter 3

Research Design

3.1 Introduction

This chapter gives an account of the research design and methods used to measure and explore nursing students' experience of belongingness. The chapter is divided into three main sections. First, pragmatism as a theoretical perspective, case study as a research framework, and the mixed-method design are explained and justified. This is followed by an outline of the quantitative and qualitative data collection approaches, along with rationales for each methodological decision.

3.2 Theoretical perspective

Paradigms are patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes though which investigation is accomplished (Weaver & Olson, 2006). Paradigms are established by communities of scholars with shared beliefs about the nature of reality and knowledge construction. As human constructions, they are historically and culturally embedded discourse practices but are neither immutable nor inviolate (Greene & Caracelli, 2003). The choice of research paradigms and methods is driven by (a) the current state of knowledge about a particular phenomenon, (b) the purpose of the research and (c) the related research question/s (Creswell, 2003). In the present study, an examination of a wide body of existing literature from the disciplines of social science and psychology revealed that belongingness is a pervasive and fundamental human motivation. However, the concept of belongingness has been inadequately explored in the nursing literature. With respect to the clinical placement experience in particular, it was apparent that a number of issues had not been addressed. This study therefore sought to explore:

- the extent to which third-year nursing students experience belongingness
- the demographic variables that impact upon belongingness

- the factors that impact upon nursing students' experience of belongingness
- the consequences of nursing students' experience of belongingness.

It was these issues that provided the guiding parameters from which paradigmatic and methodological decisions were made. Belongingness is a complex human phenomenon. Understanding the dimensions of belongingness in relation to nursing students was challenging. The aim of the study was to develop meaningful stories and to find discernible patterns of regularity amid the variety, contextuality and contingency of nursing students' clinical placement experiences. To respond to the inherent challenges, it was necessary to engage with multiple perspectives, ways of knowing and understanding, and varied ways of studying and representing the phenomenon of belongingness.

As I have many years of clinical experience as a nurse, it did not seem incongruent to combine different perspectives and approaches in a single study. After all, clinicians simultaneously utilise multiple forms of data to better understand their patients. Similarly, Rolfe (1998) provides the example of a nurse who found scientific knowledge useful to assess a patient's clinical status but relied on a different form of knowledge to better understand the patient's lived experience of illness. Meleis also suggests that "In a discipline that deals with human beings, it is perhaps not feasible that only one theory should explain, describe, predict and change all the disciplines' phenomena" (1997, p. 77). I therefore reject the assumption that one paradigmatic approach is superior to another and the assumed incommensurability of different paradigms. I am committed to the acceptance of difference and the importance of multiple and diverse perspectives. The complexity and pluralism of the contemporary world demands such a commitment. However, I acknowledge that researchers approach their work with a set of assumptions about the social world, the value of knowledge and the purpose of research. Whether these assumptions form a formal philosophical paradigm or more of a "crude mental model" (Philips, 1996), the activity of social inquiry requires an underlying conceptualisation of the situation. Greene & Caracelli (2003) argue that research rests on the researcher's mental picture of what the world is like, what counts as knowledge, what ought to be studied and how. Likewise, the question of values cannot be avoided, because value presuppositions influence the language that researchers and others use to describe reality. Because of my own philosophical assumptions and values, and the nature of the research project, pragmatism was selected as the most appropriate theoretical

perspective. Pragmatism and the knowledge claims that underpin this paradigm will now be discussed.

3.3 Pragmatism

Pragmatism, originally an American philosophical movement founded by Peirce (Houser, 2005) and James (1998), is a theoretical perspective that has become more prevalent in the literature of the last two decades (Lincoln & Guba, 2000; Tashakkori & Teddlie, 1998). The term *pragmatism* is derived from the Greek word for action, from which the words 'practice', 'practical' and 'praxis' originate (Barnhart, 1995). A pragmatic approach stresses critical analysis of facts, practical applications, the use of pluralistic approaches to derive knowledge about the problem, and integration of findings (Creswell, 2003). Doane (2003) claims that this approach can move research beyond the boundaries and restrictions of a single paradigm towards theory construction tailored to fit particular practical situations. The tenets of pragmatism—that is, commitment to what works in practice, appreciation of plurality, and desire for integrated results—are appropriate for this mixed-method study of belongingness.

3.3.1 Pragmatic knowledge claims

Cresswell (2003) suggests that the knowledge claims underpinning a philosophical approach must be made explicit early in the research process, as other methodological decisions flow on from and in fact inform the design. Stating a knowledge claim means that researchers begin a project with certain assumptions about how they will learn and what they will learn during their inquiry. Philosophically, researchers make claims about the nature of reality (ontology), what constitutes knowledge (epistemology), what values underpin the study (axiology), the language of the study (rhetoric) and the research process (methodology). Pragmatism provides a basis for the following knowledge claims and related methodological assumptions:

- Pragmatism is not committed to any one system of philosophy or reality. Thus, the pragmatist is theoretically unencumbered by an allegiance to any one specified framework and eschews the restrictions imposed by strict adherence to one epistemology (Greene & Caracelli, 2003).

- Pragmatists convey the importance of focusing on the research question/s and using pluralistic approaches to derive knowledge to best address the question/s (Tashakkori & Teddlie, 1998).

- In pragmatism there is a concern with applications—that is, 'what works' and solutions to problems. Methods are not of primary importance; the problem is dominant and researchers use all approaches to understand the problem (Patton, 1990).

- Researchers operating from this paradigm are at liberty to choose the methods, techniques, and procedures of research that best address their research question (Creswell, 2003).

- Truth is relative and what works at the time. Investigators often use both quantitative and qualitative data because they work to provide the best understanding of the research problem at that time (Creswell, 2003).

- Pragmatists base their knowledge claims on criteria such as accuracy, scope, simplicity, consistency and comprehensiveness (Howe, 1998).

- Pragmatists consider that single methods focus on a limited view of reality. The use of multiple methods provides a more comprehensive view by focusing on different slices of reality. Thus, pragmatist researchers are encouraged to draw liberally from both quantitative and qualitative assumptions when they engage in their research (Cherryholmes, 1992).

- There is a concerted and thoughtful emphasis on consequences as the defining characteristic of the pragmatic stance (Greene & Caracelli, 2003).

- In pragmatism the essential criteria for making design decisions are practical, contextually responsive and consequential. *Practical* implies a basis in one's experience of what will and what will not work. *Contextually responsive* involves understanding the demands, opportunities and constraints of the situation in which the inquiry will take place. *Consequential* means that the truth of a statement consists of its practical consequences, particularly the statement's agreement with subsequent experience (Greene & Caracelli, 2003).

Thus, pragmatism spans the divide between different world views, different assumptions and diverse methods, as well opening the door to combining different forms of data collection and analysis appropriate to a case study approach (Creswell, 2003). However, as Miles and Huberman (1994) suggest, to the practical pragmatist all of this philosophical

"mumbo-jumbo" does not get the job done…thus the chapter now turns to a more concrete discussion of the case study framework and the research methods that underpin the study.

3.4 Case study

Case study research is a frequently used approach in both social science and healthcare disciplines because it allows researchers to generate holistic and meaningful interpretations of complex social phenomena (Yin, 2003). However, the use of case study has not evolved in a clear and fixed way, in part because the term *case study* has not been used in a standardised way across and even within disciplines. Concerns surrounding a case study approach are often attributed to a lack of a clear definition and operational terms (Gomm, Hammersley & Foster, 2000). Although case study is a frequently used research design, defining the parameters of case study is challenging, as it is a flexible and adaptable design that fits into a set of principles rather than prescriptive constraints. For the purpose of this research project, *case study* is defined as a detailed study of a particular contextual phenomenon within a temporal and geographically defined or bounded system (Luck, Jackson & Usher, 2006). According to Yin (2003) a case study approach is appropriate when researching contemporary, real-life situations where the phenomenon of interest is enmeshed within the context of the study. Case studies have the capacity to provide purposive, situational, interrelated descriptions of phenomena, connecting practical and complex issues to theoretical abstractions (Stake, 2000). Case studies commonly explore, describe and/or explain the case or phenomenon of interest and generate context-constituted knowledge about real-life events (Yin, 2003). A case study is usually organised around a small number of research questions. The issues explored are complex, situated, problematic relationships. They draw attention to ordinary experience, but also to the language and understandings of disciplinary knowledge (Stake, 2000). A case study pays attention to and respects the individuality and unique nature of participants and their social world (Clarke & Reed, 2006). Thus, a case study provides an appropriate framework to explore and explain the concept of belongingness as experienced by third-year nursing students from three distinct contexts.

3.4.1 Case study typology

Stake (2000, pp. 437–438) identifies three types of case studies: intrinsic, instrumental and collective. When the researcher is interested in understanding a particular case, not because it is representative of other cases or for theoretical generalisability, it is classified

as an intrinsic case study. Using this approach the researcher aims neither to understand some abstract concept or phenomenon, nor to build theory, but because the researcher has a specific interest in the case to understand it in all its particularity and ordinariness.

Instrumental case studies are undertaken to provide insight into a phenomenon or issue. The specific case is of secondary importance, playing only a supportive role that facilitates an understanding of the phenomenon of interest. Stake (2000) suggests that in an instrumental case study it is the phenomenon or issue that drives the study rather than the case itself. The ability to make inferences beyond the single case is therefore important. Thus, the difference between the intrinsic case study and the instrumental case study is not the case, but the purpose of the study of the case (Stake, 2000).

A researcher may jointly study a number of cases in order to investigate a phenomenon, population or general condition. This is called a collective case study (Stake, 2000). It is an instrumental case study extended to several cases. The individual cases may be similar or dissimilar, redundancy and variation each being important. They are chosen because it is believed that understanding them will enhance the degree of generalisation possible and lead to better understanding of, and perhaps better theorising about, a still larger collection of cases (Stake, 2000).

For the present study, my interests lay not only in nursing students' experiences per se but also in what a study of their experiences might reveal about the phenomenon of belongingness as it relates to students' clinical placement experiences. This clearly suggested the use of a multi-site instrumental case study. The temporal and geographically defined single unit of analysis was current third-year nursing students from three university sites. The phenomenon or "case" of interest was their experience of belongingness.

3.4.2 Case study as a research framework

As a research framework, case study is defined by an interest in the case or phenomenon, not by the method of enquiry used. Stake (2000, p. 438) suggests that case study is not so much a methodological choice as a choice of what is to be studied. A case study approach is neither intrinsically qualitative nor quantitative and may span both spectrums. Therefore,

the researcher using case study is compelled to clarify and explain the methods to be used. With this in mind the mixed-method design of the study will be discussed next.

3.5 Mixed-method design

This section describes the mixed-method design that aligns with both the case study approach and the theoretical perspective of pragmatism. Mixed-method research often involves collecting and analysing both quantitative and qualitative data in a single study. This approach has attracted increasing attention and popularity in recent years (Howe, 2004; Johnson, 2004), although, citing the work of Campbell and Stanley (1963) and Glaser and Strauss (1968), Cresswell (2003) notes that mixed methods have been in use since the early 1960s. In disciplines such as nursing, the phenomena studied are often complex and mixed-method approaches can expand the impact and enhance the flexibility of research designs (Sandelowski, 2000). Recognising that all methods have limitations, many researchers (Cherryholmes, 1992; Creswell, 2003) believe that biases inherent in any single method can neutralise or cancel out the biases of other methods. I do not support this notion unequivocally, but I do contend that using mixed methods as I have in the present study presents different slices of reality and thus allowed a more holistic understanding of the phenomenon of belongingness to emerge.

In the disciplines of psychology and social science, belongingness has been researched primarily using quantitative designs. In this study, however, qualitative data were seen as an essential complement to quantitative data, because the factors that underpin belongingness are far from definitive and these factors may be hidden or distorted by the use of only a quantitative approach. Additionally, a mixed-method design incorporating quantitative and qualitative approaches allowed for the results to be generalised to a population, while also developing a detailed view of the phenomenon. In this study, I chose to survey a large number of participants and then followed up with interviews of a much smaller number to obtain their specific language and voices about the topic. Collecting both closed-ended quantitative data and open-ended qualitative data in this way proved advantageous in understanding the research problem. Numerical data allowed for cross-case comparison and the testing of relationships between variables, while the qualitative data elicited rich stories that were testament to the context in which belongingness was experienced by third-year nursing students.

One of the arguments against the use of mixed methods is the apparent divide between deduction and induction as modes of analysis. Gilbert (2006) suggests that this perspective may well be an oversimplification that ignores the thought processes involved in sustained enquiry, where deduction and induction advance in an iterative process. Because of my years of experience in nursing education, both in clinical contexts and in universities, I inevitably approached the study with a set of preconceptions. That, along with the literature on belongingness and clinical placements, allowed me to develop a set of tentative hypotheses for testing in the quantitative phase of the study, as part of a deductive process. However, the purpose of the study was also to explore, via inductive means, new and emergent ideas and concepts throughout both the quantitative and qualitative data analysis phases. Furthermore, although the process of analysis described in this thesis may seem linear, in reality it was spiral in shape: I repeatedly immersed myself in the data, formulated tentative conclusions, and then stepped back at various points in the research process to review, reflect on and reconsider those conclusions. In this way theorising about emergent themes and ideas was a process whereby deduction and induction advanced in an iterative process (Gilbert, 2006).

3.5.1 Priority of method

The mixed-method design was undertaken not only for purposes of methodological triangulation, but also to produce complementary data. The large quantitative study sample allowed belongingness to be measured and compared across sites. However, the experience of belongingness is idiosyncratic, complex and personal. Hence the qualitative data demonstrate the complex integration of factors important in understanding students' individual perspectives and experiences.

Both the quantitative and qualitative data were of immense value to the study and neither were assigned a greater priority. Although Morse, Wolfe and Niehaus (2005) refer to the components of a mixed-method study as either core or supplementary, and assert that the supplementary component cannot stand alone, is not scientifically rigorous and is of use only to the extent that it adds to the understandings generated by the core method, Creswell (2003) draws no such distinction. In this study, both the quantitative and the qualitative components are scientifically rigorous, complete and capable of offering valid and complementary understandings of the research problem. Thus, I assign no greater

priority to either method and contend that each contributes meaningfully to the understanding of students' experience of belongingness.

3.5.2 Concurrent data collection strategy

A mixed-method study employs strategies of inquiry that involve collecting data either concurrently or sequentially in order to best understand research problems (Creswell, 2003). For the purpose of this study, a concurrent data collection approach was selected. This means that the quantitative and qualitative data were collected and analysed simultaneously. The final results were integrated during the interpretation phase, allowing for a comprehensive understanding of belongingness to be generated (see Figure 3.1 for a diagrammatic representation of this concurrent data collection study).

QUAN	**+**	QUAL

| **QUAN data collection** | | **QUAL data collection** |

| Site 1 (Pilot study) 41 questionnaires | | Site 1 (Pilot study) 4 interviews |

| Site 2 61 questionnaires | | Site 2 4 interviews |

| Site 1 119 questionnaires | | Site 1 5 interviews |

| Site 3 141 questionnaires | | Site 3 5 interviews |

| **QUAN data analysis** | ⟷ | **QUAL data analysis** |

Key

+ indicates a concurrent form of data collection.

QUAN and **QUAL** stand for quantitative and qualitative, respectively (the same number of uppercase letters is used for each to indicate the importance of both forms of data).

⟷ Indicates a simultaneous but separate data analysis phase, followed by interpretation and integration of the results.

Figure 3.1 Concurrent data collection strategy (Adapted from Creswell, 2003)

3.6 Data collection

The chapter now divides into three sections. The first outlines the pilot study, the second focuses on the quantitative data collection phase of the study and the third reviews the qualitative data collection phase. Each section provides explanations for the decisions surrounding:

- research participants
- research instruments
- research protocols and procedures
- data collection methods.

3.7 Pilot study

The first stage of the data collection process was a pilot study. It was conducted by sampling one data set (n^1 = 60) from site 1, campus 2. Forty-one students completed the survey and four volunteered to be interviewed. The study was carried out in the same manner as the main study. The purpose of the pilot study was to:

- validate the choice of data collection methods in relation to the purpose of the study
- ensure the reliability of the Belongingness Scale–Clinical Placement Experience (BES–CPE)[2]
- predict the usefulness of the data generated from techniques chosen
- undertake preliminary analysis of data
- develop the preliminary SPSS command syntax file[3] for quantitative data analysis
- determine the best approach to presentation of data from the main study
- carry out an interviewer self-assessment using an amended version of Cannell, Lawson and Hausser's 'Interview Behaviour Code' (1975), provided as Appendix 3.

The report of the quantitative findings from the pilot study is included as Appendix 4; however, separate reporting of the qualitative findings from the pilot study data was not undertaken. Preliminary analysis highlighted no significant differences between the pilot study data and that collected a short time later from site 1 for the main study. Thus, the

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[1] A glossary of the statistical symbols and terms used in this thesis is provided on page xx.
[2] The BES–CPE instrument is described in Section 3.8.3 and a copy is provided in Appendix 1.
[3] A copy of the command syntax file containing data analysis and manipulation is included as Appendix 2.

data from the pilot study and the main study were amalgamated. According to Dempsey and Dempsey (1992) this is an appropriate research strategy.

During the pilot study interviews, the influence of (a) family members with nursing experience and (b) students' previous or concurrent nursing experience emerged as factors that may potentially impact students' experience of belongingness. To capture this information in the main study, two questions were added to the demographic section of the online survey:

- Have you any nursing experience apart from that included as part of your current academic program?
- Are any of the members of your immediate family nurses?

These questions were the only additions or revisions required. Had significant revision of the study procedures, including data collection methods or instruments, been required following the pilot study, formal approval for amendment would have been sought from each of the ethics committees before proceeding with the study.

3.8 Quantitative data collection phase of the study

This phase of the study sought to address the first two research questions and the related hypotheses.

Research question 1

With respect to the clinical placement experience, to what extent do third-year nursing students from three different universities experience belongingness?

Research question 2

With respect to the clinical placement experience, which of the following demographic variables influence nursing students' experience of belongingness?

- *Nursing experience apart from that included in students' current nursing program*
- *Family members with nursing experience*
- *Gender*
- *Age*
- *Country of birth*
- *English as a first language*

Hypotheses

1. There is a positive relationship between belongingness and nursing experience apart from that included in students' current nursing program.
2. There is a positive relationship between belongingness and immediate family members with nursing experience.
3. There is no relationship between belongingness and gender.
4. There is no relationship between belongingness and age.
5. There is no relationship between belongingness and country of birth.
6. There is no relationship between belongingness and English as a first language.

In order to address the research questions, explore demographic variables and provide a basis for comparison between sites, the study aimed to measure the extent to which nursing students experience belongingness while on clinical placements. Thus, quantitative data, derived from surveying a large number of participants using a modified measurement scale, allowed for belongingness to be measured and compared across different cultures and systems.

3.8.1 Study sites and participants

The study was located in schools of nursing in two Australian universities and one in the United Kingdom (UK). Site 1 refers to a university in New South Wales, site 2 a university in Queensland, and site 3 a university in the south of England. These universities were selected because, while all provide a three-year tertiary program as the requisite preparation for registration as a nurse, they differ in the duration and structure of the clinical placements, the clinical supervision model and the variables of environment, curriculum, cohort size and student demographics. The UK site was of particular interest because it offered an opportunity to explore the influence of a mentorship model of clinical supervision and extended clinical placements on belongingness. The contextual features of each site are discussed in Chapter 4.

All third-year Bachelor of Nursing students from site 1 ($n = 265$) and site 2 ($n = 75$), and all third-year Bachelor of Nursing, Diploma in Nursing and Advanced Diploma in Nursing students from site 3 ($n = 504$) were invited to complete an online survey using a specially

modified instrument referred to as the Belongingness Scale–Clinical Placement Experience (BES–CPE) (see Section 3.8.3 for a description of this instrument). Third-year students were seen as the best source for obtaining information about belongingness and clinical placements, as they had undertaken a range of clinical placements and it was reasonable to expect them to have at least some experience of belongingness. Additionally, the sample was selected to obtain data representative of students from a wide range of settings: three campuses at site 1, two clinical partner hospitals at site 2 and five localities at site 3. Table 3.1 provides a summary of the sample and sub-samples.

Table 3.1 BES–CPE survey participants

Sample composition (*n* = 362)	*n*	Per cent
Site 1	160	44.2
Site 2	61	16.9
Site 3	141	39.0
Total	362	

The participants' ages ranged from 20 to 60 years. School leavers, or participants in the 19–22-year-old age group comprised 41.5 per cent of participants (*n* = 144) and mature age students 58.5 per cent (*n* = 203). Most of the participants (90.4 per cent, *n* = 322) were women. The majority of the participants identified Australia (47.1 per cent, *n* =162) or the UK as their country of birth (41 per cent, *n* = 141). The remainder of the participants were from a wide range of other countries. For 8.14 per cent of the participants, English was not their first language (*n* = 29).

3.8.2 Participant recruitment

Third-year nursing students were informed about the proposed study by advertisements placed on *Blackboard,* a web-based platform at each of the three university sites. A copy of the advertising flyer is provided as Appendix 5. Interested potential participants were invited to access and download the survey information statement by selecting the *Download Survey Information* button on the website. A copy of the survey information statement is available as Appendix 6. After viewing the survey information statement, potential participants were given the option of either exiting the system by selecting the *Exit* button or proceeding to the survey by selecting the *Go to Survey* button, which made

the online survey available in the form of a self-report questionnaire. A copy of the BES–CPE survey is provided as Appendix 1. The questionnaire required approximately 10 minutes to complete. Participants were able to discontinue their participation part way through the questionnaire if they so desired by selecting the *Exit Survey* button. When they had completed the questionnaire, participants selected the *Submit Form* button to send it anonymously to a secure site. Submission of the online questionnaire was taken to imply consent. Each questionnaire was numerically coded for data entry purposes. No identifying personal information was recorded on the questionnaires. The IP addresses were removed from the surveys by appropriate software before the survey results were accessed by the researcher. A summary of the data collection process flow chart is provided as Appendix 10.

3.8.3 Data collection instrument

Nursing students' perceived sense of belongingness was measured by the online BES–CPE survey. The BES–CPE is a 34-item self-report instrument designed to measure belongingness specific to the clinical placement environment. I modified the BES–CPE from Somers' Belongingness Scale (BES) (Somers, 1999) with the permission of the author. Validity and reliability of the BES Scale has been cited (Somers, 1999) and is discussed in Section 3.8.4. Somers' BES was grounded in the theoretical framework of Baumeister and Leary (1995) who postulated that belongingness functions across a wide variety of situations and environments. Thus, the BES was designed to assess belongingness in four interpersonal environments: (a) family, (b) friends, (c) work or school, and (d) neighbourhood/community. As the present study focused specifically on the clinical placement environment, I developed a modified version of the BES. Modifications to the instrument were minimal. From the BES I selected only those items related to work or school, and the words "clinical placement" were substituted for "work/school", and "colleagues" for "co-workers/classmates". I have called the modified instrument the Belongingness Scale–Clinical Placement Experience (BES–CPE). Piloting of the BES–CPE was discussed in Section 3.7 and the report of the pilot study is included as Appendix 4.

The BES–CPE, like the original BES, assesses feelings, cognitions and behaviours. The items reflect the two components indicated in Somers' definition of belongingness, connectedness (being part of, feeling accepted, and fitting in), and esteem (being cared

about, valued and respected by others). Items also reflect active and passive interactions, that is, what the individual receives or perceives that they receive from others, as well as the actions they take to either enhance belongingness or in response to belongingness.

Answer choices were based on frequency responses on a five-point Likert scale, with 1 = never true, 2 = rarely true, 3 = sometimes true, 4 = often true and 5 = always true. Items were written in both positive and negative terms, so as to reduce response bias. Negatively worded items (10, 14, 22, 26) were reverse-scored so that higher-scale scores would reflect higher levels of belongingness. Demographic questions were included as the first section of the BES–CPE online survey and covered university, academic program, age, gender, native language, country of origin, previous nursing experience and family members with nursing experience.

3.8.4 Validity and reliability of Somers' Belongingness Scale

As the BES–CPE was based upon Somers' BES a discussion of the validity and reliability of Somers' instrument is essential. The development and preliminary psychometric analysis of the original BES was undertaken by Somers (1999) as part of her doctoral studies. Phases 1–3 of her study focused on the conceptualisation and development of the BES and Phase 4 focused on the psychometric evaluation of the scale to obtain preliminary validation evidence. Each of these phases will now be discussed.

Phase 1—item development and analysis

The BES was developed using standard protocols for instrument development (Clark & Watson, 1995) and was framed in consideration of the review of social support, adult attachment and related self-esteem literature. Content representiveness was achieved by clearly defining the construct of belongingness and by preparing a table of specifications from which items were generated. As the premise of Somers' study was that the construct of belongingness operates across four major environments—(a) family, (b) friends, (c) work/school, and (d) community, items representing each of these environments were included in the BES. Items were also written to indicate that belongingness relates to and influences affective consequences, cognitive processing, goal-orientated behaviour, connectedness, esteem, and a passive or active state. The items were subsequently reviewed by a psychometrician and some of the redundant items deleted.

Phase 2—review by a panel of judges

An examination of content relevance and representativeness of the belongingness construct was undertaken by independent raters, a method suggested by DeVellis (1991). The items were distributed to a panel of five judges consisting of two psychologists and three doctoral candidates in psychology. Diversity in terms of age, ethnicity, and gender was considered—ages ranged from 28 to 53 years; there were two men and three women; three were Caucasian and two were African-Americans.

Raters were asked to determine: (a) which part of the construct the item represented (connectedness, esteem or both); (b) whether the item reflected a passive/receiving state, an active/giving state or a neutral state; and (c) how important the item was in measuring belongingness on a scale of 1–3, with 1 = very important, 2 = moderately important, and 3 = not that important. Raters were also asked to evaluate the items for clarity and conciseness.

All five judges considered 87 per cent of the items to be "very important" or "moderately important" by. In classifying the items as connectedness or esteem, the judges were in agreement on the majority of items. In the items specified as representing connectedness, 70 per cent were correctly classified by all five judges, 19 per cent by four out of five judges, and 5 per cent by three out five judges. This gave a total of 94 per cent of connectedness items being correctly classified by the majority of judges. In the items representing esteem, 45 per cent of items were correctly classified by all five judges, an additional 28 per cent by four out of five judges, and 22 per cent by three out of five judges, for a total of 95 per cent of items correctly classified by the majority of judges. For the items that could be representative of both connectedness and esteem, the judges were spilt in their classifications and selected both connectedness and esteem for 71 per cent of the items. This supports the premise that these items reflect both components of the belongingness definition.

Of the esteem items, 92 per cent were correctly classified as active/giving, passive/receiving or neutral by the judges. The agreement between the judges' rating of the connectedness items as active/giving, passive/receiving or neutral was not as apparent, with a total of 74 per cent of items correctly classified. In the neutral items (connectedness or esteem) the judges were clearly split on their decision, which was

considered indicative that the item could be categorised either way. In response to the judges' feedback, further items were eliminated or reworded.

Phase 3—administration to a focus group

The third phase involved administering the survey to a focus group along with other measures of self-esteem, appraisal of social support, and loneliness (described below). On completion of the survey, participants were asked to identify the construct being measured. They named social competence, self-perception, and self-esteem/self-concept. They were then told that the survey was designed to measure belongingness and the students were asked to define belongingness. They identified the following terms: *connectedness*, *intimacy*, *inclusion*, *acceptance* and *contribution*. When asked to clarify the term *contribution*, they described it as initiating or contributing to one's own sense of belonging. This supports the idea of reciprocity, or the active/giving items. Feedback from the focus group members allowed Somers to reword some of the items that were unclear or ambiguous in meaning.

Phase 4—psychometric evaluation of the Belongingness Scale

In this phase of the study a cross-sectional descriptive survey of belongingness based on the revised scale was conducted and the preliminary psychometric properties examined. A sample of 400 adult men and women between the ages of 18 and 65 were surveyed. A total of 330 questionnaires were used for data analysis out of the 378 returned. The majority of participants were from two college settings in the United States, with an additional 23 per cent obtained through snowballing technique. Seventy per cent of participants were women, and the mean age of participants was 29.4 years. Participants were Caucasian ($n = 185$), African-American ($n = 57$), Asian ($n = 30$), Hispanic/Latino ($n = 24$), and biracial ($n = 10$), while 6 per cent classified themselves as "other". For 20 per cent of the sample, English was not their first language.

Convergent validity

The BES was administered along with brief measures of self-esteem, social support appraisal and loneliness. These additional measures were selected to assess convergent validity. To assess self-esteem, the Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1979), a 10-item measure, was used. Internal consistency reliability of this scale ranges from .77 to .88 (Blascovich & Tomaka, 1991). Test-retest reliability ranges from .85 to .88 (Corcoran & Fischer, 1987). The RSE demonstrates moderate to good convergent validity,

correlating with confidence, popularity and overall academic self-concept (Blascovich & Tomaka, 1991). The RSE also correlates with the Coopersmith Self-Esteem Inventory (Corcoran & Fischer, 1987).

To assess loneliness, Somers used a shortened form of the UCLA Loneliness Scale (Russell, Peplau & Cutrona, 1980). This scale demonstrates excellent internal consistency, Cronbach alpha = .84 (Hays & DiMatteo, 1987). Loneliness, on this 8-item shortened version of the UCLA Loneliness Scale, is positively correlated with alienation and social anxiety. This scale also demonstrates good concurrent validity, correlating with the Beck Depression Inventory, the Texas Social Behaviour Inventory and with a self-labelling loneliness index (Hays & DiMatteo, 1987).

The Social Support Appraisals Scale (SSA) (Vaux et al., 1986) is a measure of perceived social support which taps a person's feelings regarding support resources and interactions. The SSA has coefficient alphas ranging from 0.8 to 0.9 for five undergraduate samples and from .81 to .9 for three community samples (Vaux et al., 1986). The family and friend subscales of this instrument were used to measure social support appraisals in Somers' study. These subscales of the SSA show internal consistency for college samples, Cronbach's alpha = .8 and .84, and .81, and .84 for community samples (Vaux et al., 1986). The SSA has been significantly correlated with a variety of measures of social support and psychological wellbeing including network satisfaction, perceived support, depression, positive affect, negative affect, loneliness, life satisfaction and happiness.

Internal consistency reliability coefficients were computed for the established scales to provide preliminary convergent validity information with the BES. Internal consistency reliability was computed for the eight-item Family Support Subscale of the Social Support Appraisals Scale (SSA), with an alpha coefficient of .87 ($n = 330$). The internal consistency reliability coefficient for the seven-item Friends Subscale of the SSA was computed as .88 ($n=330$). The internal consistency of the ten-item Rosenberg Self-esteem Scale (RSE) was computed at .89 ($n = 330$). The internal consistency reliability coefficient of the UCLA Loneliness Scale (Version 3, 10 items Short-Form) was .87 ($n = 330$).

The psychometric integrity of the BES was determined on evidence of construct validity acquired through scale comparisons. The comparisons were between the BES and each

of the established scales described above. A Pearson's Product Moment Correlation Coefficient (*r*) was used to assess each of these relationships. Evidence of convergent validity was demonstrated for each of the scale comparisons:

- There was a significant correlation between the family subscale of the BES and the family support subscale of the SSA, demonstrating that as levels of belongingness on the family subscale increased, so did levels of family support as measured on the SSA.

- Likewise, analysis was conducted on the 35-item friends subscale of the BES and the 7-item friends subscale of the SSA. Results indicated a significant correlation between these scales indicating that as levels of belongingness increased on the friends subscale, levels of support by friends also increased on the SSA subscale.

- Full scale scores obtained on the 140-item BES were correlated with scores obtained on the UCLA Loneliness Scale (Version 3, Short Form). There was a significant negative correlation between the two scores, suggesting that the higher the loneliness score, the lower the belongingness score would be.

- Full scale scores obtained on the BES were shown to correlate significantly in a positive direction with scores on the RSE, indicating that as belongingness scores increase, esteem scores also increase. Table 3.2 summarises the Convergent validity correlations between the BES and other scales.

Table 3.2 Convergent validity correlations between the BES and other scales

Scale name	BES family	BES friends	BES full scale
SSA—Family	0.80[1]		
SSA—Friends		0.77[1]	
UCLA (Loneliness)			-0.61[1]
RSE (Self-esteem)			0.46[1]

[1]$p < .01$ ($n = 330$)

Factor analysis

Somers (1999) hypothesised that the observed four-environment model of belongingness would not differ significantly from the proposed theoretical model. The four proposed environments were family, friends, work/school and neighbourhood. These environments were posited on Baumeister and Leary's (1995) assertion that to qualify as a fundamental human motivation, belongingness would operate across a wide variety of environments. Confirmatory Factor Analysis failed to yield a 'good fit' with regard to the four-environment structure as proposed for the BES, with a Comparative Fit Index of .64. The CFI ranges from 0 to 1, with values closer to 1 indicating better fitting models (Arbuckle, 1995). Therefore, in an attempt to better understand the factor structure that might exist for the BES, an exploratory method of factor analysis was employed. A principal components analysis was run on the 140 variables using oblique rotations. The results from the Exploratory Factor Analysis (EFA) provided preliminary support for the proposed environmental model. Factors containing five or more items, with minimum factor loadings of .3 were examined for content. Ten factors met this criteria. Of these, six were 'pure' in composition, each exclusively representing one of the four environments as proposed. In analysing the correlation matrix, it was determined that the factors were not highly correlated. Correlation coefficients were low, ranging from .0009 to .42. The results of the EFA lend support to Somers' proposed environment model.

Internal consistency reliability

It was hypothesised that items within each of the four subscales (environments) of the BES would show moderate to high internal consistency. Cronbach's alpha was used to determine internal consistency of each subscale. Reliability coefficients for the subscales were excellent, ranging from .94 to .97. Of significance to the current study is the .94 Cronbach's alpha for the subscale of Work/School. As this is the subscale from which the BES–CPE was modified, the high degree of internal consistency meant that I could proceed with the modification and use of the BES–CPE with confidence.

3.8.5 The need for further testing of validity and reliability

As discussed previously, minimal modifications to Somers' BES were made in developing the BES–CPE. It is proposed therefore that the evidence of validity and reliability of the BES cited above also underpins the modified BES–CPE instrument. However, as scale construction is an iterative process requiring numerous subsequent studies to support

evidence of psychometric integrity, the present study will contribute to this body of evidence.

Validity and reliability examination of the BES–CPE were first undertaken as a part of the pilot study. Reliability analysis from piloting the instrument revealed a Cronbach's alpha of 0.9. Although the size of the pilot study sample (n = 41) limits the strength of reliability testing, there was no indication that the instrument was not rigorous and would not be appropriate for the main study. The results of validity and reliability analysis for the main study are reported in Chapter 5.

3.8.6 Quantitative data analysis

The Statistical Package for the Social Sciences (SPSS) (Version 13) was used to facilitate statistical analysis. Analysis allowed characteristics of the study population to be summarised through measures of central tendency (means, median and mode) and indicated how widely individuals differ through analysis of standard deviation and frequency distributions. Data were analysed for the effect of each predictor or outcome using t-test and analysis of variance (ANOVA).

3.9 Qualitative data collection phase of the study

The BES–CPE survey sought to measure the extent to which nursing students experienced belongingness and to draw cross-site comparisons. The qualitative data collection phase sought to explore the hidden assumptions and complexities underpinning the patterns revealed in the survey. Specifically, this phase of the study aimed to answer research questions 3 and 4:

Research question 3

With respect to the clinical placement experience, what factors impact on nursing students' experience of belongingness?

Research question 4

With respect to the clinical placement experience, what are the consequences of nursing students' experience of belongingness?

3.9.1 Participants

A purposive sub-sample of 18 third-year nursing students was recruited for the semi-structured interviews. This number provided a diverse range of data, enabled a depth of data collection and maximised the quality of the data generated. Purposeful sampling requires participants who are knowledgeable about the subject because of their sheer involvement and experience in the situation, as well as their willingness to reflect on and share this knowledge. As third-year students had undertaken a range of clinical placements, they were the best source for obtaining rich and valuable information about belongingness and clinical placements. Furthermore, they were considered to be the experts regarding their own experiences. Sixteen women and two men participated in the interviews. Their ages ranged from 20 to 47 years, with a mean age of 27.6 years. Nine students from site 1 participated in the study (four of these were in the pilot study), four were from site 2 and five from site 3. Most of the participants were either Australian (n = 12) or British (n = 5). One was Korean.

In Table 3.3 the 18 students that participated in the interviews are briefly introduced. This introduction provides a background against which the themes emerging from the thematic analysis in Chapters 6, 7 and 8 can be better understood. The introductions allow the reader to gain some insight into the participants' frame of reference. The participants are arranged alphabetically for ease of reference.

Table 3.3 Interview participants

Participant	Site	Background
Abby	1	Abby is a student in her mid-twenties. Born in Korea, she spent 10 years studying in North America before coming to Australia to enrol in a Bachelor of Nursing degree. Abby works as an assistant in nursing in an aged care facility.
Ann	1 Pilot study	Ann is a mature age student who had worked as an enrolled nurse for 15 years before enrolling in the Bachelor of Nursing degree.
Brent	1	Brent is a 23-year-old student who works as an assistant in nursing in a small metropolitan hospital.
Deanne	1	Deanne is 20 years old. She has worked as an assistant in nursing for 15 months. *(Continued)*

Elizabeth	3	Elizabeth is enrolled in the Advanced Diploma (adult branch). She is 21 years old and works as a healthcare assistant in a 40-bed nursing home. Her mother and grandmother were both nurses.
Fiona	3	Fiona is a student in her early twenties who is enrolled in the Bachelor of Nursing (adult branch). She works as an agency healthcare assistant for 12 shifts per month.
Jane	1 Pilot study	Jane is 36 years old and is married with two sons. She worked for two years as an assistant in nursing before commencing her nursing studies.
Jodie	3	Jodie is a student in her early twenties enrolled in the Advanced Diploma in Nursing (adult branch). She has worked in a care home for 2.5 years.
Kara	1	Kara is a student in her early twenties. She trained as an enrolled nurse four years ago and continues to work in that role. Her mother is a registered nurse but has not practised for 20 years.
Katherine	3	Katherine is a 21-year-old student enrolled in the child health branch of the Bachelor of Nursing degree. She was a voluntary care worker for three years before enrolling in the degree and now works part-time in a children's hospice.
Laura	1 Pilot study	Laura is a student in her early thirties. She works as an assistant in nursing in an aged care facility. Her mother has been an assistant in nursing for more than 20 years.
Laurence	2	Laurence is 21 years old. He began his nursing degree at another university but transferred when the degree was offered at site 3, as he preferred to reside at home.
Leanne	2	Leanne had just had her twentieth birthday at the time of the interview and was the youngest person that I interviewed. She has worked as a personal care assistant for the last two years.
Louise	2	Louise is a 36-year-old student with single-parent responsibilities for three children. She has no previous or current nursing experience.
Lucy	2	Lucy is a mature-age student with five children. She has 10 years' experience as an enrolled nurse, but has not worked in that role since 1994.

(Continued)

Monique	1	Monique is a student in her late forties. She is married with two teenage children. She works as an assistant in nursing in a small private hospital.
Nicole	3	Nicole is a student in her early thirties enrolled in the Advanced Diploma (adult branch). She works as an agency healthcare assistant and as a private assistant to a clinical consultant. Nicole holds a biology degree and worked as a representative for a pharmaceutical company for six years before commencing her nursing studies.
Sarah	1 Pilot study	Sarah, a 30-year-old student with a diverse range of experiences as an assistant in nursing. Sarah holds a social science degree with a double major in disability and family and children's services, and worked for a number of years in the management level of disability services. Her mother is the director of nursing of an aged care facility.

3.9.2 Participant recruitment

The sub-sample for the qualitative phase of the study was drawn from those students that had completed the BES–CPE questionnaires. On submission of the BES–CPE questionnaire previously described, an electronic invitation to participate in an interview was automatically extended (refer to Appendix 7). Participants could either exit the system by selecting the *Exit Website* button or access and download the interview information statement, a copy of which is provided as Appendix 8, by selecting the *Download Interview Information* button on the website. Interested students were invited to contact the researcher if they wished to proceed with an interview. It was not feasible to use potential participants' BES–CPE scores to determine who would be recruited for interviews, as the instrument was anonymous. However, to gain a range of perspectives, potential participants were asked to provide the researcher with their demographic information as a guide for participant selection. The researcher replied to those participants selected to take part in an interview and sent them a copy of the consent form, provided as Appendix 9, by mail or e-mail. A mutually convenient date, time and place for the interview was negotiated with each of the participants. Participants were advised to send their completed consent form to the researcher before the interview, and they were reminded that they could change their mind at any time and were not obliged to take part in the interview. Where the number of people expressing an interest in participating in an interview exceeded the

number required, those not selected were sent an e-mail thanking them for their interest but advising that they had not been selected.

3.9.3 In-depth semi-structured interviews

The interviews were conducted over a nine-month period. They were undertaken in private interview rooms at each university and lasted on average 45–60 minutes. They were audiotaped with the permission of each participant. The interviews were transcribed verbatim and pseudonyms inserted to protect the participants' anonymity.

In-depth semi-structured interviews aimed to elicit the narrative accounts of students' experience of belongingness. An interview schedule consisting of open-ended questions was designed to probe participants' understanding of belongingness as it related to their clinical placements, including the factors that impact upon and the consequences of belonging. A copy of the interview schedule is included Appendix 11. As the participants had completed the surveys before being interviewed, they had been given the opportunity to reflect upon their experience of belongingness in preparation for their interviews. On many occasions, not all the questions from the interview schedule were asked, because these areas were adequately covered by the participants when they recounted their experiences. The guiding question asked of the participants was: "Can you tell me about your clinical placement experiences?" This question was deliberately chosen because it encouraged participants to describe their experiences in a non-threatening manner by enabling them to take control of the flow of the conversation (Holloway & Wheller, 1996). Prompts were used to further elicit the participants' perspectives, for example: "Can you tell me more about that?" and "How did you feel when that happened?"

3.9.4 Qualitative data analysis

Consistent with qualitative methods, analysis began shortly after data collection started. This allowed for clarification of issues and tentative development of clusters of themes. While the stages of qualitative data collection and analysis are described separately, it is important to note that they occurred simultaneously. Constant comparison in a style similar to a grounded theory approach (Holloway & Todres, 2006) meant that the findings from each interview informed data collection in subsequent interviews. By comparing and contrasting each participant's experiences and perspectives with those of previous participants, I was able to identify issues that needed to be explored more fully in ensuing

interviews. Holloway and Wheller (1996) suggest that this process helps to increase the amount and quality of data produced, as well as expanding on the themes identified from the interview transcripts.

Development and analysis of the transcripts was an iterative six-stage process:

1. The interviews were fully transcribed by two experienced transcriptionists following the set of guidelines provided (Appendix 12). This ensured consistency and clarity between the transcripts. Both transcriptionists were asked to sign a Promise of Confidentiality agreement (Appendix 13).

2. I listened to each audiotape while reading the transcript of the interview and made minor corrections where the transcriptionist had misinterpreted the dialogue or omitted an occasional word or emphasis. Transcripts were numerically coded and pseudonyms were inserted to protect the participants' privacy and confidentiality.

3. When I was satisfied that the transcripts were accurate, line numbers were added. This version of the transcripts became the reference for quoting sections of the transcripts in the thesis. Numbering ensured that all of the quotations used in the thesis were easily relocated in the original transcript. Quotations taken from the transcripts are written in italics and followed by a code number, for example (1:13), where the number 1 indicates the number of the transcript and the number 13 indicates the line in the transcript from which the quotation was taken.

4. The audiotapes were listened to while the transcripts were read at least three more times. The transcripts were edited to make them easily readable and understandable, while retaining the distinctive flavour or voice of each participant. My questions and comments, unless required for clarity, were omitted. Because informal conversations and written documents operate under different conventions, hesitations, false starts, some repetitive fillers and obvious grammatical slips were also removed. Some minor words were added, for example "that", to make sense of the transcript. Words were changed, where necessary, to the appropriate tense or to protect an identity. Added words are clearly indicated by the use of square brackets [ ]; *** indicates that a word has been deleted to protect an identity; and […] indicates that a word or words have been removed to enhance clarity. Each participant was sent a copy of their edited transcript to review and was invited to rephrase or add to it if they wished. This is discussed more fully in Section 3.9.6.

5. By reading and re-reading the transcripts while referring to the research questions, phrases, statements or paragraphs of significance to the research questions were colour coded. These colour-coded sections of the transcripts were grouped by electronically cutting and pasting. Numeric codes were retained for future reference. Predominantly, this was a combing and sorting exercise that allowed me to combine sections of the data in a variety of configurations in an attempt to find common meanings. At this stage there were only naïve and superficial conversations with the text, as the principal task was to code into categories, factors and themes. This structure provided the framework within which data interpretation proceeded.

6. Once the material from the transcripts had been coded, it was possible to start the process of questioning and conversing with it, thereby pursuing particular lines of enquiry and uncovering embedded meanings. This was done by moving from what was already known in a fairly superficial way to a deeper understanding. In order to maintain an audit trail and to document my developing perspectives and reflections, brief notes were made in the final versions of each of the transcripts. These notes prompted me to return to a particular participant's transcript for comparison or clarification, referred me back to the related literature, and at times recorded my concerns and queries.

By immersion in the text surrounding the depicted categories, factors and themes, recurring patterns, alternative explanations, disconfirming evidence and negative cases were uncovered. As the texts were re-read a number of times on the computer screen and in hard copy new ideas emerged and were integrated into the analysis. Adherence to providing an audit trail continued throughout the analysis by retaining a copy of each version of the transcripts and of each step of the analysis.

3.9.5 Data saturation

Morse and Richards (2002) suggest that qualitative data gathering should continue until each category or theme is "rich and thick" and replicates across several cases. These authors further suggest that it is saturation that provides the researcher with confidence that the analysis is strong and the conclusions "right". Negative cases or instances that do not fit the emerging model are likewise explored. Once the data offers no new directions or raises no new questions, the data is said to be saturated (Morse & Richards, 2002). The

researcher is then able to fully describe not only the phenomenon, but also the antecedents and the consequences. Other qualitative researchers, for example Denzin and Lincoln (2000), present a different view, suggesting that saturation is a somewhat elastic concept, difficult to define and even more difficult to measure. I am of the opinion that there will always be new stories that may yield new insights and interpretations, even when data saturation (according to Morse and Richard's [2002] definition) has occurred. While this study aimed for data saturation, I cannot be sure that total saturation of the categories identified during analysis was reached, although (as will be demonstrated in the following chapters) a coherent schema of interrelated themes was generated. Nevertheless, I remain mindful that the perspectives from a different sample of participants may well have yielded slightly different, yet equally valid, findings.

3.9.6 Trustworthiness

In the quantitative phase of the research, the measures of reliability and validity were used to establish the merit of the study. In this qualitative phase, the criteria of trustworthiness will be used for the same purpose. Guba and Lincoln (1985) refer to the criteria of credibility, transferability and dependability as means to determine the trustworthiness of qualitative inquiry. These criteria are outlined below.

Credibility

Guba and Lincoln (1985) propose that a study is credible when it presents faithful descriptions and when readers confronted with the experience can recognise it as plausible. The author should be able to demonstrate how each theme was derived from the descriptions. The study should present an authentic account grounded in the data and explained by the researcher's interpretive schema (Koch, 1994). The themes emerging from the data will not always be the same for researchers and readers, because perfect agreement when analysing the same material would not be expected. Readers may not be able to share the author's interpretation but they should be able to follow the way in which the author arrived at it (Koch, 1994).

Self-awareness is essential for the researcher. This includes an understanding of the researcher's own historicity and situatedness. In this study, I maintained a journal throughout the entire research process to record my reflections, questions, emerging understandings and perplexities. I questioned the origins and legitimacy of understandings

based on my preconceptions (Were these meanings reflected in the participants' accounts? Did they stem from my own experiences? Were they represented in the literature? What other meanings were possible?). In performing the data analysis I reflected on and recorded my own values, but made every effort to ensure that they were not imposed upon the analysis. This reflexive process enabled the perspectives of the participants to dominate throughout the entire analytic and interpretive phase.

Another way of establishing credibility is by member checking (Lincoln & Guba, 1985). In the current study, participants were sent a copy of their edited transcript to review and revise. This provided them with an opportunity to check that what was written was what they had meant to say, and to delete or change their words if they preferred. Review of the edited versions of the transcripts by the participants ensured that they concurred with the minor changes made during the process of editing and that they did not wish to add to or rephrase their words. No participants chose to make any alterations.

Transferability

According to Guba and Lincoln (1985) transferability refers to the extent to which the study findings are relevant to and can fit into contexts outside the study situation. Other researchers (Koch, 1994; Sandelowski, 1986) use the term *fittingness* in the same way. Transferability is dependent upon the extent to which readers view the findings as meaningful and applicable in terms of their own experiences. Qualitative research should offer a surrogate experience in which transferability is ascribed by readers as they encounter a sense of resonance with their own experiences. For a judgment of transferability to be made, the context of the study must be described adequately. Rich description of actual contexts allows readers to imagine themselves in the social world of the case being studied. In Chapter 4 the context of each of the three study sites will be described in order to provide a detailed backdrop for the reader and to allow the study's transferability to be determined.

Dependability

Guba and Lincoln (1985) suggest that for a study to be rigorous an audit trail needs to be established. Sandelowski (1986) states that another researcher should be able to clearly follow the decision trail used by an investigator. Furthermore, other researchers should be able to arrive at the same or similar conclusions, given the researcher's data and perspective. A decision trail makes the steps taken in the research process operational by

documenting decisions about the theoretical, methodological and analytic choices (Koch, 1994). Signposts indicating research decisions and influences should be present throughout the study, and the entire study should function as an inquiry audit. In an attempt to enhance the dependability of the categorising method in the present study and to guard against potential bias, emerging themes and categories were verified by two independent researchers, both co-supervisors in the study. This checking of intersubjective agreement was undertaken to enhance auditability, that is, the ability of another investigator to follow the decision trail in data analysis.

3.9.7 Protocols and procedures

Ethical considerations

Ethical issues are inherent in all research designs involving humans. To protect the welfare and rights of participants involved in the study and to uphold my ethical and legal responsibilities, ethics approval for the study was sought from each of the participating educational institutions (refer to Appendix 14). However, I am aware that the protection of research participants extends beyond seeking one-off ethical approval from the participating institutions at the commencement of the study; it also concerns the integrity of the researcher in carrying out the entire study. In designing and conducting this study, I made a conscious decision to adhere to the four ethical principles of beneficence, non-maleficence, respect for autonomy and justice.

Beneficence

Beneficence holds that we should try to do good (Johnstone, 2004). Faculty, particularly those in university environments, have a responsibility to advance disciplinary knowledge through research. It could be argued that the intention of research to add to disciplinary knowledge is implicitly beneficial. Moreover, in researching a topic as problematic as students' clinical placements, it was anticipated that the knowledge gained would have the potential to impact positively on the placement experiences of future nursing students. In the context of this study, however, the knowledge gained and the improvements sought in practice were likely to be gauged in the longer term and would be unlikely to directly affect the study participants.

Non-maleficence

Closely linked to beneficence is the second principle of non-maleficence; in other words, if one cannot do good one should certainly try to avoid doing harm (Johnstone, 2004). Protection from harm may be enhanced when the researcher engages with issues of anonymity, privacy and confidentiality, throughout the study and subsequently.

Anonymity was maintained in the study by the following means:

- All online surveys were completed anonymously and returned to a secure website that could be accessed only by the researcher.
- Each questionnaire was numerically coded for data entry purposes.
- No identifying personal information was recorded on the questionnaire.
- IP addresses were removed from the questionnaires by appropriate software before the researcher accessed the data.

Confidentiality and privacy concerns the rights of individuals to control information about themselves. This was assured through my obligation not to use the information provided for any purpose other than that for which it was given. Confidentiality of data was ensured by the following measures:

- Consent forms were separated from other research files.
- Pseudonyms and codes were used on all transcriptions.
- Data were stored on password-protected computer files and in locked filing cabinets in my home office.
- Where aggregated demographic information about the study participants is provided in reports and publications, such publications will not lead to identification of individuals in prejudicial circumstances.
- All contact details, including e-mail addresses and telephone numbers, were destroyed on completion of the study.
- Participants were reminded of their right to have segments of the transcribed data removed from the research if they so chose.
- Audiotapes were transcribed by a transcriptionist familiar with the process of confidentiality and who was asked to sign a Promise of Confidentiality, included as Appendix 12.

- In written records all names, including those of healthcare facilities and other non-essential information, was altered and the participants were each given a pseudonym.

In regards to non-maleficence, I was particularly aware that educators who engage students as participants in their research are faced with particular challenges related to ethics. Unique ethical issues may arise from the fiduciary relationship that exists between faculty and students, and from the potential for violation of that relationship when the researcher has a dual role. A fiduciary relationship is one in which two individuals are unequal and the more powerful person is entrusted to protect the best interests of the less powerful or dependent person (Lemmens & Singer, 1998). In order to adhere to the principle of non-maleficence, methodological designs must address these ethical issues (Ferguson, Yonge & Myrick, 2004). A fiduciary relationship is central to the education of students due to the inherent and inevitable power differentials between educators and their students. Section 7 of the *National statement on ethical conduct in research involving humans* (Commonwealth of Australia, 1999) pays particular attention to the involvement of people in dependent or unequal relationships. As I held an academic position in one of the schools of nursing from which students were recruited for this study, it was imperative that the ethical implications of this study were carefully considered. To lessen the risk of compromising ethical standards, I ensured that I had not and would not in the future engage in a teaching relationship with any of the participants. Additionally, participants were recruited via websites to minimise the chance of students feeling pressured or coerced into participating.

Autonomy

One of the characteristics of personhood is the ability to make free choices about oneself and one's life—that is, to be self-governing (Johnstone, 2004). The principle of autonomy is said to be at the heart of informed consent and was an important consideration in this study. Acting in accordance with the principle of respect for autonomy I obtained informed consent from the participants by ensuring the following:

- Those who participated in the research gave their consent while in possession of all the relevant information necessary for them to make a proper choice. Study participants were provided with separate electronic copies of information

statements for the survey and the interviews (included as Appendix 6 and 8) that they could download and print before commencing the online survey.

- Information statements were written in plain English and provided participants with a clear and concise description of the study and what their involvement would entail.

- The researcher's contact details were provided on these forms so that questions or concerns could be addressed before the participant decided whether to participate.

- Participants completed the consent form in writing and sent it to the researcher before the interview.

- Before commencing each interview, adequate time was provided for questions to be asked and answered, and verbal consent was once again obtained.

- Prior permission was sought from the participants to record the interviews.

- Participants were advised that that they could withdraw from the interview at any time without needing to provide reasons, that there would be no repercussions, and that they would be provided with their interview data upon request.

- Participants were reminded of their right to have segments of the transcribed data removed from the research.

- Consent forms for interviews will be stored securely for the specified five-year period.

Justice

As a principle of research ethics, justice refers to the treatment of all participants fairly and impartially (Johnstone, 2004). In this study it translated to the competing needs of researching pedagogical issues specific to the discipline while ensuring that participants were not compromised or unfairly advantaged or disadvantaged by their participation in the study.

3.10 Conclusion

The research design and methods used to measure and explore nursing students' experience of belongingness were the focus of this chapter. An overview of the theoretical perspective of pragmatism was provided as well as a rationale for its selection for this study. Case study was proffered as an appropriate framework to explore and describe the concept of belongingness primarily because of its capacity to generate holistic, meaningful

and context-constituted knowledge about complex real-life phenomena and events. This section was followed by a discussion of the mixed-method design, an outline of quantitative and qualitative data collection methods, and a justification for each methodological decision.

In Chapter 4, the context of each of the study sites is described. This will enable the reader to appreciate the social worlds of the participants in order to make a judgment about the study's transferability—that is, the extent to which the study findings are relevant to and can fit into contexts outside the study situation.

Chapter 4

Research Context

4.1 Introduction

Researchers using a case study approach need to describe the context of the case in sufficient detail for readers to be able to vicariously experience the situation being described. To do this researchers should highlight what is common as well as what is particular about the case (Stake, 2000, p. 438). This allows the reader to consider the transferability of the results of the study to other contexts (Clarke & Reed, 2006). In this chapter the context of each of the three sites is outlined as a prelude to the research findings presented in the following chapters. A brief historical overview is provided, as well as an outline of the contemporary healthcare, nursing workforce and educational issues in Australia and the UK. The location, curriculum framework and clinical placement models of each site are then discussed.

4.2 Nursing in Australia

4.2.1 Historical context

In 1984, after decades of deliberation and intensive political lobbying the watershed decision to transfer nursing education in Australia from the hospital setting to the tertiary sector was finally announced (Levett-Jones & Fitzgerald, 2005). This controversial decision was the culmination of many years of intensive lobbying by the nursing profession, and followed a process of "delay by committee" and ongoing political debate by state and federal governments (Senate Report, 2002). However, many political and social commentators would argue that the transfer was an inevitable outcome of more than a century of discontent with the apprenticeship model of nurse training and prevailing workforce conditions (Russell, 1990).

First introduced in 1868 when Lucy Osborn established a training school for nurses in Sydney, New South Wales, the apprenticeship model became so fundamental to nursing that it remained essentially unchanged for almost a century. As a system it met the workforce needs of an emerging healthcare system, in addition to providing a way to control the vocational training of nurses and the boundaries of that training. In the later half of the twentieth century this system came under increasing pressure to change. The driving force was the recurring staffing shortages that plagued nursing (Wood, 1990). The shortages were exacerbated by a high "wastage" (resignation) rate among practising nurses, and high attrition rates among trainee nurses, estimated to be over 50 per cent (Senate Report, 2002). These problems were seen by many to be a direct result of the status of nursing, with its poor wages and conditions of work (Heath, Duncan, Lowe & Macri, 2002), which were in turn thought to be directly linked to inadequacies in the training system of nurses. These inadequacies included:

- the unstructured and variable clinical learning experiences of trainee nurses
- the lack of correlation between the theoretical and clinical components of training
- workforce demands taking precedence over the educational needs of student nurses
- the allocation of resources for nursing education being buried within global hospital budgets
- the increasing cost associated with training nurses
- the lack of applicants for nurse training
- the poor educational standard of recruits into nursing
- the incompatibility of "learning by doing" with emerging government and community attitudes to education
- lack of recognition of education as a specialised function in its own right and of nursing as a distinct profession requiring its own unique body of knowledge
- the rapid technological changes that were overtaking the apprenticeship system (Russell, 1990).

Nursing academics, influenced by international trends and evolving ideologies, increasingly considered higher education to be a means of enhancing nursing's professional status and moving beyond the concept of nursing as merely a "vocation". Improved education was seen to be the generic solution to the problems that beset

nursing, and demands for abolishment of the hospital-based training system in favour of tertiary education for nurses began (Wood, 1990).

From the 1960s to the 1980s a number of committees were established and reports commissioned: for example, the Matron's Report (Matron's Institute, 1967); the Truskett Report (Truskett, 1969); the Nobel Report (Nobel, 1974) and the Sax Report (Sax, 1978). Each aimed to address the contentious issues that existed within nursing and nursing education. While there was general consensus regarding the problems in nursing education, the reports contained conflicting recommendations on the possible solutions to the problems. The most significant area of contention was the anticipated change of venue for nursing education. Maintaining the hospital-based system in which trainee nurses provided for the service needs of the employing hospital was strongly supported by some groups, who insisted that nursing education in the tertiary sector was a system of training that was deficient in practical bedside clinical experience (Matron's Institute, 1967). By contrast, the Truskett Report suggested radical and far-reaching changes to nurse education in New South Wales (Truskett, 1969). This report stated that the apprenticeship system of nursing conducted in hospitals under the control of the Minister for Health was outdated, and that nurse education should be moved into the tertiary education system under the control of the Minister for Education. This report focused less on the service needs of the hospital and more on the actual quality of nursing education.

A new statutory body, the Nurses' Education Board (NEB), was established in 1972 and in 1974 it released the Nobel Report . The major recommendations were: (a) introduction of the Higher School Certificate as the admission requirement for nursing; (b) provision of nursing education at a variety of institutions, including colleges of advanced education, universities and regional schools of nursing; and (c) the granting of full student status to nurses (Nobel, 1974). While agreeing that changes should occur, the Sax Report (1978)— the only federally funded project of this period—suggested rationalisation and upgrading of existing hospital schools of nursing as a means of improving the standard of nursing education. Rationalisation was to include the regionalisation of schools of nursing and the closure of smaller, less efficient schools. This report also suggested that small numbers of the more "able" nursing students should be educated in colleges of advanced education (Sax, 1978). The nursing profession, noting the similarity of this report to the earlier Matron's Report (1967a), expressed frustration at its conclusions and at the government's

"delay by committee". Numerous reports in addition to those discussed above had been commissioned, yet the government continued to delay action on the premise that expert advice should be sought. It was felt by the nursing profession that there was no justification for any further delay to the transfer from hospitals to the tertiary sector. At a state nursing conference, Maureen McGrath, Executive Secretary of the NEB stated:

> The experts have been agreed for at least five years. For some basic issues they have been in agreement for even longer. Nursing education must move into the general education structure. (McGrath, 1975, p. 2)

The nursing profession continued to agitate for change, but its demands were largely ignored.

In 1974, a new nursing group, the Nursing Organisations Representative Committee (NORC), had been formed, with representatives drawn from all major nursing organisations. Until this time the nursing profession's main hindrance had been its inability to unite and kerb the political infighting and dissent that had plagued it throughout the twentieth century (Russell, 1990). The NORC was able to project a cohesive front and coordinate actions on behalf of the nursing profession. In April 1976 the NORC met with the then Minister for Education, who remained opposed to the transfer of nursing education, suggesting that further enquiries and research were necessary before the future of nurse education in Australia could be decided. This response was received very unfavourably by the NORC and the nurses that it represented. The NORC then approached the Labor Party, in opposition at the time, and received a sympathetic and informed hearing (Wood, 1990). The action by the NORC had been carefully timed to coincide with the state election. The Labor Party pledged, if elected, to phase in the recommendations of the Nobel Report (Russell, 1990). Subsequently, when the Labor Party won the election in May 1976, the government's commitment to transfer nurse education to the tertiary sector was reaffirmed. It was another 6 years before the New South Wales Minister for Health announced that from January 1985 all basic nursing education in the state would be conducted by tertiary institutions. This was closely followed by the federal government's policy announcement in August 1984 that it gave full support for the complete transfer of nurse education to the tertiary sector throughout Australia.

Nursing education finally became part of the tertiary education sector in the mid-1980s. Initially the courses were mainly at diploma level but shifted to a three-year degree

program in the early 1990s. Nearly a decade following the transfer, the Reid Report (Reid, 1994) examined the impact of the move to higher education and although overall positive in its review, concerns were expressed about the level and content of clinical education. More recently, two reviews (Clare, Edwards, Brown, & White, 2003; Heath et al., 2002) also highlighted a number of problems with clinical education. The continuing difficulties for universities in providing clinical placements within their current budgetary constraints and the challenges surrounding the sourcing of adequate numbers of quality clinical placements were noted in both of these reports. The reports placed emphasis on the reinforcement and development of partnerships between higher education and health services in order to enhance the quality and increase the quantity of clinical placements.

4.2.2 Health care in Australia

Before examining the nursing workforce and educational issues, the changing health needs of Australia and the concomitant need for significant numbers of highly skilled nurses should be considered:

> Patient acuity in both the hospital and the community health sectors has been rising. This is due, in part, to the ageing population and with it, an increase in chronic illnesses and disabilities. Demand for health services has grown and advances in technology mean that more complex interventions are available…New technology allows rapid assessment, treatment and discharge from hospitals. For example, there has been an increase of day surgery procedures. Shorter hospital stays have resulted in patients moving back into the community with more complex healthcare needs. Thus, the community sector is also experiencing an increase in patient acuity and an increase in the number of treatments provided to patients in the home. This has led to an increased demand for nursing staff outside hospital facilities. The shortage of other health professionals, such as occupational therapists, increases the burden on nursing staff in both hospitals and the community. (Senate Report, 2002, p. 14)

The National Health Priority Areas are those areas currently recognised as contributing significantly to the burden of disease in Australia, and for which there is potential for health gain. They include:

- asthma
- cancer control
- cardiovascular health
- diabetes mellitus

- injury prevention and control

- mental health

- arthritis and musculoskeletal conditions (Department of Health and Ageing [DoHA], 2005).

Australia's health system is complex, with a mix of public and private provision and financing. Health care is largely publicly funded, with governments providing around 70 per cent of health financing. In contrast, provision is largely private, supplied by medical practitioners and allied health professionals operating at the client interface, private hospitals and other health facilities. Most government-delivered services are provided in public hospitals, for which States and Territories are responsible. Funding for public hospitals is cost-shared between the federal and state governments. States and territories are responsible for the delivery of public hospital and other population-related health services. Provision of private health insurance is subsidised directly and indirectly by the federal government (Heath et al., 2002).

4.2.3 Workforce issues—Australia

In 2001 there were 260,075 nurses registered in Australia and 228,230 practising (Australian Health Workforce Advisory Committee, 2004a, p. 4). Nurses (including registered nurses, enrolled nurses and assistants in nursing) comprise 55 per cent of the entire health workforce in Australia. Since the mid-1980s, the age structure of this workforce has undergone major changes. A report by the Australian Health Workforce Advisory Committee (AHWAC) (2004a) described these changing demographic trends:

- The average age of nurses is increasing, with over 60 per cent of the nursing workforce currently aged 40 years or older.

- It is expected that over 30 per cent of the nursing workforce will contemplate retirement in the next 10–15 years.

- The proportion of nurses that work part-time (that is, less than 35 hours per week) increased from 41.2 to 44.1 per cent between 1990 and 1999.

- Nursing remains a predominantly female profession. There has been little change in the number of males employed in nursing, currently estimated to be 8 per cent of total RNs.

While there is a critical shortage of nurses in all areas of healthcare services, establishing the extent of the shortage is problematic. AHWAC (2004) advise that without clear, rigorous and nationally agreed methodology available, it is not possible to accurately determine and report on the actual number of nursing vacancies, either nationally or for each state and territory.

4.2.4 Nursing education—Australia

The AHWAC (2004, p. 10) identified that there has been a steady decrease in the number of domestic undergraduate students completing nursing courses, from a high of 9525 in 1994 to 5844 in 1999 and 5702 in 2004. It is predicted that to meet demand Australia will need between 10,182 and 12,270 new graduate nurses to enter the workforce in 2006, and between 10,712 and 13,483 in 2010 (Australian Health Workforce Advisory Committee, 2004a). Based on the projected figures, it is unlikely that these targets will be achieved and a significant shortfall is expected.

Attrition in nursing courses across Australia remains a perennial and multifactorial problem. Attrition rates in first-year nursing students range from 15 to 20 per cent (Senate Report, 2002). The following reasons are cited for withdrawal from nursing courses:

- wrong choice of course
- students using nursing as an entry point to university and then switching to the course that they initially wished to pursue
- academic failure
- pressure from other commitments outside study, such as the demands of full-time or part-time employment, and health and family issues (Senate Report, 2002).

In Australia, unlike many other counties, decisions regarding the number of new undergraduate university students and workforce planning are made by separate governments (federal and state).

4.3 New South Wales

4.3.1 Regulation of nursing in New South Wales

The New South Wales Nurses and Midwives Board (NMB) (formerly known as the Nurses Registration Board) is the statutory authority responsible for the registration of nurses and

midwives, the authorisation of nurse practitioners and midwife practitioners, and the enrolment of nurses in New South Wales. The board was established under the *Nurses and Midwives Act 1991*. The primarily purpose of the NMB[1] is to protect the health and safety of the public by:

- establishing and maintaining standards of education for nurses and midwives
- ensuring that nurses and midwives are fit to practice
- providing mechanisms to enable the public and employers to readily identify nurses and midwives who are registered or enrolled
- monitoring professional conduct and disciplinary functions (Nurses and Midwives Board of New South Wales, 2006a).

4.3.2 Workforce

In New South Wales, as of June 2006, there were 82,740 registered nurses. This reflects an increase of 1156 since the previous year (Nurses and Midwives Board of New South Wales, 2006b).

4.4 Site 1

4.4.1 Location

Site 1 has three main campuses in New South Wales. The largest campus is in a suburb of Australia's sixth largest city and serves a population that is mostly working class or socioeconomically disadvantaged. Lower education attainment is a major feature of the region and explains the higher unemployment rates and lower household incomes (Labour Force Australia, 2003). A smaller and more recently established campus is situated approximately eighty kilometres from the main campus. The third campus is a much smaller pilot campus, established three years ago to serve the population of a small coastal community in northern New South Wales.

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[1] It is planned that registration of health professionals and the accreditation of courses will be undertaken on a national basis by July 2008. It is therefore anticipated that the authority of the Nurses and Midwives Board will not continue beyond that date (Nurses and Midwives Board of New South Wales, 2006a).

4.4.2 Curriculum framework—Bachelor of Nursing program

In 2005 a new curriculum for the Bachelor of Nursing program was implemented at site 1. It uses a model of teaching and learning termed situated learning. A situated learning perspective is based on the belief that skill development and knowledge is contextually situated and is fundamentally influenced by the activity, context and culture in which it is used (Lave, 1998). Key attributes of situated learning include:

- the use of stories from the field, which may be presented as problem-based learning (PBL) scenarios
- encouragement of student reflection on learning and reflection on experience
- cognitive apprenticeship, which incorporates teaching students how to conceptualise and think
- scaffolding and coaching, which involves provision of foundations and support for student learning
- the provision of learning activities that require students to articulate their own learning
- interactivity, through designing learning opportunities where students are active in their learning and interactive with others
- the engagement of multiple senses and emotions to enhance the learning process
- multiple opportunities for practice over time, particularly of clinical skills, and of complex cognitive skills, like analysis and critique.

An innovative clinical assessment model forms the cornerstone of the new curriculum framework. This model requires nursing students to develop and demonstrate competency (according to the Australian Nursing and Midwifery Council Competency Standards for the Registered Nurse, 2005) on multiple occasions across a range of contexts before graduation (Levett-Jones, 2005a).

A flexible learning approach is fostered in the undergraduate nursing program through the use of:

- an online library and internet resources
- asynchronous online learning
- online forums for group-based work

- the use of multiple types of learning materials to cater to diverse learning styles (visual, auditory, stories, analytical etc.).

4.4.3 Duration and structure of clinical placements

Consistent with the nature of the comprehensive curriculum, the New South Wales Nurses and Midwives Board requires nursing students to undertake clinical placements across a wide range of facilities and clinical specialities that reflect diverse service levels (New South Wales Nurses Registration Board, 2003). Thus, students at site 1 undertake placements in a range of different clinical facilities, including, but not limited to, medical-surgical wards, mental health units, aged care and community health centres.

A total of 832 clinical placement hours are scheduled during the three-year undergraduate program. Students in the first semester of first year do not attend clinical placements. In second semester of first year they undertake two 32-hour (four-day) clinical placement blocks. In second year there are two 64-hour (eight-day) blocks per semester, totalling 256 hours for the year. In third year students attend three 64-hour clinical placement blocks in their first semester, and two seven-week blocks (of 24 hours per week) in their final semester. There are a total of 448 clinical placement hours in third year. All clinical placements are preceded by a week of on-campus learning in simulated clinical skills laboratories, during which students practise nursing skills specific to their level of experience under the supervision of clinical educators.

4.4.4 Model of clinical supervision

Site 1 employs sessional clinical facilitators for first- and second-year students at a ratio of one facilitator for 8–12 students. Facilitators are employed by the university on a casual basis or seconded for short periods of time from clinical venues. Qualification requirements are degree status (or equivalent) and a minimum of three years postgraduate experience. Facilitators work across a range of venues and are not always allocated to specialty areas or clinical venues with which they are familiar. A one-day orientation session is provided on employment, as well as updates throughout the academic year. Facilitators remain within the clinical environment for the total clinical placement time, working between two or more wards to supervise students. They are responsible for assisting students to acquire the required knowledge, skills and attitudes to meet the competency standards defined by the Australian Nursing and Midwifery Council (Australian Nursing Council, 2005).

Facilitators liaise between students, academic and clinical staff in a tripartite relationship; their goals include the integration of theory and practice, facilitation of student socialisation and acculturation to the workplace and development of positive relationships between students and nursing staff.

Third-year students are supported by a RN employed in a healthcare facility who assumes the role of clinical mentor.[2] Mentors are responsible for supporting, teaching and assessing students in practice, and they liaise between the student and the university. Depending on the context and staff profile, consistent mentors may not always be provided and students may be "buddied" with different RNs each day.

Table 4.1 Site 1 at a glance

Student demographics	Site 1—School of Nursing and Midwifery	3rd year undergraduate nursing students at site 1	Survey participants
Average age	27.5	27.6	27.7
Gender balance	85 % women 15% men	88% women 12% men	87% women 13% men
Attrition rate	11%		
Number of undergraduate students	1253	265	160

Information provided by the University Information Analyst (e-mail communication, 1 September 2006).

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[2] In Australia the terms *mentor* and *preceptor* have evolved and are often used interchangeably to describe a supportive educative role. For the purpose of this thesis, mentor will be used to describe registered nurse clinicians who support and guide students during their clinical placements.

4.5 Queensland

4.5.1 Regulation of nursing in Queensland

The Queensland Nursing Council (QNC) is an independent statutory body that regulates nursing and midwifery in Queensland. The QNC is directly accountable to parliament through the Minister for Health. The QNC's mission is to provide for safe and competent nursing and midwifery practice in Queensland by:

- issuing licences and keeping a register and roll of licensed nurses and midwives
- setting and monitoring standards for the approval of course providers and courses leading to registration, and approving nursing courses which meet the appropriate standards
- assessing and investigating concerns about the ability, health, behaviour or conduct of nurses and midwives (Queensland Nursing Council, 2006).

4.5.2 Workforce

In 2001 there were 36,817 RNs in Queensland. The number of registered nurses employed by Queensland Health increased by 16 per cent between 1995 and 1999 (Senate Report, 2002).

4.6 Site 2

4.6.1 Location

Site 2 is a large university with a student population of nearly 40,000. There are just over 6000 international students from 121 different countries. While the university has 50 sites throughout Queensland, there are three main campuses: two in metropolitan areas and the smallest and most recently established in a semi-rural area approximately 50 kilometres from Brisbane. The nursing program is based at this campus, although nursing students spend most of their time off-campus, co-located with students from other health professions, in clinical schools in a range of major hospitals where they attend tutorials, laboratories and clinical placements. Students attend the main university campus only for resource sessions (lectures) one day a week.

4.6.2 Curriculum framework—Bachelor of Nursing program

The recently developed undergraduate nursing program at site 2 is based upon an innovative approach that emerged from a strategically planned partnership between the university and local healthcare providers. The program was developed in response to the recommendations made by the National Review of Nursing Education (Heath et al., 2002) and aimed to improve graduate outcomes and transition to practice (Turner, Davies, Beattie, Vickerstaff & Wilkinson, 2006). The curriculum was developed by a joint curriculum advisory committee that sought to provide a forum for collaborative engagement of representatives from education and workforce sectors. The program is based on an integrated, problem-based learning curriculum where students use case studies to relate theory to practice. The principles of this program include:

- the development of fundamental knowledge in a number of specialty areas and the facilitation of students' exposure to elective specialty areas in their second year.
- responding to areas of greatest industry need by preparing registered nurses for practice in areas where there are shortages of nurses and projected areas of need within the Australian health system (such as rural health, public health, indigenous health, community health, mental health, aged care and other specialty areas) (Meppem, 2005).

Site 2 has a staffing model that is relatively new to Australian nursing programs. Jointly appointed clinical lecturers are responsible for on-site teaching conducted in clinical schools. Clinical lecturers are clinicians with relevant academic qualifications. They are often seconded from the clinical facility where they work as clinicians. For approximately every 20 students there is a designated clinical lecturer (Turner et al., 2006). The clinical lecturers' primary responsibility is to teach problem-based learning tutorials. Apart from clinical assessment and trouble-shooting, they have a limited role in clinical teaching and support (M. Sendell, personal communication, 15 July 2006).

4.6.3 Duration and structure of clinical placements

In accord with the guidelines of the Queensland Nursing Council (QNC) (2005) recommending that clinical placements are linked to the services and facilities available in local institutional and community settings, students at site 2 undertake their clinical education in a range of metropolitan and regional clinical settings.

Clinical placement locations and duration are not mandated by the QNC. Students at site 2 attend placements for two days per week (for eight weeks of each semester) during the first two years of their program. This makes a total of 240 placement hours in first and second year. An extended block of 45 shifts is undertaken in first semester of third year and 60 shifts in the final semester. In third-year there are 840 placement hours. Students undertake 1320 hours of clinical placements in total (Turner et al., 2006).

4.6.4 Model of clinical supervision

Students at site 2 are assigned to registered nurse clinicians, who act as their mentors during each clinical placement but, similarly to site 1 they do not always have a designated or consistent mentor for their placements.

Table 4.2 Site 2 at a glance

Student demographics	Site 2—School of Nursing and Midwifery	3rd year undergraduate nursing students at site 3	Survey participants
Average Age	23	27	25
Gender balance	93 % women 7% men	92% women 8% men	93% women 7% men
Attrition rate	9%		
Total number of undergraduate students	347	75	61

Information provided by the School of Nursing and Midwifery Undergraduate Program Director (e-mail communication, 24 August 2006)

4.7 Nursing in the United Kingdom

4.7.1 Historical context

Historically, the apprenticeship model was the dominant model of nurse training in the UK. Under this model students were salaried members of nursing staff and learned most of the skills of their future role through immersion in clinical practice. Although students spent three years studying in National Health Service (NHS) schools of nursing, the nursing courses leading to registration carried no academic recognition. In the second half of the

twentieth century the nursing profession in the UK expressed increasing concerns about the standards and achievements of the education provided by the apprenticeship model (Gerrish, 1990; Lathean, 1987). It was felt that nursing programs failed to provide students with the necessary knowledge and understanding that should underpin clinical skills and adequately prepare them for the role of qualified nurse. Furthermore, in the apprenticeship model there was an emphasis on the students' contribution to the workforce, with learning needs often relegated to secondary importance (Gerrish, 1990; Lathean, 1987). The tensions between learning on the job and a formal education for nurses, as in many other countries, created discord and calls for improvement (Mallaber & Turner, 2006). Over the years a number of reports had reiterated these problems (for example: Lancet, 1932; Athlone, 1939; Wood, 1947; Briggs, 1972, cited in Watkin, 1975). While there appeared to be some agreement about the problems in nursing, there was not always consensus of opinion, even within the nursing profession, about the solutions. As late as the 1970s, attempts to impose greater educational rigour on nurse training were resisted by some:

> We must abandon the dream, held by some, that nurse education in the United Kingdom will ever be divorced from service. Certainly for many years, with nurse trainees forming one third of the total hospital nursing staff labour force, and economic restrictions, this change is impossible – and for some, at least, including the writer, it is undesirable. (Bendall, 1976)

However, after nearly a century of debate about where nursing education should be situated and despite ongoing reservations from a number of sectors, the British Government announced in 1986 that there would be a phased transfer of nursing education into the tertiary education sector, and the first graduates began to appear in the mid-1990s (Burke, 2003). In undertaking a historical analysis of the factors that ultimately led to the transfer, Burke (2003) suggested that a culmination of factors were influential including:

- the inadequacy of the current nursing education model to prepare students for a rapidly changing healthcare environment
- the introduction of an internal market into the NHS
- perceived cost savings associated with transferring nursing into higher education
- a change in attitude by the higher education providers, as they began to consider the transfer as a promising financial venture
- a need to maintain recruitment numbers of nurses in an era when many young people were expecting to go to university.

It is noteworthy that before the transfer groundwork had already been laid through forward thinking health/education collaborative ventures. As early as 1965 there were nursing courses in some UK hospitals for students of above-average educational attainment that led to a non-nursing university degree and a nursing qualification (Macguire & Jackson, 1973). There were also some universities offering degrees in nursing, with the first Bachelor of Nursing degrees awarded by the University of Manchester in 1969 (MacGuire, 1970).

The introduction of the Project 2000 pre-registration nursing curriculum (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 1986) precipitated unprecedented change in nursing education. The aim of the Project 2000 curriculum was to produce a practitioner with the requisite knowledge and skills to function in a rapidly changing healthcare environment (Gerrish, 1990). The new programs were granted academic recognition and led to a diploma of higher education. These new courses involved:

- a three-year program with an 18-month common foundation program, followed by branch specialisation.
- a move from salaried to student status (apart from 20 per cent rostered service in the final year).
- an emphasis on health perspective and normal functioning as opposed to a disease and dysfunction model (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 1986).

While some studies propose that the introduction of the Project 2000 curriculum produced qualified nurses who had a greater commitment to lifelong and self-directed learning (Gerrish, 2000), other studies claimed that the increased importance given to the academic components of the curriculum led to deficits in the clinical and managerial skills of qualified nurses (While, Roberts & Fitzpatrick, 1995). These deficits were attributed to the emphasis on academic theory at the expense of practice-based training (While, Roberts & Fitzpatrick, 1995). It was suggested that students felt that their clinical placements were too short to enable them to develop confidence in their clinical skills through repetitive practice (Ross & Clifford, 2002). In some instances, individuals studying in the new three-year program had very little to do with patients in their first 18 months,

and practice placements tended to be short, with students having little time to rehearse skills in an environment with which they were familiar (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 1986).

Criticism of the lack of "fitness for practice' of registered nurses educated through the Project 2000 courses led to the recommendations of the Peach Report (Peach, 1999). These recommendations re-emphasised the need to ensure "fitness for purpose" and "competence to practise" as outcomes of three-year programs leading to registration and called for a re-evaluation of the provision of practice education with equal emphasis being placed on both the quality of clinical education and the theoretical components. Additionally the Peach Report (Peach, 1999) refocused attention on the importance of the development of constructive partnerships between NHS Trusts and the Higher Education Institutions (HEI) (Mallik & Aylott, 2005). Following two UK policy reports (Department of Health, 1999; Peach, 1999), clinical learning for UK students was increased to allow for earlier clinical exposure and longer practice placements, and supernumerary status was extended to the whole program.

4.7.2 Health care in the UK

The last two decades have seen changing healthcare demographics in the UK. Of note are: the increase in the number of older, sicker and more dependent patients needing complex technical care; shorter hospital stays and increased patient throughput; and a shift from a model of secondary to primary care. Additionally, changes in the organisation and delivery of health care have resulted in the increased use of unqualified support workers, as well as an emphasis on efficiency gains and workforce flexibility (Gerrish, 2000).

Currently in the UK seven targeted health research priority areas reflect the population health of that country. These are:
- cancer
- mental health
- coronary heart disease
- ageing and older people
- public health
- genetics

- diabetes (Department of Health, 2006).

Healthcare in the UK is managed and monitored by the NHS. Primary Care Trusts (PCTs) are at the centre of the NHS and control 80 per cent of the total NHS budget. PCTs are responsible for:

- assessing the health needs of the population in a specified region
- commissioning the right services—for instance, from general practitioners, hospitals and dentists—to meet these needs
- ensuring access and equity of services.

Hospitals in the NHS are managed by Trusts (sometimes called Acute Trusts). Their services are commissioned by PCTs and include hospital, day surgery and out-patient services.

Strategic Health Authorities (SHAs) are the link between the NHS and the Department of Health. They are responsible for managing and setting the strategic direction of the NHS locally. Specifically, they

- monitor how well PCTs and NHS Trusts (hospitals) in their area are performing and take action to improve services
- develop plans for improving health services in their area—including strategies for making better use of information technology
- ensure national priorities are fully reflected in local health service plans.

The independent sector works collaboratively with the NHS. Although this sector is run by independent companies, they are required to meet the quality clinical standards demanded by the NHS. Social care providers provide care packages to people in their own homes. These aspects of care are arranged by social services departments managed by local authorities. The provision of care packages aims to maximise people's quality of life and independence (NHS, 2006).

4.7.3 Workforce issues—UK

The NMC (2005, pp. 3–4) provides the following summary of the demographic trends of the nursing workforce in the UK:

- The number of nurses registered in the UK in the year 2004–5 was 672,897. This is at its highest level and reflects a small but steady increase over the last decade.

This number does not necessarily translate to the number of practising nurses in the UK.

- The majority of RNs reside in England (520,579), reflecting the population density of the UK.
- There are 21,814 RNs in Northern Ireland, 64,915 in Scotland and 32,310 in Wales.
- The number of nurses leaving the profession each year averages 3–3.5 per cent, a trend that has been consistent over the last 7 years.
- There is a continued long-term trend of a gradually aging workforce, with over 60 per cent of the nursing workforce older than 40 and more than a quarter older than 50 years.
- The gender balance of the nursing workforce is 89 per cent male and 11 per cent female.

4.7.4 Nursing education—UK

Recent government statistics indicate that in 2005 over 180,000 students (164,000 females and 20,000 males) were enrolled in pre-registration nursing programs in the United Kingdom (Higher Education Statistics Agency, 2005). This reflects a significant growth in numbers over the last five years, and is in line with the government's modernisation agenda (Department of Health, 2000). Attrition rates for student nurses in the UK are estimated to be between 19 and 18 per cent, although figures as high as 25 per cent are evident in some areas of London and Scotland (Royal College of Nursing, 2006). While the need to increase the number of students entering nursing education has become a clear priority for the government, there still remains a significant shortage of nurses in the UK.

Funding for nursing education is centrally controlled through Workforce Development Directorates (WDDs). The contracting system nominally allows the HEI to ensure that the costs of supporting students in practice are met. However, problems exist where there is competitive tendering between universities for pre-registration contracts or where there is limited funding in central budgets (Mallik & Aylott, 2005).

4.7.5 Regulation of nursing in the UK

The Nursing and Midwifery Council (NMC), an organisation set up by parliament, is the regulatory body for nurses, midwives and specialist community public health nurses in the UK. Until 2002, this function was the responsibility of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). The principle function of the NMC is to protect the public by:

- maintaining a register of qualified nurses, midwives and specialist community public health nurses
- setting standards for conduct, performance and ethics for the professions it regulates
- considering allegations of misconduct, lack of competence or unfitness to practice
- ensuring the quality of nursing and midwifery education, including approval of educational programs and annual monitoring processes to confirm that the standards of proficiency are being met in practice.

4.8 Site 3

4.8.1 Location

Site 3 is situated in the south of England. The School of Nursing and Midwifery is one of the largest schools in the UK, providing pre-registration education to over 5000 students. Within the local geographical area, site 3 is the major local provider of nursing education. The school's main campus is based in a well-equipped, purpose-built building on the university's main campus.

The government's drive to increase the numbers of nursing students, mentioned previously, is evident at site 3, where the total number of nursing student numbers commissioned by the Workforce Development Directorate (WDD) has substantially increased. From 1998 to 2005 the intake for pre-qualifying nursing students has nearly doubled (WDD, 2004). Until recently the majority of students in pre-registration nursing education programs at site 3 have undertaken their placements in the local geographical area. Increasing numbers of student enrolments placed significant pressure on the capacity of clinical units to support students, adversely affected the quality of the clinical learning experiences and impacted on attrition rates (WDD, 2004). In order to address

these issues, an initiative termed *locality commissioning* was developed by the local WDD (WDD, 2004). Locality commissioning refers to the process of commissioning required numbers of nursing students by geographical locality (WDD, 2003). Students are then allocated to a geographical area for the duration of their course and undertake the majority of the theoretical components and their practice placements within that region. The aim is to enable mapping of placements with the potential employment opportunities across the local region (Lathlean & Myall, 2006).

The implementation of locality commissioning for pre-registration nursing education in the Strategic Health Authority (SHA) linked to site 3 was introduced in 2003 throughout five localities. Each locality includes one or more Primary Care Trust(s) (PCTs) and their local Acute Trusts. Within each of the localities, the WDD undertakes nursing commissions based on information provided by the local NHS Trusts in relation to future workforce demand. Commissions are made (a) in the four branches of nursing—adult, child, mental health and learning disability, as well as in midwifery; and (b) to each of the three pre-registration award programs—degree, diploma or advanced diploma. Once commissioning targets have been set it is then the role of the university to market and recruit students to the planned localities (Lathlean & Myall, 2006). Contractual arrangements with Trusts require that adequate numbers of clinical placements are provided and that students are provided with a designated mentor for the duration of their placement (Nursing and Midwifery Council, 2004a).

4.8.2 Curriculum framework

Students at site 3 complete a common foundation program and then pursue their choice of branch—adult, children's, learning disability or mental health nursing (Nursing and Midwifery Council, 2002). In line with the European Union Directives 77/452/EEC and 77/453/EEC (European Union Directive, 1977a, 1977b), the Nursing and Midwifery Council (NMC) (2002) has dictated that nursing programs are to be 4600 hours long and to comprise 50 per cent theory and 50 per cent clinical practice learning. The purpose of these requirements is to achieve mutual recognition of formal nursing qualifications by all members of the European Union, and to define the minimum standards to be observed by each member country.

The curriculum of the nursing program at site 3 is based on the principle of enquiry-based learning (EBL), a strategy designed to develop skills in reflection, clinical reasoning and critical thinking. Working in small groups led by academic facilitators, students explore concepts of practice by examining a variety of scenarios and clinical case studies (School of Nursing and Midwifery, 2006). Contemporary educational approaches such as EBL depend heavily upon the principles of self-directed learning (Albanese & Mitchell, 1993). EBL teaching methodologies demonstrate the complementary nature of theory and practice and promote conceptual understanding, development of reasoning skills and self-directed learning strategies. In EBL the handling of a complex problem or issue defines and drives the learning experience of the students. Students are then challenged, either individually or more commonly within the context of a small group, to define for themselves the issues emerging from the problem, to decide what further knowledge they require in order to address these issues, to undertake the research they have identified as requisite, and to apply that research towards the presentation of outcomes. The curriculum is thus structured by a series of problems or issues, rather than a systematic presentation of subject content (Levett-Jones, 2005b).

In addition to EBL, learning opportunities are provided in larger groups, via lectures and tutorials, using multimedia resources and in skills laboratories. Interprofessional learning is emphasised: nursing students work with students from other health and social care programs. Students are allocated an academic tutor to support and guide them through the program (School of Nursing and Midwifery, 2006). In line with NMC requirements, evidence of the achievement of the standards of proficiency in the practice of adult nursing, mental health nursing, learning disabilities nursing or children's nursing is required to be eligible to qualify as a nurse (Nursing and Midwifery Council, 2004b).

4.8.3 Duration and structure of clinical placements

The NMC (Nursing and Midwifery Council, 2002) and the European Union Directives (European Union Directive, 1977a, 1977b) prescribe the amount and type of experience that students must have in order to be eligible for registration. Students in the adult nursing branch undertake clinical placements in a variety of facilities, including hospital wards, clinics and community settings such as nursing homes, home visits and local health centres. Students enrolled in the mental health branch gain experience in a range of mental health settings, as well as one general nursing placement aimed at developing

physical nursing skills. Similarly, learning disability placements include a broad range of settings in addition to one placement in mainstream health services. Students studying in the field of children's nursing undertake placements across a range of settings aimed at learning about the healthy child and providing care for children and young children experiencing ill health (School of Nursing and Midwifery, 2006).

Clinical visits occur in first semester and placements early in the second semester. Clinical shifts are 7.5 hours. Rosters are full-time and are organised by the student in negotiation with the ward sister and/or clinical mentor. Students are advised to work the same shifts as their "named" mentor for at least three out of five shifts per week. Nursing students undertake a minimum of 2300 clinical placement hours over the three years, with 562.5 hours in both first and second year, and the remainder in third year.

4.8.4 Model of clinical supervision

Support for practice learning is delivered through practitioner–student partnerships in practice environments. Students are supervised by a designated mentor who is a registered nurse. The requirements of the UK regulatory and educational authorities specify the following:

- Nurses must have held their registration for at least a year before taking on the role of mentor.
- Prospective mentors are required to undertake an approved mentorship preparation course (ENB 998 or equivalent) funded by the WDD and NHS Trusts, and to meet the eight NMC defined standards for mentors and mentorship, which outline the role of the mentor in nursing and midwifery education (Nursing and Midwifery Council, 2004b).
- Mentors are to attend and record annual mentor updates.

Advisory standards issued by the UKCC clarified the functions and responsibilities of the mentor role (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 2000). Further clarification was produced by the ENB and Department of Health, which defined a mentor as a practitioner "who facilitates learning and supervises and assesses students in the practice setting" (ENB & DoH 2001, p. 6). Subsequent generic guidelines for mentors in the UK were produced by the Nursing and Midwifery Council (2002; 2004b; 2005a). These guidelines stated that the responsibilities of the role were to include:

provision of support and guidance in the practice area; facilitation of student learning; assessment and evaluation of the student; acting as a positive role model; and ensuring students are fit for purpose, practice, and award. Typically mentors have three interview sessions with students during the placement period. The first aims to identify clinical learning objectives and the related strategies to achieve these objectives, and the second and third interviews review and assess progress towards achievement of the students' objectives.

Following consultations by the NMC relating to the quality and nature of support for assessment and learning in practice and fitness for practice, new standards for mentors, practice teachers and teachers will come into effect from September 2007 (Nursing and Midwifery Council, 2006). The document *Standards to Support Learning and Assessment in Practice* will replace all previously published standards and will introduce changes to the role of the mentor and the way in which students are assessed in the clinical area. In particular, "sign-off mentors" who have met additional NMC criteria will make the final assessment of students and confirm to the NMC that they are fit for practice. The standards provide a more regulated, structured and rigorous approach to the provision of quality mentorship and clinical teaching in the UK.

Site 3 also provides a university link team that helps to support the interface between university life and students' clinical placement areas. Members of academic staff, called link tutors, liaise between specific areas of practice and the School of Nursing and Midwifery. Link tutors are based at the university and visit clinical venues as required. They are primarily responsible for helping to ensure that placement facilities meet the NMC requirements and, when required, carrying out audits of the clinical facilities (School of Nursing and Midwifery, 2006). Site 3 also utilises learning environment facilitators. These are registered nurses who are based within NHS Trusts and the independent sector. The main responsibility of learning environment facilitators is the development of quality learning experiences that enable students to meet learning outcomes of the award in which they are enrolled by developing fitness for practice within the nursing profession. They also support mentors, and work in partnership with practitioners, students, the university, the NHS and the independent sectors to manage clinical placement issues (School of Nursing and Midwifery, 2006).

Table 4.3 Site 3 at a glance

Student demographics	Site 3—School of Nursing and Midwifery	3rd year nursing students at site 3	Survey participants
Average age	29	27	26
Gender balance	91% women 9% men	93% women 7% men	93% women 7% men
Attrition rate	16%		
Total number of pre-registration students	5000	504	142

Information provided by the Senior Student Support and Records Officer (e-mail communication, 9 August 2006)

4.9 Conclusion

In this chapter the similarities and differences between nursing in Australia and nursing in the UK have been described, as well as the defining features of each curriculum. The purpose of this chapter was to provide a contextual backdrop to the study and to provide a level of detail and description that will allow the reader to gain an appreciation of the social world of the case being studied. In the following chapter the results from the quantitative data analysis are presented. The chapter begins by describing the demographic characteristics of the total study sample and the three sub-samples. This builds upon the knowledge gained from Chapter 4, and the reader is afforded a more complete understanding of the contextual features of each site. Following on from this, the quantitative data from the survey are subjected to descriptive and inferential statistical analysis.

Chapter 5

Results from the Quantitative Phase of the Study

5.1 Introduction

In Chapter 3 the research design was outlined and in Chapter 4 the context of each of the study sites was described. Both chapters provided a background to the subsequent data analysis. In this chapter the results of the quantitative phase of the study are presented as the first two research questions and the related hypotheses are addressed. The chapter unfolds in the following order:

- data preparation
- demographic characteristics of the study participants
- descriptive and inferential statistical analysis of research questions 1 and 2 and hypotheses 1–6
- validity and reliability measures
- factor analysis.

5.2 Data preparation

A total of 368 online questionnaires were submitted. Data were cleaned before analysis and six questionnaires were excluded from analysis based on a conservative criterion of having 20 per cent or more missing data. In analysing missing data for the remaining questionnaires (items 1–34), it was determined that some had no missing values, most were in the range 0.5–2 per cent, and the highest was 3.3 per cent. On examination it was noted that there was no discernable pattern to the missing data nor did it appear to relate to the nature of the questions. A table in which missing values were analysed is provided in Appendix 15.

5.3 Demographic characteristics of participants

As outlined in Chapter 4, the participants were recruited from three universities, two in Australia and one in the UK. The three universities were labelled site 1 (New South Wales), site 2 (Queensland) and site 3 (UK). The largest segment, or 44.2 per cent of the sample, came from site 1 (n^1 = 160). This figure includes the pilot study sub-sample. Site 2 comprised 16.9 per cent of the participants (n = 61), and 39 per cent of the sample were from site 3 (n = 141). The majority, or 90.4 per cent, of participants were women (n = 322). The participants' ages ranged from 20 to 60 years. School leavers, or those in the 19–22 age group, comprised 41.5 per cent of participants (n = 144). Mature-age students, aged 23 years and above, comprised 58.5 per cent (n = 203).

The award of Bachelor of Nursing is the only nomenclature offered to Australian nursing students whereas in the UK Bachelor of Nursing, Advanced Diploma in Nursing and Diploma in Nursing are offered. The majority of the participants, 68.3 per cent, were enrolled in a Bachelor of Nursing program (n = 244).

In both Australia and the UK, a number of students work or have worked in the field of nursing in roles such as assistant in nursing, enrolled nurse or healthcare assistant. During the pilot study interviews, it was identified that this factor may influence students' experience of belongingness. Consequently, a question eliciting whether or not participants had nursing experience apart from that included as part of their current studies was added to the demographic section of the survey for the main study. Results revealed that the majority, or 60.2 per cent of participants in the main study, had previous or concurrent nursing experience (n = 189).

The influence of immediate family members on students' experience of belonging was also identified during the pilot study interviews as a potential influence on their experience of belongingness and a related question was added to the survey for the main study. It was shown that 26.8 per cent of participants in the main study had immediate family members with nursing experience (n = 85).

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[1] A glossary of the statistical symbols and terms used in this thesis is provided on page xx.

The majority of the participants identified Australia (47.1 per cent, n =162) or the UK (41 per cent, n = 141) as their country of birth. A wide range of other countries were represented by 11.9 per cent of participants (n = 41). For 8.14 per cent of the participants, English was not their first language (n = 29). Table 5.1 contains a summary of the demographic characteristics of the participants.

Table 5.1 Demographic characteristics: total sample

	Sample	Per cent[1]
Sample composition (N = 362)		
Site 1 (includes pilot study n = 41)	160	44.2
Site 2	61	16.9
Site 3	141	39.0
Academic program (N = 357)		
Bachelor of Nursing	244	68.3
Advanced Diploma in Nursing	82	23.0
Diploma in Nursing	31	8.7
Age (N = 347)		
19–22	144	41.5
23–25	44	12.7
26–30	47	13.0
31–40	67	18.5
41–50	42	11.6
51–60	3	.8
Gender (N = 356)		
Women	322	90.4
Men	34	9.6
		(Continued)

	Sample	Per cent[1]
Previous or concurrent nursing experience (N = 314)		
Yes	189	60.2
No	125	39.8
Family members with nursing experience (N = 317)		
Yes	85	26.8
No	232	73.2
English as first language (N = 356)		
Yes	327	91.9
No	29	8.1
Country of birth (N = 344)		
Australia	162	47.1
UK	141	41.0
Asia[2]	24	7.0
Other[3]	17	4.9

[1] Not all percentages add up to 100 due to rounding.

[2] Asia: Brunei, Cambodia, China, Korea, Malaysia, Philippines, Singapore.

[3] Other: Czech Republic, France, Germany, Kenya, New Zealand, Papua New Guinea, South Africa, Tonga, USA, Zimbabwe.

5.3.1 Demographic characteristics of participants from site 1

A total of 265 third-year students were enrolled at site 1 during the period of the study and 160 participated in the study, giving a response rate of 60.8 per cent. The sample was representative of the population in terms of campus of enrolment, age and gender (refer to Table 5.2 Demographic characteristics: site 1). These demographic characteristics were tested using a one-sample chi-squared test in which the population frequencies were taken as the expected values for comparison with the sample values. The following results

were obtained: campus of enrolment, $\chi^2(2, n = 160) = .64, p = .73$; age $\chi^2(5, n = 160) = 6.3, p = .28$; and gender $\chi^2(1, n = 160) = .4, p = .53$.

Site 1 consists of three campuses. The majority of participants, or 71.2 per cent, were from campus 1 ($n = 114$). Campus 2—the pilot study sub-sample—comprised 25.6 per cent of participants ($n = 41$). Campus 3, a recently established, much smaller site, comprised 3.2 per cent ($n = 5$). The majority of participants from site 1, or 88.1 per cent, were women ($n = 141$). Participants' ages ranged from 20 to 60 years. School leavers comprised 33.1 per cent of participants ($n = 53$) and mature-age students 66.9 per cent ($n = 107$).

The majority, or 65.8 per cent, of participants had additional nursing experience ($n = 77$). Approximately a quarter, or 26.9 per cent, of participants had immediate family members with nursing experience ($n = 32$). As the pilot study was undertaken at campus 2, there are no data related to nursing experience or family members for this cohort of participants.

The majority, or 76.8 per cent, of the participants identified Australia as their country of birth ($n = 119$). A sizable number, 14.2 per cent, identified one of a group of Asian countries as their country of birth (n = 22). A range of other countries were represented by 9.1 per cent of participants ($n = 14$). For 15.1 per cent of the participants, English was not their first language ($n = 24$). Table 5.2 contains a summary of the demographic characteristics of the participants from site 1.

Table 5.2 Demographic characteristics: site 1 (New South Wales)

	Sample	Per cent	Population	Per cent[1]
Sample composition ($n = 160$)			($N = 265$)	
Campus 1	114	71.2	196	74.0
Campus 2	41	25.6	61	23.0
Campus 3	5	3.2	8	0.3
Age ($n = 160$)				
19–22	53	33.1	102	38.5
23–25	25	15.6	47	17.7
				(Continued)

	Sample	Per cent	Population	Per cent[1]
26–30	25	15.6	35	13.2
31–40	33	20.6	53	20.0
41–50	22	13.8	24	9.0
51–60	2	1.3	4	1.5
Gender (*n* = 160)				
Women	141	88.1	229	86.4
Men	19	11.9	36	13.6
Previous or concurrent nursing experience (*n* = 117)				
Yes	77	65.8		
No	40	34.2		
Family members with nursing experience (*n* = 119)				
Yes	32	26.9		
No	87	73.1		
English as first language (*n* = 159)				
Yes	135	84.9		
No	24	15.1		
Country of birth (*n* = 155)				
Australia	119	76.8		
Asia[2]	22	14.2		
Other[3]	8	5.2		
UK	6	3.9		

[1] Not all percentages add up to 100 due to rounding.

[2] Asia: Brunei, Cambodia, China, Korea, Malaysia, Philippines.

[3] Other: France, Germany, New Zealand, South Africa, Tonga, Zimbabwe.

5.3.2 Demographic characteristics of participants from site 2

As discussed in Chapter 4, site 2 was a recently established school of nursing and midwifery, and as such had the smallest student cohort of the three sites (N = 75). As a consequence there were fewer participants from site 2 than from the other two sites (n = 61). This indicates a response rate of 81.3 per cent. The sample was representative of the population in terms of clinical partner hospital, age and gender (refer to Table 5.3 Demographic characteristics: site 2). Demographic characteristics were tested using a one-sample chi-squared test in which the population frequencies were taken as the expected values for comparison with the sample values. The following results were obtained: clinical partner hospital χ^2(2, n = 61) = 3.55, p = .17; age χ^2(1, n = 56) = .46, p = .5; and gender χ^2(1, n = 56) = .56, p = .81.

Once again the majority of participants from this site, or 92.9 per cent, were women (n = 52). Their ages ranged from 20 to 50 years. School leavers comprised 57.1 per cent of participants (n = 32) and mature-age students comprised 42.9 per cent (n = 29). The participants from site 2 were located at one of two clinical partner hospitals, with the majority, or 50.8 per cent of participants, located at hospital 2 (n = 31), and the remainder, or 23 per cent, located at hospital 1 (n = 14). It should be noted that 16 of the participants did not specify their clinical partner hospital.

The majority, or 64.3 per cent of participants, had additional nursing experience (n = 36). Participants who had immediate family members with nursing experience comprised 40.4 per cent (n = 23).

The majority, 81.1 per cent, of the participants identified Australia as their country of birth (n = 43). A range of other countries were represented by 18.9 per cent of participants (n = 10). English was not the first language for 3.5 per cent of the participants (n = 2). Table 4.3 contains a summary of the demographic characteristics of the participants from site 2.

Table 5.3 Demographic characteristics: site 2 (Queensland)

	Sample	Per cent	Population	Per cent[1]
Sample composition (n = 61)			(N = 75)	
Clinical partner hospital 1	14	31.1	20	26.7
Clinical partner hospital 2	31	68.9	55	73.3
Not specified	16			
Age (n = 56)				
19–22	32	57.1	40	53.3
23–25	3	5.4	Note[4]	
26–30	5	8.9		
31–40	8	14.3		
41–50	8	14.3		
Gender (n = 56)				
Women	52	92.9	69	92.0
Men	4	7.1	6	8.0
Previous or concurrent nursing experience (n = 56)				
Yes	36	64.3		
No	20	35.7		
Family members with nursing experience (n = 57)				
Yes	23	40.4		
No	34	59.6		
English as first language (n = 57)				
Yes	55	96.5		
No	2	3.5		

(Continued)

	Sample	Per cent	Population	Per cent[1]
Country of birth (*n* = 53)				
Australia	43	81.1		
UK	3	5.7		
Asia[2]	2	3.8		
Other[3]	5	9.4		

[1] Not all percentages add up to 100 due to rounding.

[2] Asia: Philippines, Singapore.

[3] Other: New Zealand, Papua New Guinea, South Africa, USA.

[4] Note: combined statistics for the age group 23–53 (*n* = 25, 46.7%).

5.3.3 Demographic characteristics of participants from site 3

Of the three sites, site 3 had the largest number of third-year student enrolments (*N* = 504). Of these, 141 students participated in the study, giving a response rate of 28 per cent. This is a relatively low response rate. However, comparison of the demographic characteristics of this sample with those of the overall population suggested that the participants were a representative sample in terms of locality and gender, although not in terms of academic program or age (refer to Table 5.4 Demographic characteristics: site 3). Demographic characteristics were tested using a one-sample chi-squared test in which the population frequencies were taken as the expected values for comparison with the sample values. The following results were obtained: locality χ^2(4, *n* = 141) = 9.22, *p* = .06; gender χ^2(1, *n* = 140) = .11, *p* = .74. In the demographic of age, the 19–22 age group was over-represented in the sample and the other age groups slightly under-represented: χ^2(5, *n* = 131) = 79.1, *p* = <.001.

Students from site 3 were enrolled in either the Bachelor of Nursing, Diploma in Nursing or Advanced Diploma in Nursing. The largest group of participants, 56.4 per cent, were those enrolled in the Advanced Diploma in Nursing (*n* = 79). Participants from the Bachelor of Nursing and Diploma in Nursing were approximately equal in number, 22.1 per cent (*n* = 31) and 28.4 per cent (*n* = 30) respectively. In the sample group, the Bachelor of Nursing and Advanced Diploma in Nursing categories were over-represented and the Diploma in Nursing under-represented: χ^2(2, *n* = 140) = 13.5, *p* = .001). These statistics need to be

considered in light of the overall picture, as significant differences in mean BES–CPE scores between academic programs were not evident. The BES–CPE scores for academic program were analysed with a one-way analysis of variance (ANOVA). Using α = .05 and with test assumptions found to be satisfactory, the result was not statistically significant, $F(2, 137) = .73$, $p = .48$. Thus, although the low response rate is a concern in terms of representativeness of the population of nursing students at site 3, the lack of difference in mean belongingness scores against the demographic variable of program provides some assurance that the sample is not biased.

Of the participants from site 3, women comprised the majority, or 92.1 per cent ($n = 129$). Participants' ages ranged from 20 to 60 years. School leavers comprised 45 per cent of participants ($n = 59$) and mature-age students comprised 55 per cent ($n = 72$). The participants from site 3 were allocated to one of five localities, with the majority allocated to locality 1 (27.5 per cent, $n = 39$) and locality 5 (52.8 per cent, $n = 75$). Both of these localities were in major cities. Just over half of participants, or 53.9 per cent, had nursing experience apart from that provided as part of their academic program ($n = 76$). Participants who had immediate family members with nursing experience comprised 21.3 per cent ($n = 30$).

At site 3 a small number of participants, or 2.9 per cent, were born in countries other than the UK ($n = 4$). These participants identified the Czech Republic, Kenya, New Zealand or Zimbabwe as their country of birth. It should be noted that these students are not full fee-paying international students but British citizens. English was not the first language for 2.1 per cent of participants ($n = 3$). Table 5.3 contains a summary of the demographic characteristics of the participants from site 3.

Table 5.4 Demographic characteristics: site 3 (United Kingdom)

	Sample	Per cent	Population	Per cent[1]
Sample composition (*n* = 141)			(*N* = 504)	
Locality 1	39	27.7	135	26.8
Locality 2	7	5.0	38	7.5
Locality 3	7	5.0	38	7.5
Locality 4	14	9.9	23	4.6
Locality 5	75	53.2	270	53.6
Academic program (*n* = 140)				
Bachelor of Nursing	31	22.1	79	15.7
Advanced Diploma in Nursing	79	56.4	245	48.6
Diploma in Nursing	30	21.4	180	35.7
Age (*n* = 131)				
19–22	59	45.0	84	16.7
23–25	16	12.2	142	28.2
26–30	17	13.0	96	19.0
31–40	26	19.8	118	23.4
41–50	12	9.2	60	12.0
51–60	1	.8	3	.6
Gender (*n* = 140)				
Women	129	92.1	468	92.9
Men	11	7.9	36	7.1
Previous or concurrent nursing experience (*n* = 141)				
Yes	76	53.9		
No	65	46.1		

(Continued)

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	Sample	Per cent	Population	Per cent[1]
Family members with nursing experience (*n* = 141)				
Yes	30	21.3		
No	111	78.7		
English as first language (*n* = 140)				
Yes	137	97.9		
No	3	2.1		
Country of birth (*n* = 136)				
UK	132	97.1		
Other[2]	4	2.9		

[1] Not all percentages add up to 100 due to rounding.

[2] Other: Czech Republic, Kenya, New Zealand, Zimbabwe.

5.4 Research question 1

With respect to the clinical placement experience, to what extent do third-year nursing students from three different sites experience belongingness?[2]

To answer this question the mean BES–CPE scores for each question and for each site were computed and compared. Mean and standard deviation for BES–CPE scores for each item are demonstrated in Table 5.6 and ranked scores in Table 5.7. Answer choices for the BES–CPE were based on a 5-point Likert scale, with 1 = never true, 2 = rarely true, 3 = sometimes true, 4 = often true and 5 = always true.

The highest scoring item was number 2: "It is important to feel accepted by my colleagues" (*M* = 4.56, *SD* = .62). A mean score of 4.56 indicates that the majority, or 92.3 per cent, of students selected either often true (30.7 per cent, *n* = 111) or always true (61.6 per cent, *n* = 223) as their response to this item. As acceptance is one of the major components of belongingness (Baumeister & Leary, 1995; Hagerty, Lynch-Sauer, Patusky, Bouwsema &

[2] Belongingness is measured by the BES–CPE, a copy of which is provided as Appendix 1.

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Collier, 1992; Somers, 1999), this demonstrates the relative importance of belongingness to the vast majority of students.

To item 6, "I view my placements as a place to experience a sense of belonging", the majority of students, 61.1 per cent (n = 221), indicated that they perceive their clinical placement as an experience that should foster a sense of belonging. However, it should be noted that the majority of participants, or 61.6 per cent, indicated by their responses to item 14r, "On placements I feel like an outsider", that they do not experience a sense of belonging all or most of the time when on clinical placements (n = 223). It can be surmised that although belonging is important to the majority of students, a significant number do not experience belonging when on clinical placements and as a consequence often feel like outsiders. Noteworthy are the differences between the responses to question 14r by the participants from the three sites. At site 1, 74.2 per cent of participants indicated that they always, often or sometimes felt like an outsider. At site 2, 62.5 per cent of participants indicated that they always, often or sometimes felt like an outsider. At site 3, however, 50.4 per cent of participants indicated that they always, often or sometimes felt like an outsider.

BES–CPE scores for items 8, 12 and 26r were the lowest of the 34 items. This becomes particularly apparent when reviewing the error bar plot (Figure 5.1). For students who were in many respects short-term visitors to the clinical environment, it is perhaps not surprising that they kept "their personal lives to themselves" (item 26r) and were rarely "invited to social events outside of the placement" (item 8). Nor was it surprising that for many it was not "important that someone at the placement acknowledged their birthday" (item 12). While belonging is important to students, for the most part their clinical placement experiences were limited in duration and they did not have the same expectations of clinical staff as they would have of close friends or family members.
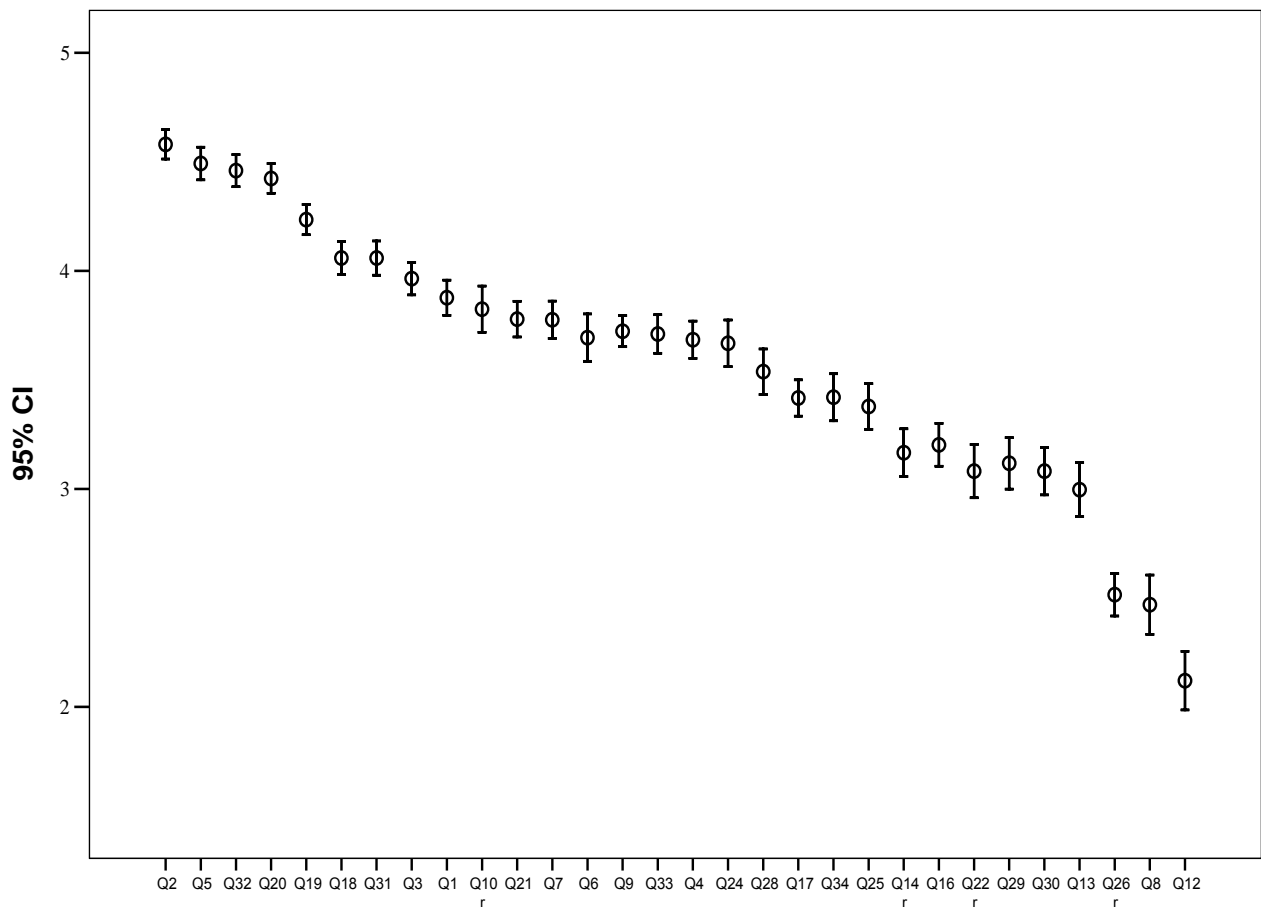
Figure 5.1 Error bar plot identifying questions 26r, 8 and 12 (on the right of the figure) as the lowest scoring items

The BES–CPE scores for the three sites were analysed with a one-way analysis of variance (ANOVA), using α = .05.[3] ANOVA test assumptions were found to be satisfactory, and the result was statistically significant, $F(2, 355) = 21.70$, $p = <.001$, $\eta_p^2 = .11$. Post hoc comparisons using the Tukey HSD test revealed significant differences between site 3 and both of the other sites; with a higher BES-CPE score being achieved at site 3, for sites 1–2 $p = <.81$, for sites 1–3 and for 2–3 $p = <.001$. Descriptive statistics are shown in Table 5.5 and mean BES–CPE scores with their 95 per cent confidence intervals are shown in Figure 5.2.

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[3] Unless otherwise specified, α = .05 for all statistical analysis in the study and all test assumptions are satisfactory.

Table 5.5 Mean BES–CPE scores for each of the three sites

Site	n	M	SD
Site 1	160	3.47	.39
Site 2	57	3.51	.39
Site 3	141	3.77	.42
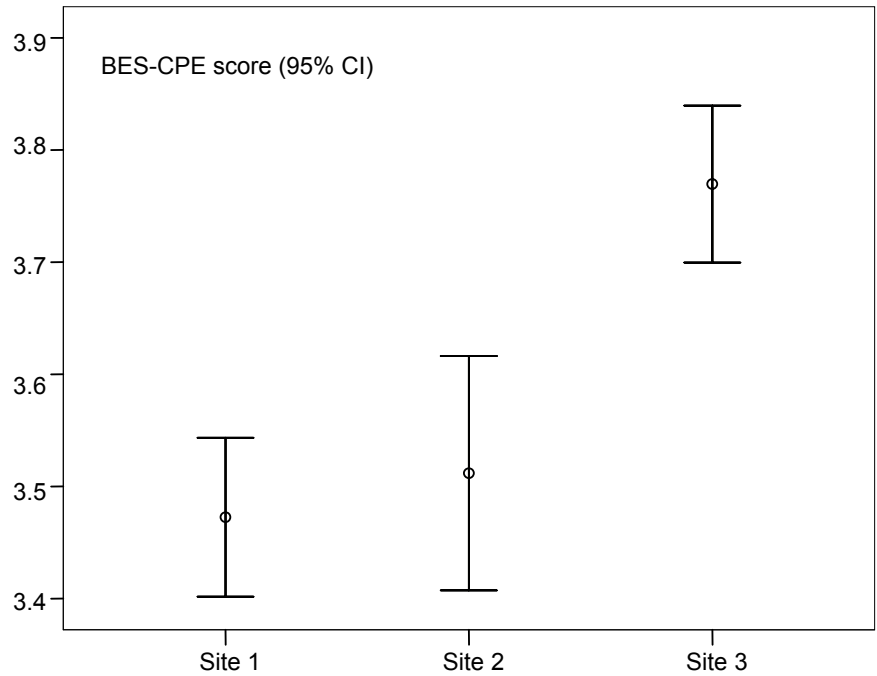
Figure 5.2 Mean BES–CPE scores with their 95 per cent confidence intervals for each site

Table 5.6 Mean and standard deviation for BES–CPE scores for each item

Items		*M*	*SD*	*N*
Q1	I feel like I fit in with others during my placements.	3.86	0.71	358
Q2	It is important to feel accepted by my colleagues	4.56	0.62	356
Q3	Colleagues see me as a competent person.	3.93	0.68	355
Q4	Colleagues offer to help me when they sense I need it.	3.69	0.78	358
Q5	I make an effort to help new students or staff feel welcome.	4.49	0.67	358
Q6	I view my placements as a place to experience a sense of belonging.	3.70	0.94	358
Q7	I get support from colleagues when I need it.	3.77	0.77	357
Q8	I am invited to social events outside of my placements by colleagues.	2.45	1.21	356
Q9	I like the people I work with on placements.	3.70	0.64	357
Q10r	I feel discriminated against on placements.	3.81	0.94	358
Q11	I offer to help my colleagues, even if they don't ask for it.	4.09	0.71	348
Q12	It is important to me that someone at my placement acknowledges my birthday in some way.	2.13	1.22	348
Q13	I invite colleagues to eat lunch/dinner with me.	2.99	1.11	347
Q14r	On placements I feel like an outsider.	3.21	0.97	354
Q15	There are people that I work with on placements who share my values.	3.64	0.57	354
Q16	Colleagues ask for my ideas or opinions about different matters.	3.19	0.88	356
Q17	I feel understood by my colleagues.	3.43	0.73	356
Q18	I make an effort when on placements to be involved with my colleagues in some way.	4.04	0.67	356
Q19	I am supportive of my colleagues.	4.23	0.63	355
Q20	I ask for my colleagues' advice.	4.42	0.62	354
Q21	People I work with on placements accept me when I'm just being myself.	3.79	0.74	355
Q22r	I am uncomfortable attending social functions on placements because I feel like I don't belong.	3.11	1.09	354
Q23	When I walk up to a group on a placement I feel welcomed.	3.32	0.77	351
Q24	Feeling "a part of things" is one of the things I like about going to placements.	3.66	0.96	351
Q25	There are people on placements with whom I have a strong bond.	3.38	0.92	352
Q26r	I keep my personal life to myself when I'm on placements.	2.50	0.88	351
Q27	It seems that people I work with on placements like me.	3.81	0.62	352
Q28	I let colleagues know I care about them by asking how things are going for them and their family.	3.52	0.93	354
Q29	Colleagues notice when I am absent from placements or social gatherings because they ask about me.	3.09	1.06	346
Q30	One or more of my colleagues confides in me.	3.07	0.98	355
Q31	I let my colleagues know that I appreciate them.	4.04	0.71	352
Q32	I ask my colleagues for help when I need it.	4.44	0.69	350
Q33	I like where I work on placements.	3.70	0.78	355
Q34	I feel free to share my disappointments with at least one of my colleagues.	3.43	0.95	355

Table 5.7 Mean and standard deviation for BES–CPE scores ranked highest to lowest

Items		M	SD	N
Q2	It is important to feel accepted by my colleagues.	4.56	0.62	356
Q5	I make an effort to help new students or staff feel welcome.	4.49	0.67	358
Q32	I ask my colleagues for help when I need it.	4.44	0.69	350
Q20	I ask for my colleagues' advice.	4.42	0.62	354
Q19	I am supportive of my colleagues.	4.23	0.63	355
Q18	I make an effort when on placements to be involved with my colleagues in some way.	4.04	0.67	356
Q31	I let my colleagues know that I appreciate them.	4.04	0.71	352
Q3	Colleagues see me as a competent person.	3.93	0.68	355
Q1	I feel like I fit in with others during my placements.	3.86	0.71	358
Q10r	I feel discriminated against on placements.	3.81	0.94	358
Q21	People I work with on placements accept me when I'm just being myself.	3.79	0.74	355
Q7	I get support from colleagues when I need it.	3.77	0.77	357
Q6	I view my placements as a place to experience a sense of belonging.	3.7	0.94	358
Q9	I like the people I work with on placements.	3.7	0.64	357
Q33	I like where I work on placements.	3.7	0.78	355
Q4	Colleagues offer to help me when they sense I need it.	3.69	0.78	358
Q24	Feeling "a part of things" is one of the things I like about going to placements.	3.66	0.96	351
Q28	I let colleagues know I care about them by asking how things are going for them and their family.	3.52	0.93	354
Q17	I feel understood by my colleagues.	3.43	0.73	356
Q34	I feel free to share my disappointments with at least one of my colleagues.	3.43	0.95	355
Q25	There are people on placements with whom I have a strong bond.	3.38	0.92	352
Q14r	On placements I feel like an outsider.	3.21	0.97	354
Q16	Colleagues ask for my ideas or opinions about different matters.	3.19	0.88	356
Q22r	I am uncomfortable attending social functions on placements because I feel like I don't belong.	3.11	1.09	354
Q29	Colleagues notice when I am absent from placements or social gatherings because they ask about me.	3.09	1.06	346
Q30	One or more of my colleagues confides in me.	3.07	0.98	355
Q13	I invite colleagues to eat lunch/dinner with me.	2.99	1.11	347
Q26r	I keep my personal life to myself when I'm on placements.	2.5	0.88	351
Q8	I am invited to social events outside of my placements by colleagues.	2.45	1.21	356
Q12	It is important to me that someone at my placement acknowledges my birthday in some way.	2.13	1.22	348

5.5 Research question 2

With respect to the clinical placement experience, which of the following variables influence nursing students' experience of belongingness?

- *Nursing experience apart from that included in students' current nursing program*
- *Family members with nursing experience*
- *Gender*
- *Age*
- *Country of birth*
- *English as a first language*

Hypotheses

1. There is a positive relationship between belongingness and nursing experience apart from that included in students' current nursing program.
2. There is a positive relationship between belongingness and immediate family members with nursing experience.
3. There is no relationship between belongingness and gender.
4. There is no relationship between belongingness and age.
5. There is no relationship between belongingness and country of birth.
6. There is no relationship between belongingness and English as a first language.

5.5.1 Hypothesis 1

Hypothesis 1 posited that there is a positive relationship between belongingness and nursing experience apart from that included in students' current nursing program. The majority, or 60.2 per cent of participants in this study had previously or currently worked in the field of nursing as an assistant in nursing, enrolled nurse or healthcare assistant ($n =$ 198). To determine whether this experience impacted on participants' experience of belonging, independent t-tests were conducted for the total sample and for each site. Refer to Table 5.8 for mean BES–CPE scores, standard deviation, t-tests and confidence intervals for the total sample and each site.

No statistically significant difference in the mean BES–CPE scores was identified between those participants who had nursing experience and those who didn't, either in the total

sample or at any of the three sites. Thus, hypothesis 1 was not supported. There is no relationship between belongingness and nursing experience apart from that included in students' current nursing program.

Table 5.8 *t*-tests for difference in mean BES–CPE scores with standard deviation and confidence intervals for those with and without nursing experience

	M	*SD*	*t*-test	95% CI
Total sample			*t* (312) = .15, *p* = .88 (two-tailed)	.12 to .44
With experience[1]	3.61	.44		
Without experience[2]	3.62	.41		
Site 1			*t* (117) = .7, *p* = .49 (two-tailed)	.2 to .98
With experience	3.58	.42		
Without experience	3.62	.41		
Site 2			*t* (56) = 2.04, *p* = .5 (two-tailed)	.1 to .43
With experience	3.61	.44		
Without experience	3.62	.41		
Site 3			*t* (141) = .23, *p* = .82 (two-tailed)	.12 to .16
With experience	3.78	.44		
Without experience	3.76	.40		

[1] Participants who had nursing experience apart from that included in their current nursing program.

[2] Participants who had no nursing experience apart from that included in their current nursing program.

5.5.2 Hypothesis 2

Hypothesis 2 proposed that there is a positive relationship between belongingness and immediate family members with nursing experience. Independent *t*-tests were conducted for the total sample and for each site. Refer to Table 5.9 for mean scores, standard deviation, *t*-tests and confidence intervals for the total sample and each site.

No statistically significant difference in the mean BES–CPE was identified between those participants who had immediate family members with nursing experience and those who did not, in the total sample or at any of the three sites. Thus, hypothesis 2 was not supported. There is no relationship between belongingness and immediate family members with nursing experience

Table 5.9 *t*-tests for difference in mean BES–CPE scores, standard deviation and confidence intervals for those participants with and without family members with nursing experience

	M	*SD*	*t*-test	95% CI
Total sample			t (178.3) = .50, p = .62 (two-tailed)[3]	.12 to .07
With family[1]	3.60	.37		
Without family[2]	3.62	.45		
Site 1			t (119) = .27, p = 0.79 (two-tailed)	.14 to .18
With family	3.49	.37		
Without family	3.47	.40		
Site 2			t (57) = 1.25, p = .22 (two-tailed).	.08 to .34
With family	3.39	.41		
Without family	3.46	.38		
Site 3			t (141) = .91, p = .36 (two-tailed).	.25 to .09
With family	3.71	.32		
Without family	3.79	.44		

[1] Participants who had immediate family members with nursing experience.

[2] Participants who did not have immediate family members with nursing experience.

[3] Equal variances not assumed.

5.5.3 Hypothesis 3

Hypothesis 3 posited that there is no relationship between belongingness and nursing students' gender. Independent *t*-tests were conducted for the total sample and for each site. Refer to Table 5.10 for mean scores, standard deviation, *t*-tests and confidence intervals for the total sample and each site.

No statistically significant difference in the mean BES–CPE was identified between those participants of different gender in the total sample or at sites 2 and 3. At site 1 a significant difference was identified, although there is no compelling evidence to suggest that this was a widespread effect. Thus, hypothesis 3 was supported. There is no relationship between belongingness and nursing students' gender.

Table 5.10 *t*-tests for difference in mean BES-CPE scores, standard deviation and confidence intervals for gender

	M	*SD*	*t* test	95% CI
Total sample			*t* (356) = .1.27, *p* = <.21 (two-tailed)	.05 to .25
Men	3.68	.34		
Women	3.59	.43		
Site 1			*t* (158) = .2.31, *p* = 0.02 (two-tailed)	.31 to .40
Men	3.67	.37		
Women	3.45	.40		
Site 2			*t* (54) = 1.24, *p* = .22 (two-tailed).	.16 to .66
Men	3.75	.33		
Women	3.50	.40		
Site 3			*t* (138) = .63, *p* = .53 (two-tailed).	.35 to .18
Men	3.69	.32		
Women	3.77	.43		

5.5.4 Hypothesis 4

Hypothesis 4 posited that there is no relationship between belongingness and age. The mean BES–CPE scores for the six age groups 19–22, 23–25, 26–30, 31–40, 41–50 and 51–60 years were analysed with a one-way analysis of variance (ANOVA), and for the total sample the result was statistically significant, $F(5, 341) = 2.7$, $p = .021$, $\eta_p^2 = .04$. Post hoc comparisons using the Tukey HSD test revealed significant differences between (a) the 19–22 and 26–30 age groups; and (b) the 19–22 and 41–50 age groups. A higher BES–CPE score was evident in the 19–22 age group than in either the 26–30 or 41–50 age groups. While there was an apparent relationship between belongingness and age (refer to Figure 5.3), there appeared to be no apparent pattern or discernible reason for the identified differences. As the same result was not evident for the ANOVAs conducted for each site (refer to Table 5.11), it is suggested that this random statistical variation was an aberration. Thus, for hypothesis 4 the results are inconclusive: the relationship between belongingness and age is uncertain.
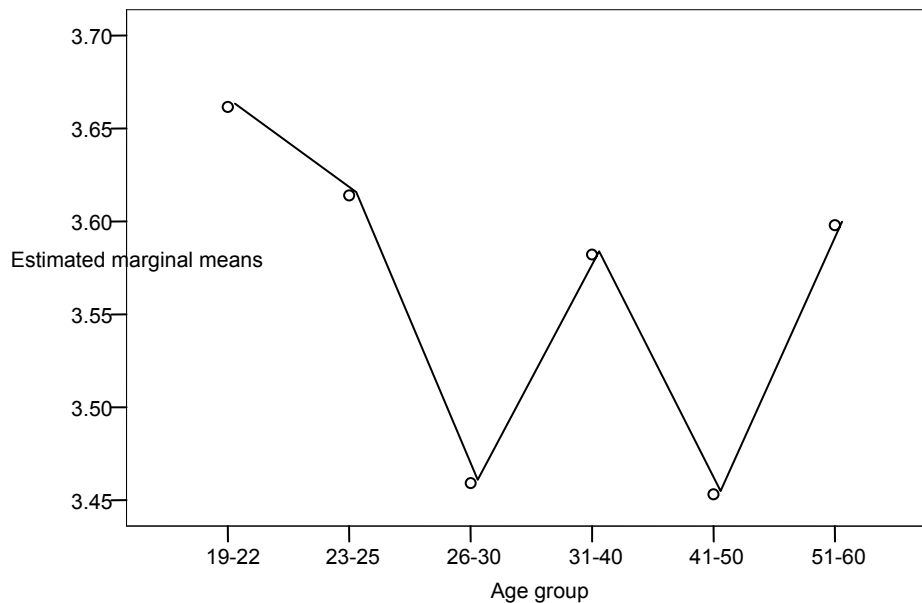
Figure 5.3 Estimated marginal means of BES–CPE scores for age groups

Table 5.11 ANOVA for age groups

Site	ANOVA
Total sample	$F(5, 341) = 2.7$, $p = .021$
Site 1	$F(5, 154) = 1.21$, $p = .35$
Site 2	$F(4, 51) = 1.53$, $p = .21$
Site 3	$F(5, 125) = 1.38$, $p = .24$

5.5.5 Hypothesis 5

Hypothesis 5 posited that there is no relationship between belongingness and nursing students' country of birth. The categories for country of birth were Australia, UK, Asia and Other. The Asia category included Brunei, Cambodia, China, Korea, Malaysia, Philippines and Singapore. The Other category included Czech Republic, France, Germany, Kenya, New Zealand, Papua New Guinea, South Africa, Tonga, USA and Zimbabwe. Descriptive statistics are shown in Table 5.12.

Table 5.12 Mean BES–CPE scores for country of birth

Country	n	M	SD
Australia	162	3.51	.38
UK	141	3.75	.41
Asia	24	3.30	.40
Other	17	3.53	.41

The BES–CPE scores for the four country-of-birth categories were analysed with a one-way analysis of variance (ANOVA), and the result appeared to be statistically significant, $F(3, 339) = 14.3$, $p = <.001$. Post hoc comparisons using the Tukey HSD test revealed

significant differences between (a) UK and Australia, p = <.001 and (b) UK and Asia, p = <.001. A higher BES–CPE score was evident in the UK group than in either Asia or Australia. However, two factors detract from the strength of these findings. The first is the statistically significant higher mean scores for site 3, as discussed in Section 5.4.1. The second factor to consider is that 97.1 per cent of the participants from site 3 identified the UK as their country of birth and that no students at that site were Asian. Conversely, at site 1, 22 of the participants were Asian. It is therefore difficult to ascertain whether there is a true difference or whether the difference is due to the effect of country of birth or site. Thus, hypothesis 5 was further tested to determine whether the effect of country of birth was significant if site 3 was excluded from analysis. The BES–CPE scores for the four country-of-birth categories with site 3 excluded were analysed with a one-way analysis of variance (ANOVA), and the result was not statistically significant, $F(1, 207)$ = .59, p = <.67.

Thus, hypothesis 5 was supported. There was no relationship between belongingness and country of birth. This supports the notion that the higher BES–CPE mean for site 3 was due to a difference between sites rather than country of birth.

5.5.6 Hypothesis 6

Hypothesis 6 proposed that there is no relationship between belongingness and English as a first language. Independent t-tests were conducted and the mean BES–CPE score for participants for whom English was a first language (M = 3.62, SD = .42) was significantly different to that of participants for whom English was not a first language (M = 3.34, SD = .46). A statistically significant t value was found, t (354) = 3.48, p = <.001 (two-tailed). The 95 per cent confidence interval for the difference between the means was 0.12 to 0.44. However, when ANOVAs were computed for each site, no statistically significant differences was apparent (refer to Table 5.13).

Table 5.13 ANOVA for English as a first language

Site	ANOVA
Total sample	$F(1, 354) = 12.05$, $p = .001$
Site 1	$F(1, 157) = 3.23$, $p = .07$
Site 2	$F(1, 51) = .47$, $p = .5$
Site 3	$F(1, 138) = 3.52$, $p = .06$

It should be noted that at site 2 there were two participants for whom English was not their first language and at site 3 there were three participants. These numbers limit the strength of the findings for these sites. At site 1, where the majority ($n = 24$) of participants were located, the p value approached a level of significance, but was nonetheless not significant at this site. Thus, although hypothesis 6 was supported and a relationship was not identified between belongingness and English as a first language at site 1, these results should be considered with a degree of caution.

It is noteworthy that the mean score for item 10, "I feel discriminated against on placements", was significantly higher for those participants for whom English was their first language ($M = 2.14$, $SD = .93$) than it was for those for whom English was not their first language ($M = 2.66$, $SD = .97$). A statistically significant t value was identified, $t (354) = 2.88$, $p = <.004$ (two-tailed). The 95 per cent confidence interval for the difference between the means was .87 to .16. This indicates that participants for whom English is not their first language are more likely to feel discriminated against by the staff they work with on clinical placements. Indeed, this discrimination may also have a negative impact on their experience of belonging.

5.6 Validity and reliability of the BES–CPE

Somers' (1999) original BES scale was developed on the premise that the construct of belongingness is composed of two basic components that are not mutually exclusive:

(a) feeling connected to and accepted by others; (b) feeling cared about and held in esteem by others. Somers also proposed that belongingness operates in a two-way active and passive attribute. As discussed in Chapter 3, items representing each of these components were included and psychometrically evaluated in the development of the BES instrument. However, testing of the extent to which the data were a good fit with this conceptualisation of the BES instrument was not the purpose of Somers' study. Therefore, in order to better understand the underlying dimensions of the BES–CPE and to ascertain its construct validity, exploratory factor analysis was employed. From this, three new subscales were subsequently developed.

5.6.1 Factor analysis

Principal components analysis with varimax rotation (and Kaiser Normalisation) was performed on the 34 belongingness variables. There were no missing data and no outliers. Six components with eigenvalues greater than one were extracted, accounting for 54.65 per cent of the variance. Examination of the Scree plot (Figure 5.4) indicated that three components accounting for 44.1 per cent of the variance should clearly be retained, with a further three as possibilities. Although factor solutions from three to nine components were carefully examined, the three-factor solution was seen to be most appropriate. The rotated component loadings and percentages of variance for the three-factor model are shown in Table 5.14. Component loadings of less than .3 have been suppressed to aid interpretation in this table, but a complete set is included as Appendix 16.

Twenty of the variables were pure, loading onto only one factor; eight onto factor 1 (Esteem), five onto factor 2 (Connectedness), and seven onto factor 3 (Efficacy). Three items (6, 12 and 22r) cross-loaded or were too poorly correlated to be included in the scales (refer to Table 5.15). Item 6, "I view my placements as a place to experience a sense of belonging", cross-loaded equally onto the three factors of Esteem, Connectedness and Efficacy. This is to be expected, as the three factors are each integral to belongingness. Items 12 and 22r did not correlate strongly with any of the items, suggesting that they are tapping something quite different to the three identified factors. Item 12, "It is important to me that someone at my placement acknowledges my birthday in some way", and item 22r, "I am uncomfortable attending social functions on placements because I feel like I don't belong", seem to be indicative of the fact that the participants

view their placements as temporary and themselves as visitors. As such, they do not have the same expectations as one would associate with close friends or family members.

As evident from Table 5.14, variables loading on factor 1 seemed to be concerned with being held in esteem by one's work colleagues: for example, item 3, "Colleagues see me as a competent person", and item 27, "It seems that people I work with on placements like me". Those loading on factor 2 were concerned with interpersonal connections: for example, item 13, "I invite colleagues to eat lunch/dinner with me", and item 25, "There are people on placements with whom I have a strong bond". Variables loading onto factor 3 were concerned with efficacious behaviours undertaken to enhance one's experience of belongingness: for example, item 11, "I offer to help my colleagues, even if they don't ask for it", and item 18, "I make an effort when on placements to be involved with my colleagues in some way". Thus, the subscales were labelled *Esteem, Connectedness* and *Efficacy* respectively.
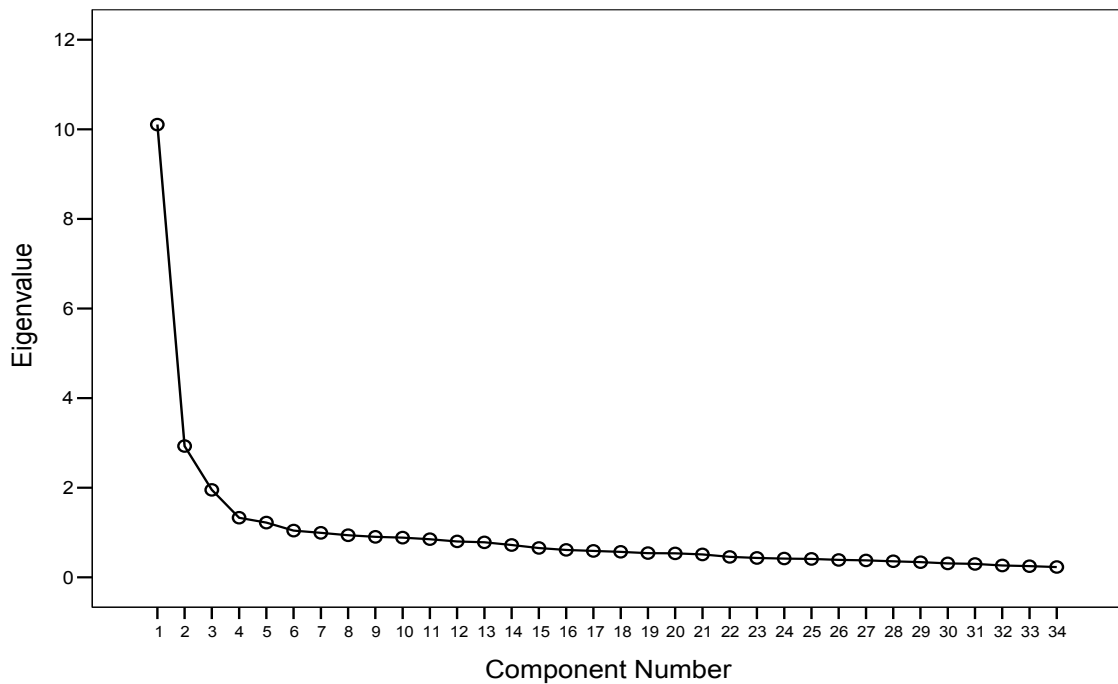
Figure 5.4 Scree plot

Table 5.14 Rotated component loadings for belongingness variables

Item		Factor 1 Esteem	Factor 2 Connectedness	Factor 3 Efficacy
Q1	I feel like I fit in with others during my placements.	0.68	0.31	…
Q3	Colleagues see me as a competent person.	0.54	…	…
Q4	Colleagues offer to help me when they sense I need it.	0.65	…	…
Q7	I get support from colleagues when I need it.	0.71	…	…
Q9	I like the people I work with on placements.	0.61	…	…
Q10r	I feel discriminated against on placements.[1]	0.65	…	…
Q14r	On placements I feel like an outsider.[1]	0.67	0.37	…
Q17	I feel understood by my colleagues.	0.57	0.49	…
Q21	People I work with on placements accept me when I'm just being myself.	0.69		…
Q23	When I walk up to a group on a placement I feel welcomed.	0.65	0.31	…
Q24	Feeling "a part of things" is one of the things I like about going to placements.	0.44	0.39	
Q27	It seems that people I work with on placements like me.	0.56	…	…
Q33	I like where I work on placements.	0.61	…	…
Q8	I am invited to social events outside of my placements by colleagues.	0.33	0.62	…
Q13	I invite colleagues to eat lunch/dinner with me.	…	0.64	…
Q15	There are people that I work with on placements who share my values.	…	0.44	…
Q16	Colleagues ask for my ideas or opinions about different matters.	0.42	0.60	…
Q25	There are people on placements with whom I have a strong bond.	0.43	0.59	…
Q26r	I keep my personal life to myself when I'm on placements.[1]	…	0.32	…
Q28	I let colleagues know I care about them by asking how things are going for them and their family.	…	0.61	…
Q29	Colleagues notice when I am absent from placements or social gatherings because they ask about me.	0.32	0.60	…
Q30	One or more of my colleagues confide(s) in me.	…	0.73	…
Q34	I feel free to share my disappointments with at least one of my colleagues.	0.34	0.47	
Q2	It is important to feel accepted by my colleagues.	…	…	0.50
Q5	I make an effort to help new students or staff feel welcome.	…	…	0.52
Q11	I offer to help my colleagues, even if they don't ask for it.	…	…	0.61
Q18	I make an effort when on placements to be involved with my colleagues in some way.	…	0.35	0.49
Q19	I am supportive of my colleagues.	…	…	0.65
Q20	I ask for my colleagues' advice.	…	…	0.71
Q31	I let my colleagues know that I appreciate them.	…	…	0.68
Q32	I ask my colleagues for help when I need it.	…	…	0.66

[1] These items were reverse scored

Table 5.15 Poorly fitting or cross-loading items removed from the scales

Item		Factor 1 Esteem	Factor 2 Connectedness	Factor 3 Efficacy
Q6	I view my placements as a place to experience a sense of belonging.	0.34	0.31	0.33
Q12	It is important to me that someone at my placement acknowledges my birthday in some way.	−0.27	0.29	0.19
Q22r	I am uncomfortable attending social functions on placements because I feel like I don't belong.[1]	0.48	0.47	-0.13
Percentage of variance		29.7	8.6	5.7

5.6.2 Reliability of the BES–CPE scale and Esteem, Connectedness and Efficacy subscales

Cronbach's alpha was used to measure the internal consistency reliability of the BES–CPE scale and each subscale after removal of the poorly fitting items. Reliability coefficients for the BES–CPE scale and the subscales were excellent: BES–CPE scale .92; Esteem subscale .9; Connectedness subscale .82; and Efficacy subscale .8.

5.7 Descriptive and inferential statistics using subscales

Mean scores for the BES–CPE and the subscales Esteem, Connectedness and Efficacy are given in Table 5.16. Paired *t*-tests demonstrated that there are significant differences in mean scores between each of the subscales (refer to Table 5.17). Scores for the subscale Efficacy are higher than those for the subscales of Esteem or Connectedness, denoting that many participants engage in self-efficacious behaviours to enhance their experience of belongingness. From the mean scores it is also apparent that more participants felt they were held in esteem by their work colleagues than those who felt a sense of interpersonal connectedness with colleagues.

Table 5.16 Mean scores for subscales Esteem, Connectedness and Efficacy

Scale/Subscale	*n*	*M*	*SD*
BES–CPE	358	3.60	.43
Esteem	339	3.68	.52
Connectedness	334	3.11	.70
Efficacy	331	4.33	.43

Table 5.17 Paired *t*-tests for subscales Esteem, Connectedness and Efficacy

Scale	*M*	*SD*	Paired *t*-tests	95 % CI
Esteem–Connectedness	−.55	.03	*t* (321) = 17.84, *p* = <.001 (two-tailed)	−.61 to −.49
Connectedness–Efficacy	−1.23	.71	*t* (317) = 31.06, *p* = <.001 (two-tailed)	−1.31 to −1.16
Efficacy–Esteem	.67	.55	*t* (319) = 21.73, *p* = <.001 (two-tailed)	.61 to .73

In order to better understand participants' experience of belongingness, descriptive and inferential statistics that displayed significant differences or strong ambiguity on previous analysis of the BES–CPE data were re-examined using the subscales Esteem, Connectedness and Efficacy. Thus, research question 1 and research question 2, hypotheses 4 and 5, are now discussed.

5.7.1 Research question 1

With respect to the clinical placement experience, to what extent do third-year nursing students from three different sites experience belongingness?

In data analysis previously undertaken, a statistically significant difference in mean BES–CPE scores was identified, with a higher score being achieved at site 3 that at either sites 1 or 2. Mean scores are now examined using the three subscales. Descriptive statistics are shown in Table 5.18.

Esteem, Connectedness and Efficacy scores for the three sites were analysed with a one-way analysis of variance (ANOVA), and the result was statistically significant. Refer to Table 5.19 for ANOVA results. Post hoc comparisons using the Tukey HSD test revealed significant differences between sites. A higher Esteem score was achieved at site 3 than at both of the other sites: for sites 1–2 *p* = .86, for sites 1–3 and for sites 2–3 *p* = <.001. A higher Connectedness score was achieved at site 3 than at both of the other sites: for sites 1–2 *p* = .26, for sites 1–3 and for sites 2–3 *p* = <.001. For Efficacy, a higher score was achieved at site 3 than at site 2, *p* = .003. However, there was no statistical difference between Efficacy scores for sites 1 and 3, *p* = .07, or for sites 1 and 2, *p* = .2.

Table 5.18 Mean scores for BES–CPE and subscales Esteem, Connectedness and Efficacy for each site

Scale/Subscale	Site	*n*	*M*	*SD*
BES–CPE	Site 1	160	3.47	.39
	Site 2	57	3.51	.39
	Site 3	141	3.77	.42
Esteem	Site 1	152	3.56	.48
	Site 2	52	3.60	.51
	Site 3	135	3.84	.52
Connectedness	Site 1	152	2.90	.70
	Site 2	50	3.07	.66
	Site 3	132	3.37	.64
Efficacy	Site 1	154	4.30	.46
	Site 2	48	4.18	.44
	Site 3	129	4.42	.39

Table 5.19 ANOVA for BES–CPE, Esteem, Connectedness and Efficacy

Scale/Subscale	ANOVA
BES–CPE	$F(2, 355) = 21.70$, $p = <.001$
Esteem	$F(2, 336) = 11.80$, $p = <.001$
Connectedness	$F(2, 331) = 17.88$, $p = <.001$
Efficacy	$F(2, 328) = 5.92$, $p = .003$

In summary, site 3 achieved higher Esteem and Connectedness scores than either site 1 or 2. In the Efficacy scores, site 3 achieved a higher score than site 2 but not higher than site 1. Thus, analysis using the subscales provides an added layer of understanding of participants' experience of belongingness.

5.7.2 Research question 2

With respect to the clinical placement experience, which of the following variables influence nursing students' experience of belongingness?

- *Nursing experience apart from that included in students' current nursing program*
- *Family members with nursing experience*
- *Gender*
- *Age*
- *Country of birth*
- *English as a first language*

5.7.2.1 Hypothesis 4

Hypothesis 4 posited that there is no relationship between belongingness and age of nursing students. This hypothesis was not supported when the BES–CPE data for the six age groups 19–22, 23–25, 26–30, 31–40, 41–50 and 51–60 were analysed. Participants of different age did score differently from each other on the BES–CPE. Specifically, a higher BES–CPE score was evident in the 19–22 age group than in either the 26–30 or the 41–50 age group.

The Esteem, Connectedness and Efficacy scores for the age groups were analysed with a one-way analysis of variance (ANOVA), and the results were not statistically significant. Refer to Table 5.20 for ANOVA results.

Table 5.20 ANOVA for BES–CPE, Esteem, Connectedness and Efficacy for age groups

Scale/Subscale	ANOVA
BES–CPE	$F(5, 341) = 2.70$, $p = .02$
Esteem	$F(5, 324) = 2.11$, $p = .06$
Connectedness	$F(5, 318) = 1.49$, $p = .19$
Efficacy	$F(5, 318) = 1.30$, $p = .27$

Thus, even though significant differences were identified in the BES–CPE scores between different age groups, no statistically significant differences were identified in the Esteem, Connectedness or Efficacy scores. This supports the assumption that random statistical

variation for the BES–CPE scores for age was an aberration, and therefore there is not a strong relationship between age and belongingness.

5.7.2.2 Hypothesis 6

Hypothesis 6 proposed that there is no relationship between belongingness and English as a first language. This hypothesis was supported. However, as a degree of ambiguity was apparent in the results, *t*-tests were repeated for the subscales of Esteem, Connectedness and Efficacy in order to better understand the effect of English as a first language. Table 5.21 shows the *t*-tests for difference in mean scores, standard deviation and confidence intervals. In each subscale a statistically significance difference was apparent. Similarly to the analysis of the BES–CPE scale in Section 5.5.6, the small sub-samples at sites 2 (*n* = 2) and 3 (*n* = 3) cast some doubt on this result.

Table 5.21 *t*-tests for difference in mean scores for the BES–CPE and subscales with standard deviation and confidence intervals for English as a first language

	M	*SD*	*t* test	95% CI
BES–CPE			*t* (354) = 3.48, *p* = <.001 (two-tailed)	.12 to .44
EFL[1]	3.62	.42		
ENFL[2]	3.34	.46		
Esteem			*t* (335) = 2.66, *p* = .008 (two-tailed)	.07 to .48
EFL	3.70	.51		
ENFL	3.43	.56		
Connectedness			*t* (331) = 2.31, *p* = .02 (two-tailed)	.05 to .62
EFL	3.14	.70		
ENFL	2.80	.69		
Efficacy			*t* (327) = 4.22, *p* = <.001 (two-tailed)	.19 to .51
EFL	4.36	.40		
ENFL	4.01	.60		

[1] Those participants for whom English was a first language.
[2] Those participants for whom English was not a first language.

5.8 Conclusion

Chapter 5 presented the results of the quantitative phase of the study and addressed the first two research questions and the related hypotheses. The chapter began by outlining the demographic characteristics of the study participants as a background to the data analysis. In examining the extent to which nursing students from three university sites experience belongingness, it was determined that the mean belongingness (BES–CPE) scores of participants from site 3 were statistically higher than those of either site 1 or site 2. Of the demographic variables analysed, nursing experience apart from that included in students' current nursing program, family members with nursing experience, gender and country of birth were not a strong influence on students' experience of belongingness. The effect of age and English-speaking background was less certain. Exploratory factor analysis was employed to better understand the underlying dimensions of the BES–CPE and to ascertain its construct validity. From this the subscales of Esteem, Connectedness and Efficacy were developed. Cronbach's alpha was used to measure the internal consistency reliability of the BES–CPE and the subscales. Reliability coefficients were excellent for each.

In the following three chapters belongingness is explored qualitatively to more fully understand the dimensions of this phenomenon. In Chapters 6 and 7 the factors that influence nursing students' experience of belongingness are explicated, and in Chapter 8 the consequences of that experience are examined.

Chapter 6

Findings from the Qualitative Phase of the Study

Part 1: Organisational and Contextual Factors that Impact upon Belongingness

6.1 Introduction

Although belongingness is a universal phenomenon, its expression is individualistic (Hagerty, Lynch-Sauer, Patusky, & Bouwsema, 1993). Therefore, in Chapters 6, 7 and 8 it is the perspectives of the interview participants that dominate. As the students shared moments of their lives and thoughts with me, fragments of their stories provided contextually rich and meaningful data that generated insights into their experience of belongingness as it related to their clinical placements. Numerous quotes from the transcripts have been included in these chapters to allow the participants' voices to stand out and to enhance the credibility of the findings. Many of the quotes are presented as short vignettes. These vignettes include the participants' perspectives and feelings, to give the reader a sense that they are viewing the experiences through the eyes of the participants.

The 18 interviewees held clearly defined opinions regarding their own experience of belongingness and their clinical placements. Each participant easily recalled diverse placement experiences that spanned the continuum from those that promoted a high degree of belongingness to those that engendered intense feelings of alienation. The diversity of their experiences and perspectives suggests that belongingness is not generally applicable and consistent across contexts, but varies in response to certain situations, environments, encounters and events, although undoubtedly mediated by the individual's personal attributes and previous life experiences. From the students' accounts, it was evident that a range of factors played a part in their experience of belongingness. Chapters 6 and 7 illuminate these factors by addressing the third research question:

With respect to the clinical placement experience, what factors impact on nursing students' experience of belongingness?

In addressing this question the intention is to aid understanding by disentangling complexities, clarifying meanings and raising the level and focus of debate.

6.2 Thematic content analysis

During data analysis and interpretation, the interview transcripts were studied intensively and the main issues articulated by the participants were highlighted, coded and clustered into five broad categories: organisational, contextual,[1] interpersonal and individual factors that impact belongingness, and the consequences of belongingness. Within each of the factors are a number of themes that reveal and illuminate dimensions of the definition of belongingness that emerged from the study.

Belongingness definition

A deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels: (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group. The experience of belongingness may evolve passively in response to the actions of the group to which one aspires to belong and/or actively through the actions initiated by the individual.

The discussion of the qualitative findings begins in this chapter with the primary focus on the organisational and contextual factors that influence belongingness. Chapter 7 then explores the interpersonal and individual factors that impact on students' experience of belongingness. Finally, the consequences of belongingness for the students themselves, for the profession into which they are moving, and for the patients for whom they care are discussed in Chapter 8. Throughout the discussion, many of the themes are explicated and further illuminated by reference to the literature. Table 6.1 provides a structural map of the factors that influence student's experience of belongingness.

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[1] 'Contextual' in this instance refers to those factors specific to particular clinical units, not to one of the three study sites.

Table 6.1 Factors that impact on nursing students' experience of belongingness

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Chapter 6

Category 1: Organisation factors

Factor 1: Duration and structure of clinical placements

Factor 2: Clinical facilitators

Category 2: Contextual factors

Factor 1: Orientation structure

Factor 2: Consistency and structure of mentoring

Factor 3: Nurse unit managers or ward sisters

Factor 4: Practice standards

Chapter 7

Category 3: Interpersonal factors

Factor 1: Receptiveness of nursing staff

Factor 2: Inclusion/exclusion

Factor 3: Legitimisation of the student role

Factor 4: Recognition and appreciation

Factor 5: Challenge and support

Category 4: Individual factors

Factor 1: Preconceptions about nursing

Factor 2: Willingness to adopt the role of an unpaid 'worker'

Factor 3: Resilience versus resignation

Factor 4: Tendency to engage in extenuation

6.3 Organisational factors that impact on students' experience of belongingness

The quality of students' clinical placement experiences and the degree of belongingness they experience is attributable to both their immediate ward or unit experience and wider strategic and organisational issues. While there is undoubtedly a range of organisational factors (mandated by health services, universities and regulatory bodies) that impact on students' experience of belongingness, this section focuses on the two major organisational factors that students specifically identified as significant. Table 6.2 lists the organisational factors that impact on belongingness and the related themes.

Table 6.2 Organisational factors that impact on belongingness

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Factor 1: Duration and structure of clinical placements

Theme A: Getting settled

Theme B: Becoming a member of the team

Factor 2: Clinical facilitators

Theme A: Advocates and intermediaries

Theme B: Visitors to the area

Theme C: A nicety

6.3.1 Duration and structure of clinical placements

Getting settled

For the majority of the students in this study, the duration and structure of their clinical placement blocks was a significant contributor to their experience of belongingness. Students from each of the three sites stressed the importance of having adequate time to settle in, so that they could familiarise themselves with the personnel, culture and practices of each unit or ward. They described the uncertainly that surrounded their clinical placement experiences during this settling in phase and how they often felt lost and unsure of themselves, not knowing staff, patients or ward routines. Once settled, most students

began to progress from feeling like an outsider to feeling like an integral and recognised member of the nursing team. Importantly, students felt that until they were settled and comfortable in the clinical environment they were unable to confidently engage with learning opportunities. Not surprisingly, some students noted that when faced with unreceptive and unfriendly staff, shorter placements were often preferred.

Upon beginning each clinical placement, students focused on adjusting to the clinical milieu in preparation for learning to nurse. Many students equated this experience with the notion of feeling stable and described it as a process of settling in. This initial period of adjustment took between two and four weeks in most cases, but varied to some degree depending on the students' personal characteristics and the receptiveness of nursing staff. During the settling in phase students began to learn the routines, language, values and practices specific to the ward or unit and sought to become familiar and comfortable with the staff. Students' socialisation and acculturation to the ward environment was dependent upon this period of time for settling in. Ann, an Australian student, explains:

> *I had a four-week placement in recovery, at *** [hospital]. Four weeks is better than the two weeks that we usually have. The first couple of weeks you settle in and find the routine and whatever else, have a look around, and get to know the staff a bit…You find out what their policies and procedures are. It really takes a couple of weeks before you start to feel comfortable.* (4: 595–598, 641–642)

A number of students described the settling in phase as a period of "watchful waiting". Sarah explained how she initially observed the way staff interacted with each other so that she could begin to understand the interpersonal dynamics at play and determine what is considered to be acceptable in a particular unit:

> *I watch very carefully for starters, to see how everybody acts towards each other. You look at what's acceptable behaviour.* (1: 431–432)

Newcomers need to learn the relevant discourses of the profession, including the significance of what is said and what is left unsaid. It appeared from the students' accounts that language played an informal role in the process of socialisation. Learning the professional jargon unique to a ward or unit was seen to be essential to settling in, and students felt excluded, especially during shift handover, until they had become familiar with the shared language. As Monique explained, gaining an understanding of the informal and

more subtle nuances of the language particular to the context was a key factor in becoming an insider:

> *I listen to what they say and how they talk, and—that type of thing.* (10: 603)

From the students' accounts the process of settling in seemed to be an inevitable process in each new clinical placement, irrespective of the students' level of experience. Frequent changes of placements meant that the settling in process resulted in large amounts of seemingly wasted time. This was particularly evident from the perspectives of the Australians. However, even in the UK, where placement blocks are usually for four weeks or longer, when students undergo short placements they experience the same types of problems as their Australian counterparts. Fiona, a student from the UK, emphasised how unsettling she found the unfamiliarity and uncertainty surrounding short clinical placements:

> *I went on the cancer care rotation and worked in three different areas during those eight weeks: the acute cancer ward, the bone marrow transplant unit and radiotherapy outpatients…That was very unsettling…The week in radiotherapy just wasn't long enough. The first week is always awkward because you don't know where anything is, you don't know who anyone is—it is very hard.* (14: 524–525, 528, 943–945)

Kara noted that although short placements may be preferable in some situations, they can detract from the potential for learning and the consolidation of practical skills:

> *Two-week placements are not enough when you're enjoying it but plenty when you're not liking it. As a general rule, two weeks are not long enough because in the first couple of weeks, you're just focused on finding your way around, getting to know the people, sort of watching people, observing how things are done. There are big gaps between the placements too, and you feel inadequate because you just don't have enough time to practise your skills.* (12: 513–518)

Abby highlighted an advantage of extended clinical placements where the settling in process includes becoming familiar, not just with the staff and routines, but also with the patients. Longer placements allowed her the opportunity to better understand her patients and their conditions, and as a result she felt more confident in providing quality nursing care:

> *I was in palliative/renal/gastroenterology. The patients had quite chronic conditions, so if I was away for the weekend, I'd come back on Monday, and they were still there. Once you get to know patients, it's so much easier to give that holistic nursing care that [the]*

university emphasises. It is possible when you actually get to know them, you know what their needs are and you know what their conditions are. (13: 276–283)

In addition to the duration the actual structure of clinical placement models must be considered. Both sites 1 and 3 utilise a block placement model typical of most universities in Australia and the UK (Mallik & Aylott, 2005). Conversely, in the model at site 2 first- and second-year students receive weekly exposure to clinical areas at a ratio of two days per week, and block placements are not undertaken until third year. The students from site 2 felt that there were more benefits, in terms of belonging and learning, in the block pattern rather than the two days per week model. Lucy explains:

> *We've been on clinical two days a week and it does make the continuity hard. If you're there for a block you can get a bit of a run with a particular person, but not when you're only there two days a week…It's disruptive and I prefer to do it as a block myself…Because the other way, you just start to get comfortable with the staff and what you're doing over the two days, and then you have a week's break and have to start all over again—you know, there's just no chance for follow through.* (8: 506–510, 514, 518–521)

Becoming a member of the team

Students' primary motivation in the first few weeks of each clinical placement was settling in, getting to know the routines and staff, and developing the interpersonal relationships that would sustain them—all with a view to belonging to the nursing team. Once students felt settled, they were able to move forward from this comfortable position to the next phase, which I term the integration phase. In this phase students began to feel like an integral member of the nursing team and were able to consolidate their knowledge and skills by embracing new learning opportunities. Jodie shared her experience of what she termed her "best placement", one in which she had been able to settle in and begin to feel like part of the team. She was then able to move on to confidently and independently explore the learning opportunities available:

> *My best placement was the elderly care ward in *** [locality]; it was fantastic. It was for nine weeks overall and I began to feel like I was a member of the team, so it was really nice…I learned a lot because there was a lot of support and it was quite a long placement. You settle in more with a long placement. It takes about four weeks to settle in and get to know people. In shorter placements you are off just as you settle in and that is quite difficult. But if you can sort of get yourself settled then you feel more confident, you can try new things and do more things on your own and that is a lot better.* (16: 129–131, 242–250)

Belonging to the nursing team was a significant outcome of placements of longer duration. It seemed that in longer placements students went beyond feeling like a "visitor" to becoming an active team member, primarily because of the relationships they were able to establish with other team members. This was a recurring theme in many of the transcripts. Sarah explains that a placement of four weeks allowed her to feel like she "worked there as opposed to being a visitor". As workers have a rightful place within the team, Sarah's comments are indicative of the importance she attributed to being afforded a legitimate place in the clinical environment:

> *With the four-week placement I actually felt more like I worked there, as opposed to being a visitor. And I think it also gave me a chance to get to know the staff, and the way the ward ran, much better than previously.* (1: 651–653)

Elizabeth agreed that longer placements influence the quality of the relationships between students and nursing staff, and enhance the feeling of belonging to the team. She described one of the benefits of her three-month placement as becoming "really friendly with everybody". The importance of friendship is often overlooked because of the apparent simplicity of the term. If friendship is explicated more fully, its meaning is illuminative to the experience of students. When friendship is understood as "being in accord or harmony, feeling a sense of familiarity, sincerity, understanding, goodwill, warmth and welcome" (Roget, 2006), Elizabeth's words take on an even deeper meaning:

> *It was my favourite placement—I loved it there. I enjoyed the fact that I was there for so long. I really became part of the team…and I became really friendly with everybody.* (15: 528–530, 555–556)

A number of students explained the importance of developing sound interpersonal relationships and how the mutual understandings gained through a period of sustained immersion in a clinical environment affected their sense of belonging and potential learning. Laura emphasised the importance of feeling liked to belonging to the team and to her learning:

> *There are some places you can't wait to get out of, and there are some wards you just want to stay on for that bit longer and learn a bit more. Because that's where you grow in confidence, so to move it is like you have to start again. If you're with a good nurse [mentor] you don't want to move, you want to stay where they like you. You might get to know a couple of the nurses and build up a rapport with the whole team. They're used to you being there, and they know your limitations, what you will do and what you won't do…It comes*

down to if they like you; it determines how well you go and how much you learn.
(2: 396–407)

From the students' perspectives it was evident that an adequate period of time (of approximately two to four weeks) to traverse the settling in phase of their journey is important. It was during this phase that students became familiar with the physical environment, the prevailing nursing culture, ward routines and accepted practices. Importantly, the relationships between students and staff began to develop during this time. These relationships were fundamental to students' experience and often resulted in them feeling like an accepted and integral member of the nursing team. Until students felt settled and stable within the clinical environment and familiar with the staff and routines, they were uncertain of their place and often lacked confidence. Students who did not settle in did not acquire the security that came from feeling assured of their rightful place within the environment. This is in line with Anant's (1966) suggestion that a person who is an integral part of a social system, that is the person who belongs, will feel more secure and at ease than a person who does not belong and feels alienated. The students' primary focus during the integration phase was active negotiation of learning opportunities and engagement with nursing staff in a meaningful way. Students cited the benefits of inclusion in the nursing team, and in particular feeling comfortable and confident enough to engage in and maximise learning opportunities, as a crucial outcome of an extended clinical placement. However, they acknowledged that there were few advantages to long placements where the staff were not welcoming or facilitative of their learning.

6.3.2 Clinical facilitators

In Chapter 4 the context of the sites was described. Included in that discussion was reference to the clinical education and support provided by the clinical facilitators at site 1.[2] From the students' accounts, it was apparent that, although facilitators fulfil a number of important roles, their impact on students' belongingness is less certain.

The students expressed a range of opinions about the impact of facilitators on their clinical experiences. They described facilitators as fulfilling a number of important functions:

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[2] Students from sites 2 and 3 provided no indication that clinical lecturers or link tutors had any impact on their experience of belongingness while on clinical placements. Therefore, the roles of these staff members are not featured in the following discussion.

advocacy, liaison, mediation, clinical teaching, assessment, role modelling, mentoring, debriefing and appraisal. However, it was when students struggled to fit into the clinical environment or had experiences that were distressing and disempowering that facilitators were seen to be a pivotal support. By contrast, when students felt welcomed, and their student role was legitimised by the nursing staff, they were less dependent on facilitators. Without exception, it was the nurses that students worked with on a day-to-day basis that were described as having the greatest influence on whether students had a positive clinical placement experience or felt as if they belonged. From the students' accounts it seemed that facilitators had little control over these crucial nurse–student relationships.

Advocates and intermediaries

Facilitators often provided a safety net for students placed in unwelcoming or hostile environments. For some students, it seemed that facilitators made the difference between disappointment and complete disillusionment. Facilitators frequently stepped in when students found their placement experiences distressing or they felt inadequate to deal with the situations they experienced. The facilitators attempted, although not always successfully, to liaise between students and nursing staff with a view to creating an environment that was supportive of students and conducive to their learning. Kara described an experience where her facilitator advocated on her behalf:

> *I remember specifically an RN who, when she found out I was an enrolled nurse, went to morning tea and expected me to look after her patients while she was gone, and the other RN went as well. So there was only me on the floor. I contacted my facilitator and she came up straight away and spoke to the RN and the NUM. She said to the RN that it's not acceptable for any student to be left unsupervised, whether they are an enrolled nurse or anybody else…The RN ignored me for the rest of the time. She must have realised [that] she'd done the wrong thing and couldn't face me. That was the upsetting thing.*
> (12: 276–283, 290–292)

The students frequently called on their facilitators to reconcile the dichotomy between what they believed to be appropriate professional behaviour and what they sometimes observed in contemporary practice. The resultant chasm between what students learned at university and saw in practice often caused them to become discouraged and disillusioned. The facilitator appeared to be a key factor in the extent to which students were able to reconcile these types of challenging situations and remain committed to the nursing profession, even if not to a particular clinical environment. Ann described the

importance of facilitators acting as an advocate when poor clinical practice was evident, although in this example the efficacy of the facilitator's role is brought into question. It would seem from Ann's account that firmly entrenched attitudes and behaviours are difficult to overcome, and that facilitators are often powerless to make a difference to prevailing ward cultures:

> *I found problems at *** [aged care facility]—they were restraining residents, and the way they treated patients I didn't approve of either…I went to see the sister in charge, but when I tried to approach her, another RN said "she's too busy, she can't talk to you". So I went to my facilitator, who went straight to the educator and said, "Look, it's not on. There's all these problems". They were supposed to fix it up, but by the time I left they were still restraining patients.* (4: 35–38, 58–64)

Visitors to the area

Because of the sessional nature of their employment, the facilitators at site 1 are frequently unfamiliar with the clinical venue in which they are contracted to undertake their work. They rarely belong to the ward and are not in clinical areas long enough to develop effective professional relationships with staff. Both facilitators and students are then cast as visitors to the clinical area. When facilitators do not themselves feel comfortable in the environment, they cannot be expected to help students to fit in. This lack of familiarity is described by Deanne:

> *A lot of our facilitators haven't worked at the hospital, so they don't know anyone, or they work at the hospital but in different sections. So I don't think they [facilitators] really play a huge part in helping us to fit in.* (11: 565–568)

It was evident that facilitators sometimes struggled with their own sense of alienation and the resistance displayed by some nursing staff. Collegial relationships were not always apparent between facilitators and ward staff, and at times facilitators were deliberately excluded. Abby describes her first clinical placement, and the distress she experienced at being ignored by the nurse she was working with. She then describes the facilitator's attempts to reconcile the situation. It appears that the facilitator's own difficulties with staff interactions meant that her overtures to create positive and supportive interpersonal relationships between staff and students were futile.

> *My first placement was in orthopaedics. I felt so isolated and unwanted there. I did go to my facilitator about how difficult it was. She tried to talk to the RN and the nursing unit manager but I think she had a lot of trouble with them because she was very young. They constantly*

tried to make her help them out with the duties they were supposed to do. When she said, "no, I have to go and assess this student, I can't help you out with bathing this patient", you could feel the tension, and it was very difficult for her. She ended up crying from this treatment. (13: 80–86)

A nicety

It is important to remember at this point that many clinical placement experiences were described by students as positive and rewarding, and that the role of the facilitator when students were welcomed and accepted by clinical staff was far less important than in the troubling experiences previously described. Jane felt that facilitators may be beneficial when students first undertake a clinical placement, but from then on they assume a less significant role. She believed that she was able to fit into the clinical environment with little assistance from a facilitator, and that should problems occur there were other support mechanisms she could call on:

> *If you do have those doubts at the beginning, it's like you've got 'Mum' next to you. Not that I call on them [facilitators] all the time, [but] its nice having them around…They don't need to be with me all the time. They'll come and see me, but they know I'm just off doing my own thing and that I'll ask them if I need their help. I think they help when things aren't so good and they're really good for the quieter students…I don't think I'm going to have a big problem on my third-year placement when I don't have a facilitator, because a lot has to do with me. If I'm in trouble I'll ask for help. If I get stuck I'll just ring someone at the uni.* (3: 402–404, 415–418, 422–425)

Students who were confident of their place in the nursing team were less dependent on facilitators. In those situations facilitators were recognised as having a minor role to play in liaison and support, and not essential to a positive placement experience. Ann explains:

> *They [facilitators] introduce us to the nurses and say, "This is what the students are here for, this is the extent of their experience, this is what they can do and this is what they can't do" …They never really come near me again, because they say, "Look, we know you're competent".* (4: 502–504, 511–512)

At site 2 clinical facilitators are not employed to support students in practice. Instead students are mentored by clinicians. At this site, the students appeared to be keenly aware that they were in uncharted territory, as most of the registered nurses they worked with were more familiar with the sessional facilitation model used by other universities and were not always supportive of the new system. Louise describes her perceptions of this issue:

We haven't had facilitators all the way through this course. Most RNs are used to students being facilitated by someone employed by the university. And they [the facilitators] are the mediators between the RNs and the students, whereas this course doesn't have that. I think it's just a whole new learning thing for the RNs. They have to become aware that, "Okay you new students aren't facilitated, so it's up to us". And it's up to the student, as well, to make the most of the learning environment. (7: 165–171)

Without the support of a facilitator, a number of students from site 2 felt they needed greater support, or at least someone who could advocate on their behalf. Although Lucy described taking advantage of ad hoc and serendipitous learning opportunities when they presented and managed her learning in a self-directed manner, she nevertheless felt the need for more guidance and support:

What I would like to see is one person, whether that's a facilitator or nurse unit manager, one person who is in charge of the students on the wards. So that if you're having a problem working with nurse X, you can go to that support person and say, Look, I'm really having a conflict here. Can I be placed with someone else?"…Without a facilitator, you usually take each day as it comes and try to grab opportunities as they present. (8: 329–333, 335–336)

Facilitators employed at site 1 acted as advocates and intermediaries between students and clinical staff, although there was little evidence in the students' accounts to suggest that in this capacity they effectively influenced the staff–student dyad in a way that enhanced students' experience of belonging to a particular ward or unit. Even though the stated goals of the facilitator's role include the facilitation of students' acculturation and socialisation to clinical environments, there was minimal indication from the students interviewed that this did occur. There is little doubt that facilitators played an important role when students did not feel welcomed or accepted. The support provided at these times was seen to be immensely important and may have offset, at least to some extent, the negative experiences and the sense of alienation that some students experienced on placements.

6.4 Contextual factors that impact on students' experience of belongingness

Although belongingness is an intensely personal experience, it is contextually mediated. For nursing students, there were a number of contextual forces and influences that impacted directly and indirectly on their clinical placement experiences and significantly influenced the extent to which they experienced belongingness in particular environments. Four factors specific to the clinical unit or ward environment were identified by students as influential in their placement experience. These are listed in Table 6.3, along with the related themes.

Table 6.3 Contextual factors that impact on belongingness

Factor 1: Orientation structure

Theme A: A state of readiness

Theme B: A time of uncertainty

Factor 2: Consistency and structure of mentoring

Theme A: Consistent mentorship

Theme B: Lack of continuity

Theme C: Floating

Factor 3: Nurse unit managers or ward sisters

Theme A: Of little consequence

Theme B: A key role

Factor 4: Practice standards

Theme A: Values dissonance

Theme B: Values congruence

6.4.1 Orientation structure

Many students referred to the importance of having a structured orientation session at the commencement of their clinical placements. When this was provided, it served two

purposes: it created a strong message that students were expected, welcomed and valued, and it alleviated, to some extent, the anxiety surrounding the beginning of clinical placements. An orientation provided reassurance about basic issues such as students' place within the team, hospital and unit geography, location of equipment, routines surrounding meal breaks, and reporting lines. The students' basic needs had to be met before they could move on to become productive and participative team members. An orientation to the unit, even when brief, went some way to meeting these basic needs and laid a firm foundation for the development of a sense of belonging. Brodie et al. (2005) and Clare, White, Edwards and van Loon (2002) also emphasise the importance of a formal orientation period during which students become acquainted with the unit and their role in the team. However, it was evident from the students' accounts that the provision of an orientation was not consistent across all clinical contexts. In some contexts, students were expected to just "jump in at the deep end" and learn to cope by themselves, and the staff showed little awareness of the fears and uncertainties that students were feeling.

A state of readiness

In many clinical contexts it was routine practice to provide an orientation for students as a way of facilitating their settling in. Louise described the commencement of a placement where the staff planned for and welcomed her, provided resource materials and introduced her to the team members. These small courtesies are vitally important, but are often overlooked. That it was the nurse unit manager who provided the orientation emphasised that in this context students were valued and important:

> *The friendliest placement I've had and where I think they really planned for me to come and where I was really accepted, was my placement in renal dialysis…They gave me a book explaining what they do there, journal articles, quite a lot of question-and-answer things, books and references that you could use to see what they do there…The nurse unit manager introduced me, showed me around and made sure I was okay.* (7: 92–93, 100–102, 131–132)

Lucy described another context where the orientation was a planned and structured process. From her perspective, apart from providing an introduction to the unit, there are a number of other advantages to a planned orientation session: it indicated a state of readiness and receptiveness to students, it enhanced students' feelings of belonging to the team, and it provided an indication of the type of support that students could expect to receive in the unit:

The placement where I felt I belonged the most and felt accepted was probably *** Medical Centre. They were ready for us; they were keen to have us there. They had an orientation schedule for what I was going to do on the first day. Every day they asked, "Is there anything you want to go over? Is there anything more you need?" You know, they checked all the time whether I was getting all my learning needs met there. (8: 146–151)

Fiona explained that an orientation does not have to be an extensive and time-consuming process. The primary goal is to make students immediately feel accepted, welcomed and secure in the new environment. Fiona's experience demonstrates that an orientation, even if brief, sets the tone for the placement and establishes a climate that indicates that students will be valued and supported:

You know it if, when you walk in for the first time, people are smiling at you, they acknowledge you, they don't just totally ignore you, and you are not left standing around for ages on your own—if you are shown where everything is and the basics of the ward are explained to you—that says, "Yeah, this is going to be a placement where I am going to be OK; I'm going to fit in here". (14: 1100–1104)

A time of uncertainty

Kara's experience provides a contrast to those previously described. Without an initial introduction to the staff, routines and ward practices, she felt completely at a loss, anxious and confused. Unsure of even where to sit, Kara was keenly aware of being an outsider:

On the general surgical ward the staff weren't welcoming on the first day. I didn't know where anything was. I was in this packed little tearoom for handover and I felt really uncomfortable. I was thinking, "Am I sitting in somebody's seat and should I get up?" and "Where do I get the handover sheet from?" and "What do I do next?". (12: 130–135)

Laurence emphasised the importance of students needing to become familiar with surroundings and basic routines. Until this is accomplished he, like so many other students in the study, felt anxious and apprehensive—emotions said to interfere with learning and success (Meisenhelder, 1987). Laurence's experience demonstrates that when students fear the unknown their progress is hindered, and they focus on little else but trying to find their place in the environment. Once a degree of familiarity is established, they feel secure and can move forward to what Laurence describes as "being the best nurse you can be":

When I went to *** hospital, being a new area and so far away, I was worried about where everything was, if I was going to actually get my lunch breaks, was I going to have enough food to eat? And I was really anxious at first, 'cause I'd never been there. But once they

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showed me around and I got to know the surroundings, I was comfortable and that made everything better…When you know what's happening, you're not anxious, so you can straight away start being the best nurse you can be 'cause you're not worried about what's going to happen. (5: 337–338, 351–357)

For some students mental health placements provoke feelings of anxiety and fear (Charleston & Happell, 2005). Monique explained her initial fear and anxiety about beginning a placement in a mental health unit. Although she acknowledged that the staff were friendly and interested in her learning, the lack of a formal introduction and preparation to the placement experience meant that she was ill-prepared and unable to maximise the learning opportunities presented. In this example, it is evident that students' basic needs for safety and security initially take precedence over learning:

They [the nursing staff] were friendly and interested to know what I wanted to learn while I was there. But I have to say I was quite frightened when I went in there. I spent two days in the office because I really was scared to venture out into the courtyard on my own. There were some people [mental health clients] there and I didn't understand where they were coming from or what they could do. It's quite volatile in the acute unit and I didn't have a great deal of background knowledge when I started…A lot of the people [clients] in there, a lot of the men, were quite tall and heavy in size. They could have made mincemeat out of me in two seconds. Looking back now if I'd been told a bit more, and things had been explained at the beginning, I'd have been better prepared and I think I would have gotten so much more out of the placement. (10:298–305, 309–313)

At the beginning of each clinical placement, the students focused on seeking information that would allow them to feel comfortable in their new and foreign surroundings. Many students reported feeling anxious and fearful at first and needed reassurance about basic issues such as their place within the team, unit geography, basic routines and reporting lines. Clinical units that were committed to providing an orientation facilitated students' feeling of being accepted, and supported and helped them to navigate through the initial stage of uncertainty and unfamiliarity.

6.4.2 Consistency and structure of mentoring

In Chapter 7 the attributes and interpersonal skills of effective mentors are discussed in detail. In this section, although the importance of quality mentorship is acknowledged, the discussion focuses on the consistency and structure of the mentoring process, and how this impacts upon students' capacity to build effective relationships with their nursing colleagues. An important purpose of clinical education is for students to work with and

learn from good role models. When students are not provided with opportunities to work with a designated mentor for a extended period of time, both their sense of belonging and their learning outcomes can suffer (Lloyd Jones & Akehurst, 2001).

Although both the literature and students' accounts bear testimony to the importance of mentors to students' experience of fitting in and being accepted, this type of supportive relationship is not always evident in clinical environments. Forces in current clinical contexts such as staffing shortages and increased workforce casualisation can mitigate against consistent mentoring relationships being sustained (Clare et al., 2002; Levett-Jones & Fitzgerald, 2005). This was particularly true of the experiences of students from sites 1 and 2, who described how the provision of a consistent mentor for the duration of their clinical placement was an infrequent occurrence. Brammer (in press) suggests that in Australia an ad hoc system, in which students are "buddied" up with a different nurse each day or for a few days at a time, has become increasingly apparent. There are no national guidelines for mentoring in Australia and the process and practice of supporting students vary across contexts. The students from site 3 told a somewhat different story. In UK clear guidelines are provided by the Nursing and Midwifery Council (2002, 2004b, 2005a) and the Royal College of Nursing (2002) outlining the expectation that an allocated mentor is to work with a student for at least three out of five shifts each week. Although these recommendations are not followed in all clinical contexts, most of the students I interviewed reported working with a consistent designated mentor or associate mentor for the majority of their clinical placements. This finding is supported by a recent evaluative study undertaken by Lathlean and Myall (2006) that explored the mentorship experiences of nursing students from site 3.

Consistent mentorship

Mentors employ a range of strategies to support students. This includes spending time with them to identify and plan for the achievement of their goals, and then, in an ongoing and progressive way, helping them work towards the realisation of their goals. In busy clinical environments this type of support is highly valued by students. As students progressed through their program they often became increasingly self-directed and appreciated mentors who were able to accept their current level of ability, yet support them and motivate them towards achieving individualised and increasingly sophisticated learning objectives. Fiona explains:

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At *** I had the same mentor the whole time. She was brilliant and couldn't do enough to help me. We went through all my objectives and she was like, "Right you can achieve this by doing that and we will arrange for you to go here and here and here", and it was brilliant…It was great to be able to say, "Well, I need to achieve all these things" and for us to come together and work out how I was going to achieve them, and then work together to achieve them. (14: 272–276, 286–287)

Deanne suggested that while it is beneficial to have one consistent mentor there are advantages to working with different nurses. Deanne feels that remaining close to one person may limit interactions with the rest of the team. It would appear that the security gained through a supportive mentor–mentee relationship fosters the confidence to interact with and learn from other members of the nursing team. This may well be an ideal situation for students, as it both enhances their sense of belonging and facilitates a wide range of learning and interpersonal experiences:

In the community placement I had one particular person who was my mentor, yet I had the opportunity to work with everyone. If something was happening they'd come and get me. Although I didn't spend the whole time with my mentor, I felt secure because I could go to her whenever I needed to. It was a way of building up a relationship with her [the mentor] and the rest of the staff. If you're with one particular person for the whole time, then you start to build up a dependence on them and you start to focus on that rather than interacting with everybody else. (11: 508–518)

Lack of continuity

Without the understandings generated though ongoing student–mentor dialogue, students' needs for support and clinical learning are often overlooked. Deanne described some of the educational disadvantages of working with inconsistent mentors during her clinical placement:

You don't usually work with the same person each day. It's probably been about fifty-fifty really and at *** [hospital] I think I was with someone different nearly every day. That makes it hard, because one nurse has just started to learn what you're capable of and what you want to achieve, and then you come in the next day and you've got someone else. They send you off doing beds and obs and you're going, "But, but, you know, I want to do this and I want to do that". (11: 491–496)

Lucy explained that staff–student relationships can suffer when consistent mentors are not provided. Following on from that, a student's learning may be adversely affected. Although

there are some advantages from seeing different practices, Lucy nevertheless preferred working with one nurse and building up a rapport with that person:

> *I've pretty much worked with a different RN every day. It is good to see different ways of doing things and you can always pick up something off one person that you don't necessarily get from another. You know, if they've got an interest in particular things, you can focus on those aspects one day and other aspects another day. But I would like just one person, instead of working with lots of different people. I did find it comfortable the days where you would get the same person a few days in a row. You got to build up a rapport with them. And they start to understand where your skills were at. If you're working with someone different each day it takes them a while to feel comfortable with your abilities and what you can do and the things you need more practice with.* (8: 356–365)

Contextual factors either supported the provision of consistent mentors or worked against this happening. Workforce pressures such as short-staffing and skill mix were often cited as reasons why consistent mentors could not be provided. As mentioned previously, while the Nursing and Midwifery Council (2004) and the Royal College of Nursing (2002) clearly articulate the importance of consistent mentorship, it appears that in some UK contexts these guidelines are not always followed. Although the majority of students from site 3 worked the requisite three out of five shifts each week with their mentor, Elizabeth described an experience where the busyness of the ward precluded this from happening:

> *When I first got there [to the ward] I had a mentor who was going on paternity leave. So I was thinking, "Why did you put me with a guy whose wife you knew was having a baby? That is just silly". But that was sorted in the first couple of weeks. Then I got this nice new mentor and she seemed really nice. But she just couldn't teach me anything because she just didn't have the time. I hardly ever got to work with her, even when she was on the same shift [as me], which was really annoying. In a way I can't blame her, because she was unbelievably busy and she always had to leave the ward and do other things. She was managing the ward on some days too, so wasn't actually doing clinical nursing.* (15: 321–333)

Floating

In some units, such as the mental health unit described by Kara, students were not provided with a mentor for the placement or even for the shift that they were working. This is termed *floating*. Students found this to be particularly distressing, as it left them feeling uncertain, unwanted and at a loss to know what to do. This was unsettling for students in

unfamiliar environments such as mental health where they were unsure of their role, the staff's expectations of them and the client profile. Kara explains:

> *I did a mental health placement and I did not feel part of the team at all. On several occasions they'd say, "Oh, we won't put you with anyone today; you can just float"…I like the days where I'm placed with someone, and I'm working with them. Then I know where I'm at. I don't feel comfortable or supported when I'm just told to float.* (12: 164–166, 178–180)

Students' ability to gain entrée to clinical units by developing strong and effective relationships with their nursing colleagues and their potential for learning was influenced by the security they gained from working with designated mentors for an extended period of time. In some clinical units it was evident that there was a commitment to the provision of consistent mentors, despite the challenges inherent in contemporary practice. From the students' perspectives, an ad hoc system of being paired up with a different registered nurse each day was not effective, nor did it influence students' experience of belongingness as much as more consistent and formal mentoring processes and structures.

6.4.3 Nurse unit manager or ward sister

The students provided detailed descriptions of their interactions with and perceptions of the ward manager's[3] influence on their sense of belonging. Many students suggested that as a clinical leader the ward manager remained a key player in creating a supportive and facilitative clinical learning environment and in influencing staff's attitudes towards students. Clinical managers who were accepting, supportive and inclusive facilitated students' perception of being valued and respected as members of the nursing team and as a welcome addition to the clinical milieu. However, some students expressed a degree of ambivalence about the ward manager's role, implying that they were often inconsequential to their placement experience, and certainly to their experience of belonging.

Of little consequence

This example from Laura paints the picture of a nursing unit manager who, while not completely indifferent to students, was not personally committed to the provision of a

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[3] Ward managers are often referred to as "sister" in the UK, or nurse unit manager (NUM) in Australia

welcoming and supportive placement experience, nor did she convey a sense that she valued Laura's presence:

> *Normally you'll see the nurse unit manager on the first day. They'll say, "I'm not expecting you", and race around trying to fit you in somewhere. You don't really see much of them after that, once they've assigned you to someone to take care of you, like that's their responsibility done.* (2: 253–257)

Leanne shared an experience where the manager's response to students is one of indifference and disinterest. She attributes the manager's behaviour to a preoccupation with administrative responsibilities, although it seems to be more indicative of a general ambivalence to students and possibly resentment of their intrusion. Either way, the managers' attitude conveyed the message that Leanne was not important, welcomed or valued on this ward. The words, "She didn't even look at us" project a sense that she felt disregarded and insignificant:

> *At the *** [hospital] the nurse unit manager is not really involved in the ward—they seem to have more of an office job really…The NUM didn't even look at us. It was just like, you'd walk in, you would say hello to her and she wouldn't even say hello back.* (6: 213–215, 219–221)

A key role

Not all students recalled negative experiences with nurse unit managers. Laurence tells how his sense of belonging and acceptance were enhanced by his interactions with some managers. It is apparent through Laurence's story that ward managers can have an important influence on students' socialisation to the workplace and their experience of belonging. Much of the manager's behaviour conveyed to Laurence that he was valued. Asking if he was "alright" showed her concern for his welfare, and enquiring whether he had "time to do some of his competencies" signified the manager's respect for him. Remembering that Laurence had competencies to achieve while on placement and setting time aside to help him with them conveyed the sense that his learning needs were legitimate and important. The manner in which the manager validated Laurence's learning sent a strong message of support and emphasised how influential managers can be in communicating to students that they are accepted and welcomed in the clinical environment:

> *In some of the wards the managers make sure you're okay. They come around, and say, "You alright? Have you got any problems?" The nurse unit manager on my paediatric*

placement was really supportive. On the first day she asked us what we expected to get out of the placement and what we had to do. We said, "We've got this competency book that we've got to get through. Well as soon as we told her that she said, "Oh, I'll make sure we get some of that done". When she thought the ward was a bit slow, she would say, "If you've got time let's go and do some your competencies", and she'd help us with it. She was always looking after us and making sure we were doing our work. Not bugging us, but making it easy for us. She was really, really good. I didn't expect that, but when it happened it was really nice. She helped me to fit in, even though I was only a student. (5: 753–767)

The importance of the manager (or sister) in providing individualised teaching to students and promoting an environment that facilitated learning was noted by a number of students. By doing this managers also sent a message of support and acceptance to both students and staff that said this student is valuable and so are their learning needs. Katherine explains:

The sister makes a big difference to how you fit in and what you learn while you're there. When I did my adult placement, the sister just seemed to know so much, and it was really good because she imparted all that knowledge and told you all these things that you wouldn't necessarily think to ask. And if they are good with the students and spend time explaining things, I think that influences the other nurses. It certainly made me feel valued. (17: 958–965)

The manager's influence on the culture and tone of the ward was referred to by a number of students. Sarah described the role of the ward manager in creating a receptive and facilitative clinical learning environment. In this example the ward manager makes a statement that students are to be provided with a clinical learning experience that is free from "problems". Her expectation was that the nursing staff would support students in having a positive and productive placement and she was confident that "her staff" would uphold her expectations:

In that placement I barely saw her [the nurse unit manager] but on the first day she said that if I had any problems I would be more than welcome to stick my head into the office and discuss that with her. But she said she didn't anticipate any problems because her staff were wonderful, which she said in front of them too—so that was sort of like a vote of confidence for them, but also a "I don't expect you guys to have any problems" very clearly stated so that, you know, she didn't want there to be problems, for me or the staff. (1: 234–240)

Ward managers were described by students as a significant influence on the ward ethos and on whether students felt as if they were welcome and accepted members of the ward team. From the students' accounts it was apparent that although some managers were supportive of students others were indifferent and at times even hostile to their presence. This often made the students feel excluded, unwanted and unimportant.

6.4.4 Practice standards

The therapeutic relationship is essentially a reciprocal one. It is reasonable to assume, therefore, that the stories elicited during the interviews with the students would reflect, at least to some extent, contextually rich data about their interactions and reciprocal relationships with their patients. By contrast, the interviews were almost exclusively monologues of what might be referred to as self-contained anecdotes. In these anecdotes students described in detail their dynamic and diverse relationships with their nursing colleagues. However, descriptions of their patient care interactions were largely absent. In the thinking of many interviewees it seemed that interpersonal relationships with nursing staff took precedence over patient care. The significant exception to this was when students undertook clinical placements in contexts where the general standards of practice challenged their professional and personal values. These experiences were often described at great length and a number of students expressed a sense of relief at being able to share their stories. Distressed, disempowered and unable to effectively alter the poor standards of care they observed, their reactions almost invariably were emotional detachment and disengagement. In effect, they deliberately chose to alienate themselves. Sarah's poignant words exemplify this issue:

> There are some places where you'd never want to belong—where the care is so bad that you have to distance yourself just to survive. (1: 706–707)

According to Hagerty, Lynch-Sauer, Patusky, Bouwesma and Collier (1992) one of the defining attributes of belongingness is the perception that a person's characteristics or values articulate with, or complement, a particular system or environment. For many of the students in this study, undertaking placements in clinical environments perceived as having poor practice standards led to feelings of alienation resulting from a dissonance between their own values and those of nursing staff. Hajda (1961, pp. 758–759) defines alienation as "an individual's feeling of uneasiness or discomfort which reflects his [sic] exclusion or self-exclusion from social and cultural participation". Many students in this study deliberately chose to distance or detach themselves emotionally and

psychologically, if not physically, and excluded themselves because of the discomfort they experienced at being witness to poor nursing care. It is important to note that a number of the excerpts from the transcripts included in this section are necessarily lengthy as students often spoke about the same negative experiences many times throughout their interviews. Many students had not been able to resolve these difficult issues.

Values dissonance

Ann described how her professional and personal values were challenged while undertaking a placement in an aged care facility, and how as a result of this experience she felt she could not fit in to the environment, nor did she want to. Ann did not demonstrate an ageist attitude and in fact seemed to understand and appreciate the importance of older person care. She had worked in aged care previously, and it was not the type of work nor the residents that caused Ann's distress, but rather the poor practices she observed and the fact that she had no power to improve the situation for the residents:

> *I found problems at *** [aged care facility]—they were restraining residents and the way they treated patients I didn't approve of either. I have a very big problem if you don't show respect and things like that. So that really got to me. It felt horrible because I wasn't employed there to work, so I couldn't really do anything to change their attitudes…It [the standard of practice] didn't fit in with the way I've been taught, the way I actually practice— 'cause I believe you've got to respect those who have been through world wars, depressions. They've got a huge history and they deserve our respect and kindness. They were just being rough-housed or ripped out of bed or put in restraints or whatever. No, I just didn't approve…I went over to the patients and asked them if they were okay and if I could do anything for them. I made sure they were comfortable. I mean a lot of them had hand marks, bruise marks on them. They [the nurses] still didn't do anything. They didn't particularly care…I wrote one of my nursing narratives on restraint, and I had to rewrite it three times, because I was angry and you could tell by the way I wrote it. I had to redo it a few times before I could hand it in. It was just one way of getting it out when you can't do anything and you're not in a position to actually change it and they're just going to carry on. I can't work in places like that. That was my most negative placement. I just did not fit in, because of the quality of care, well lack of.* (4: 35–44, 80–84, 94–97, 214–223)

Many of the negative experiences described by students were related to aged care facilities or involved caring for elderly patients. Negative placement experiences were frequently perceived as synonymous with poor standards of patient care. Monique shared her perceptions of an aged care placement and the poor quality of nursing care she

observed there. This was a distressing and alienating experience where Monique concluded that "the only thing that made me happy was the thought that I could leave there after two weeks":

> *I went to *** aged care [facility] and I can honestly say I don't want to work in aged care ever again. I don't know if that particular facility was indicative of most aged care facilities, but I didn't find it an environment that I that I liked very much…Some of the ENs [enrolled nurses] were particularly rude to the patients, like derogatory. There were so many residents with incontinence and they were made to feel like they'd done the wrong thing. It was just a very, very negative environment. If I ever got to that stage I would leave the profession…There was a complete lack of quality care. Even in the simplest tasks of communicating with somebody. There were residents there that had dementia and other problems. The tone and some of the words that were used were not appropriate. I know that, even with the little experience I have…I still tried to maintain some sort of enthusiasm, but five minutes after I walked in that enthusiasm was right out the door. That probably would be my most negative experience by far. (10: 121–123, 144–149, 163–167, 186–188)*

Staffing shortages that affect nurses' ability to provide safe and effective care are a major cause of job dissatisfaction among nurses (Frazier, 2003). Brodie et al. (2005) assert that environments with perceived poor standards of care also impact negatively on students' placement experiences. Katherine was a student enrolled in the children's nursing branch of nursing. She described her experiences on a paediatric surgical ward where staff shortages and competing demands had a deleterious effect on practice standards. Because of the dissonance between Katherine's professional values orientation and those she observed, she felt uncomfortable and struggled throughout the placement:

> *They were very short-staffed and it was always very manic and busy, with highly dependent children. It felt like patient care was being neglected with no time being spent with the children. I didn't like the way it was rush, rush, rush, get all the jobs done without the caring side of nursing—actually looking after the children and preparing them for things, letting them know what is going on…A lot of the time there would only be one nurse who could do IVs so they were given a list of drug charts to just go and do a round. The patient care did suffer. I didn't feel very comfortable in that placement. I didn't enjoy it at all and I'm not sure that I even learned anything while I was there. (17: 732–742)*

Values congruence

For most students, it appeared that quality care was considered to be the norm and therefore did not stand out as exceptional. This may explain why their descriptions rarely

mentioned quality practice but instead focused on patient care that was considered to be aberrant or atypical. The following example provided by Jodie is one of the few exceptions to this pattern. Jodie equated a good placement as one where she could readily identify with the quality standards of practice. As a consequence of the standards of care demonstrated by the nursing staff in the radiotherapy/palliative care unit, she felt that she could relate to the nursing staff and actually enjoy the placement. In essence, her professional values were in accord with those of the staff she worked with, and she shared their sense of pride in the provision of quality patient care. The feeling of oneness with the team is evident by her use of the word "we" when describing the provision of care:

> *My last placement was a cancer care rotation. I started off in radiotherapy and palliative care, which I loved. I really felt part of the team there…I just felt like I belonged. And I loved what we were doing with the patients. I liked the fact that we were doing what I thought was good care and I had a lot of support from the nurses. The sisters were very, very good at their job and I really enjoyed my time there.* (16: 506–507, 515–518)

The ability to provide quality patient care is crucial to nurse satisfaction (McNeesh-Smith 1999). Patient care is just as important to nursing students entering the workplace. In this study, environments with perceived poor practice standards negatively impacted on students' placement experiences, and the values dissonance that resulted caused students to feel alienated, disempowered and detached. Conversely, those students who described quality practice standards referred to the strong sense of collegiality they felt with the staff in those contexts.

6.5 Conclusion

There is no question that the organisational and contextual factors described by students were crucial moderators of the extent to which they felt secure and confident of their place in the clinical milieu and accepted by and integral to the nursing team. The organisational factors outlined in this chapter (that is duration and structure of clinical placements and the role of clinical facilitators) were those mandated by the universities, nurse regulatory authorities and/or healthcare services. The ways in which these factors were actioned at the three sites were seen to be either barriers to or facilitators of belongingness. The differences between sites, across contexts and inherent in the students' accounts provide a broad perspective and enhance our understanding of the organisational factors that influence belongingness.

The contextual factors described in this chapter were those specific to the real world clinical environment where nursing students seek to develop the knowledge, skills, attitudes and values of a registered nurse. Clinical environments are essential to student learning. Despite the complex and dynamic nature of contemporary practice environments, it was evident from the students' accounts that many contexts were conducive to both their sense of belonging and their learning. These positive environments provided a milieu in which students felt a sense of connection with the nursing team and were socialised to the culture and ethos of nursing. By contrast, some of the environments described by students were inhospitable and unwelcoming. The processes and practices evident in those contexts engendered intense feelings of alienation and often caused students to become distressed and disillusioned. Many students disengaged psychologically and emotionally, and focused on merely surviving until the placement was complete.

In Chapter 7 the interpersonal relationships between staff and students and the impact of students' own attributes and preconceptions on belongingness are discussed. An understanding of these factors complements the findings from this chapter and creates a comprehensive and compelling view of nursing students' experience of belongingness.

Chapter 7

Findings from the Qualitative Phase of the Study

Part 2: Interpersonal and Individual Factors that Impact upon Belongingness

7.1 Introduction

The discussion of the qualitative findings began in Chapter 6 with the organisational and contextual factors that impact on nursing students' experience of belongingness. The discussion continues in this chapter with a review of how belongingness is influenced by (a) the quality of the interpersonal relationships developed between students and their nursing colleagues, and (b) individual students' previous life experiences, world views and personal attributes.

7.2 Interpersonal factors that impact on students' experience of belongingness

Interpersonal relationships occur within groups and between individual group members. Understanding relationships is of particular relevance to nursing teams, for whom the ability to communicate and interact in a positive way is crucial. When on clinical placements students learn how nurses interact, feel and think, what they value and how they communicate (Levett-Jones & Bourgeois, 2007). For nursing students a sense of belonging is intimately linked to the people with whom they undertake their clinical placements. Thus, an understanding of the interpersonal factors that influence students' experience of belongingness is essential. In this section the centrality of staff–student relationships is emphasised, as the staff that supported students in practice either facilitated or undermined their experience of belongingness. Their behaviour, attributes and professional orientation were categorised under the heading of "Interpersonal factors that impact on belongingness". The themes in this category are listed in Table 7.1.

Table 7.1 Interpersonal factors that impact on belongingness

Factor 1: Receptiveness of nursing staff

    Theme A: Made to feel welcome

    Theme B: Lack of acknowledgment

Factor 2: Inclusion/exclusion

    Theme A: Involved and included

    Theme B: Exclusion from patient care

    Theme C: Informal socialisation

    Theme D: Social exclusion

Factor 3: Legitimisation of the student role

    Theme A: A valid and valued role

    Theme B: Just a nuisance

Factor 4: Recognition and appreciation

    Theme A: Trusted and valued

    Theme B: In the way

Factor 5: Challenge and support

    Theme A: Pushing the boundaries

    Theme B: Expecting too much

    Theme C: Being held back

    Theme D: Undermining confidence

7.2.3 Receptiveness of nursing staff

The students said they judged the receptiveness of the nursing staff by whether or not the staff were welcoming and friendly on the first day of a clinical placement. They believed that their first impression of the ward culture was like a barometer that measured and foreshadowed how their placement would unfold. It seemed that in most cases they were correct in this assumption, and the quality of the ensuing experiences was closely linked to how they were received initially. The students described how the nursing staff's receptiveness and approachability directly affected their level of anxiety, their emotional

wellbeing and their experience of belongingness. Staff who were welcoming and receptive made students feel more valued and accepted. This led students to approach the placement with a sense of anticipation and excitement, rather than with apprehension. It is encouraging that most students could recall positive experiences where they were greeted enthusiastically and made to feel welcome by the nursing staff. It is sobering that almost as many examples of nursing staff being indifferent or overtly hostile were described. In the latter situations students felt like unwanted intruders (Levett-Jones, 2006b). In consequence, students were uneasy and uncomfortable, and began their placements with feelings of dread. The sense of alienation that they experienced as a result of the unfriendliness and resentment demonstrated by nursing staff led to varying degrees of distress and exacerbated the anxiety that inevitably surrounded the commencement of each placement. For some students their feelings of alienation led to isolation and a sense of powerlessness, which has been described by Dean (1961) as a lack of control over events and feeling helpless to influence or change those events.

Made to feel welcome

Leanne outlined how she was welcomed on the first day of her placement and the impact it had on her feelings of self-worth. For this student, being accepted, appreciated and valued were closely linked to her feeling of belonging. This experience set the groundwork for the creation of a warm, supportive and positive learning environment:

> *At *** [hospital] when you walked in on the first day, all the nurses had the biggest smiles on their faces…They actually looked excited that you'd turned up. They made little comments like "I'm so glad you're here today". After the first shift they said, "Thank you so much. I wouldn't have been able to it without you"—really nice things that make you think, "Oh, maybe I <u>am</u> kind of appreciated here".* (6: 180–181, 350–353)

Brent describes a similar clinical placement where he was also enthusiastically welcomed and included. The team's receptiveness was signified by their words, "Oh, we've got a student—great" and their inclusion of Brent is indicated by them saying, "join in". He understood their receptiveness as proof that they were happy for him to be there. It is noteworthy that the positive and supportive environment described by Brent enhanced his own motivation, happiness and enthusiasm for the clinical placement:

> *Those guys in the ECT suite, they really made you feel welcome. You know, "Oh, we've got a student—great, excellent, come in. This is what we're doing. Join in. Would you like to do this? Here, stick these dots on the patient. This is what they're for". They were more than*

happy to have you there—it was just great. It really felt good—one of those placements that you were excited to get up in the morning to go back to. (9: 335–340)

In describing the importance of the kindnesses and courtesies extended by nursing staff to students on their arrival, Kara shows how simply offering a cup of tea and providing introductions met her needs for psychological safety and support. She felt secure and supported rather than being left to struggle on her own:

When I arrived they [the nurses] said, "Oh, would you like a cup of tea, grab a seat, we'll have handover"—"I'm so and so and this is our NUM". So I knew who everyone was straight up and I didn't have to fumble round and ask, "Oh, who do I ask, where do I go?" (12: 111–114)

Lack of acknowledgment

Louise's experience is in direct contrast to those described above. It emphasises the importance of the staff's receptiveness when students are new and unfamiliar in the environment. In this example, Louise's need to feel safe and secure was not taken into account. The staff were indifferent and she was left without support or direction:

When I was in mental health, the staff didn't acknowledge us—not even so much as a "Hello". There were two students placed there at the time. When they did handover, they didn't allocate us to an RN. They walked away from handover and we were left standing there going, "Well, what do we do?" (7: 55–59)

Nursing staff were not always welcoming or accepting of students and some were openly resentful of their intrusion. Many students expressed the belief that nursing staff were already overworked and stressed, and therefore saw students as an extra burden. Even though the students in this study were in their third year, the nursing staff did not always value the contribution they could make to the team. Kara attributed the staff's lack of receptiveness to the intensity and pace of nursing work.

The pace of the work was pretty stressful and the patients were fairly heavy. I think that that was a huge factor in how helpful they were to us, or how receptive they were to us as students. (12: 75–78)

Katherine described an experience where her need for support and guidance on her first day was overlooked by staff anxious to get on with their work. While their indifference was interpreted by Katherine as an oversight, it displays a lack of understanding and sensitivity to the feelings and needs of inexperienced students. This is another example of staff not

understanding or acknowledging the student's need for familiarity and consistency in a busy clinical environment that often seems to a newcomer to lack order and certainty:

> *I remember on my first day I went in and didn't know anything about vascular surgery. I'd never even been in a hospital before. I remember coming out of handover and just standing there with my bag and my coat looking completely lost. I didn't know what I was doing. I stood at the desk. Everyone dispersed off to their patients and their jobs and I just stood there, thinking, "What do I do now?". A third-year student came along and said, "I'll show you where to put your bag and coat and show you around the ward". None of the other staff did. They were obviously very busy and just getting on with their work.* (17: 305–313)

The students' accounts were polarised, indicating either strongly positive experiences where the staff were receptive and welcoming, or completely negative experiences where the staff were resentful or indifferent to the presence of students. Staff who were receptive of students enhanced their feelings of being valued and accepted. Students then began the placement with anticipation rather than apprehension. Conversely, staff who were indifferent or hostile had a negative impact on students' level of confidence, anxiety and self-worth.

7.2.4 Inclusion/exclusion

The participants in this study described many clinical environments that were inclusive and welcoming of students. Students believed that their experience of belongingness was directly linked to whether they felt included or excluded by the nursing staff and to a lesser extent by other members of the healthcare team. Students felt included when they were provided with opportunities to work with positive role models in undertaking patient care activities. When staff socialised informally with students on the wards as well as during meal breaks, students felt included through the informal channels of communication that they shared. A number of experiences of exclusion were recounted also. Students described how staff overtly left them out of conversations, learning experiences and general ward activities, and how this led them to feel alienated and isolated.

Involved and included

In some clinical environments, including students was a practice inherent in the team culture and as such was undertaken by all nurses irrespective of whether they were responsible for mentoring the student. Ann's description of how she felt included by the staff and their responsiveness to her learning needs captures the sense that belonging is

directly linked to inclusion. In this environment, Ann felt like a valued member of the team, or in her words "one of them":

> *Even if your RN was off on a break at the time, or doing something else, another one would pick you up, and go, "Come on, come and do this" or "Come and watch me do this", and it was really, really good…They made you feel like you were one of them—always asking, "How're you doing? Is there anything you need to know? Is there something we could show you?"—that type of thing.* (4: 109–112, 150–154)

Deanne shares a similar experience of being included, supported and involved. It is noteworthy that she refers to the ward as "our ward", denoting her strong sense of belonging in that environment. This was not typical of the language most students used:

> *On our ward, the staff were great. They'd say, "Oh we're doing this. Do you want to come and watch?" Even nurses that we hadn't worked with would come and get us…The staff on our ward were really supportive and let us get involved as much as we possibly could.* (11: 188–190, 193–194)

Students particularly valued staff who were willing to share their knowledge, skills and insights while involving them in patient care activities. Monique describes how the nurse she was working with included her by asking for her help. This request signified to Monique that she was needed and that her assistance was valued. By taking the time to explain the procedures and underpinning rationales, and by asking probing questions as they worked together, this nurse demonstrated that Monique's learning was important and she was worth the investment of time:

> *One particular RN in high dependency was fantastic, and I'll never forget the way she worked, her efficiency—she was so structured. She included me in everything she did and [told me] why she did it…She included me by asking me to help, and she explained [things] as we worked. I think it was the first time I'd seen a piggy-back IV. She explained why they did it this way, what was in it, why it was needed…She questioned me on a couple of things and asked, "Why do we do this?". Every time she went to go [somewhere] she said, "I want you to come with me" and explained everything to me. That was a really, really good experience.* (10: 72–76, 80–83, 85–88)

Students appreciated being included in learning opportunities by members of the healthcare team other than nurses. Students from site 3, in particular, shared stories of doctors including them and supporting their learning. Nicole described an experience where a surgeon and an anaesthetist included her, and how this compensated for the indifference and exclusion demonstrated by the nursing staff, at least to some extent:

The nurses in [operating] theatres didn't even acknowledge me. I would say, "Hello" and they just said nothing and went off and did their own thing. So I ended up just sort of standing in the corner. Thankfully there was a very nice surgeon who said, "Come over. Let me show you what I am doing". And the anaesthetist said, "You can help me. I want you to do this". So I was sort of helping him while the surgeon was explaining what he was doing. If it wasn't for those two including me, I would have been stood like a lemon in the corner of the room for the day. (18: 1245–1253)

Elizabeth provides another example of being included by doctors and the positive impact it had upon her sense of belonging. It is evident that by taking the time to engage with students and become involved in their learning, doctors can create a sense that students are valued and important:

People recognised that I was there to learn and it was so, so good. The doctors there were great too. I had my own patients and one consultant would come along and I would give him a handover. He would start firing questions at me and I was just like, "Oh, my God". But then he would say, "Look, just give me yes or no, higher or lower or anything like that. You've got a 50 per cent chance of getting it right". And I was like, "Okay then". Sometimes I'd get it wrong and sometimes I'd get it right, but he would say, "At least you tried" or "Well done". And I realised that he was really nice. They [the doctors and nurses] just saw my uniform and wanted to teach me. They included me whenever there were opportunities for me to learn something new. (15: 543–555)

Exclusion from patient care

In contrast to the inclusive experiences described above, Louise recounted what it was like to be excluded by the nurse she was working with. Louise's words are a strong indication of how unwanted and unwelcome she felt. She also describes how difficult it was to become involved with the patient care activities and potential learning opportunities when she was excluded by the nurse she was working with:

Not everyone likes students, and I think some of them are just lumbered with students and don't really want you there…They're not very nice to you. They don't include you; they just walk off and do their own thing, and you're running along behind them trying to catch up and see what they're doing. (8: 604–605, 609–611)

When students felt excluded, they sometimes gravitated to other staff whom they also considered to be "outsiders". In this example, Deanne describes a placement where she developed a supportive relationship with a casual staff member who also felt excluded

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from the team. Deanne clearly differentiates between those she considers to be "insiders" (the permanent ward staff) and "outsiders" (the casual staff and students):

> *In my first placement at *** hospital I didn't feel as though I fitted in. A lot of it was to do with us being new but also the nurses there were a really cliquey group. They seemed to know each other well. They worked on their own but called each other if there was a problem…The casuals [nurses from the casual pool] weren't included either. I think the nurses that worked there thought their [the casuals'] skills were not as good as theirs…There was a lot of bitching about them when they [the casuals] weren't around. And there was this general air that you don't talk to 'em, you don't associate with them, you only help them if they ask for help. So my first day, when I was with the casual, I barely saw anyone else because she didn't ask for help and no one offered to help her. It was really segregated…I think at times students tend to bond with casuals because they're both outsiders in some sense.* (11: 334–337, 344–346, 349–354, 359–360)

Informal socialisation

Informal interactions with nursing staff were seen to be a powerful mechanism for students to become socialised to the ward culture. This was particularly apparent during meal breaks, when the stressors of the work were temporarily forgotten amid the informal banter and gossip. Inclusion in these informal conversations and tea room chatter appeared to signify that a student was accepted as a member of the team. Laurence described how sharing meal breaks with the registered nurses was an informal opportunity to socialise away from the stress of the ward, and how this broke down barriers between students and staff:

> *I was in paediatrics and when the RN went to morning tea or lunch she would tell me to come too. You could start to see the other side to the nurses then, not just the work side— even the ones that you think are cranky. When they're outside you think they're not that bad. The meal break is like a bit of a de-stressor…Away from the ward when you're not talking about work, you get to talk about their personal life…When I was working with them for a couple of days, they would include me in their conversations and ask, "Have you got a girlfriend? "Are you living at home?" It was good that they didn't think of me as just extra help. They thought of me as a person who is worth getting to know. That then made the work a lot easier as well.* (5: 818–824, 830–831, 839–845)

Social exclusion

In this example, Abby described how she felt excluded and alienated by the nursing staff. These staff drew a clear distinction between those that belonged and those that didn't. By

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clearly articulating that "you are not allowed in our staff room", they sent a clear message that students were not included as part of the team. Abby then compared this experience to one where she had been encouraged to socialise with the nurses during their meal breaks:

> *There is always tension between students and nurses, always a big territorial divide. It's quite a difficult situation…At *** hospital all the students [on one ward] were told not to eat lunch in the staff room, because that's a place just for the staff. We were not allowed to enter the staff room during our break or during lunch. We had to go some place else because that was their space…At handover on the first day they said, "Just to let you guys know, you are not allowed in our staff room". We had to make our tea in the patients' and family area, make the tea and then get out. I was very upset and angry, to be honest. But in *** [hospital] we were encouraged to have lunch with the staff. I am a smoker and I was going outside for a smoke, and they're like, "Where are you going? Come and sit with us." And I'm like, "I've got to go for a smoke". And they are like, "Ah, you don't need that. Come and sit with us"—completely different to the other hospital.* (13: 656–657, 660–664, 674–680)

From the students' perspective, the degree to which they felt included by the staff they worked with was a major influence on their experience of belongingness. Students reported feeling included (a) when they were provided with opportunities to work beside effective and supportive role models in undertaking patient care, and (b) through informal channels of communication such as and gossip and jokes, shared during meal breaks or when staff socialised with them informally on the wards. A number of experiences of exclusion were also described by the students. When staff deliberately left them out of conversations, or denied them the learning opportunities that they needed and wanted, students felt alienated and isolated.

7.2.5 Legitimisation of the student role

Students at the three sites freely described registered nurses who willingly gave of their time to provide clinical teaching and support, often going beyond what would normally be expected. Students interpreted this professional generosity and collegiality as confirmation that their student role was valid, valued and respected. They described the experience of having a legitimate role as a "safe place", where they felt secure enough to risk making mistakes or ask what might be construed as foolish questions. From this safe and protected foundation, students felt they could venture out to become self-directed and independent learners, enabled and empowered to negotiate new opportunities for

developing their knowledge and skills. Because their student role was legitimised they were confident of their place in the nursing team and believed that they performed at a higher level because of the encouragement, support and acceptance they received. Not surprisingly, students did not experience this type of utopian learning environment in every clinical placement. Too often, registered nurses seemed resentful of the time students required, impatient with their questions and frustrated by their "slowness". In these environments students were reluctant to risk the ire of the registered nurses and as a consequence they were hesitant to ask questions or initiate self-directed learning opportunities.

A valid and valued role

Sarah shared an experience of being valued and supported as a student, and respected as a person. In this excerpt she emphasises how important it is to feel that she has a legitimate role in the nursing team. The security of having a recognised place in the team allowed her to feel comfortable about asking questions and making the most of the learning opportunities presented. The personal interest in Sarah's learning displayed by the registered nurses allowed her to feel that she fitted in:

> *It's the interest that they show in you, not only as a student but as a person as well, that makes you feel as if you fit in there. It is so simple…It's a welcoming attitude combined with an awareness that you are a student and sometimes you're going say or do something that is just totally stupid. You're a student and that's to be expected. And yes they have to tell you that "No, that's not right or that's not the way it's done", but doing that in an understanding and accepting manner is so important…I haven't always had that in my placements—but I found that in my last placement they valued the fact that I was a student and they were really keen to make sure that I got out of the placement what I needed to. That made my life so much better—I felt like I had a valid role, even as a student.* (1: 226–230, 457–458, 465–470)

Monique described a similar experience with a registered nurse, who gently and patiently provided clinical teaching in a way that demonstrated that she valued Monique's learning and believed that as a student she had a valuable and important contribution to make. By taking the time to consider Monique's questions, this nurse indicated that she felt that Monique's learning was important and worthy of her attention. There is a strong sense that Monique felt valued, accepted and secure of her place in this environment. Because of this she felt comfortable in asking questions and confident in attempting new clinical skills:

There was one nurse who had been nursing for a number of years. She was very straightforward and I was a bit scared of her to start with. She was my mentor for a few days, and she was absolutely fantastic. If I gave an injection and I didn't do it so well, nothing was said in front of the patient. She'd go, "Well done" or whatever, and then we'd come outside the patient's room and she'd say, "Well, just try this. You might find it's easier if you do it this way". She didn't say, "What you did wasn't right". She would just say, "Maybe you would be more comfortable if you try this"—very positive and very helpful…And you learn more because you feel confident that even if you don't do procedures correctly the person's not going to criticise. They're going to help you or give you a little bit of advice, show you different techniques that might be more suitable, or give you a few more options. I didn't feel intimidated in asking questions and even if the question was silly I knew she that she wouldn't reply in a manner which would make me feel silly. I remember she used to sit there and she would never answer my questions straight away. She'd have a little think and then she'd come back with the answer. It certainly encouraged me to ask more questions, because I didn't worry what I asked. I knew I wasn't going to get a sarcastic reply; I was only going to get a reply that helped. (10: 241–250, 256–265)

At times registered nurses find it challenging and time-consuming to support and teach students. However, the skills and knowledge acquired through on-campus learning need practical application under the guidance of experienced practitioners in order to become meaningful to students. Nicole described her first clinical placement and the way in which her mentor willingly embraced the role of clinical teacher. By so doing this nurse sent a clear message that Nicole had a rightful place in the clinical environment and that her need for direction and support was appropriate, not burdensome:

That very first day when I said, "I don't know how to use the obs machine", my mentor came with me and said, "Oh don't worry, I will show you the first couple, then I'll watch you do a couple and then if you are happy, off you go. So that was fine and it was like that with everything really…With any new skill she would show me and then supervise me and then let me go and practise on my own. It was the best way to learn really. (18: 116–120, 124–125)

Sarah described how she felt enabled and supported to confidently negotiate her learning in a self-directed manner because of the nature of the relationship she developed with the nursing team and their attitude towards her as a student. It is readily apparent that the staff felt that her learning needs were a priority and that this belief translated to the provision of a supportive and educative placement experience:

I tend not to be overly assertive in new environments…So the fact that they were really interested in knowing what I needed to do helped make me feel comfortable enough to say, "Actually—I need to do this today, is that okay? They accepted me and said, "While the student is here, she needs to do certain things—we need to help her with that". Their support gave me the confidence to continue asking for new learning opportunities while I was there. (1: 208–209, 213–219)

Just a nuisance

As inspiring as these stories are, many negative incidents were also described. It was evident that some registered nurses found the responsibility of supporting students in practice difficult and onerous. Many seemed to disregard students' feelings and made little attempt to hide their impatience and frustration. In these environments students often felt they were imposing. Some students described how the attitudes of staff diminished their confidence and detracted from their enthusiasm for learning. Days when students were working with unsupportive and dismissive nurses were often considered to be wasted learning opportunities, where they survived but certainly did not thrive. In these situations students felt that they were of little worth to the nursing team; they certainly did not feel that they had a rightful place in the clinical environment. Brent described such an experience:

Not everybody likes having students around. That's a fact that we've had to come to accept. You know, you get out there and it's your first prac, bright-eyed and bushy-tailed, and there are occasionally nurses that will come along and shut you down…Nothing direct, always very snide, whispering behind your back. It's not like you don't notice…You don't learn very much at all, not off them. On my second-year prac, I was assigned to a nurse who made it very clear that she didn't want me with her. In handover she just completely ignored me. When I was assigned to her she sort of sighed and under her breath said, "Not again". She was not impressed that she had to baby-sit a student all day. (9: 169–172, 176–177, 196–202)

When students are struggling with the expectations of registered staff as well as the challenges inherent in busy and complex learning environments, they are particularly vulnerable to criticism by unsupportive and resentful nurses. In this example Katherine described a situation where she felt that the staff had little time for her learning needs. As a consequence her confidence was undermined and she dreaded each shift:

I went on to a paediatric surgical ward for six weeks just before Christmas, and there were staffing problems. It was quite difficult at times and I struggled quite a lot with the placement

because I went in and they all sort of said, "Oh you are a third-year, you should be able to do this, this and this"…Because of the staff's expectation that I could not live up to, it just knocked my confidence so much that I just ended up hating going in…It felt like because they were so short-staffed they didn't have time to actually teach me anything or to spend time explaining what was going on…I just felt like I was a nuisance and just in the way. I think a lot of the learning opportunities went by the wayside because they didn't have time to teach me, whereas I really needed to pick as much up as possible during that time. Each night when I went home I didn't want to go back. (17: 709–714, 744–746, 779–781, 818–823)

The students I interviewed were aware of the demands and complexities of contemporary practice. Likewise they were cognisant that they were entering clinical environments in a student capacity, when what was really needed was workers. This awareness made them particularly appreciative of the many registered nurses who, despite their workload, created opportunities for students to engage in quality learning and supported them in that endeavour. By valuing and legitimising the student role and demonstrating a willingness to teach, these nurses sent a powerful message that students were important contributing members of the nursing team and well worth the investment. This impacted on students' self-worth and confidence, and allowed them to feel secure and accepted in the team. Essentially students experienced a strong sense of belonging when they felt they had a legitimate role in the team. Conversely, when registered nurses were unsupportive or, even worse, were ambivalent or hostile towards students, this resulted in students feeling abandoned and estranged from the staff, and as if they were little more than an imposition. Their confidence and feelings of self-worth were diminished, they were reluctant to ask questions or to initiate learning opportunities, and they often found the placement unsatisfying and unproductive in terms of learning.

7.2.6 Recognition and appreciation

Students wanted to be recognised as capable and competent, and trusted with increasing levels of responsibility as they progressed through their program. The importance of being acknowledged, respected and valued for their contribution to patient care was a recurring theme in the students' accounts. They believed that this verified not only their developing capabilities but that they were a valuable addition to the team. When students were given the opportunity to work autonomously and to demonstrate their abilities, they felt trusted and accepted; their confidence was enhanced and this encouraged further participation. Conversely, while students longed to be acknowledged and appreciated, they often felt

that their work was unappreciated and overlooked. They reported feeling unimportant, inadequate, lacking in self-worth, anxious and doubtful of their own abilities when they were not trusted with a level of responsibility appropriate to their skills and scope of practice. Students felt that this retarded their clinical performance, which then impacted negatively on their subsequent acceptance as a member of the team.

Trusted and valued

Ann described a situation where short-staffing in the neurology ward led to her being given greater responsibility. This engendered a feeling of being valued, trusted and appreciated for her contribution to the work of the nursing team and enhanced her self-esteem:

> *They were really short-staffed, and I and another student were given a room of patients to look after…It felt really good that they trusted us to take care of those patients, like we were accomplishing something—not just doing a series of allocated tasks. We gained their respect and they actually thanked us at the end of the day for doing it. That doesn't happen often.* (4: 12–113, 121–124)

Lucy described a similar situation where, because of staffing shortages, she was called upon to assume a greater level of responsibility for patient care. This example reinforces how important it is for students to be recognised as capable and valued for their contribution to the work of the team. Lucy felt needed and as if she had something to offer the team. This in turn led to feelings of affiliation and inclusion. The appreciation expressed by the staff at the end of the shift reinforced her feeling of self-worth:

> *Usually down at *** medical centre, there are two RNs on. Recently one was off sick, and they didn't have a replacement. I really did feel like they relied on me that day. They said, "You can do the minor ops theatre with the doctors"…I was used to setting up the equipment, getting the patient organised and doing the patient education…I felt like they trusted me to get on with it. At the end of the day the doctors and the nurses said, "Thanks for your help today". It felt good that they appreciated me.* (8: 468–471, 489–490, 502–504)

Being trusted with additional responsibilities, such as using advanced clinical skills, gave students greater job satisfaction. Contributing to patient care with increasing levels of responsibility boosted their confidence and validated their worth to the team. Brent explained:

> *I do like being challenged. On that prac, I was given a central line dressing to do…That was just amazing as a second-year student. I'd only been back at uni for three or four weeks and I'm here doing this dressing on something that's very complicated essentially…It felt*

good that they trusted me to do it. I hadn't requested to do it. My facilitator had seen on the handover sheet that it needed to be done and she had independently gone to the nurse and said, "Leave that. I want him to do it", and then she had come to me and said, "You're going to do this. He is leaving it for you. We think you're ready. (9: 271–272, 278–280, 284–288)

In the way

In contrast to the positive examples quoted above, the following experience described by Abby is one where she felt as if she was in the way, unwanted and unaccepted. The nurse's attitude and behaviour clearly indicated to Abby that he felt her inexperience prevented her from being able to engage in nursing care activities in a meaningful way. His unkindness, lack of support and disregard for Abby meant that she felt completely alienated in this new environment:

> *It [was] really bad. For a first placement it was really, really difficult to fit in. They [the nursing staff] were very unaccepting…You would ask a question, and it was the silent treatment altogether. I felt like I was invisible. And the nurse that I was buddied up with intentionally ignored me. I didn't exist as far as he was concerned. And I was just following [him] around, just trying to do stuff and the most he would say to me was, "It's not to your ability—get out of my way".* (13: 66–67, 72–76)

As their skills and confidence increased the students sought a measure of independence and wanted to be more self-directed in their work and their learning. When they were recognised as capable and trusted and given increasing levels of responsibility, they felt affirmed and accepted. As a consequence, they participated more actively in the work of the team and felt a strong sense of fit. Being given the freedom to direct their own practice allowed the students to manage their own time, to test out their knowledge and to become problem-solving critical thinkers. Students indicated that they thrived when given opportunities to display initiative and work with a degree of autonomy. Conversely, when they did not feel the nurses they worked with trusted them to engage in patient care activities, or when their contribution was overlooked, they felt unappreciated and of no real worth to the team.

7.2.7 Challenge and support

Daloz (1999) maintains that mentors (or nurses that support students in practice) fulfil two quite distinct roles: they support and they challenge. The experiences of the students in this study supported this assertion but extend this line of thinking by suggesting that an

appropriate blend of challenge and support, achieved through facilitative mentorship, also enhanced students' feelings of belongingness and self-worth.

The notion of support refers to the provision of a safe space where students feel secure, valued and accepted. This type of support forms the basis for future growth and learning. It confirms students' sense of worth and helps them see that they are capable of moving forward (Daloz, 1999). By contrast, challenge means identifying or creating a gap between students' current perceptions and their future expectations ("I think I should be *there*, but I see myself *here*"). Challenging students means believing that they are capable of more than they realise and creating opportunities for them to fulfil their potential. Daloz (1999) adds that mentors challenge students by tossing little bits of disturbing information in their paths: facts, observations, insights and perceptions that raise questions about students' world views and invite them to entertain alternative ideas and aspirations. Creating a shared vision with students provides the context that hosts both support and challenge (Daloz, 1999). In this context and through their mentors' eyes, students can visualise their current self and the self they hope to become.

If both support and challenge are minimal, little learning or growth is likely to happen. If support is enhanced, there is potential for some growth but it is likely to emerge from the inner needs of a dependent learner rather than from any stress imposed by the clinical environment. Students may feel good about themselves but lack the capacity or motivation to engage as productively in the clinical environment as they might if they were encouraged to communicate more actively with it. Conversely, too much challenge in the absence of appropriate support can overwhelm students, and cause them to doubt their abilities and knowledge. At times it may even drive the insecure student to withdraw. In this study, when students were supported and challenged by their nursing colleagues they felt accepted as students and as people. The investment of time and interest in the students' growth and learning was interpreted by students as evidence that they were valued and that their learning was important.

Pushing the boundaries

A number of students described the importance of being challenged or pushed beyond the comfort of the boundaries they had established. Mostly they welcomed opportunities to extend themselves, but were able to do so only to the extent that they felt secure of their

place in the environment and supported by the nursing staff they were working with. Brent described how he embraced the learning opportunities he gained by being challenged by the nursing staff. Being pushed was interpreted by Brent as an indication that the staff believed he was capable and competent, and that they were committed to working with him to help him achieve his potential. Brent identified the staff's willingness to engage with his learning in a passive or active way as "being there and willing to answer questions" (passively supporting), or promoting students' independence and autonomy (actively challenging):

> The staff on that ward were just brilliant. They helped me to push the boundaries and go a little bit further. I would say, "Oh, I want to do this" and they'd say , "You can do this and do that and you might as well do this as well while you're at it". More than simply being there and ready to answer questions, they would say, "Right, come along, you're going to do these medications, you're going to do them all, then you're going to do this and I'm going to help you" rather than "I'm going to do this and you're going to help me". I'm a "doing" learner, so that helped me a great deal. I like to know the theory and then I like to get out and have a go. (9: 259–266)

The interest shown by the nursing unit manager in the following example is indicative of the esteem in which Leanne is held. The manager's interest and involvement in the student's learning implied that Leanne was valued and well worth the investment of time and interest. Leanne explained how she embraced the way that the manager challenged her. Inherent in this example is the implication that the manager was able to simultaneously challenge the student while sending a clear message of support:

> The NUM [nursing unit manager] was good too. She was the sort of person that would challenge you. If you did an ECG [electrocardiograph], she'd make sure that you understood every single bit of it. And then she'd say, "What if this was elevated instead of that elevated?" She really challenged us. She would always walk down the corridor and ask us a question…It was great. I like to be put on the spot. I like a challenge. (6: 226–230, 238)

Expecting too much

While students valued being challenged, there were times when they felt overwhelmed by the degree of responsibility they were given. Deanne explained that because she felt a growing sense of belonging within the team and felt accepted, respected and supported, she was able to speak out confidently when she felt the challenge exceeded her abilities:

In second year I had two weeks up at *** [hospital] and that was really good. By then the camaraderie was starting to build and my self-confidence was starting to grow. There was a team nursing model used on my ward and so that was an experience in itself, just seeing how it was done. By then they were starting to expect me to take on a workload of my own. In a sense it was good, but they had a tendency to expect too much of me and I had to keep saying, "Excuse me. I'm down here and I need a little bit of help". (11: 111–118)

Being held back

Elizabeth shared an experience where she did not feel she was being challenged enough and needed to request more complex learning opportunities. This is in accord with Daloz's (1999) assertion that on its own support does not stimulate learning and growth. It is apparent from this example that students require more than an environment that is friendly and supportive. While this type of environment may engender feelings of comfort and security, students recognise that staff who really value them and their learning are willing to structure the learning environment in a way that allows them to fulfil their potential:

I went to orthopaedics in *** [hospital] for about two months…The ward was busy and understaffed but they [the nurses] were supportive and really friendly. I was very helpful to them getting everybody washed and dressed and all those sort of things…But eventually I did speak out about how I wasn't really being used for the purpose I was actually there for. I ended up sitting down with a nurse and explained that I was coming into work and just being shoved with a care assistant and not a nurse. I already knew what they [care assistants] do and I was trying to learn more than that…I think word got around that I didn't want just to be washing patients and things. I wanted to learn about drugs, I just wanted to learn. (15: 287–288, 291–295, 298–303, 306–308)

Undermining confidence

It is important to remember that the degree of challenge students need is very particularistic, and that what one student interprets as exciting and challenging, another may consider to be confronting. This is especially evident when the challenge is not underpinned by a high degree of support. As discussed previously, too much challenge in the absence of appropriate support can overwhelm insecure students, causing them to doubt their abilities and making them want to withdraw. Katherine explained:

My surgical placement just knocked me. It just blew my confidence so much that I just didn't want to go into the placement. I felt like I didn't know anything…I am not particularly good when I am put on the spot. I don't particularly like people just expecting me to know things. I don't think that is the way I learn best. I know the answer if I sit down and discuss it but not

off the top of my head, boom, there is your answer. I think it was made worse by the fact that the nurses in my surgical placement expected me to know so much and if I didn't it was like, "You are in third year. You should know this. Haven't you had a lecture on this?". It wasn't just, "Oh, you don't know, that's okay. Let me explain it to you". (17: 927–930, 936–943*)*

While balance of challenge and support is critical for learning (Eraut, 2006), in terms of belongingness the staff's investment of time and interest in students' growth and learning signified to students that they were valued and that their learning was important. The provision of a supportive clinical learning environment created a safe place where students felt secure and accepted. When staff provided an appropriate degree of challenge, a student felt validated as a person who is becoming a nurse. In contrast, when students felt that they were challenged without concomitant support, they often felt uncertain, insecure and anxious, and they reported a loss of confidence and motivation.

7.3 Individual factors that impact on students' experience of belongingness

Each student brings with them a personal view of the world, of people, how it all works, what it all means and subsequently a personal way of learning. Additionally, students' perspectives are influenced by past and present events and circumstances. As students approach their clinical placements, their experiences and personal attributes colour their perceptions and influence their thinking and behaviour. The individual factors that were described by students as important influences on their sense of belonging are listed in Table 7.2 along with the related themes.

Table 7.2 Individual factors that impact on belongingness

Factor 1: Preconceptions about nursing

      Theme A: What nursing is all about

      Theme B: Familiarity with the ethos and environment

      Theme C: Previous experience of little consequence

      Theme D: Seeing nursing from different perspectives

      Theme E: Work ethic

Factor 2: Willingness to adopt the role of an unpaid worker

      Theme A: Working hard for acceptance

      Theme B: Learning as the priority

Factor 3: Resilience versus resignation

      Theme A: Don't take it personally

      Theme B: Passive acceptance

Factor 4: Tendency to engage in extenuation

      Theme A: Making excuses

7.3.1 Preconceptions about nursing

Students' pre-conceived images and conceptualisation of nursing are shaped by a range of factors. Two of these factors were particularly evident in the students' accounts. These were working in a nursing capacity, either before or during their current nursing program, and having a significant family member who was or is a nurse. The students' images of nursing were strongly influenced by these factors. For some students, their preconceptions about nursing were a significant influence on their attitudes and behaviours when in clinical contexts and particularly on how they experienced belongingness.

What nursing is all about

More than half of the students in the present study had either worked in nursing (as an assistant in nursing [AIN], healthcare worker/assistant or EN) before beginning their academic program or currently did. For some of these students, the opportunity for employment was seen as a means to become familiar with the nursing ethos and culture, to gain an understanding of the language of nursing, and to develop competence and

confidence. Some students felt that their nursing experience meant that they were more likely to be accepted, as they could contribute to the work of the team with minimal support and supervision, but in their student role they did not experience a sense of belonging. The students noted that their previous or concurrent nursing experience did not offset the unwelcoming and unreceptive nature of some clinical environments.

Sarah holds a social science degree with a double major in disability and family and children's services, and worked for a number of years in the management level of disability services. Since she started her nursing degree, Sarah has worked as an AIN in a number of different hospitals. She felt that her experience as an AIN was advantageous in a number of ways. However, it did not help her reconcile the dissonance created when her preconceived image of nursing was at odds with the way the nursing was enacted in some environments. In reference to a difficult clinical placement where Sarah felt she did not fit in, she described how her previous nursing experience tempered the negative and distressing situation. In this situation she held onto her previous experiences like a lifeline, using them to remain focused and committed to her career goals:

> *My first placement was a horror, but because I had the AIN skills already, I could just get in and do the work, which I found made a big difference to the RNs and their attitude…It meant that they used me as an AIN—but it also meant that I survived the placement…fairly intact…I suppose I was lucky in a way, because I had my AIN work, and so I knew that this wasn't the way it was on every ward. I knew it just wasn't what nursing was all about.* (1: 275–277, 281–283, 346–348)

Familiarity with the ethos and environment

Laura has worked in a nursing home as an AIN since she began studying at university. She believes that she was better able to contribute to the work of the team because of her familiarity with the clinical environment and the nursing skills she has acquired. Laura feels that the nurses with whom she works on clinical placements appreciate her skills and are more willing to teach her because they feel that it is not such an onerous task. It is interesting that Laura believes that even as a student she needs to complete her "share of the work", and that the staff's acceptance of her is dependent on the degree to which she is able to do so. Laura's experience is not so much one of belongingness but one of mutual need—Laura needs to feel validated by the nurses and works hard to elicit their acceptance and approval; the nurses welcome Laura to the extent that she can work effectively and apparently autonomously:

Because you're an AIN you're used to the environment, of having to get in there and do your work, no messing around like. You know the procedures better, and what you have to do. That means the nurses can get on with what they need to do. It makes you feel like you're contributing something, doing your share of the work…The nurses say, "Oh, you know what you're doing. I'll leave you alone then". (2: 415–421, 424–425)

Previous experience of little consequence

Kara is an enrolled nurse. She believes that her nursing experience helped her to relate to members of the nursing team effectively, although she did not think that being an EN was a panacea that could magically transform the learning environment—and it certainly did not change the attitudes and behaviours of unreceptive and unwelcoming registered nurses:

I am confident. I know the layout of the wards and what equipment to use, and what it's for. That helps tremendously. Then I can get on with learning the more complex stuff like IVs and medications. And just knowing how to approach other members of the team is a big thing and knowing the avenues of communication…But the fact that I'm an enrolled nurse doesn't change the way some RNs respond. It doesn't matter what job you're in; if you feel that the other person's not receptive to you, then you're not going to feel comfortable or welcome. (12: 207–211, 228–230)

Seeing nursing from different perspectives

Of the students interviewed, only a small number had family members with a nursing background, but their influence was sometimes strong and long-lasting. Sarah's mother has had a considerable influence on her conceptualisation of nursing, her nursing values and her attitude towards patient-centred care. Her mother's influence began at a very early age, continued through her formative years and remains today as a pivotal influence on Sarah's identification with the nursing profession:

I grew up with nursing. Mum's a nurse, my auntie's a nurse, my cousin's a nurse [chuckles]. All of Mum's friends are nurses. Nursing has been a very large part of my life and I think it's given me a very good historical perspective on what it used to be like…Mum has been a nurse for 40 odd years, from when she did her 12 months as an AIN right through…She knows so much, and she's seen so much—and she shares that quite freely, always has done. So I've grown up hearing about her nursing experiences…I know what nurses used to go through with their training. I know that it wasn't always as nice as perhaps it is now— even though it's hard now; you have a lot more horizontal violence and aggression, and I know about that. And I can also accept that, no, we don't get enough clinical skills, we don't

know what we're doing well enough when we get out, not compared to what those girls did, because all they did was clinical. They might not have had the theoretical basis that we do, but they had their clinical skills down pat, because if they didn't they were out on their ear. So I can see nursing from different points of view and I think that helps me interact with and be accepted by some of the more old-school nurses. (1: 754–757, 759–760, 770–771, 779–789)

Sixty per cent of nurses in Australia are aged over 40 years (Australian Health Workforce Advisory Committee [AHWAC], 2004b). This means that in the nursing profession there is a wide generational cross-section. Different generational attitudes towards work and learning, particularly in nursing, often result in misunderstandings (Levett-Jones & Bourgeois, 2007). It seems that the insider perspective that Sarah has gained into the culture, history and language of nursing, even if not a complete understanding, facilitated respect for and the ability to communicate with nursing colleagues from different generational groups.

Sarah has a pre-determined image of patient-centred care generated through years of conversations with her mother and other significant family members. These influences on her professional values have at times created a dilemma, as Sarah's values do not always coincide with those of staff in clinical contexts. During the interview she described a number of placement experiences where she felt a sense of alienation as a result of the dissonance between her own image of nursing and the reality of practice. Refer to Section 9.4.3 for one example of this.

Work ethic

Stories of nursing shared by Laura's mother, an AIN with over 20 years' experience, have provided a rich backdrop against which Laura has defined ways in which she believes that belongingness is best achieved while undertaking clinical placements. Her mother has provided Laura with guidance into the process of attempting to negotiate a respected place in the nursing team. However, the extent to which the strategies provided by Laura's mother are successful is difficult to ascertain. Laura frequently mentioned the importance of competence in the ward staff's acceptance of her, and that she works hard so that they will accept her. In this excerpt, we can see how she may have acquired this perspective:

She [my mother] was always coming home with stories about student nurses and saying, "They get there [clinical placement] and do nothing. We teach them. We get them to do the

dirty jobs". She'd say, "You get some good students and you can always tell the ones that are happy to be there and willing to work hard. Some try and get out of work and to get away early—it doesn't work with us". (2: 471–476)

From the students' accounts it was evident that, for some, their preconceptions about nursing had an impact on their clinical placements and the strategies they used to fit in and be accepted. However, this influence was particularistic and varied considerably from student to student. Some felt that their employment in the nursing field allowed them to gain a better understanding of nursing and that as a result they had been able to more easily traverse the divide between outsider and insider when on clinical placements. Others expressed a different view, feeling that because of their experience they were accepted and "used" by nursing staff as worker, but that in their role as a student they were not valued nor wanted. Similarly, while insights into the culture, history and language of nursing had been gained by some students through close association with family members with a nursing background, these insights and understandings did little to alleviate, and may have actually exacerbated, the distress experienced in clinical environments that did not fit with their preconceived image of nursing.

7.3.2 Willingness to adopt the role of an unpaid worker

One of the primary goals of the transfer of nursing education from hospitals to universities in Australia and the UK was to provide students with supernumerary status so that their learning needs would be given precedence over the demands of workload when undertaking clinical placements. Being granted supernumerary status was meant to enable students to "become increasingly self-directed as their educational programme progresses and—explore areas of skill and knowledge on an individual basis" (United Kingdom Central Council for Nursing [UKCC], 1986, p. 55).

A study by Elcock, Curtis and Sharples (in press) suggests that awarding students supernumerary status has failed to make a real difference to the way many students learn in practice. The students in the current study frequently expressed the belief that their acceptance into the nursing team hinged upon the extent to which they were prepared to forgo their supernumerary student status and take on the role of a worker, albeit unpaid. Similar findings have been described by Joyce (1999) and Parahoo (1992), who reported that students often feel emotionally blackmailed into working and repeating the same tasks

that they have already mastered, with supernumerary status being seen as a privilege, not a right.

Many students in this study expressed the view that they did not feel valued as a student but only as an extra pair of hands. Research has identified that people who feel excluded or rejected tend to compensate by working harder than normal on a group task in order to improve their future chances of inclusion (Kelly, 1999). For many students their belief that working hard heightened their chance of acceptance translated into their learning being relegated to a position of secondary importance. If adopting the role of a worker ensured their acceptance, then many students considered this a small price to pay. Others resented the expectation that they were there to work and that the work took precedence over their learning, yet they were not willing to challenge these expectations if it meant jeopardising their relationships with the nursing staff. Often this was a process of passive acceptance, yet it created an uneasy tension. Many used their willingness to work as bargaining tool so that the staff would feel obliged to contribute some time to their learning. In contrast, when students were secure of their place in the team, experienced a sense of belonging and believed that in their student role they were accepted, they felt empowered to advocate for their learning needs to take precedence over the work, and were less concerned about the fragility of their relationships with their nursing colleagues.

Working hard for acceptance

Laura related how she allowed the role of learner to be subsumed into that of a worker. She did not feel uncomfortable or resentful in this situation, as she believed that working hard was her avenue for developing effective relationships with the nursing staff and being valued, respected and accepted by them:

> *If you want to build up those relationships and feel accepted you've go to be willing to pitch in and show them that you're not there just to laze around…You have to just get in there and do the work and then they think, "She's a good worker. I can rely on her", and you just build up that rapport from there.* (2: 189–191, 550–551)

Laurence shared Laura's belief that working hard and demonstrating initiative was pivotal to his acceptance by the nursing staff:

> *I think if you get in there straight away and start working, and if you're not doing anything ask them for more work, then they accept you, as you are a hard worker, not a slacker. And*

as soon as they think that you're there to work, and you're taking it seriously, it makes the whole working experience better. They start to accept you more. (5: 576–580)

Leanne's response to being expected to take on tasks she feels were not conducive to her learning was one of passive acceptance. Because she was not secure or confident in her relationships with the staff, she believed that she had no control over the situation and was unwilling to protest. While she resigned herself to the apparent inevitability of the situation, she nevertheless harboured resentment and frustration:

They [the nurses] always tell you what to do and get you to do the really repetitive jobs. You're not treated like a student. You're treated like an AIN [assistant in nursing]. You do all the jobs that they don't want to do…I get really frustrated because I'm there to learn, but I'm just not learning anything…And you're missing out on all the other things. Like one of the nurses would say, "I'm going to go and put this nasogastric tube down, can you go and shower Mr so and so". And you'd be like, "Oh, okay". As a student I feel as though I can't say anything—I just do it. (6: 86–89, 90–92, 96–99)

Louise believed that being accepted by the staff was dependent upon her adoption of a worker role. Like Leanne she seemed to accept, for the most part, the apparent inevitability of the situation, but acknowledged that at times she was also able to successfully advocate for learning opportunities:

If you want to be accepted, you need to just let them know that you're there if they need a hand. You know, "If you want me to do anything, just give me a yell"…But I've been in situations where you get more involved in completing tasks than in learning…You just have to accept those things, and some wards are just like that. They're just flat strap. And you do get used if they know you can do something. And I'm quite happy to help with the workload. If for that day my skills and what I want to achieve doesn't get done, it doesn't matter…But there'll be times where [I say], "I really want to do this today". And nine times out of ten they'll do that. (7: 280–283, 287–288, 303–306, 311–312)

Katherine talked about her placement in a nursery where once again the students' learning needs were secondary to the workload. In this example, she describes how she was reluctant to "rock the boat", as by doing so she felt it would impact negatively on her relationship with the staff and she "wanted to get on with them":

We felt like a lot of the time we were being sent to do jobs that the staff didn't really want to do, and while they had the extra people to do it they could get out of their turn of doing it by allocating it to someone else more junior to them…I wanted to just say, "I am not here to do all the odd jobs that you don't want to"…But I didn't really feel that I could say anything

because I wanted to get on with them and I was being assessed by them. A bad comment is difficult to overcome, particularly with your first placement. And you don't want to rock the boat too much at the beginning. (17: 78–82, 163–164, 168–172)

Learning as the priority

Jane presented a somewhat different perspective. She felt that she had a secure place within the nursing profession and because of this, although she willingly participated in the work of the nursing team, she did so on her own terms. She did not allow this work to detract from her learning, as she clearly articulates in this excerpt:

> *Yeah, sure I'll do the showers and baths etc. but I'm not there just to be used, I'm there to learn. I'll help out but I'll do it when I need to learn something from it. Although it sounds quite selfish, it's not…I'm there for two weeks, and I need to learn so [that] when I come out, I can help out then. If I don't learn, I'm not doing the best for the people that I need to take care of in the future. And I certainly hope that the nurses that are already out there appreciate that I do that 'cause I care.* (3: 774–776, 783–786)

When supernumerary status is respected, students feel that their learning is enhanced, but when it is denied the quality of the clinical learning experience can be compromised (Elcock et al., in press). This is a significant concern for nursing education. Many students in this study expressed the view that the nurses they worked with expected them to pull their weight and contribute to the work of the team. These students believed that their willingness and ability to do so determined whether they would be accepted by the staff. Some students did not find this problematic and allowed their learning needs to be subsumed into their worker role, while others were resentful of the staff's expectation. Students who were secure of their place in the team seemed less concerned about their relationships with their nursing colleagues and, while they were conscious of the fact that quality learning can be a by-product of work, they nevertheless proactively advocated that their learning needs be given priority.

7.3.3 Resilience versus resignation

Resilience is a vital trait for nursing students entering a chaotic practice world. Resilience, as described by students in this study, included the ability to cope and maintain a positive attitude in the face of hardship, and the capacity to learn from past experiences in order to adapt more easily when faced with challenging situations in clinical practice. Resilient students recovered quickly, were flexible and bounced back, rather than becoming despondent or disheartened when hurt by unreceptive or hostile nursing staff. Moreover,

they were able to accept or adapt to difficult or distressing situations and move forward regardless. Often students' resilience was hard won. Many acknowledged that their resilience had come at a cost and that they had experienced stress, anxiety and depression along the way. Wolin and Wolin (1994) suggest that resilience requires both suffering and perseverance—the ability to work through difficult times and integrate those experiences into one's sense of wellbeing.

Don't take it personally

It was evident that some students had the capacity to recover quickly when challenged by the unwelcoming and unfriendly nature of some nurses. Resilience was fostered, to some extent, by supportive mentors, but students also described how their resilience developed over the years of their nursing program and how it linked closely with their burgeoning confidence. Students acknowledged that when they felt as if they were welcomed and belonged in a particular environment they were more able to cope with negative experiences and be resilient to the stressors they faced. Students who had maturity and life experience on their side appeared to be at an advantage, as their more highly developed interpersonal skills allowed them to view negative and unreceptive staff with a degree of dispassion, rather than taking the staff's rebuttal as a personal affront. Louise explained:

> *It's just a case of just getting on with it. I've learnt over the years you don't take their rejection personally; often it's not a personal thing against you. It's just that person's obviously got issues or something going on in their life that's making them react the way they react. I don't take it personally. I just think, "Well okay, we'll just leave that one well enough alone for now"…I think it's life experiences and age, and just learning how to interact with people and deal with people, [that] makes a big difference. It's probably something I would not have been able to do straight from school. I wouldn't have had the skills, or the life experiences I needed.* (7: 321–325, 347–350)

In line with Wolin and Wolin's (1994) suggestion that resilience requires both suffering and perseverance, Ann's capacity for resilience has developed greatly since she started her nursing degree. While initially she found negative placement experiences with unreceptive staff distressing and damaging, she now suggests that "personality clashes" are an inevitable facet of working life. Ann uses her belief in her own ability and competence as a buffer against the negative attitudes she encounters:

I don't mind if people don't like me, because I'm a competent person and it doesn't worry me. I am who I am. And I'm not going to change myself, to fit other people's expectations…No matter where you go, or where you work, you're going to have personality clashes. You're going to have people that aren't going to like you and you've just got to get on with it. You can't take other people's attitudes on board because then it takes you down and then you don't perform as well. (4: 308–311, 366–370)

Contextual factors and previous experiences impacted upon students' resilience. Some of the students who displayed resilience in this section are the same students who in other contexts felt distressed, angry or anxious when faced with indifferent or unwelcoming staff. The crucial factor seemed to be whether the interpersonal problems described by students were related to an isolated incident with a single registered nurse, or if they were perceived to be related to a more general ward attitude shared by a group of nurses. In this excerpt, Laurence explained his strategies for coping with an occasional nurse who was not supportive or accepting of students. He pointed out that it was not unusual to come across a particular nurse with whom he found it difficult to engage, but he did not to seem to be overly concerned by the occasional negative incident:

You will come across a nurse now and then who will give you a hard time. You don't know if it's just you, or if she's like that to everyone…I've always had at least one nurse that just doesn't accept you, and so you just try to stay clear of them, or just don't argue, just do your work and get on with it. (5: 232–234, 237–239)

When Laura's need for learning and support was resisted by nursing staff, she attributed her ability to cope to her maturity and personality. She described the strategies she used to have her needs met in spite of the challenges she encountered:

She [the RN] kept scooting off on me. I could never find her, and in the end I thought, "I'll just attach myself to one of the other nurses and explain the situation"…I think it depends on your maturity as to whether you're just going to stand around and do nothing, or [whether] you're going to say, "Right, this isn't working out. Find someone else". It comes down to personality and the student's maturity as well. I think there comes a time to say, "Okay, I'm not putting up with this. I don't need to take your crap anymore". (2: 301–303, 461–464)

Passive acceptance

Resilience should not be mistaken for resignation, although at times as I reflected on the students' accounts it was difficult to distinguish between the two. Resignation is defined as the act of relinquishing a right or claim (*Oxford English dictionary*, 2006). It seemed to me

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that the students who were resilient were cognisant of their student rights (in particular their right to have a legitimate place in the clinical environment), and had found ways of adapting to negative situations or renegotiating when their rights were challenged. However, students who responded with resignation rarely recognised that they even had student rights and certainly did not advocate for them to be upheld. This is similar to a study by Champion, Ambler and Keatinge (1998, p. 31), in which they described how participants appeared to accept with resignation their place in the healthcare environment, rarely retaliating when criticised and believing that they had to "take the punches to start with".

In the present study, resilience allowed students to actively and positively make a decision to move forward despite a negative situation, but resignation was a passive response that resulted in a state of seeming inertia. Most often resignation occurred in response to a group attitude towards students that was indicative of a context-specific culture or general staff attitude rather than a one-off negative interaction with an individual staff member. When faced with these types of distressing situations, some students displayed a type of weary resignation or a passive acceptance of the status quo. There was a sense of giving up, or conceding that there was nothing that could be done to change an inevitable situation. When students described these experiences, the language they used was often minimalist and abrupt. They rarely provided detailed discussion, often using the following types of statements to conclude their description of a negative placement where they had felt alienated and unwelcome:

> *They'll never change—they're too set in their ways.* (Jodie, 16: 475)

> *I had to just put my head down to get through it. It was just survival. Yeah, just head down, do what you have to do.* (Sarah, 1: 270–271)

> *I just left it and walked away.* (Brent, 9: 225)

> *I just let it go, I couldn't be bothered.* (Jodie, 16: 32)

Resilience was seen to be a mediating factor in determining whether students remained receptive to, and hopeful of, belongingness or resigned themselves to simply enduring the placement with no expectation of being accepted and supported. Resilience was identified as a factor that both impacted on students' experience of belongingness and was a consequence of belongingness. That is, students who were resilient accepted occasional negative interactions with staff as part and parcel of the busy, stressful and complex world

of contemporary practice, but did not allow these experiences to detract from their more global feelings of acceptance and camaraderie with nursing staff. Supportive environments were recognised as a major factor in promoting resilience. Students acknowledged that when they felt as if they were welcomed and belonged in a particular environment, they were more able to cope with negative experiences and be resilient to the stressors they encountered.

7.3.4 Tendency to engage in extenuation

Many students justified or found excuses for the shortcomings they identified in the level of support and quality of teaching provided by clinical staff. At first glance this could be mistaken for insightfulness or an understanding of the complexity of the clinical environment. On closer examination it became apparent that this was often a coping mechanism that helped students rationalise the negative and unreceptive behaviour of some registered nurses, and a way of attempting to offset the sense of alienation students experienced. Kiger (1992) refers to this process as "extenuation" and describes it as identification of mitigating circumstances that lighten the seriousness of an otherwise unacceptable disparity between what should occur and what actually occurs. Students in this study varied considerably in the amount of extenuation they displayed.

Making excuses

Several students made excuses for nursing staff who were reluctant to support them. Jane gave a number of possible reasons for this reluctance, including a lack of knowledge and understanding surrounding the expectations of the mentor role, their unfamiliarity with the tertiary system, not remembering what it was like to be a student, and the general busyness of the ward:

> *I've had experiences where they don't really want us there because they don't know what's expected of them as mentors. And I don't know whether that's because they've been brought up in the old school and they haven't been through the system, or whether they forget, or they're just too busy.* (3: 28–33)

According to Lloyd Jones and Akehurst (2000), the value of student activity to the service provider outweighs the value of the time spent by qualified staff on their supervision and clinical education. I was not left with the impression that this was a perspective shared by the majority of the registered nurses that were involved in supporting the students in this study. One of the excuses frequently given by students for registered nurses' lack of

interest in teaching and mentoring students was their workload and competing responsibilities. Leanne described the perceived problems of a constantly changing stream of students. It is evident that she did not recognise that students can be more of an asset that a burden, influenced no doubt by the attitudes of the registered nurses that she has worked with. This is an example of extenuation, but it is also strongly indicative of a poor self-concept resulting from the resistance and hostility Leanne experienced in many of her clinical placements:

> *I can see that we [nursing students] could be a pain sometimes. 'Cause they [the nursing staff] have first years on Monday, Tuesday; second years Wednesday, Thursday. We are always under their feet; always asking questions. All they want to do is get their work done. They're not being paid extra…They've got to fix up our mistakes as well, and instead of them being able to do a dressing in three minutes, it's taking them ten minutes.* (6: 380–383, 387–388)

Jane justified a situation where the nursing staff were overtly reluctant to accept students for a clinical placement. Jane appears to view students as an unnecessary intrusion rather than valued learners with a valid and important role. This perception leads her to excuse the negative attitudes of nursing staff:

> *I don't know whether they [the nursing staff] are just suspicious of us. I mean I wouldn't want people coming in and messing up my ward. There are many students that are not enthusiastic or helpful. So I don't blame them for saying, "I'm busy and I don't want them coming in and messing up what's already a really stretched system of people".* (3: 487–494)

Kara described her experience of being greeted less than enthusiastically by a registered nurse when beginning a clinical placement. She allows herself to be grouped with all students as a de-identified mass, without individual attributes and skills. Her words "I'm wearing a uniform that says student" indicates her perception that registered staff view all students in the same way, as a burden:

> *She [the RN] doesn't know me as a person. It's the first day she's met me, I'm wearing a uniform that says student, I've lobbed up with a big book and all these sheets to mark off…and the pace of the work is pretty stressful and the condition of the patients fairly heavy. I think that that was a huge factor in how helpful she was and how receptive.* (12: 200–202, 252–255)

Although some students made no effort to justify or excuse the shortcomings they identified in the level of support and quality of teaching provided by clinical staff, others seemed to use extenuation as a way of coping with the overt hostility and indifference they

sometimes encountered in clinical placements. Some seemed reluctant to criticise their soon-to-be peers, particularly when they were all too aware of the challenges inherent in complex contemporary practice environments. I wondered whether this was indicative of their early socialisation to the profession and of what Tradewell (1996) refers to as the subconscious process of internalising the values, outlooks and views of the profession. For some, their attempts to rationalise the reticence of nursing staff to teach and support them appeared to be a way of being seen to be cognisant of the challenges of nursing in the twentieth century; for others it was merely a way of surviving difficult and distressing experiences.

7.4 Conclusion

It is significant that belongingness, as reflected in this study, defied national and cultural boundaries. That is, the experiences and perspectives of the participants from each of the three sites were remarkably similar in many respects. It is also significant that despite the complexity, messiness and competing demands inherent in contemporary practice environments, the majority of interview participants recalled a number of positive placement experiences that facilitated both belongingness and learning. This is encouraging and bodes well for the future of nursing education. It is noteworthy that many students also described clinical placements that led to feelings of alienation, diminished confidence and reluctance to engage in learning opportunities. For many, the capacity to engender belongingness was seen as a defining feature of a good placement. Students often used word "lucky" to explain how a good placement was neither an expectation nor an entitlement, but rather attributable to good fortune. They emphasised that the legitimacy of their place in the clinical milieu was dependent upon whether their relationships with clinical staff facilitated of belongingness.

This chapter has focused on the pivotal nature of the interpersonal relationships between students and the staff that support them in practice, as well as the students' individual attributes and preconceptions. Nursing is dependent upon effective teamwork and the students in this study showed how important it was for them to feel included and as if they had a legitimate place in the nursing team. Belongingness was seen to have both active and passive dimensions. Many students were aware of the influence they exerted over their own experience of belonging and described how they worked to develop the kind of

interpersonal relationships that would best meet their learning needs. In this chapter the students often referred to the implications of belongingness as they shared their stories. This discussion is further extended in the following chapter, where the consequences of students' experience of belongingness are the central focus.

Chapter 8

Findings from the Qualitative Phase of the Study

Part 3: Consequences of Belongingness

8.1 Introduction

In the previous two chapters it was determined that the degree of belongingness students experienced in their clinical placements was attributable to a range of organisational, contextual, interpersonal and individual factors. In this section I focus on the outcomes of belongingness for the students themselves, for the nursing profession into which they are moving, and for the patients for whom they care. The research question that guides this section is:

With respect to the clinical placement experience, what are the consequences of nursing students' experience of belongingness?

This crucial "so what" question was the impetus for this study and its driving force. It explores the implications of belongingness at the macro and micro levels. It asks "if" and "how" belongingness matters, and it seeks to generate understandings that will inform those stakeholders with a vested interest in undergraduate nursing education. In this chapter the consequences of belongingness are explored with reference to the themes listed in Table 8.1.

Table 8.1 Consequences of belongingness

Factor 1: Optimal clinical learning

    Theme A: Motivation to learn

    Theme B: Self-directed learning

    Theme C: Anxiety—a barrier to learning

    Theme D: Confidence to ask questions

Factor 2: Enhanced self-concept

    Theme A: Feeling worthwhile

    Theme B: Feeling worthless

Factor 3: Self-efficacy

    Theme A: Taking responsibility

Factor 4: Degree of conformity and compliance

    Theme A: Don't rock the boat

    Theme B: Getting the RNs offside

    Theme C: Speaking up

Factor 5: Future employment considerations

    Theme A: I'm seriously considering it

    Theme B: I'd never go back there

Factor 6: Joy at work

    Theme A: Transmission of joy

8.2 Optimal clinical learning

The nature of clinical learning and how it was impacted by belongingness was the major focus and a recurring theme of the students' accounts. Throughout the transcripts learning was seen to be inextricably linked to belongingness. Students clearly articulated how belongingness facilitated learning or, alternatively, how the absence of belongingness was a barrier that undermined their learning. Given that clinical placements are specifically designed to provide meaningful experiential learning opportunities, a clear understanding of the relationship between belongingness and student learning is immensely important.

Motivation to learn

For many students the need to belong and to be accepted into the team was far more important than the clinical specialty or the type of nursing experience offered. In this example Elizabeth explains how inclusion in the nursing team was a pivotal antecedent to her learning:

> *As long as I get on with the nursing staff, as long as I feel like a part of the team, as long as it is friendly, I don't care what kind of nursing it is. I can't learn in an environment where I am not feeling as if I am really wanted. I want to walk in in the morning and every one will go, "Hi Elizabeth, how are you? How was your weekend?" That is the sort of environment I want, and obviously that is the kind of environment I want to work in when I qualify in October. I just can't learn in unwelcoming places.* (15: 680–689)

Many students said that the belief that they were accepted and valued as a student was a significant motivator for their learning. When students felt secure in the knowledge that the nursing staff they worked with were supportive of their learning and committed to their professional development, they focused on learning rather than being preoccupied with interpersonal relationships and trying to fit in (Levett-Jones, 2006a). Fiona compared the influence of different clinical environments on her motivation for learning and explained that she felt better equipped to make the most of the learning opportunities presented when she had the support of the nursing staff she worked with:

> *If you feel you are not wanted or they [the nurses] don't care whether you are there or not, it is disheartening and you are like, "What is the point of me trying to learn; they don't acknowledge me, they don't want me here". But when you feel welcome and as if they really want you there, you try harder and you are more motivated to do well.* (14: 1118–1123)

Alienation is said to result in anxiety, depression, lack of motivation and a lack of direction (Hajda, 1961). Abby insightfully described how difficult it was to be enthusiastic and motivated when her placement experiences had been overshadowed by the alienation she had experienced as an international student. She explained that the staff's apparent lack of acceptance of her, and her resultant despondency, acted as a barrier and caused a cycle of feeling rejected and then rejecting others:

> *When you're feeling sad, depressed and unaccepted it's difficult to motivate yourself to ask questions and learn. It's difficult to put a smile on your face and pretend everything's okay, and [that] you're having a good time. And I feel that when you are not smiling, when you're not enthusiastic, that itself pushes people away from you. When you are feeling like that it's*

difficult to put yourself out there, especially when there are already cultural and language barriers. (13: 615–621)

Simply undertaking a clinical placement does not necessarily develop competence; just being in a clinical context does not guarantee learning (Levett-Jones, 2007). In the midst of the semi-structured chaos that characterises contemporary health care, it is difficult for students to appreciate and learn from the learning opportunities that exist. Caught up with "getting the job done", students frequently feel compelled to work hard in order to fit in, and their motivation for learning is sometimes diminished. However, according to Brent, when nursing staff are receptive and accepting, students frequently respond by becoming interested and enthusiastic learners. Rather than the clinical placement being an experience to be endured it becomes one that is relished, and learning becomes paramount:

> *When nursing staff have a positive attitude towards students, you know that you're going to have a good time and you are going to learn. And you learn so much more when you're in a better frame of mind, when you're having a good time and you are interested. Whereas, if it's a prac where the staff don't want you there, you really don't want to be there and that means you stop being interested and don't pay that much attention. So you don't learn much, and you definitely don't take as much away from those types of pracs. In a situation like that, it's all about the hours, "I've been here for so many hours—can I go home now"? Whereas, in a good prac it's, "Oh, I've been here 15 minutes longer than I should have—but I don't want to go because there's so much to learn". You definitely take a lot more away from a prac when you're enjoying yourself and you've been accepted.* (9: 523–534)

Self-directed learning

The benefits of self-directed learning (SDL) have been well described in the literature (Levett-Jones, 2005b; McMillan & Dwyer, 1990; Nolan & Nolan, 1997). It has been suggested that a self-directed approach to learning not only increases nursing students' confidence in their own ability, but also their capacity to learn in novel situations (McMillan & Dwyer, 1990). SDL is an essential vehicle for nursing students to develop independent learning skills and a commitment to lifelong learning. It increases their capacity for learning in dynamic and challenging work environments (Nolan & Nolan, 1997). SDL allows learning to progress beyond mere knowledge acquisition to being a memorable and motivating experience. In an era when self-directed and autonomous learning are driving forces in both academic and professional healthcare settings, it is essential that students' capacity to be self-directed independent learners is fostered and promoted. It would

appear that clinical environments that provide students with a feeling of security and acceptance empower and enable them to make the most of the learning opportunities presented. Sarah explained how her sense of belonging provided a solid foundation that allowed her to negotiate her learning in an autonomous way:

> *If I feel like I fit in and belong I feel more comfortable to advocate for myself—and to say, "Well guys, I actually need to do this. I know you want me to go with this RN, but she's only going to be doing this, this and this today, whereas so and so is doing something that I really need to learn while I am here. Would it be possible for me to go and have a look at that?" That feeling of belonging means that you feel safe enough to say, "Well, no, actually guys, this isn't working for me today, I need to do this instead".* (1: 492–500)

Many students in this study said they had greater confidence in being self-directed in environments where they experienced a sense of belonging. Nicole recounted how her growing sense of belonging while undertaking a clinical placement in operating theatres motivated her to engage in independent and self-directed learning activities:

> *Belonging makes a huge difference to your attitude towards the staff and to learning as well…It makes the world of difference to whether you want to actually get up and go into work in the morning and how much you learn and want to learn while you're there. I mean, in theatres I did so much work outside [of the placement] as well—reading up on cases and doing my own revision. When you actually enjoy being somewhere and feel as if you fit in, it spurs you on to want to learn and to actually contribute to your own learning.* (18: 1615–1616, 1623–1628)

Anxiety—a barrier to learning

A number of students described their clinical placements as stressful and typified by a fear of making mistakes or saying something foolish. Many were confronted with feelings of anxiety and apprehension as they traversed different clinical placements. These types of stressful experiences, often derived from a diminished sense of belonging, are reported to impede learning by authors in various countries (Kleehammer, Hart & Fogel Keck, 1990; Lindop, 1999; Lo, 2002; Meisenhelder, 1987; Timmins & Kaliszer, 2002). Laurence's experience exemplifies this issue:

> *I feel more comfortable if I fit in and belong, and then I can learn. Because with my anxiety I get worried if I am in a situation where I am not welcome and I would rather opt out of it. I think it makes it easier on me if I find a place where I belong, because otherwise the anxiety can get in the way of learning.* (5: 337–340)

Laura adds to this discussion by providing an example of the importance to her learning of feeling comfortable and accepted. She related how, when she is free from the worry of nurses "having a go" at her, she can relax and learn:

> *When I'm comfortable and feel accepted I do learn more, 'cause I'm not worried about getting into trouble from the nurses, or if I'm doing the right thing. I'm not waiting for someone to have a go at me. So I can relax and get on with learning.* (2: 354–357)

Jane mentioned the significance of positive interpersonal relationships to her learning and explained that it is much easier when the staff are supportive, as she can relax and focus on learning, rather than being preoccupied with, and anxious about, developing relationships:

> *If you go onto a ward and they're really enthusiastic, welcoming and supportive, that does make your learning so much easier, 'cause you're not having to set up those relationships first. You can just relax, and focus on what you need to learn. When you feel as if you belong it is a lot a lot easier and less stressful.* (3: 788–792)

Confidence to ask questions

When newcomers are welcomed, they feel able to ask more questions and patterns of communication can be established that enhance learning and the quality of practice. Essential to students' learning are the confidence to ask questions and the certainty that their questions will be answered respectfully and patiently. Students frequently described placement experiences where they were reticent to ask anything more than the most rudimentary questions, fearing that their questions would not receive a favourable response, if any. These types of unwelcoming and unresponsive placement experiences prevented students from developing critical thinking skills and testing out tentative ideas and thoughts, as they did not want to risk making mistakes in front of staff. Deanne compared two different placement experiences and explained how her willingness to ask questions was influenced by the receptiveness and acceptance of the nursing staff:

> *I tend to ask more questions in an environment where I feel as if I fit in. At *** hospital they were so welcoming and supportive that I was asking questions within about 10 minutes of arriving. I was going, "Why are you doing that" and "What are you doing that for" and "What are we going to do next?" I felt like I was constantly at them, but they said, "It's really good because we have to actually justify what we're doing". The comparison would be *** hospital where I tended to just stand back and watch. I didn't feel comfortable asking questions…There was this sense that you weren't going to get an answer that was going to*

justify your question. I think that the only time that I actually asked a question was when a situation arose and I had no choice. You didn't just come out and go, "Can you tell me why we do this" or "What's this?" or "What's that"? It wasn't really an environment where you felt comfortable asking questions. (11: 454–460, 465–471)

Louise reiterated the importance of feeling comfortable enough in the clinical environment to ask questions of the nurses. She explained that the inclination to ask questions is linked with the degree to which students feel welcome and to how supportive the nursing staff are of their learning:

When someone really supports you and makes you feel welcome, you're so much more inclined to ask questions and to learn. That's just the perfect learning environment. If they're giving you the impression that, "Yeah, you're welcome and we really want to teach you things", you just jump at it and thrive on it. It definitely makes for a much better learning environment. (7: 353–359)

There are suggestions in the literature that the need to belong affects cognition, as people devote a considerable amount of time to thinking about and attempting to understand interpersonal relationships, particularly when those relationships do not fulfil their belongingness needs (Baumeister & Leary, 1995). Additionally, the anxiety produced by a diminished sense of belonging is said to produce a short-term impairment in cognitive performance and reduce intelligent thought (Baumeister, Twenge & Nuss, 2002). The students in this study emphasised time and again that both their capacity for learning and their motivation to learn was influenced by whether or not they experienced a sense of belonging. Their interviews echoed with the repeated assertion that belongingness is a pivotal precursor to optimal clinical learning (Levett-Jones & Lathlean, in press). Furthermore, students felt that environments that were supportive and receptive enhanced their confidence and allowed them to be self-directed in their learning. In these types of environments students felt empowered to ask questions and to negotiate specific objective-related learning opportunities.

8.3 Enhanced self-concept

During the interviews the issue of self-concept recurred many times. It was through the participants' language that their meanings, beliefs and perceptions of self-concept were revealed. Maslow (1987) contends that a person must experience belongingness and acceptance as a necessary precursor to the development of self-esteem. Closely related

to self-esteem is the notion of self-concept, which is defined as a set of innate beliefs, values and attitudes learned and developed through transactions in an environment that creates a self-image (Bandura, 1997). A positive self-concept includes positive self-evaluation, self-respect, self-esteem, self-confidence and self-acceptance. A negative self-concept is synonymous with negative self-evaluation, inferiority and feelings of worthlessness and diminished self-acceptance (Burns, 1979).

Often the language students used to describe their role and their place within clinical environments was self-deprecating and dismissive. It appeared that a negative clinical placement—where students did not feel they were welcomed, valued or accepted—often resulted in a poor self-image, because they internalised the views expressed by the nursing staff they worked with. However, in contrast to Burns' (1979) contention that self-concept is an enduring construct, it became apparent that students' self-concept was not static but evolved in response to the degree of belongingness they experienced in particular contexts. What could not be determined from the students' accounts was the degree to which poor self-concept resulting from a negative placement impacted their attitudes towards future placements, and how this was played out. Although most students experienced one or more negative placements where their self-concept was adversely affected, their degree of resilience (as discussed in Chapter 7) and other individual characteristics determined how severe and enduring the consequences of this were.

Feeling worthwhile

In this example, Laura's mentor showed that she valued Laura and was interested in her progress. This in turn impacted on Laura's self-concept, and instead of feeling like a "nuisance" she felt "worthwhile":

> *The mentor I had in the palliative care ward at the S [hospital] was good. She didn't make me feel like I was a nuisance or in the way. She was happy, and would ask, "How are you going. Are things going all right?" She was really interested and that made me feel good about myself, like I was okay, I was worthwhile.* (2: 262–265)

It was often staff other than registered nurses who sought to address the poor image students had of themselves. In this example Leanne was reminded by a doctor that being a nursing student is not something she should apologise for:

> *When a patient came in with a laceration, one of the doctors turned around and said to me, "Can you stitch him up?", and I said, "Oh, I'm only a student", and he said, "Don't say you're*

only a student, be proud…you are a nursing student, now come with me and we'll stitch it together". (6: 489–492)

Feeling worthless

Many students said they thrived in warm and accepting environments, and that these experiences had a positive impact on their developing image of themselves as nurses. Conversely, some described feeling guarded, timid, self-conscious and inarticulate as a result of the way they were treated in hostile and unwelcoming clinical environments. Laurence expressed a view that seemed to be common to many students who had experienced placements where they were neither welcomed nor accepted. The words "nuisance" and "only a student" recurred in many of the students' accounts, as did the inference that students don't "know much". Laurence seemed to have resigned himself to the staff's perception that students have little knowledge or skill:

In some places you think that you're holding them back, slowing them down. And you feel like you're just a nuisance. I think that's just the student life…And because you're only a student, you're not expected to know much or be able to do much. (5: 534–535, 783–784)

Leanne described a placement where she felt unwelcome, inept and uncertain much of the time. These feelings seemed directly related to her perception of the nursing staff's opinion of her as a student. The disparaging words "they already think you're stupid" encapsulated Leanne's poor self-concept. Her reticence and fear of asking questions were a direct result of her poor self-image in this environment:

*At the *** [hospital] you're too scared to ask questions, cause they already think you're stupid. So you don't want to prove to them that you are.* (6: 165–167)

The perceptions of many of the students in this study suggest that a diminished sense of belonging, and the factors that cause it, lead to a poor self-concept. Elsworth and Coulter (1977) suggest that if nursing education is viewed, in part, as a socialisation process, then changes in self-concept should be used as a criterion to judge the effectiveness of programs. From the students' perspective it also seems reasonable to propose that changes in self-concept can be used as one indicator of the capacity of a clinical learning milieu to engender a sense of belonging in students. Clinical education experiences should promote the attainment of a positive and realistic self-concept, as the image of oneself as "becoming nurse" affects performance and learning.

8.4 Self-efficacy

The concept of self-efficacy has been discussed extensively in social psychology literature to explain motivation and learning theory. Self-efficacy is defined as a conscious awareness of one's ability to be effective in controlling actions or outcomes (Kear, 2000); and the perceived confidence for learning or performing specific tasks or skills necessary to achieve a particular goal (Jeffreys, 2004). Self-efficacy is related to, but distinct from, self-concept. While self-concept is an introspective and descriptive composite of one's self, self-efficacy is concerned with one's judgments of or belief in personal capabilities (Bandura, 1997). Individuals gauge the effects of their actions and their interpretation of those effects helps to create their efficacy beliefs. Pajares (1997) points out that it is not only what people know, the skills they possess or what they have accomplished that predict subsequent attainment, it is the actual beliefs that people hold about their capabilities that are powerful influences on how they behave. People with high self-efficacy believe that they are capable of accomplishing their goals and are willing to pursue them in spite of the difficulties they may encounter. On the contrary, inefficacious beliefs, fostered by experiences of failure, hinder a person's willingness to persist (Bandura, 1997). Thus, self-efficacy is dynamic in nature—positively or negatively influenced by intersubjective/ environmental experiences.

Self-efficacy is a concept that is of particular importance to nursing students. In this study the students' accounts made it clear that their degree of self-efficacy was strongly influenced by personal traits, previous experiences and the degree of belongingness they experienced while on a placements. Like professional self-concept, self-efficacy both influenced and was influenced by the extent to which students experienced belongingness. It became evident as I interviewed the students that those with a high degree of self-efficacy were more confident and capable both in engaging with the clinicians they worked with and in negotiating learning opportunities within placements.

Taking responsibility

Bandura (1997) suggests that self-efficacy is both situation and task specific. Louise related how she confidently and proactively identified learning opportunities once she felt accepted in the clinical environment. She was well aware of her responsibility for taking control of her learning and felt capable of doing so, as long as she was comfortable within the clinical context:

When I arrive on a new ward I tend to find my feet first and make sure I sort of fit in and that the staff are happy for me to be there. Once I feel confident and comfortable, I'll make it known at handover that I really need practice on certain skills, and I say, "If anyone's got any [nursing procedures], can they come and grab me and let me do it?"…I find that does work, but it is up to me to make the most of it, and to make sure that my skills were up to scratch, and that I get the opportunities to practise. (7: 176–179, 183–184)

Ann is a confident student who is clearly focused on her learning needs when on clinical placements. Most of Ann's clinical placements have been positive experiences and she prides herself on her ability to establish effective relationships with the registered nurses she works with. Because of this, Ann demonstrates a high degree of self-efficacy, both in accessing the support she needs and in achieving her learning goals in a self-directed way:

I'm a real forward person. When I feel accepted by the staff and comfortable in the environment and I know what I've got to do, I'll just go and do it. I'm self-directed…I'll just say, "Look, this is what I need to practise"…If a particular person doesn't meet my needs, I'll go and find somebody to help me. I'll just find my way. I tend to seek out who I need to help me…I've just got a get-up-and-go attitude, and I think if you've got confidence and you know what you're doing you find that the nurses you work with are confident in you too. They'll find what your abilities are, and then push you further. (4: 336–337, 342–343, 354–355, 428–430)

Dunn and Hansford (1997) suggest that students should be encouraged to recognise the influence they exert over their own clinical learning environment, and to work proactively to create the kind of environment that will best meet their learning needs. Monique agreed and further asserted that students need to take some responsibility for the quality of their relationships with the registered nurses that they work with. She believes that students' personal attributes and attitudes impact on their self-efficacy and their ability to engage with registered nurses:

It goes without saying that those students who go on to placement and are confident and willing to stick their neck out get the most out of it. I think personality has a bit to do with it. If you're prepared to chat to somebody and say, "Hi, how are you going. Do you enjoy nursing?", they tend to melt a little bit. There's ways of getting round them…We [students] have to take some responsibility for our attitudes and we have to take some responsibility for the treatment that we get. We need to try our best to let them know that we are willing to learn and willing to take constructive criticism. (10: 428–434, 442–444)

For Fiona, the belief that she fitted into and had a secure place in the clinical environment gave her the confidence to use her initiative and be a proactive team member, without fear of negative repercussions. In this example, self-efficacy is shown to be situation-specific and strongly influenced by student's experience of belongingness:

> *I think if you fit in you are more likely to feel confident enough, when you see something that needs doing, to just go and do it without being asked or without asking whether it is appropriate to do it. But if they are not so welcoming, you might think, "Oh, they might yell at me if I do that. I don't want to make it even worse"…The atmosphere and the kinds of feelings you get from the other staff help you to decide whether it would be appropriate, what is right and wrong on that ward, so you know whether to do it or not.* (14: 1022–1027, 1036–1040)

The students often discussed behaviours that they engaged in that were indicative of a high degree self-efficacy, but this was tempered by the admission that their confident overtures were specific to particular clinical contexts in which they felt welcomed and accepted. They described their initial steps to the establish relationships with their nursing colleagues as tentative, as they watched for cues to see whether their attempts were met with rebuttal or acceptance. Once they were sure that nursing staff were receptive to their presence, they felt more confident to proactively engage with them and to negotiate learning opportunities.

8.5 Degree of conformity and compliance

In a study by Baumeister and Tice (1990), it was suggested that, in order to avoid exclusion by others, people conform, obey, comply, change their attitude, work harder and generally attempt to present themselves in a favourable light. Traditionally, nursing students were socialised to obedience, respect for authority and loyalty to the team. Both their acceptance into, and continued membership of, the healthcare team depended upon their recognition of this subordinate role (Kelly, 1996). Society expected nurses to be servile, accepting, humble and self-sacrificing. Within the hierarchy of the healthcare system nurses became acculturated to do and say what was expected, to conform rather than question, to accept rather than debate important issues (Levett-Jones & Bourgeois, 2007). Synonyms for conformity include obedience, compliance, submission, traditionalism, uniformity, conventionality and acquiescence (*Oxford English dictionary*, 2006). Baly (1991) argues that unquestioning obedience and conformity is inimical to

innovation and improvement. The aim of contemporary nursing education is the development of innovative, questioning and assertive practitioners. Yet, in this study conformity and compliance were perceived by a number of students to be strategies that enhanced the degree to which they were accepted by nursing staff. In this respect, the need to belong can be seen to have negative as well as positive consequences.

When students felt sure of their acceptance and rightful place in the clinical environment, they were far less likely to comply with the directives of RNs when they felt that to do so might put patients at risk. Conversely, students who felt insecure, isolated or ostracised were more willing to conform and less likely to question practices with which they felt uncomfortable. There appeared to be somewhat of a continuum along which differing levels of conformity and compliance were sanctioned. Some students refused to engage in any practice that they felt uncomfortable about, others were willing to comply with some degree of questionable practice but had a limit, and another group—albeit much smaller— willingly, unquestioningly and knowingly engaged in poor practice, as directed by the registered nurse they were working with, in order to fit in.

Don't rock the boat

Moreland and Levine (1989) suggest that group conformity may be viewed in the context of enhancing one's chances of inclusion in groups. This provides an understanding as to why some students conform to clinical practices that they know to be incorrect—so as not to rock the boat and be viewed as an outsider. Fiona said she was reluctant to risk being alienated from the nurses she worked with and because of that went along with practices she knew to be incorrect. Her words, "I don't want people to hate me—that's the thing" are indicative of her determination not to estrange the nursing staff and serve to reinforce the importance of fitting in to students' thinking and behaviours:

> *I have seen some manual handling manoeuvres used that we are taught are banned and shouldn't be used. I am like, "I am only a student, who am I to criticise". So I don't say anything because I don't want to rock the boat. You think, Well, I need to pass this and I don't want people to hate me—that's the thing.* (14: 977–982)

In the next example Elizabeth sums up the perspective of a number of students as she explains that her primary motivation, particularly until she has had time to settle in, is belonging, and that she will "do whatever they tell her to do" because she wants to "get on with people":

I am quite shy and especially in the first couple of weeks I do whatever they [the registered nurses] tell me to do because I want people to like me. I want to get on with people because in this profession if you don't get on with somebody then your whole placement is going to be ruined, and I can't have that. I have worked in what I call like bitchy places and it is just awful. (15: 180–187)

Laurence described two experiences. In the first he explained how he chose to "keep the peace" by not challenging poor nursing practice. In the second he related how, when he felt accepted in a clinical environment and supported by nurses who were "nice" to him, he experienced a greater sense of freedom to practise in a way that maintained quality care:

I know that I do some things the unsafe way, just to get through the day quicker and not to interrupt their routine. You just think, "Oh, I'll just agree with them [the registered nurses] to keep the peace. But with the nurses that are actually nice to you, and that you get along with, they don't really care what you do. As long as you do it, you can do it your way. (5: 655–662)

Jodie described an experience where inappropriate manual handling techniques were an issue. The importance of not rocking the boat is again mentioned. In this example, Jodie clearly states that there are contextual and interpersonal factors that determine the extent to which students are willing to comply with poor practice. She explained that because she felt comfortable with the staff in this particular clinical environment she was more willing to challenge the practices of the registered nurses:

*Moving and handling practices are pretty bad. In my last placement I started to challenge it. I was like, "You really shouldn't do this". I think it was because I was so comfortable with the staff there that I could challenge it…Some places, like *** [hospital], I wouldn't have felt comfortable challenging what they were doing. But it really just depends on whether they are going to make your life hell if you do. And then you think, I'm not going to rock this boat.* (16: 701–705, 719–724)

Getting the RNs offside

Abby provided yet another layer to this discussion by describing her belief that by standing up for patient safety she may well jeopardise her relationship with the registered nurses she works with and her potential learning opportunities:

I've been in situations where patient safety was compromised and I should have said no! It is very distressing and it makes me feel bad about myself…And I do question why I wasn't strong enough to say no, but at the same time, as a student it is very difficult to say no to a registered nurse…And is it wise for me to jeopardise my placement experience? Because,

unfortunately it's really difficult to seek learning opportunities unless the staff are willing to cooperate and give you that opportunity. So if you give [a] bad impression by challenging what they do, then your opportunity to learn is taken away from you. (13: 304–306, 374–375, 380–385)

Monique had a similar perspective to that of Abby. While she was mindful of her responsibility to address poor practice standards, Monique nevertheless admitted that due to her lack of confidence she would not risk getting the RNs "offside":

There have been times when I've seen RNs give injections that I thought were a little bit over-rough, or handled patients in a way that I thought wasn't quite appropriate. But I have never questioned it with the person. I'm not qualified, so I don't feel I could say it, and I feel I would get them offside and that would be detrimental to my learning in other areas where that nurse could probably show me something that is quite correct and quite safe. No, I don't feel confident at all that I could say anything to a RN and I don't even feel confident enough that I could talk to the NUM on the ward either…And isn't that terrible? Because really when we see something that's unsafe, I think it's our job to report that type of thing. (10: 472–481, 492–494)

Speaking up

Not all students complied with inappropriate practices so willingly. Brent was a confident student who was secure of his place both within the nursing team and the nursing profession. In this example he described how he refused to engage in practices that were outside his scope of responsibility:

In aged care the RN that I was with was a smoker and would leave every 20 minutes to go outside and have a cigarette, then come back. He expected me to continue to give out the medications while he wasn't there. I said, "I have to wait till you come back". His rationale was that because they were in Webster packs, the chemist takes responsibility for them. I said, "It's not that simple. 'Cause we're the ones giving the medication we're still partially responsible". I just said, "No, I'm not going to do it. It's against the rules". (9: 353–361)

Nicole described how she has become increasingly confident of her place in the nursing environment as she has progressed through her nursing program, and because of that she has become more willing to challenge poor practice. She attributed her ability to "speak up" to having a secure place in the nursing team:

I have seen things and not said anything…That has changed as my confidence and my knowledge has grown. I still remember seeing two healthcare assistants pulling an elderly woman up the bed in the most hideous manner and not saying anything to them…But now I

would definitely say something. But like I said earlier, it is feeling secure with the staff that makes a world of difference to whether or not you speak up. (18: 1638, 1647–1649, 1660–1663)

It goes without saying that students are expected to comply with recognised standards and codes of practice. In this study students related how they complied with unacceptable standards of nursing practice because they were reticent to endanger their precarious sense of belonging. This was particularly true of students who felt less secure of their place in the nursing team. Conformity was often seen as a means of improving their chances of inclusion and, by contrast, as a way of reducing their risk of rejection. Even though students complied with particular behaviours that they felt uncomfortable with, they did not always adopt and integrate the RN's norms and values, and although they complied they remained cognisant of the professional boundaries they were breaching. However, while compliance at times led to guilt and regret, it was often seen as the lesser of two evils; from the students' perspective it was often better to comply than to be rejected.

8.6 Future employment considerations

The nursing profession is experiencing a workforce crisis recognised globally as the worst nursing shortage in the last 50 years (Heath, Duncan, Lowe, Macri & Ramsay, 2002). Against this backdrop it is essential that factors that impact upon graduate recruitment are considered. Nursing research highlights that even though convenience, familiarity and loyalty affect recruitment, it is the first-hand experience gained through undergraduate clinical placements that is most likely to affect graduates' employment decisions (Brodie et al., 2005; Dunn & Hansford, 1997; Hayman-White, 2004).

I'm seriously considering it

Interwoven in the students' accounts were their perceptions of what constituted good and bad placements. Invariably bad placements were those undertaken in environments where they would never consider seeking employment. Primarily, it was the interpersonal relationships between registered nurses and students that were identified as key to students' employment decisions. Where the clinical environment was perceived as inclusive, supportive and encouraging students, were more likely to consider it as a potential employment opportunity. Louise explained:

When you feel as if you belong, it gives you a more positive attitude towards the placement and you are more encouraged to look down that avenue of work later on, that speciality. (7: 117–119)

In a similar example, Nicole said that her positive placement experience in operating theatres influenced her consideration of it as a career specialisation:

It was just a lovely, really welcoming, friendly, warm atmosphere. They have been fantastic and I made some great friends there. It was wonderful. I'd never thought about theatres before and but now I am seriously considering it for when I qualify. (18: 1364–1369)

I'd never go back there

In contrast to the student's experiences detailed above, when staff were not receptive or accepting of students, or when they displayed hostility or engaged in behaviours that were perceived as being horizontal violence, students clearly asserted that they would never return to work in those environments. Katherine elaborated on this line of thought:

I could never go back there to work. A lot of people have said that it would be different if you were a staff nurse because you would know more about what was going on. But the way I was treated by a lot of the staff I don't think I would want to. I wouldn't want to work in an environment where I was made to be that unhappy and wasn't given any supervision or support. (17: 835–840)

Belongingness was identified as crucial to students' consideration of potential employment options upon registration. Louise summarised the sentiments of most students in this study when she stated:

If you have a bad experience, and you don't feel welcomed by the staff members, you're not encouraged to want to go and work back there, 'cause you know what the environment is like, and it doesn't give you any encouragement. (7: 123–125)

Students who were welcomed, encouraged and supported by nursing staff during their clinical placements were more likely to seek employment in that area upon registration. Other studies reiterate that respect and acceptance from experienced colleagues are significant issues in employment decision making (Brodie et al., 2005; Gidman, 2001; Hayman-White, 2004; Heslop, McIntyre & Ives, 2001). In this study, students reiterated the significance of the quality of their clinical placement experiences to their employment decisions. In light of current workforce deficits their perspectives are worthy of serious consideration.

8.7 Joy at work[1]

Baumeister and Leary (1995) posited that belongingness has a positive influence on a person's feelings of joy or happiness. Manion (2003, p. 652) defines joy as an intensely positive, vivid and expansive emotion that arises from an internal state or results from an external event or situation. This author asserts that while the capacity to enjoy the work one is involved in results from a personal predisposition and a range of organisational and contextual factors, the strongest influence on feeling happy at work is the quality of one's interpersonal relationships with colleagues. In the current study, many students gave examples of feeling happy or joyful in clinical environments as a result of the sense of connectedness they experienced. Students also felt a sense of satisfaction and happiness when they perceived their clinical skills and knowledge to be developing. Manion (2003) suggests that the perception of competence is intrinsically rewarding and strongly linked to enhanced self-esteem and feelings of joy. Students' feelings of happiness also increased when the staff they worked with recognised their developing competence and expressed appreciation for the contribution that they made to the team.

Transmission of joy

In this study joy was seen to be a powerful emotion. Students who experienced joy as a consequence of feeling that they belonged felt more satisfied and secure in the clinical environment and gained more pleasure from their experience. Nicole explained how experiencing a sense of belonging and collegiality during her placement in operating theatres contributed to her joy and happiness. Her experience demonstrates that joy is transmissible and can be enhanced through working within a positive environment and with a friendly team:

> When you are segregated and you feel like you don't belong it does have negative connotations because you don't feel as happy, whereas if there is more of a belonging ethos then there is support and people to talk to when you need someone—you can just enjoy yourself so much more at work. Everyone in theatres was just so friendly, and there was such a happy, jolly atmosphere about the place. (18: 1298–1303)

Baumeister and Leary (1995) propose that to experience belongingness and happiness, you must believe that another person cares about and likes you. Supporting this assertion are numerous studies that show that a "framework of mutual concern produces a

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[1] Throughout the interviews students often referred to their clinical placements as "work".

relationship qualitatively different from one based on self-interested social exchange" (Baumeister & Leary, 1995, p. 505). Additionally, helping behaviours appear to be increased by the existence of a social bond and, as Schoenrade, Batson, Brandt and Loud (1986) found, the existence of a social bond increases the actual motivation for helping. In this study students described how they became more involved and helpful when they experienced joy as a consequence of the mutual understanding and respect developed with staff. Sarah's recollections of a positive placement experience exemplify this type of reciprocal interaction:

> *Belonging means feeling welcomed—not just as a student, or a nurse, but as a person as well, and feeling like people are quite happy to be around me, not just because they have to be. Then work becomes more social. And I feel that you have to have that sort of social network at work—in order to fully enjoy your work…Because look, the work takes up so much of your life, you've got to be able to have a little bit of enjoyment in there as well. So that, you know, when they [the nurses] are having a bad day, you can say, "What do you need me to do for you?", and when you're having a bad day they can do the same. Not only can you look at somebody that you know well and say, "Hmm, not having a good day. I've got five minutes. I'll go and see what they need", but also you have the inclination to do that. Where as if you don't know the people from a bar of soap, if you don't feel like you're a part of the team, and you're just not happy in your work, you're more inclined to just sort of go, "This is my job, and this is what I'm doing".* (1: 401–405, 415–425)

Manion (2003) proposes that for most people their primary source of joy is the quality of their interpersonal relationships. Like many of the students in this study, Laurence explains how he was enthusiastic and motivated and enjoyed the placement more because of the relationships he developed with staff. This is another example of how joy can be contagious. Because the nursing team and the work environment described by Laurence were happy and welcoming, he "enjoyed going to work":

> *I went to *** [hospital] medical and renal palliative care ward, which was excellent. The staff were welcoming and it was a really happy team. It was a 10-week placement and I got to know them so well and the workplace became a lot happier…I actually enjoyed going to work because I was working with people I liked and they liked me.* (5: 799–802, 808–809)

In this chapter, as in the previous two, numerous examples have been included of students feeling happy as a result of the relationships they established in clinical environments where they felt a sense of belonging. Their feelings of happiness had an impact on their motivation, enthusiasm and commitment to learning and the satisfaction

they gained from the learning experience. Feeling joyful for some students also meant that they were more involved and participative and were more responsive to the needs of the other members of the nursing team. In contrast, many examples of students feeling distressed and unhappy as a result of feeling alienated, excluded or resented by nursing staff have been described. These types of experiences impacted on their learning, commitment to nursing and future career decisions.

8.8 Summary of the findings from Chapter 8

In Chapters 6, 7 and 8, the stories told by the 18 interview participants were explored. Their insights created a rich and colourful tapestry that brings greater understanding to the multiple dimensions of belongingness. Each of the participants recalled diverse clinical placement experiences. These spanned the continuum from experiences promoting a high degree of belongingness to those that engendered intense feelings of alienation. It was apparent from the students' accounts that belongingness is mediated by a range of individual, interpersonal, contextual and organisational factors. It was also evident that the registered nurses with whom students worked on a day-to-day basis were the single most important influence on their sense of belonging and learning (Levett-Jones & Lathlean, 2006).

Chapter 8 specifically set out to identify and explicate the consequences of students' experiences of belongingness. Not surprisingly, a number of affective consequences of belonging were identified. Feeling safe, comfortable, satisfied and happy was reported by many students to be an outcome of a placement that facilitated belongingness. In addition, belongingness was seen to be a phenomenon that was directly related to nursing students' self-concept, degree of self-efficacy, the extent to which they were willing to conform with poor practice, and their future career decisions. Importantly, the influence of belongingness on students' capacity and motivation to engage in clinical learning opportunities when on placements emerged as a critical and recurring theme.

Students felt more empowered and enabled to capitalise on the available learning opportunities when they felt they had a legitimate place in the nursing team, and they were often more self-directed and independent in their approach. They were also more confident in negotiating their learning needs, in asking questions and in questioning

practice. Students who were secure in the knowledge that the nurses they worked with were receptive to and supportive of their learning focused their attention and energy on learning rather than trying to fit in. Conversely, an absence of belongingness, or alienation, was seen to have a negative and at times long-lasting impact on students' attitude towards learning and on their confidence to become involved in experiential learning opportunities. The anxiety and apprehension resulting from a diminished sense of belonging drew their attention away from learning and they focused on little else but trying to fit in. Many students sacrificed their supernumerary status and became "an extra pair of hands" to enhance the likelihood that they would be accepted into the nursing team and, as a consequence, their opportunities for learning were compromised. Some students conformed to poor practice rather that risk being seen as an outsider and rejected or ostracised by the nursing team. Given that clinical placements are specifically designed to provide authentic and meaningful opportunities for students to develop competence in preparation for their future practice, these are significant findings that have repercussions for students and for all those with an interest in their education.

8.8.1 The relationship between learning, belongingness and alienation

This chapter now presents the amalgamated findings from a second level of analysis in which the interview data were reinterrogated in order to elucidate and better understand the dimensions of belongingness and alienation, and the relationship between these phenomena and learning. Illuminative words, phrases, descriptors and meanings were highlighted and clustered into logical patterns that added new depth to the interpretation. Table 8.2 lists the dimensions of belongingness and alienation, as seen through the students' eyes, in the following categories: nature of the practice learning milieu, nature of student–staff relationships, attitude towards students, and attributes of students as learners. The descriptors in each column are representative of either end of the belongingness/alienation continuum.

Table 8.2 The dimensions of belongingness and alienation

Category	Belongingness ◄─────►	Alienation
Nature of the practice learning milieu	safe / secure	threatening / frightening
	welcoming / receptive	hostile / unreceptive
	comfortable / novel	uncomfortable / foreign
	challenging	confronting
	complex / busy	confusing / chaotic
	perception of values congruence	perception of values dissonance
	patient-centred / student-centred	task-orientated / profession-centred
Nature of student–staff relationships	inclusive	exclusive / isolating
	accepting	rejecting / resistant
	facilitative	undermining
	encouraging	discouraging
	friendly	unfriendly
	committed	uncommitted
	consistent	inconsistent
	interested / enthusiastic	disinterested / indifferent
	supportive	unsupportive
	caring	uncaring
	challenging	demeaning
	affirming / positive	degrading / negative
	connected	disconnected
	communicative	uncommunicative
	reciprocal	self-centred
	inspiring	disillusioning
Attitude towards students	legitimate / valid role as learner	interloper / nuisance
	valued	worthless
	asset	burden
	investment	waste of time
	important	unimportant
	integral to the team	imposition / intrusion
	wanted	unwanted / resented
	respected	disregarded
	appreciated / recognised	unappreciated / overlooked
	trusted	doubted

(Continued)

Category	Belongingness	Alienation
	confident	lacking in confidence / fearful
	resilient	resigned
	active / proactive / participative	passive / reactive
	assertive	submissive / acquiescent
	innovative	conforming / compliant
	enthusiastic	apathetic
	motivated	unmotivated
	questioning	accepting
	empowered	disempowered
Attributes of students	enabled	disabled
as learners	relaxed / calm	anxious/ worried / tense
	self-directed / independent	dependent
	engaged	disengaged
	productive	unproductive
	satisfied	dissatisfied
	positive self-concept	negative self-concept
	involved	uninvolved / distanced
	happy	unhappy / distressed
	efficacious / effective	inefficacious / ineffective
	capable	incapable
	settled	unsettled

The category "Nature of the practice learning milieu" lists the features of clinical environments in which belongingness and learning flourish or flounder. The descriptors in the left-hand column are those that, according to the interview participants, are conducive to the creation of an environment that facilitates belongingness and learning. In contrast, the descriptors in the right-hand column are those that result in alienation and impede learning.

The category "Nature of student–staff relationships" elucidates the qualities of interpersonal relationships that either facilitate or obstruct belongingness and learning. Similarly, the perceptions of students held by nursing staff, as listed in the category "Attitudes towards students", are those that are indicative of a mindset that views students as either having a legitimate and valued place in the clinical environment or conversely as an unwanted imposition.

Students exert a strong influence over their learning and the extent to which they are accepted, and this is reflected in the final category "Attributes of students as learners", where the individual characteristics of students are provided. The descriptors in this category reflect the reciprocal nature of the experience of belonging; that is, they indicate those attributes that are influenced by belonging as well as those that have an influence on belonging and learning. For example, a student who is self-directed, enthusiastic and confident is more likely to be accepted by nursing staff, while feeling as if they belong and are accepted is likely to provoke students' enthusiasm, confidence and independence. Similarly, a student who feels alienated may become unmotivated and disinterested, or conversely a student who is unmotivated and disinterested may be rejected by nursing staff.

8.9 Conclusion

This chapter expanded the findings from Chapters 6 and 7 in order to understand the consequences of belongingness not only for students but also for the wider nursing community. In this chapter, as in the previous two, it was my intention to allow the perspectives of the interview participants to dominate, and thus their voices were interwoven throughout the discussion. However, the participants' stories were further illuminated and informed by reference to the relevant literature, and framed by my interpretative perspective. In the following chapter, these findings are further explicated and converged with those from the quantitative data analysis, in order to permit a deeper and more comprehensive understanding of students' experiences to emerge.

Chapter 9

Discussion of Findings

9.1 Introduction

Belongingness is a phenomenon of importance to nursing students and to all those with a vested interest in their education. A comprehensive and compelling view of nursing students' experience of belongingness was achieved through the mixed-method design selected for this study. The complementary data enhanced the breadth, depth and rigour of the investigation and demonstrated the complex interplay of factors that influence students' perspectives and experiences.

This chapter interprets and discusses the quantitative and qualitative data that were presented in Chapters 5–8. Each research question is addressed in turn. Research questions 1 and 2 are informed by the findings from the quantitative and, where appropriate, qualitative data. Research questions 3 and 4 are addressed by a montage that draws the emergent themes together in a juxtaposition of the narratives of belongingness and alienation. The montage allows for a deeper understanding of students' experiences as the factors that impact upon belongingness and its consequences are re-examined. In this chapter the data drive the direction of the discussion, but it is informed by the relevant literature and framed by my interpretative perspective.

9.2 Research question 1

With respect to the clinical placement experience, to what extent do third-year nursing students from three different university sites experience belongingness?

To examine the extent to which nursing students experience belongingness, the mean belongingness (BES–CPE) scores of participants from each site were measured and compared. Statistical differences emerged, with participants from site 3 (UK) scoring significantly higher than those from either of the Australian sites. This finding was

supported by analysis of the mean scores of the Esteem and Connectedness subscales, which also demonstrated that site 3 achieved the highest score. Additionally, the survey responses indicated that, compared with sites 1 and 2, fewer students from site 3 felt like an outsider. The reasons for these findings are multifactorial.

Analysis of the quantitative data revealed that there were few widespread or significant differences between the sites. In examining the qualitative data, it also became apparent that in many respects the students from the three sites shared similar perspectives and experiences. However, in two major areas the students' experiences diverged, and these differences may help to explain why the mean BES–CPE score of site 3 is the highest of the three sites. These factors are: (1) the duration and structure of clinical placements, and (2) the consistency, structure and quality of the mentorship provided to students. These factors, how they influence students' experience of belongingness, and the way in which they differ between sites, will now be discussed.

9.2.1 Duration and structure of clinical placements

Although the survey did not investigate whether or how the structure and duration of clinical placements influenced students' experience of belongingness, the interviews with the 18 students did shed light on this issue. Their perspectives are best understood by exploring the processes of settling in and integration, which were described and analysed in Chapter 6 and are revisited here.

On starting each clinical placement, the students focused on settling in. During this initial phase they aimed to become familiar and comfortable with the staff and to learn the routines, terminology, language, values and practices specific to the ward or unit. There was general agreement between the students from the three sites that this period of adjustment took a minimum of two to four weeks, although it varied somewhat depending on the students' individual characteristics and the receptiveness of nursing staff. For most students the settling-in phase was described as one of uncertainly and anxiety; it signified a period of time where their primary motivation was establishing the fundamental interpersonal relationships that would allow them to progress from feeling like an outsider to becoming a recognised member of the nursing team. The students felt that successfully negotiating the settling-in phase made them feel as if they had a legitimate place in the clinical unit; they felt secure, supported and comfortable with the team. In essence,

students began to experience belongingness. The process of settling in was described as an inevitable precursor to each new clinical placement, irrespective of the students' level of experience. A number of students felt that frequent changes of placements resulted in large amounts of "wasted" time, as they had to renegotiate the settling-in process each time.

Once students felt settled, they were able to move forward from this comfortable position to the integration phase, during which their sense of belonging was strengthened and learning became the primary focus. In this phase students sought to consolidate both their place in the team and their knowledge and skills, and they embraced new learning opportunities with a greater degree of confidence. In placements that were of adequate duration, students were more likely to progress beyond feeling like a visitor to becoming an active, integral and participative member of the nursing team. While the students viewed active participation as essential to their learning and professional development, it often did not occur until they felt as if they belonged. In situations where placements were shorter than required for a particular student's needs, their ability to capitalise on learning opportunities was reported as limited. A sense of belonging to the nursing team was seen as crucial to a positive and productive learning experience, but it was dependent upon, among other factors, the provision of an adequate and uninterrupted length of time in the clinical unit.

The clinical placement models of each of the three sites will now be reviewed to examine the extent to which they facilitate the settling-in phase in preparation for the integration phase and ultimately belongingness.

The New South Wales Nurses and Midwives Board requires nursing students to undertake clinical placements across a wide range of facilities and clinical specialities that reflect diverse service levels (New South Wales Nurses Registration Board, 2003). This is consistent with the nature of a comprehensive curriculum. In complying with these guidelines, site 1 uses a placement model similar to that of many universities in Australia (Heath, Duncan, Lowe, Macri & Ramsay, 2002; Mallik & Aylott, 2005). Students undertake a series of four- or eight-day placements in a range of different clinical facilities during the first two-and-a-half years of their degree, followed by two extended blocks in their final semester. Students at site 1 complete a total of 832 clinical placement hours during the

three years of their undergraduate program. In analysing the qualitative data of students'
from site 1, it became evident that four- or eight-day placements negatively affected their
ability to successfully negotiate the settling-in phase. Without sufficient time to settle in,
many found it more difficult to establish effective interpersonal relationships with nursing
staff and to develop a rapport with the team. Devoid of a strong sense of belonging,
students felt that their confidence and capacity to engage in quality learning were often
impeded. Instead of moving forward from a position of strength, they often found their
placements concluding just when integration should have begun. Because of this,
opportunities for learning were not always optimised.

Site 2 provides a comprehensive curriculum in accordance with the broad guidelines of the
Queensland Nursing Council (QNC) (2005), which recommend that clinical placements be
linked to the services and facilities available in local institutional and community settings.
Clinical placement locations and duration are not mandated by the QNC. Students at site 2
attend placements for two days per week (for eight weeks of each semester) during the
first two years of their program, with extended blocks of ten and twelve weeks (of nine
days per fortnight) in their final year. Students undertake 1320 hours of clinical placements
in total. This is a model similar to the one being adopted by a small number of universities
in Australia (Turner, Davies, Beattie & Vickerstaff, 2006). From many of the students'
accounts, it was apparent that weekly exposure to clinical units, even when students
returned to the same unit each week, did not always facilitate belongingness. It seemed,
from the students interviewed, that the clinical placement model used for first- and second-
year students did not provide a consolidated and consistent period of time for the students
to settle in. Without this continuity most students felt that they had little opportunity to
establish the strong collegial relationships needed to sustain them, and that it was more
difficult to become comfortable in the clinical environment or to feel secure and at ease
with the nursing staff.

In line with the requirements of the European Union Directives 77/452/EEC and
77/453/EEC (1977a and b) and the Nursing and Midwifery Council (2002), 2300 clinical
placement hours are included in the undergraduate curriculum at site 3. This site typically
uses placements of four to twelve weeks (at five days per week), throughout the three-year
program, with half of the placement hours undertaken in the students' final year. This is a
similar model to many university programs in the UK, where extended clinical placements

are the norm (Mallik & Aylott, 2005). For most of the students in this study, this model allowed them to move well beyond the settling-in phase, provided adequate time for the establishment of quality relationships between students and nursing staff, and, as a consequence, enhanced their feelings of belonging to the team.

From the accounts of students from site 3, it seemed that a series of extended placements during the three years of the program provided multiple opportunities for them to become increasingly at ease in clinical environments, immersed in the ethos and culture of nursing, and socialised into the nursing profession through close and extended relationships with their nursing colleagues. In this way the students experienced a sense of belonging, not only in relation to a particular unit but also to the nursing profession.

It seems reasonable to suggest that the higher belongingness scores achieved by site 3 may be attributable, at least in part, to the extended clinical placements typical of that site. It is also possible that the difference in the total clinical placement hours between the sites may have contributed to the belongingness scores, although the extent to which this is true cannot be determined from the students' accounts.

Currently there is little contemporary robust evidence to support many of the practices related to clinical placements (for example, minimum clinical hours and structure of clinical placements). Most have evolved through years of experience, custom and in response to industry/professional expectations (Clare, Edwards, Brown & White, 2003; National Nursing & Nursing Education Taskforce, 2006). In the nursing literature opinions are divided about how the duration and structure of placements impacts on students' experiences. Nursing students frequently complain that they do not spend enough time in clinical areas to feel comfortable (Elliot, 2002; Mallik & Aylott, 2005). Mannix, Faga, Beale and Jackson (2006) state that much valuable time is wasted as a result of the frequency and duration of clinical placement rotations, and students' constant need to re-familiarise and re-orientate themselves to new clinical environments. Nolan (1998) asserts that while students are attempting to familiarise themselves with new settings, routines and staff, they focus on little else but needing to fit in and be accepted. There is some agreement in the literature that clinical placements of short duration in a wide variety of clinical areas impact negatively on students' feelings of belongingness (Bradby, 1990; Clare et al., 2003; Elliot, 2002; Hart & Rotem, 1994; Kleehammer, Hart & Fogel Keck, 1990; Mallik & Aylott,

2005; Nolan, 1998), although it is argued by others that it is not the clinical placement hours that matters but the quality of the experience (Battersby & Hemmings, 1991; Edmond, 2001). Kiger (1992, p. 265), although highly supportive of extended placements, suggests that long placements in clinical areas with "bad" staff, in systems that offer inadequate support mechanisms, do not provide environments that are conducive to either belonging or a quality learning experience. The students in the current study certainly acknowledged that placements in environments where staff were not welcoming or facilitative of their learning were of little benefit, irrespective of the length.

It is important to consider the potential impact of short clinical placements on the registered nurses who support students in practice, and specifically on the registered nurses' attitudes and behaviours towards nursing students. One might expect that clinicians would feel challenged by the increased demands associated with an ever changing and constantly revolving mass of transient students. There are few intrinsic rewards in working with students who move on just as they have begun to progress in knowledge and skill. Would clinicians be more likely to welcome and support students if they attended clinical placements for longer periods of time? The students' accounts, as well as anecdotal evidence, indicate that this may be the case. Previous research further endorses this line of thinking (Hart & Rotem, 1994; Levett-Jones, Fahy, Parsons & Mitchell, 2006), suggesting that this is an issue that warrants further investigation.

Although there appear to be some benefits to exposing students to fewer clinical placements and increasing their length, in Australia a number of constraints surrounding this issue have been cited. These include the competing curriculum goals, escalating costs of providing clinical supervision staff (Beadnell, 2006), the increased requirements of patient care in the health service (Heath, Duncan, Lowe & Macri, 2002), and the concurrent shortage of qualified nurses to support students in practice (Mallik & Aylott, 2005). These are very real concerns although they are not unique to the Australian context. It may well be time to consider alternative models of clinical placements that use fewer placements of longer duration. This suggestion is in line with the recommendations of the Senate Report (2002), which specifies that, while maintaining a balance between theoretical and practical training, undergraduate courses should be structured so that clinical placements are of longer duration than those available in many nursing programs at present. The results of this study add some sound elements of justification for re-

examination of the assumptions, educational philosophies, policies and practices that underpin the duration and structure of clinical placements.

The importance of a consolidated period of practice for students to settle in and to establish collegial relationships has been identified as a significant influence on their experience of belonging, and as a necessary precursor to their active and participative learning. Although most Australian universities, in line with the recommendations made in the Reid review (Reid, 1994), provide an extended clinical placement in the final semester of the degree, it seems from results of the current study that waiting until students' final year or semester is not educationally sound, nor is it likely to maximise the potential for active and purposeful clinical learning. Both in Australia, and to a lesser extent the UK, the scheduling of short clinical rotations should be reconsidered as, in the light of these findings and related literature, they may not be best practice. The arguments presented here should be of particular interest to nurse regulatory authorities as well as to academics who design undergraduate nursing programs, as the criticism surrounding students' preparedness or fitness for practice may well be linked, at least in part, to the structure and length of clinical placements in nursing programs and the impact of current models on students' clinical learning.

9.2.2 Consistency, structure and quality of mentoring

Working beside professional role models is one of the most important purposes of clinical education. However, when students have insufficient time with a designated mentor, both their sense of belonging and learning outcomes can suffer (Lloyd Jones & Akehurst, 2001). According to Henderson, Twentyman, Heel and Lloyd (2006), the strong relationships that are developed by working with consistent mentors contribute to students' perception that they are accepted and integral members of the nursing team. In comparing the impact of mentorship and other clinical supervision models in Australia, these authors concluded that consistent mentorship was the most effective in creating a supportive environment that is conducive to clinical learning. In this section, while it is acknowledged that the interpersonal attributes and attitudes of mentors influence students' experience of belongingness, it is the actual mentoring process that is discussed. It is in this area that the experiences of students from site 3 diverged from those of their counterparts at sites 1 and 2. For this reason it is proposed that this may well be partly responsible for the higher belongingness score at site 3.

Students from site 3 described their experience of mentoring as a formal and structured process where, in each placement, they were routinely provided with an experienced and qualified mentor and an associate mentor. In line with the guidelines provided by the Nursing and Midwifery Council (2004b) and the Royal College of Nursing (2002), most of the students I interviewed had worked with their mentors on a regular basis, and together they had developed learning objectives specific to the placement. These findings are supported by a study undertaken by Lathlean and Myall (2006), which also examined the clinical placement experiences of students at site 3. In that study it was determined that 76 per cent of students worked with their mentor in three or more shifts per week, and 87 per cent reported having positive experiences of mentoring. Additionally, 74 per cent of the students in that study agreed or strongly agreed that their mentors discussed their learning objectives for the placement and provided regular and constructive feedback.

Although in the current study not all of the experiences described by students from site 3 were positive, the majority did refer favourably to the way in which the mentoring process influenced their experience of belongingness and learning. From these students' accounts it was apparent that, although supportive relationships with registered nurses were appreciated irrespective of their length, the provision of an extended period of time to work with a trained mentor and build relationships based on mutual understanding and respect enhanced their sense of belonging, and allowed them to feel accepted and valued in the nursing team. Furthermore, because in most cases the mentor–student relationship was recognised by and integral to the ward or unit culture, as well as being underpinned by educational and organisational policies and processes (Nursing and Midwifery Council, 2004b; Royal College of Nursing, 2005), mentorship was rarely viewed as a burden by nursing staff. The experiences and perspectives of students from site 3 support the contention that there may be a link between the higher belongingness scores at that site and the formal and structured process of mentoring that underpins clinical placements.

In contrast to the experiences outlined above, students from sites 1 and 2 described most of their experiences of mentoring as informal and somewhat ad hoc arrangements. In many contexts the provision of consistent mentors was not a workplace priority, and often the absence of this type of support was rationalised by the constraints imposed by staffing shortages and skill mix. Students from sites 2 and 3 were often "buddied" with a different

nurse each day or for a few days at a time, a practice that is not uncommon in clinical learning environments across Australia (Brammer, in press).

The largely informal and unstructured mentorship approach that has developed in Australia may be partly attributable to the emergence and proliferation of the sessional clinical facilitation model that occurred following the transfer of nursing education to the tertiary sector. Clinical staff are sometimes of the belief that facilitators assume primary responsibility for the supervision and teaching of undergraduate students and that mentors have been relegated to a less important position (Levett-Jones et al., 2006), although, as discussed in Chapter 7, it was the registered nurses that students worked with on a day-to-day basis who had the greatest influence on their placement experiences and particularly on their sense of belonging, a finding that is supported by the literature (Clare, White, Edwards & van Loon, 2002; Hart & Rotem, 1994). However, it has been suggested that the inherent goodwill and commitment of registered nurses to support students to become competent and confident professionals appears to have been eroded over time (Mallik & Aylott, 2005).

Australia has no nationally recognised guidelines for mentors, and from the students' accounts it is evident that the process and practice of supporting students varies considerably between contexts. It is difficult to ascertain how many mentors are adequately prepared for their roles, but some studies indicate that the provision of training programs for mentors is inadequate and that they often feel ill-prepared to be a mentor (Henderson et al., 2006). Additionally, nurses who support students in practice often complain about the lack of organisational support and recognition they receive as mentors and the lack of protected time they have to spend with their mentee (Charleston & Happell, 2005; Clare et al., 2003; Levett-Jones et al., 2006; Levett-Jones & Fitzgerald, 2005).

Students from each of the sites referred to the influence of mentors on their sense of belonging, the quality of their clinical placement experience and their learning. This finding is supported by the literature on mentoring (Andrews, Brodie, Andrews, Wong & Thomas, 2005; Langridge & Hauck, 1998; Workman, 1998). Many students suggested that the quality and consistency of the student–mentor relationship determined whether they fitted into a clinical placement and felt accepted by the staff. They commented that, without the sense of collegiality and connectedness they experienced when working with a regular

mentor, they often felt as if they were on the periphery of the clinical team. Similarly, Champion et al. (1998) found that consistent quality mentorship was rated as one of the most significant contributing factors to graduates' experience of fitting in or remaining an outsider. The need for physical and emotional support by mentors is essential to successful placements (Brown, Herd & Humphries, 2005). Sibson (2003) also emphasised that regular and protected contact time between students and mentors is vital for relationships and connections to be forged. This type of support helps students to feel less alone and anxious when entering the clinical environment and their opportunities for learning escalate when they are able to develop supportive relationships with their mentors over an extended period of time.

In a study by Watson (1999), it was determined that when a consistent mentor was not provided students felt that there was a lack of structure to their learning and expressed concerns about being a burden and "just hanging around", without purpose or direction. Brown, Herd and Humphries (2005) observed that students often felt passive about their own learning outcomes when there was not a specific person to oversee and support them in the clinical practice setting. Gillespie (2002) concurred, suggesting that students with a positive connection to their mentor tend to maximise their clinical placement learning opportunities. Conversely, this author also found that when students felt disconnected from a mentor and unsupported in their learning, they felt a lack of autonomy, fear, diminished confidence and inability to achieve learning objectives.

Mentors give students entrée to clinical environments that are sometimes perceived as unfriendly and unwelcoming (FitzGerald et al., 2001; Pigott, 2001; Smith & Camooso-Markus, 2002), and help students find their way in the unfamiliar territory of clinical environments. It was evident from the students' accounts that an ad hoc system of pairing up students each day with different registered nurses who are often unprepared for the role is not effective, nor does it influence students' experience of belongingness as much as more consistent and formal mentoring processes and structures, such as those described by students from site 3. The provision of consistent mentors who are adequately prepared for their role depends to a large extent on organisational structures that are supportive of and committed to the mentoring process. Recommendation 20 of the Senate Report (2002) echoed these findings and proposed that formal mentoring programs should be developed nationally, with improved training and the payment of allowances for nurses

chosen to become mentors. While mentoring is recognised for its important contribution to students' clinical learning experiences, this study has found that it is also pivotal to students' experience of belongingness. What is equally apparent is that, unless underpinned with organisational and managerial support, the benefits from mentoring are difficult to achieve.

9.2.3 Partnerships

The length and structure of clinical placements, and the consistency and structure of the mentoring process, are dependent upon and operate within the organisational and contractual relationships that exist between higher education providers and heathcare agencies. The impact of these contractual relationships, specific to the two countries and the three study sites, on students' experience of belongingness is difficult to ascertain, although these factors do need to be taken into account. Additionally, any attempt to specify the impact of the different partnership models, health systems, educational programs and health service models operating in the UK and Australia, in light of the parameters of this study, would be conjecture, although these influences must also be taken into consideration when reflecting on the conclusions arising from the study.

9.3 Research question 2

With respect to the clinical placement experience, which of the following demographic variables influence nursing students' experience of belongingness?

- *Nursing experience apart from that included in students' current nursing program*
- *Family members with nursing experience*
- *Gender*
- *Age*
- *Country of birth*
- *English as a first language*

These variables are now examined and, where appropriate, qualitative data are integrated into the discussion:

9.3.1 Hypothesis 1

Many students begin their nursing program having had previous work experience in nursing, often as enrolled nurses, assistants in nursing or healthcare assistants; a large

number also work in these roles while undertaking their studies. The majority of participants in the main study, or 60.2 per cent, had previously or currently worked in the field of nursing (n = 198). In the past, the majority of these students were employed in the aged care sector; increasing staffing shortages in the acute care sector has meant that students are being employed in a range of facilities. Hypothesis 1 posited that there is a positive relationship between belongingness and nursing experience apart from that included in students' current nursing program. This hypothesis was not supported; no statistically significant difference in the mean BES–CPE scores was identified between participants who had nursing experience and those without experience. The qualitative findings further elucidate this issue.

During the interviews a range of different perspectives regarding the influence of nursing experience on belongingness were revealed. While the majority of students felt that their previous nursing experience had minimal impact on their sense of belonging (refer to Chapter 7), some felt that their experience did add to their repertoire of skills and enhanced their confidence when in healthcare environments. These students often said that they felt accepted by the nursing staff, not in their capacity as a student but because they were "an extra pair of hands" requiring little supervision or support. Even though this meant that their learning became of secondary importance, some students were willing to forgo their supernumerary status and use the skills gained from their previous nursing employment to win the approval of their nursing colleagues.

Many students expressed the belief that their nursing experience had little impact upon the attitudes and behaviours of unreceptive and unwelcoming registered nurses; neither did it help students reconcile the values dissonance experienced when their values did not articulate with those of the registered nurses in some clinical environments. However, for some students, previous nursing experiences did temper negative and distressing clinical placements to a degree, as it gave them an alternative point of reference and a different perspective.

In the literature there are mixed opinions about the benefits of student employment. Some authors, for example Clare et al. (2003), propose that the employment of students in nursing positions while they are studying is beneficial both to the students and to the health service provider. Jowett, Walton and Payne (1994) suggest that students who have

been previously employed as healthcare assistants can more easily identify their learning needs but often revert back to their previous role when the clinical environment is busy. Concern has been voiced that the poor nursing practices that students are exposed to while working in some environments may be adopted by students as the norm (Clare et al., 2003). Greenwood (1993) adds that students can become desensitised to human needs after repeated exposure to poor nursing practices in clinical environments. These concerns are valid, yet not well substantiated in the literature. In the current study there was no indication that students' previous or current nursing experience made them more or less likely to adopt poor nursing practices. It seemed from the students' accounts that their willingness to comply with or excuse poor practice was more closely related to their degree of belongingness in a particular environment than to their previous work experiences. That is, those students who were sure of their place in the team and comfortable with the staff were more empowered to speak up and question poor practice than those who felt alienated or isolated.

9.3.2 Hypothesis 2

Hypothesis 2 proffered that there is a positive relationship between belongingness and family members with nursing experience. This hypothesis was not supported; no statistically significant difference in the mean BES–CPE scores was identified between participants who had an immediate family member with nursing experience and those who did not.

From the students' accounts it was apparent that the influence of family members with nursing experience was unpredictable. Some students claimed that they were afforded the opportunity to gain an insider perspective because of the understandings generated though a close and extended relationship with a family member with nursing experience, and that this impacted positively on their socialisation to the nursing profession and their ability to develop effective relationships with the nursing staff. However, this belief was not common to all students.

The influence of family members gave some students insight into the culture, history and language of nursing, and was a pivotal influence on their identification with the nursing profession as a whole. However, this insight and understanding did not alleviate, and may in fact have worsened, the distress experienced in clinical environments that did not

coincide with their preconceived images of nursing. The alienation that students felt in clinical environments where they believed the practice standards to be poor was often exacerbated because of their image of what nursing "should be" and the mindset developed as a result of their interactions with close family members.

9.3.3 Hypothesis 3

Hypothesis 3 proposed that there is no relationship between belongingness and gender. This hypothesis was supported; no statistically significant difference in the mean BES–CPE scores was identified between participants of different gender. The literature discussing belongingness and gender is inconclusive. While a body of literature suggests that there are important differences in psychological development, communication and interpersonal relationships between men and women (Jordan, Kaplan, Miller, Stiver & Surrey, 1991), other researchers (Hagerty, Williams, Coyne & Early, 1996) found no significant gender differences when examining sense of belonging. In undertaking research to develop and psychometrically test the Belongingness Scale, Somers (1999) did identify a difference between the mean belongingness scores for women and men. In her study women scored significantly higher than men in the family and friends subscales, but not in the work/school subscale.

Nursing is a predominantly female occupation. In this study 9.6 per cent of the participants were men (n = 34). Although the number of men in the nursing profession is increasing, they remain an under-represented minority (approximately 6 per cent) (Stevenson, 2003). It has been suggested that between 40 and 50 per cent of male students who enter nursing courses either withdraw, transfer to other courses or fail (Wilson, 2005). While the reasons behind this are obviously multifactorial and not necessarily gender-specific, additional challenges for male nursing students may contribute to attrition rates. Stott (in press) suggests that male nursing students sometimes feel isolated or excluded from clinical settings and that this experience makes them reluctant to actively participate in learning opportunities. This author further asserts that feeling excluded influences some male students to reconsider their choice of study program. The current study has added to the literature on gender and belongingness by identifying that there are no significant differences in belongingness scores between male and female nursing students.

9.3.4 Hypothesis 4

Hypothesis 4 proffered that there is no relationship between belongingness and age. This hypothesis was not supported; a relationship was identified between belongingness and age, although the results are somewhat ambiguous. A higher BES–CPE score was evident in the 19–22 age group than in either the 26–30 or 41–50 age groups. However, these differences appeared to have no apparent pattern or discernible cause, and the same results were not evident at each site. Therefore, these results should be interpreted with a degree of caution.

Consistent with global and multidisciplinary trends, enrolments of older students in nursing programs have increased over the last decade, while enrolments of school leavers have simultaneously declined. This is particularly true in Australia and the UK (Jeffreys, 2004). While it is acknowledged that grouping according to age fails to take into consideration that neither school leavers nor mature age students are homogeneous groups, it does provide a useful basis for comparison and sheds some light upon factors that may or may not influence students' experience of belongingness.

9.3.5 Hypothesis 5

The nursing professions in Australia and the UK are not reflective of the cultural diversity of those societies. Similarly, minority groups are under-represented in nursing education and incur higher attrition rates (Jeffreys, 2004). In this study a wide range of countries, apart from Australia and the UK, were represented by 11.9 per cent ($n = 41$) of the participants. Hypothesis 5 proposed that there is no relationship between belongingness and country of birth. This hypothesis was supported, as no statistically significant difference was identified in the mean BES–CPE scores of participants from different countries.

North American studies related to ethnicity and belonging have had varying results. In examining sense of belonging, Hagerty et al. (1996) identified no significant differences between Caucasian, African American, Hispanic, Native American, Asian and other ethnic groups. Conversely, in Somers' (1999) study of belongingness, it was identified that Caucasians scored significantly higher on the BES than African Americans in relation to friends, and higher than Asians and Hispanics in relation to neighbours. In that study no

significant difference in BES scores was identified for any of the ethnic subgroups in the work/school or community environments.

Baumeister and Leary (1995) contend that belongingness is universal in the sense of applying to all people of all cultures. While this may be true, it is possible that barriers to nursing students experiencing belongingness when on clinical placements may include stereotyping, prejudice, discrimination and racism related to ethnicity. It should be noted that in this study, although no direct relationship was identified between belongingness and country of birth, the effect of English as a first language (as discussed in Section 9.4.6) was less certain. Indeed, this factor may be a stronger influence on nursing students' experience of belongingness than country of birth.

9.3.6 Hypothesis 6

Global trends in immigration have resulted in increased numbers of students whose first language is not English (Devlin, 1996). International students admitted to the nursing programs at sites 1, 2 and 3 are required to have English language skills of at least International English Language Testing Service (IELTS) 6.5 level. While language is only one of the multidimensional factors that impact upon the belongingness experiences of immigrant, refugee or international students, it nevertheless acts as a useful unit of analysis.

For 8.14 per cent of the participants in this study, English was not their first language ($n = 29$); the majority ($n = 24$) of these students were located at site 1. Hypothesis 6 proposed that there is no relationship between belongingness and English as a first language. This hypothesis was supported at site 1; however, as the p value did approach a level of statistical significance, these results should be carefully considered.

It should be noted that the mean scores for item 10 of the BES–CPE, "I feel discriminated against on placements", was significantly lower for the group of participants for whom English was not their first language, indicating that they were more likely to feel discriminated against by the staff they worked with on clinical placements and that this discrimination may have had a negative impact on their experience of belonging.

In a study undertaken by Shakya and Horsfall (2000) that explored the experiences of international undergraduate nursing students for whom English was a second language, the strongest finding was that most of the participants experienced difficulties with various aspects of language. In particular, the participants reported problems with speaking and listening in clinical contexts. They reported negative reactions from both staff and patients, and described how this reduced their confidence and feelings of self-worth and made them feel isolated. Menon (1992, p. 330) observed that, when conversing with international students, "Australian nurses rarely listened for longer than 10 minutes to someone whose pronunciation was difficult to understand. They became restless, they changed the subject or they interrupted so that they could speak instead". International students also express difficulty in listening. Local accents, shortened fast speech and the use of colloquialisms and complex technical language can cause difficulties for students for whom English is not their first language (Chiang, van der Riet, Levett-Jones, King & Hazelton, 2005; Levett-Jones & Bourgeois, 2007). Having to ask people to repeat their words by frequently using apologetic phrases such as "I beg your pardon", "Pardon me" and "Sorry" made the participants in Shakya and Horsfall's (2000) study feel embarrassed and frustrated. Similarly, in a study by Dijkhuizen (1995), some students pretended they understood, rather than feel humiliated by admitting that they didn't. These studies add another layer to the somewhat tentative conclusions made in regard to Hypothesis 6.

This section concludes by quoting Abby's words, as they are illustrative of her experience as a student for whom English is not a first language. Abby's words encapsulate the communication difficulties that she experienced when undertaking clinical placements in a predominantly white, English-speaking community, as she tried to deal with entrenched and stereotypical attitudes and, on occasion, overt racism from both staff and patients:

> *When something was explained to the students on that ward, if I didn't pick up on a few words and asked, "What was that again?" the RN would say to another student, "Er, you explain to her", and just walked off. It was so discouraging. Afterwards I didn't ask too many questions and I was really self-conscious not to make grammatical mistakes when I spoke. It was really distressing and I thought, "You don't speak my language, why do you expect me to speak your language perfectly?"…Even some patients automatically think that you don't speak English very well. They think you won't be able to help them, you won't be able to talk to them, you won't be able to understand them…So they avoid Asian students. They say, "I want an Australian student to help me, I want an Australian".* (13: 433–439, 441–445, 448–449)

9.4 A montage of belongingness and alienation

Stories define:

Who we are.

Where we have come from.

Where we are going . . . and

What we care about.

Stories give life!

Dana Winslow Atchley III, artist, storyteller and musician, 1941–2000

A series of narratives in the form of a montage is presented in this section as a means of addressing the third and fourth research questions:

Research question 3

With respect to the clinical placement experience, what factors impact on nursing students' experience of belongingness?

Research question 4

With respect to the clinical placement experience, what are the consequences of nursing students' experience of belongingness?

A montage combines several contrasting textual images to make a composite picture. A succession of images revolving around a central focal point are used to illustrate the themes. A montage creates the sense that images and understandings are blending together, overlapping and forming a new creation. The images shape and define one another, and an emotional gestalt effect is produced (Denzin & Lincoln, 2000, p. 4). In montage, different voices, perspectives and points of view are presented. The researcher who uses montage brings slices of reality together, creating psychological and emotional unity to an interpretive experience. These are dialogical texts. They presume an active reader and create spaces for give and take between researcher and reader. A montage invites the reader to construct interpretations that build on one another as the stories unfold (Denzin & Lincoln, 2000, p. 5).

The montage depicted in this chapter integrates the themes from the qualitative data analysis into coherent and meaningful narratives that focus on the broad contours of

participants' stories in contrast to the somewhat fractured and decontextualised segments of text derived from the content analysis. The narratives are used to form a montage concerned with description, meaning, understanding and interpretation. The montage provides a framework that captures the phenomenon of belongingness and its antithesis, alienation, in a way that may be only partially conveyed by other interpretive methods. There is a juxtaposition of the narratives of alienation and belongingness; like a silhouette, the darkness and shadows created by the images of alienation provide a contrast to the illumination cast by the images of belongingness (Levett-Jones, Lathlean, McMillan & Higgins, 2007). Each provides greater clarity and insight into the meaning of the other.

Narratives provide the building blocks of the montage. Narratives are stories that relate the unfolding of events, human action and feelings from the perspective of an individual's lived experience (Muller, 1999, p. 221). Although stories vary in form, they are ubiquitous, and storytelling, or narration, is one of the oldest and most significant of human activities (Rubenstein, 1995). It is in the telling and hearing of stories that people disclose and make sense of their own experience, as well as that of others (Churchill & Churchill, 1982). Narratives compel the reader to "brood" upon or "dwell with" the story (Broyard, 1992). When using narratives as a research product, the researcher seeks the meaning an individual gives to life events thorough the story being told and then re-presents that story in a way that is meaningful and memorable to a larger audience (Muller, 1999). Narratives portray context-bound, constructed social realities. A story reflects an individual's experience as they see it and wish to present it to others (Becker, 1997). Narratives do not attempt to represent objective reality; rather, a narrative gives a rich understanding of an individual's sense of his or her own reality.

Narratives are frequently "produced" in conversation, but they are not simply "told" by the teller (research participant) to the listener (researcher). They take shape in the interactions between the teller and the listener (Reissman, 1993). In the interviews conducted for the purpose of this study the stories were co-creations. I was an active participant in the story-making process through the questions I asked and the prompts I used. In turn, the interview participants responded to these, and the answers they gave continually informed the evolving conversations.

Coherent narratives were derived by condensing sections of the transcripts. Pieces of conversation not relevant to the particular theme or themes being discussed were omitted. During the interviews participants were sometimes sidetracked and these words, which detracted from the key ideas of each story, were also deleted. Sections from the text were grouped and organised either chronologically or into a logical order. The aim was to keep intact the content and context of each story, its sequential features, and the meaning and consequences of events for the individuals concerned. A palate of six narratives has been selected for this montage. These particular narratives were selected for a number of reasons:

- They exemplify different dimensions of the belongingness and alienation experience.
- They re-present and integrate recurring themes drawn from the content analysis.[1]
- They are reflective of the shared perceptions, experiences and insights of students from the three sites.

Additionally, each of the following narratives encapsulates the features of a narrative as defined by Frank (2005):

- Plot and characters of significance to the emergent themes
- The evaluative perspective and moral reasoning of the narrator
- The relationships between people and their experiences
- Animation—that is, they allow the reader to be "caught up in" and "moved by" the story
- Relevance and resonance—that is, the inherent themes in the story are generally recognisable; and the story and its dominant themes can be transferred to another context.

9.4.1 Leanne's story: "I don't want her, I don't want her"

In this evocative account, Leanne shares her recollections of her first clinical placement experience and her feelings when confronted with nursing staff that were overtly reluctant to support students in achieving their learning goals. Leanne speaks of the sense of alienation she experienced as a result of the unfriendliness and resentment demonstrated by nursing staff, and indicates how this impacted negatively on her emotional wellbeing, her self-concept and her commitment to nursing:

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[1] Appendix 17 presents a table that lists the themes encapsulated within each narrative.

You'd sit there in handover, and the manager of the ward wouldn't allocate you to a registered nurse, so you'd say, "Who's taking me today?". And they'd sit there for 10 minutes arguing and saying, "I don't want her, I don't want her, I don't want her"—it was really awful. They didn't want us there and they made it really plain that they just had no interest in students. They'd say, "I don't have time for students", "I'm too busy for students", "Students are just a pain"…and in front of us, too, so it wasn't even diplomatically done. I can sort of understand that students are hard work, they take time; they take energy; you're busy already, but you know—we've got to learn somehow. And I really didn't learn in that environment. Because I felt so unwelcome there I didn't feel comfortable. I felt like if I asked any questions I would just get told to go away, 'cause I was just a stupid student.

We were often going home crying—but the manager of the ward didn't take charge of the situation or try to make it better for us. Each day when I went home, and I thought about going back the next day I just didn't want to. I didn't want to be there. I really questioned whether I wanted to keep going with nursing. I certainly didn't feel like nursing was a good thing in that particular place. And even now I wouldn't want to work in that hospital. And that's almost three years on.

The type of reception that students received when they began a new clinical placement either contributed to their experience of belongingness or resulted in varying degrees of alienation. This is in accord with Dean's (1961) assertion that alienation is not a personality trait but a situation-relevant variable. Staff who were welcoming and receptive of students and ensured that their student role was legitimised enhanced their feelings of being valued and accepted. As a result, students approached the placement with anticipation and enthusiasm. However, in the above narrative the opposite is true. Leanne felt like an unwanted intruder and approached each day with feelings of dread. Her story exemplifies some of the dimensions of alienation, such as feeling uneasy, uncomfortable and distressed as a result of the staff's rejection and overt exclusion, and feeling separated from the group. Her sense of alienation also led to feelings of resignation and powerlessness, described by Dean (1961) as a lack of control over events and feeling helpless to be able to influence or change those events. As outlined in Chapter 7, and as evident in this narrative, this type of passive resignation usually occurred in response to exclusion by a group of nurses, rather than to a one-off negative interaction with an individual staff member.

Healthcare contexts present dynamic and complex situations where students are often enmeshed in a complex web of competing priorities. The current climate of nursing

workforce shortages in Australia and the UK has led to increased workloads and stress for nursing staff (Mitchell, 2003). The presence of students, with their need for teaching and support, is reported to increase this stressful burden (Edmond, 2001). While these complex and multidimensional issues are often cited to explain the reluctance of nursing staff to support students in practice, it appears from Leanne's account that the staff's negative attitude also stemmed from the prevailing ward culture and their professional orientation. It is evident that some nurses do not recognise or accept their professional responsibility for supporting and guiding a new generation of nurses. However, the attitudes of nursing staff are not always determined by the complex and busy nature of contemporary practice. Many nurses are welcoming and accepting of students despite the pressures they face (Beadnell, 2006), and this was evident in many of the students' accounts.

In a study by Hajda (1961), it was determined that alienation is contextually mediated and connected to perceived levels of peer support. For Leanne, as for many of the participants in this study, the sense of alienation she experienced in this environment as a result of the lack of support and acceptance from the staff led to emotional distress, a lack of motivation and a lack of purpose and direction. The experiences she described can also have negative consequences in terms of attrition and recruitment; for example, she states, "I really questioned whether I wanted to keep going with nursing" and "I wouldn't want to work in that hospital".

Hajda (1961) suggests that alienation may be influenced by the individual's self-concept and their perception of how they are viewed by others. This placement had a negative impact on Leanne's self-concept and this exacerbated her feelings of alienation. The words "just a stupid student" and "students are a pain" are indicative of how she internalised the attitudes and opinions of the registered nurses she worked with, and of her distress and feelings of worthlessness.

It is evident from Leanne's story that the nursing staff did not see her as an asset but openly resented her intrusion and freely verbalised their hostility. Griffin (2004) labels the types of behaviour described by Leanne as bullying or horizontal violence, and suggests that this includes any of the following behaviours: verbal affront (such as snide remarks or abrupt responses); nonverbal innuendo (raising of eyebrows, rolling of eyes or pulling

faces); and activities designed to undermine students (being unavailable or exclusion). Conflict and bullying of beginning nurses in the workplace is a recurring problem, with up to 25 per cent reporting negative experiences and a lack of support from clinicians (Clare, White, Edwards & van Loon, 2002). Students have been identified as a group that is especially vulnerable to horizontal violence during their clinical placement experiences, for horizontal violence prevents students from feeling as if they are accepted or fit in (Levett-Jones & Bourgeois, 2007).

In this narrative Leanne also tells how the horizontal violence directed towards her by the registered nurses affected her confidence and willingness to ask questions. Nurses are the gatekeepers and guides to students' learning (Dunn & Hansford, 1997). It is apparent from the students in this study that some nursing staff considered their learning needs to be an intolerable burden and as a result they displayed resistance or indifference. Leanne reveals this by saying, "I felt like if I asked any questions I would just get told to go away". There is an element of quiet desperation in her words, "We've got to learn somehow". Students are all too aware that their opportunity for clinical learning is, to a large degree, dependent upon whether nursing staff are receptive of them. Without the support of nursing staff students such as Leanne know that their clinical learning is often impeded.

A number of studies from the 1980s explored the role of the ward manager in establishing the culture of the clinical learning milieu (Fretwell, 1983; Melia, 1987). Since that time the role of the ward manager has expanded from being predominantly clinical to increasingly managerial. Despite these changing role expectations there is evidence in the literature that ward managers remain key players in creating positive learning environments (Dunn & Hansford, 1997). However, Leanne's account demonstrates that managers do not always assume an active role in supporting students, who at times are left to struggle alone in unfamiliar surroundings. Clinical managers who are accepting and inclusive facilitate students' experience of belonging and their perception of being valued and respected as members of the nursing team (Dunn & Hansford, 1997). In Leanne's story, however, the manager's lack of involvement had the opposite effect, as indicated by Leanne's words: "We were often going home crying…but the manager of the ward didn't take charge of the situation or try to make it better for us". Despite this, Leanne excuses and justifies the nurses' and the manager's behaviour, stating, "I can sort of understand that students are hard work. They take time; they take energy; you're busy already". This extenuation

appeared to be a way of attempting to make sense of or offset the alienation she felt in this hostile environment.

In this narrative Leanne describes her feelings of alienation and isolation brought about by the indifference of the manager and the nursing staff and their resistance to her needs for learning and support. Her distress, disillusionment and powerlessness in this situation caused her to reconsider her decision to become a nurse and had a negative impact on her motivation and capacity to learn.

9.4.2 Laura's story: "They inspired me to start looking at mental health as a career option, just for the way they were, they were happy"

Laura's story contrasts markedly to Leanne's account. In this narrative Laura clearly describes her placement in mental health as one that enhanced her sense of belonging and as a consequence influenced her motivation for learning and her future career decisions:

> *In my second year I did mental health with the assessment team. That was good, going into the hospital emergency and seeing how clients were assessed. There was one time that one of the psychiatrists had to leave, and he let me ask the patient questions. When he got back he let me continue on, because he liked some of the answers the client was giving me. I got to learn a lot from that team. And they were really helpful and fantastic people to work with—supportive, encouraging, giving you access to all their resources, and explaining things to you. The mental health team were there constantly and they were great. They inspired me to start looking at mental health as a career option, just for the way they were— they were happy.*

> *They really included me. The clinical nurse consultant for mental health took me to a couple of meetings. They encouraged me to ask questions, to be involved in it. They didn't put you down, didn't make you feel you weren't wanted there, didn't demean you because you were nothing but a student. The staff were interested in getting across that mental health is good. It's not like the old stereotype. It's not the institutions any more. They always took care of me, made sure I was put first if there was a problem. I just loved it.*

Through Laura's detailed description it becomes apparent that this placement was one that facilitated her experience of belongingness by enhancing both her sense of connectedness and esteem. In this environment she felt like an integral part of the team and as if she had a legitimate role. The inclusion and acceptance of her by the nursing staff, as well as the way they cared for and valued her, support this assumption. Laura's

concluding statement, "I just loved it", bears testimony to the significance of this placement; until this phase of the interview she had been reserved and quite unmoved. Indeed, Laura spoke of no other clinical placement experience with the same degree of passion. Her description of the mental health placement as one where, "They didn't put you down, didn't make you feel you weren't wanted there, didn't demean you because you were nothing but a student" is poignant, and the language Laura uses also leads us to consider her frame of reference, her self-concept, and the underlying assumptions and experiences that coloured her preconceptions.

This story shows how positive interpersonal relationships between staff and students are fundamental to a clinical placement that facilitates belongingness. When the psychiatrist recognised and appreciated Laura's interview skills, it boosted her confidence, as revealed by her statement, "When he got back he let me continue on, because he liked some of the answers the client was giving me". The inclusive, supportive and encouraging nature of the nurses' relationships with Laura influenced not only to her emotional wellbeing, but also her future employment decisions. Brodie (2005) suggests that feeling valued, recognised and appreciated is a major factor underpinning students' career decisions. Laura's declaration, "They inspired me to start looking at mental health as a career option, just for the way they were—they were happy", supports this contention. While exploring how connectedness impacts staff morale and sense of belonging, Manion (2003) notes that a workplace where staff enjoy their work will be one that is likely to retain and attract staff. This is particularly relevant to the Australian mental health context, as the introduction of a comprehensive curriculum has had a negative impact on recruitment to this field of nursing (Clinton & Hazelton, 2000; Happell, 1999). Recruitment deficits have also been associated with negative placement experiences in mental health (Clinton & Hazelton, 2000; Hayman-White, 2004; Stevens & Dulhunty, 1997). Furthermore, the anxiety and fear that is sometimes associated with mental health placements can affect recruitment (Charleston & Happell, 2005; Hayman-White, 2004). Laura's description of how the staff in her mental health placement created an environment in which she felt safe and secure provides further insight into how recruitment may be positively influenced by a supportive placement experience: "They always took care of me, made sure I was put first if there was a problem".

Clinical placements are specifically designed to provide optimal experiential learning opportunities. By providing opportunities for active participation (such as the client interview), as well as "access to resources", "explaining things", "encouraging questions" and "involving" Laura, the staff created an environment conducive to learning, as seen in her statement: "I got to learn a lot from that team". In addition, because Laura felt safe and secure in the clinical environment, she was better able to learn, because the anxiety that can impede learning (Meisenhelder, 1987; Timmins & Kaliszer, 2002) was reduced, if not completely dissipated. When students are secure in the knowledge that the nursing staff they work with are committed to and supportive of their professional development they are able to focus on learning rather than being preoccupied with trying to fit in (Nolan, 1998). Laura's perception of being involved, accepted, cared for, valued and respected by her nursing colleagues enhanced her experience of belonging and resulted in a positive and productive clinical placement experience; it influenced her career decisions, as well as her capacity and motivation for learning.

9.4.3 Sarah's story: "My aged care placement…was just a nightmare"

Sarah has a pragmatic view of nursing with realistic but high expectations of the quality of care that should be provided to patients. In this story she describes a clinical placement where perceived poor practice standards challenged her personal and professional values and resulted in her feeling alienated and distressed:

> *There are some places where you'd never want to belong—where the care is so bad that you have to distance yourself emotionally just to survive. My aged care placement was like that—it was just a nightmare. I'm very pedantic about the care I give my patients. I must admit, my aged care experience prior to this placement had been state of the art. I mean my first aged care experience was in my mother's aged care facility where the secure dementia unit is less than three years old. It's sensored, it's secure, it doesn't smell. My mother is very pedantic about making sure things are kept thoroughly clean and cleaned properly. And I've walked into this aged care facility where I was to do a two-week placement and the smell of urine made my eyes water for the first half hour I was there— where you were being told that you couldn't change an incontinence pad because they didn't have enough of them; where patients had foot drop by sheer fact that nobody was bothering to prop their feet properly; where somebody told us this resident was getting extra care because she was bed bound, and yet when we bathed her we found thrush in her tightly closed hands, and thrush in the groin…and thrush in her mouth as well—that was really horrible and hard for me. It only took one day for me to just go, "Nooo". I walked in the*

second day and burst into tears. I couldn't deal with it, 'cause I knew what it was going to be like. I knew some nursing homes were bad but it had never gelled quite how bad some of them could be.

I think it's disgusting how we treat our elderly people—reducing 80 years of life to a wardrobe and a chest of drawers in a four-bed room—it's disgusting. On top of which you don't have enough staff, you don't have enough money, you don't have enough care given. And it's not necessarily the nursing home's fault, although some of them do it better than others.

I was lucky, I suppose—the facilitator I was with knew that I was having trouble, so if I disappeared for any length of time she'd come looking for me, and she'd bring me back. She knew I just needed five minutes to take a few deep breaths before I could come back to it. For me to be in that environment, where I didn't belong and I didn't want to belong, it was really just a countdown time for me— it was a matter of, "I have to do this, I have to get through it, I just have to survive". It was really awful.

In this narrative Sarah recounts a story where the converse of belongingness—that is, alienation—is enacted. She tells how her personal and professional values did not fit with those she observed in the clinical environment, and explains how she distanced herself, both physically and emotionally, in order to "survive". Hajda (1961, pp. 758–759) proposes that alienation is related to the extent to which one's values and beliefs are in accord with those of the particular group with which one is associated. Hagerty et al. (1993) add to this by suggesting that a person's experience of fit or congruence depends upon shared or complementary characteristics and values. Sarah's words, "I'm very pedantic about the care I give my patients" demonstrates her perception that she did not fit in because her professional values and commitment to patient-centred care seemed out of place in this environment. Sarah's previous work experience ("my aged care experience prior to this placement had been state of the art"), along with her mother's influence ("my mother is very pedantic about making sure things are kept thoroughly clean and cleaned properly"), made her feelings of alienation and distress worse, because she recognised the contradiction between the values she had developed though her previous life experiences and those she believed were evident in this environment. Even so, Sarah attempts to rationalise or excuse the situation by stating, "It's not necessarily the nursing home's fault".

In accord with Brodie et al.'s (2005) assertion that environments with perceived poor standards of care have a negative impact on students' placement experiences, the

students in this study described their distress when their personal and professional values were challenged by the poor practices they witnessed. Feeling distressed, disempowered and unable to effectively alter the poor standards of care she observed, Sarah chose instead to alienate herself. However, her experience of alienation was not one of passive acceptance; instead it was a deliberate choice. Her statement, "There are some places where you'd never want to belong…where the care is so bad that you have to distance yourself just to survive", reveals how strongly this negative experience affected her. Her description of her physical departure from the unit for "five minute" breaks seems to be a metaphor for how she psychologically and emotionally disengaged "to survive".

As discussed in Chapter 6, students frequently called on their facilitators to reconcile the dichotomy between what they believed to be appropriate professional behaviour and what they sometimes observed in contemporary practice. Sarah told how her facilitator supported her: "The facilitator I was with knew that I was having trouble, so if I disappeared for any length of time she'd come looking for me". As evidenced in this narrative, while facilitators may be important in helping students to become reconciled to these types of challenging situations and remain committed to the nursing profession, they are often powerless to make a difference to prevailing ward cultures or practice standards.

It is reasonable to suggest that environments with poor practice standards may well lead students to feel alienated as a result of a dissonance between their personal and professional values and those observed in such an environment. Sarah's experience is representative of that of many students in this study. Placements with perceived poor practice standards were endured rather than enjoyed, and students said they resigned themselves to "waiting it out" or "counting the days" until their placement was finished. Students established few collegial relationships in these environments, preferring instead to keep to themselves. Many said they struggled each morning to return to the placement, and almost invariably these were environments that students never wanted to return to in a student capacity or as an employee. Sarah's experience exemplifies some of the possible consequences of alienation, such as emotional and psychological distress, disengagement, dissatisfaction, disempowerment and surviving rather than thriving in the clinical environment.

9.4.4 Ann's story: "If you get a good mentor, you know you're set. That connection is the key"

In this story Ann describes how consistent, quality mentorship helped her to feel connected and to fit into the clinical environment. She recalls how her developing relationship with her mentor promoted her learning, enhanced her confidence and challenged her thinking:

If you get a good mentor, you know you're set. That connection is the key to fitting into the ward and one person can make all the difference. On my last placement I was with the same mentor for almost two weeks. That made a huge difference. She knew where I was at—she knew what I wanted to get out of the placement 'cause we'd already discussed it— so we didn't need to talk about it again. I was really pro-active, 'cause I had a lot that I wanted to get out of the two weeks, and I knew I was going to be pushing time. So I was very clear about sitting down with her and showing her my objectives very early on. She also knew where my skills were at after the first couple of days of watching me and helping me, she knew what level I was at. That makes such a big difference to what happened in that two weeks. Because she wasn't assessing me every day. When you've got a different RN every day—they assess you for the first half of it before they'll let you have that little bit more leeway, or encourage you to take a few more steps towards developing skills and things. By the end of the first week my mentor knew exactly what I could and couldn't do competently, and how much she could push me. She knew what she had to educate me on, and what she didn't have to educate me on. It really felt great because when you have to re-go through that every day you don't feel like you're getting anywhere. You feel like you're repeating the same stuff all the time. I felt like she was enabling me to really consolidate all the skills I already had and extend them. I felt like I had the power to turn around and say, "I know how to do that. Do you mind if I go and have a look at that because I haven't done that before, or I haven't seen that before".

I felt confident in that placement because we'd had that time of getting to know each other. She'd asked me what experience I had and I knew where she'd come from. Not just work stuff, but I knew that she had family, I knew that she'd been nursing for x number of years. I knew exactly where she'd come from in a lot of respects, because we'd chatted as we'd worked, and gotten to know each other quite well. We both knew each other's general attitudes to the work we were doing. We didn't always have similar attitudes but we could see each other's points of view because we'd been able to chat around it, and I think, in a lot of ways we had a very similar outlook. Just because we don't necessarily agree with everything that somebody else tells us doesn't mean that it's not valid either. So we both

had that sort of point of view where we're quite open to other people's opinions—without necessarily having to agree with them.

A mentor can be pivotal to students' success and in Ann's words "one person can make all the difference". In this story Ann affirmed the importance of mentorship to belonging, suggesting that the quality and consistency of the student–mentor relationship determined whether she fitted into the clinical environment. She states, "That connection [between herself and her mentor] is the key to fitting in". In a study by Gillespie (2002), the factors that contributed to students feelings of being connected were explored. In that study students said that "getting along" with their mentor and working together in a position of relative equality was essential to feeling connected. Conversely, students in that study felt that being disconnected from their mentor resulted in a lack of autonomy, fear, lack of confidence and an inability to achieve learning objectives.

Hagerty et al. (1993) assert that closely related to belongingness is the concept of mutuality—that is, the experience of shared visions, goals, characteristics or values, including shared acceptance of differences. While for Sarah (above) a dichotomy between her values and those of the staff she worked with led her to feel alienated, Ann experienced belongingness because of the understanding that developed between her and her mentor. Ann explains it thus: "We didn't always have similar attitudes but we could see each other's points of view because we'd been able to chat around it, and I think, in a lot of ways, we had a very similar outlook". The provision of a consistent mentor for the duration of the placement facilitated communication between Ann and her mentor, and a supportive and open relationship developed.

Ann relates how her confidence and ability to engage in self-directed learning escalated because of the nature of the relationship she developed with her mentor and the protected time they had to work together. She asserts that she "felt confident in that placement because we'd had that time of getting to know each other". Ann was "empowered" and "enabled" by the liberating relationship developed with her mentor. In the messiness and complexity of contemporary clinical environments, it is crucial that students feel that they can negotiate their learning in an autonomous and confident manner. The quality of Ann's relationship with her mentor enhanced her feeling of belonging and acceptance in the clinical environment and allowed her to seek out her own learning opportunities. This is an example of the impact that belongingness has on students' ability to be efficacious.

Because Ann felt secure as a member of the team and supported by a consistent mentor, she was capable and confident in taking control of her learning.

As well as demonstrating the importance of supporting students in practice, this narrative shows how challenge is key to students' learning and development. Because of the extended period of time they had worked together, Ann's mentor "knew exactly what [Ann] could and couldn't do competently". Ann says that her mentor knew when and how far to "push" her and that this allowed her to "consolidate"and "extend" her skills. The appropriate balance between challenge and support is not always easy to achieve (Daloz, 1999). However, it is evident from Ann's account that it is possible when ongoing dialogue, in a trusting relationship between mentor and student, is maintained.

Contextual factors either support the provision of consistent mentors or work against this happening. Workforce pressures such as staffing shortages, skill mix and patient acuity are often cited as reasons why consistent mentors cannot be provided. However, it is evident from Ann's story that she experienced a clinical environment that remained committed to providing consistent quality mentoring. As result, she felt a sense of belonging and had the confidence to pursue learning opportunities in an efficacious and self-directed manner.

9.4.5 Abby's story: "I should have said no"

As an insecure international student who had to deal with rejection and overt racism, Abby was determined not to endanger her precarious sense of belonging. This narrative demonstrates how she complied with the directives of her buddy in order to be accepted by the nursing staff she worked with, even though doing so put her patients at risk:

> One registered nurse that I was buddied up with asked me to shower a blind patient and I said, "Okay, no problem", and went in and started the shower. Then the nurse asked me to do something else while the patient was in the shower. I said, "I can't really leave her here by herself, she's blind. Can I at least finish and make sure she's safe?" But the nurse said, "She's showered herself numerous times at home before, you don't need to be there. I need you to come and help me now". I should have said no, but as a student it is very difficult to say no to a registered nurse. They will just make your life hell, to be honest. They will ignore you or reject you from then on. I really regret it now, but I did leave the patient there by herself. There was another patient in that room who was going home that day, and I said to her, "Can you just make sure she's all right, I really have to go?" The patient said to

me, "You really shouldn't leave", and I'm like, "I know". So it was something that I really didn't want to do. If I was a registered nurse I could have said, "This patient's my responsibility. I'll help you when I have time", but as a student I couldn't say that.

The patient got up, tried to get out of the shower on her own and water went everywhere. The nurse unit manager found her like that, blind, naked, shaking and hovering around the bathroom, with the water everywhere. She said, "Who left you here?" She found out it was me, and got really upset with me. She said, "What do you think you are doing? You should know better than this. You're in second year, you should know this". I just said, "I'm really sorry, I should have known". I wanted to take responsibility because the nursing unit manager was telling me that in front of all the patients, other staff members and that registered nurse. I made the decision not to confront that nurse. I thought to myself, even though I was pressured I really shouldn't have left her there. So I said, "I'm really sorry, it won't happen again. I should have known better"—and then I was furious inside, I was upset. I tried to forget about it; these things happen. But this memory has really stuck in my mind.

Although multiple benefits of belongingness have been cited in this thesis, Abby's story reveals that the need to belong can also have negative consequences. Research has demonstrated that in order to avoid exclusion by others, people conform, obey, comply, change their attitude, work harder and generally attempt to present themselves in a favourable light (Baumeister & Leary, 1995; Baumeister & Tice, 1990; Clark, 1992; Lakin, 2003; Williams & Sommer, 1997). When students' need to belong takes precedence over their commitment to patient-centred care, a serious dilemma results. Abby's decision "not to confront that nurse", and by so doing endangering her patient's safety, left her feeling guilty and remorseful. Yet she felt that she had no choice, as she believed that refusing to comply with the nurse's request would mean rejection or exclusion, "They [the nurses] will ignore you or reject you from then on".

There is another layer to this discussion and, as Cecchin (1998) points out, students from Southeast Asia, in particular, may be imbued with beliefs about the status of those perceived to be in a superior position, and may feel that they must show respect by taking a subservient role. Social rules and expectations of "obedience and conformity" may prevail in the social and family milieu of Asian students like Abby (Cecchin, 1998). Having come from this type of cultural and educational background, and because of her need to belong, she felt uncomfortable challenging the registered nurse with whom she was buddied. Although Abby was reluctant to comply with the registered nurses' request, she

believed that "as a student it is very difficult to say no to a registered nurse", and that her inclusion in the team was dependent upon her unquestioning compliance. In other words Abby was compelled by both her determination not to rock the boat and a belief that she should be subservient to those in authority. This is evident in her interaction with the nurse unit manager also. Abby's words, "I'm really sorry, it won't happen again. I should have known better" and "then I was furious inside" are indicative of both her subservience and the inner turmoil that she experienced as a result. However, for Abby, her decision seemed almost inevitable…it was better to comply than to risk ostracism.

Hajda (1961) suggests that people's attempts to avoid being alienated and to enhance their chance of inclusion in defined groups may lead to unquestioning acceptance of group norms, compliance with existing traditions and latent conservatism. In this study subservience and compliance were not behaviours that were unique to Abby's experience; as described in Chapter 8, many of the students that I interviewed were reluctant to question or confront the registered nurses they worked with, especially when they felt unwelcome or unwanted or hoped to avoid being excluded. In an era when the nursing profession aspires to develop independent, assertive and innovative practitioners, stories such as Abby's remind us that the tendency to be compliant has not been erased from the repertoire of behaviours that students adopt in order to fit in and be accepted by their nursing peers. It is important to note that students who felt secure and were confident of their place in the team and who experienced a sense of belonging in a particular ward or unit were more willing to question practice and challenge the decisions of those that they worked with.

These findings are supported by previous studies. Champion et al. (1998) said that some of the participants in their study made a calculated decision to conform in order to be accepted into the nursing team. Hemmings (1993) concurred; participants in that study stated that they quickly learned that the best way to fit in and be accepted by the team was through unquestioning agreement and compliance. Therefore, it is crucial that we recognise the relationship between belongingness and conformity, and devise ways to empower students to become assertive and confident practitioners.

9.4.6 Nicole's story: "It was so nice to be given responsibility and to be trusted"

Many students related how, as their skills and confidence increased, they sought a measure of independence and wanted to be more self-directed in their work and their learning. They felt that they thrived when their skills and abilities were recognised and they were given opportunities to display initiative and to work with a degree of autonomy. Nicole shares a community nursing experience where she was able to work independently with her own clients and use her previous experience as a pharmaceutical representative to improve her patient's health status:

> *I did a six-week placement in the community, working specifically with the district nurse as my mentor. By the end of that placement she was letting me go out with my own caseload in my own car. I have to say it was so nice to be given responsibility and to be trusted to go and do those things. I was given patients that my mentor and I had seen together on quite a few visits. Two of the ladies were known as being quite difficult. One of them was a real challenge and I actually felt a lot of satisfaction that I had done all I possibly could for her by the time I left. She had very poor mobility because she had bad arthritis and her pain wasn't being controlled. She'd been attending a pain clinic for a long, long time for unknown cause of abdominal pain. She was on a massive cocktail of morphine, diamorphine and codeine. She was constipated; she couldn't get to the loo quickly enough because of her mobility and she was becoming mildly incontinent.*

> *I went and saw the GP [general practitioner] and asked if I could have a quick word about one of her patients; she was very receptive. I had all the information ready and ran through the situation. I showed her the list of all this massive concoction of drugs that she was on and told her all the problems the medications were causing. We sat and went through them all and I actually suggested to the doctor that the patient might be a good candidate for fentanyl patches. So we tried the patches and they worked an absolute treat, so she was finally pain free. We got her on to some detrusitol for her incontinence which helped because she was looking at getting pads and she was getting depressed about that. I got social services to get in touch with her and I gave her all the information to get a lifeline fitted, which she did. She was a very intelligent lady, but very lonely and in pain, suffering all these different things, and because of that she was labelled as being difficult. And she wasn't at all. It was really nice to know that I was trusted enough to go and see that lady on my own, to make the decisions and to go and review patients with the GP. My mentor was full of praise. It was a fantastic experience.*

In this narrative Nicole was recognised by her mentor as being capable and competent and was therefore trusted with increasing levels of responsibility as she progressed through the placement. Anant (1966) asserts that belongingness implies recognition and acceptance of a person by members of a group. Nicole felt that she had a recognised place in the community nursing team, and that this verified not only her developing capabilities but that she could make a valuable contribution to the work of the team. By being given the opportunity to work autonomously and to demonstrate her skills and knowledge, she felt validated and valued; her confidence was boosted and this encouraged her to use her initiative to improve the health outcomes of her patient. Nicole explains this by saying, "it was so nice to be given responsibility and to be trusted to go and do those things". The importance of being recognised, respected and valued for their contribution to patient care was a recurring theme in the students' accounts. They wanted be acknowledged and appreciated but sometimes felt that their work was taken for granted. When they were not trusted with a level of responsibility commensurate with their developing skills and abilities, they felt that they weren't valued. For some, this led to feelings of isolation, inadequacy, diminished self-worth and anxiety, and they became doubtful of their own abilities. Many believed that this negative self-appraisal retarded their clinical performance and because of this they were less likely to be accepted by the nursing staff. A study of third-year nursing students by Hart and Rotem (1994) revealed similar findings. These authors note the importance of students being valued and acknowledged for their contribution to patient care, and the negative impact it had on students' self-esteem when this did not occur. Similar findings were evident in a study by Champion et al. (1998), where beginning practitioners listed being appreciated and recognised by nursing staff as essential to feeling like "one of the team".

It is important to note that the period of relatively independent practice described by Nicole came towards the end of a six-week community placement in the UK. This uninterrupted length of time had allowed her to settle in before moving into the integration phase, during which her sense of belonging was strengthened and the development of clinical knowledge and acumen, through immersion in patient care, became her primary focus. In this phase, she felt assured of her place in the team and she was able to embrace the new learning opportunities presented with confidence. Active participation was described as an important preface to learning by Nolan (1998). In this situation, Nicole became an active,

integral and participative member of the nursing team because of the belongingness she experienced.

The importance of mentors to students' sense of belonging, the quality of their clinical placement experience and their learning is frequently referred to in the literature (Andrews et al., 2005; Langridge & Hauck, 1998; Workman, 1998). During the extended period of time in the community placement, Nicole had been afforded the opportunity to work with a consistent mentor and to build a relationship based on mutual understanding and respect. Thus, Nicole's mentor became confident that she would be able to manage with less direction and supervision. She therefore sought to challenge Nicole with her own caseload and two patients who "were known as being quite difficult". However, this challenge was matched with an appropriate measure of support, as Nicole was allocated patients that she and her mentor "had seen together on quite a few visits".

Being given the freedom to direct her own practice allowed Nicole to manage her own time, to test out her knowledge and skills and to develop her problem-solving abilities in a self-directed manner. She was able to apply the knowledge gained from her nursing experience and her previous experience as a pharmaceutical representative to a complex and challenging clinical problem, and effectively liaised with the patient's doctor with a confident and assertive approach: "I had all the information ready and ran through the situation. I showed her the list of all this massive concoction of drugs that she was on and told her all the problems the medications were causing".

Being trusted with additional responsibilities boosted Nicole's confidence and her self-concept. Being recognised as capable and competent validated her worth to the team and was both intrinsically and extrinsically rewarding. Her mentor's acknowledgment of her further strengthened these feelings and she concluded her story by saying, "My mentor was full of praise. It was a fantastic experience". As students progress through their nursing program, they want opportunities to initiate and prioritise patient care with decreasing levels of direction from their nursing colleagues. Opportunities such as the one described by Nicole promote learning and engender feelings of satisfaction and self-worth. Because students feel that they are valued and appreciated for their contribution, they feel validated and assured of their place in the team. However, when working with students registered nurses are aware that they remain accountable and responsible for their

patients' care. Research suggests that mutual trust is a prerequisite for being willing to share one's practice with a newcomer, especially when there are situations of some complexity and/or uncertainly (Fielding et al., 2005). For registered nurses to be able to trust novices to work with increasing amounts of independence and to allow them to assume escalating levels of responsibility, it requires a degree of confidence that is not always achieved in brief encounters or without opportunities for ongoing observation of students' practice through a consistent mentor–student relationship.

9.5 Conclusion

In this chapter the quantitative and qualitative data presented in Chapters 5–8 were interpreted and, where appropriate, converged in order to develop a more comprehensive understanding of students' experience of belongingness. The cross-national, multi-site approach taken for the case study proved advantageous, as it allowed the research findings to be integrated, while also supporting a comparative approach.

Research questions 1 and 2 were addressed by interpreting the quantitative data analysed in Chapter 5. It was ascertained that the mean belongingness (BES–CPE) scores of participants from site 3 were statistically higher than those of either site 1 or 2. Of the demographic variables explored, the following were not a strong influence on students' experience of belongingness: nursing experience apart from that included in students' current nursing program; family members with nursing experience, gender and country of birth. The effect of age and English-speaking background was less certain.

The quantitative results raised a number of important issues that were better illuminated through insights drawn from the qualitative data and by reference to the relevant literature. A montage of belongingness and alienation integrated the themes from the qualitative data analysis into coherent and meaningful narratives that addressed research questions 3 and 4. The montage allowed for a deeper and more comprehensive appreciation of the factors that impact on and are consequences of belongingness to emerge.

The following chapter brings the thesis to a close. The conceptual framework that emerged from the study is presented, along with implications for practice, and the research journey is reviewed and reflected upon.

Chapter 10

Conceptual Framework and Conclusion

The method cannot transcend the talent or the moral character of the interpreter but when the canons of textual evidence and consensual validation and dialogue are followed, a citizenry of critical readers and practitioners can discern…ways of articulating common everyday taken-for-granted understandings. Practice then will have gained a way to influence and shape theory more directly and effectively (Benner, 1994, p. 124).

10.1 Introduction

A case study should be presented in a way that has the "catalytic ability to make people think about their current knowledge and practice" (Clarke & Reed, 2006, p. 314). In this study it has been my intention to re-present the participants' stories in a way that resonates with readers and invites them to "brood upon" or "dwell with" the story, while at the same time considering the broader implications of the findings for practice. By providing an alternative perspective on the challenges related to clinical placements and student learning, viewed through the lens of belongingness, my goal was to reconceptualise students' experiences in a way that was meaningful and of practical significance to nursing education. This is in accord with the tenets of pragmatism, which emphasise the importance of practical applications (Creswell, 2003), searching for realistic solutions to real world problems (Patton, 1990), and simplicity, consistency and comprehensiveness of findings (Howe, 1998).

As this dissertation draws to a close, the practical implications of the study are brought to the foreground and made explicit by presenting the conceptual framework that emerged from the study. The framework derives from the concepts of motivation to learn and the creation of an environment conducive to learning. It applies a modified version of Maslow's (1987) theory of human motivation to the clinical placement experience of nursing students. This offers an alternative perspective on Maslow's theory and sheds light on the challenges associated with the particular needs of students who are learning to nurse in contemporary practice environments. Recommendations for practice are included in and

informed by the discussion of the conceptual framework. Finally, the chapter concludes with an outline of my personal reflections on the study, a discussion of the study's strengths and limitations, and recommendations for further research.

10.2 Conceptual framework

The purpose of a conceptual framework is to interpret and explain reality. As such, the knowledge generated should evolve out of an examination of a specific case or cases and the theory underpinning the framework should approximate reality (Cookes & Davies, 2004). A conceptual framework can act as a bridge between what has gone before (existing knowledge) and what has been learnt (generated knowledge). A theoretically sound, well thought through and clearly presented framework provides insight into the researcher's thoughts, reasoning and conclusions (Cookes & Davies, 2004). Knowledge organised as a conceptual framework allows the reader to more easily understand and apply it to practice because of its inherent relational nature (Andersen, 1981).

The aim of the conceptual framework presented in this chapter is to add to the existing body of knowledge by identifying the relationship between what is already known about belongingness and what has been generated through the current study. This framework provides a way to describe the major concepts that emerged from the study, and to explain the connections that I (as the researcher) perceive between them. The framework is presented using both text and a diagram. By providing a visual summary as well as written details of concepts and relationships considered in the study, this combination aims to facilitate a greater understanding of belongingness as it relates to nursing students and their clinical placements. It is acknowledged that when deconstructing and reconstructing a phenomenon such as belongingness there is a risk that the complexity, depth and meaningfulness of the knowledge generated will be diminished. In this study I sought to carefully "unpack" or deconstruct belongingness through the detailed data analysis presented in Chapters 5–9. This allowed a closer interrogation of the phenomenon, its antecedents, attributes and consequences. In the conceptual framework it is my intention to diligently reconstruct students' experiences of belongingness in order to facilitate better synthesis of the emergent themes in a way that is relevant and applicable to practice.

10.2.1 Maslow's theory of human motivation

One way to understand the clinical learning experience of student nurses is to revisit Maslow's theory of human motivation (1987). Although Maslow acknowledged that his theory was based upon clinical experience rather than empirical data (Maslow, 2000), it continues to be used to understand human behaviour. The clarity and apparent simplicity of Maslow's hierarchy of needs resonates with people's lived experiences, and its longevity attests to its usefulness in practice. Maslow's theory has been studied in various disciplines. In business it is viewed as a model for understanding human motivation, and in the social sciences it is used as a model for understanding the needs of individuals. Maslow's influence has been felt in two major directions in health care: the first brought direct application of his theories to established healthcare organisations, while the second impacted upon the development of a holistic healthcare perspective (Benson & Dundis, 2003). Regardless of the discipline, the theory continues to be used to bring understanding to what motivates individuals. While numerous studies use Maslow's theory in the areas of nursing, medicine, hospital administration and nursing education, none was found to have used it to explore and explain the clinical placement experience of nursing students.

10.2.2 Maslow's theory and human resources management

Maslow has left an indelible imprint on human resources management. Understanding the hierarchy of needs and its implications for creating self-actualising workplaces is beneficial to those concerned with building effective teams and organisations. Maslow (2000) proposed that people achieve an optimal level of functioning when organisations develop practices that embrace the holistic nature of human beings and recognise their motivations for being (Benson & Dundis, 2003). He believed that a humane, enlightened management policy focused on human potential would also attract and retain staff. Calling this concept of utopian leadership "eupsychian management", he pointed out that individuals can and should experience a therapeutically oriented work situation (Maslow, 2000, p. 5). In regard to the management of human capital he proposed the following:

- Human beings are capable of extraordinary accomplishment.
- Creativity and innovation are intrinsic motivators.
- Teamwork, although imperative to successful organisations, is an overlooked source of community and esteem for people.
- Enlightened management not only improves productivity, it also improves people and thus improves the world in which they live. (Maslow, 2000, pp. 2–5)

Although nursing students are supernumerary to the workforce and in their student role are not employees of the healthcare organisation, they nevertheless contribute to the health service by engaging in patient care activities. As such, they are affected by, and in turn affect, the organisational and unit culture. Therefore, while Maslow's theory is a constructive tool for understanding both organisational and individual human behaviour, its application to nursing students' clinical placements provides a way to better understand their needs and to subsequently develop therapeutically oriented clinical environments that best address those needs.

10.2.3 Ascent to Competence conceptual framework

Maslow's defining work was the development of the hierarchy of needs. He proposed that human beings aspire to become self-actualising and viewed human potential as a vastly underestimated and unexplained territory. A similar model, relating to nursing students' clinical placements, is featured in this section. The Ascent to Competence framework provides a system of interrelated concepts arranged in a hierarchical sequence of generalisable relationships. Each of the subordinate ideas or themes in the model is also a concept in its own right. The title of the framework, Ascent to Competence, indicates that the primary purpose of clinical education is to facilitate students' progress towards the attainment of competence[1] in the fullest sense of the word. Competence is not developed serendipitously, but requires: the personal commitment and active involvement of students; the explicit support, guidance and careful attention of academic and clinical staff; clinical environments that are receptive to and welcoming of students; and organisational and regulatory policies and processes that facilitate the process.

The framework has five levels and the definitions have been modified from Maslow's original hierarchy. These concepts or levels include: the need for safety and security, the need to belong and be accepted, the need for a healthy self-concept, the need to learn to nurse and, finally, the need for competence. The concepts are related to each other, being arranged in a hierarchy of importance with the most basic needs at the base of the pyramid. From the students' accounts, it was apparent that unless their basic needs for

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[1] For the purpose of this study, competence is defined as: "The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area" (Australian Nursing Council, 2005, p. 8).

physical and psychological safety and security (including freedom from anxiety and stress) were met, higher-level needs became less important, as survival was their primary motivation. Once the students felt secure and their stress levels had been moderated, if not alleviated, they then focused on finding their place in the team—they needed to belong and be accepted. Following on from this the third level of the model is the need for self-concept, where the students sought personal and professional validation through the recognition, appreciation and respect of their nursing colleagues. Once the students' needs1–3 had been satisfied, they began to focus on learning, that is, the acquisition of the knowledge, skills, values and attributes essential to a professional nurse. Although learning may have occurred at all stages in the hierarchy, once students reached this stage they were more motivated and more capable of engaging with learning opportunities in meaningful, memorable and increasingly autonomous ways. Finally, when students had ascended through the previous levels of the hierarchy they reached a place where the attainment of a level of competence was possible. However, there is an elusive quality to competence and, even if nurses are deemed competent at a novice or beginner level, they invariably have aspirations for further levels of competence.

A diagrammatic representation of the conceptual framework is shown in Figure 10.1. The following pages give a more detailed explanation of each of the levels in the hierarchy. The distinctions between and among hierarchical levels depicted diagrammatically are in reality less clear cut. The levels merge and the boundaries between them are somewhat blurred, neither is there a set time-line for students' progress. It should be noted that a pyramid, rather than a triangle, has been chosen to conceptualise the hierarchy in order to represent the multidimensional nature of the concepts in the hierarchy as well as students' individual attributes, capabilities, attitudes, learning styles and experiences.

Students' ascent through the hierarchy is dynamic and influenced by a range of factors. In Figure 10.2, the diagram of the hierarchy is situated within a series of concentric circles. This arrangement acknowledges that clinical placements do not operate in a vacuum divorced from the complex and dynamic individual, interpersonal, contextual and organisational factors and forces that exert an influence on the students' ascent through the hierarchy. The innermost circle represents the individual factors identified by students as contributing to their experience of belongingness. Moving outwards, the circles

represent the interpersonal, contextual and organisational factors that mediate the students' experiences.

10.2.4 Recommendations for practice: principles

At this stage I preface the discussion of the conceptual framework with an outline of the principles followed in developing the recommendations for practice that are included in this section:

- The primary purpose of the recommendations is to guide decision-making involved in the organisation, implementation and evaluation of clinical placement models and processes.

- The recommendations take into account that clinical learning and the achievement of competence are not ends in themselves but are instrumental in promoting and maintaining patient safety, health and wellbeing. Thus, achievement of competence is considered to be critical to individual nurses, their patients and the professional standing of nurses.

- The recommendations are intended to expedite students' ascent through the hierarchy. The ultimate goal is for students to reach a place where their learning can be optimised, with a view to potentiating their achievement of competence as professional nurses.

- The recommendations reflect the need for collaborative partnerships between higher education, health services and regulatory bodies, and take into account that clinical and academic leaders, mentors, managers and the students themselves all play an integral role in optimising the benefits of clinical placements.

- The recommendations are concise, clear, strategic and able to be implemented. As such, they reflect the realities of contemporary practice environments.

- The recommendations are generic and can be implemented in a range of contexts.

- The recommendations are designed to be an evolving set of beginning guidelines and are open to review, re-validation, amendment and improvement as part of an iterative process.

The need to become a competent, confident, efficacious and capable professional with a passion for, and commitment to patient-centred care.

The need to learn in an authentic environment, beside professional role models and the freedom to test out one's knowledge and skills in an increasingly self-directed way.

The need to be appreciated, recognised and respected for making a valuable contribution to patient care, and as a person who is becoming a nurse.

The need for connectedness, acceptance and fit, as well as the assurance of having a legitimate place in the clinical milieu. This includes the need for harmony between one's professional values and those of the team.

The need for physical and psychological safety and security.

COMPETENCE

LEARNING

SELF-CONCEPT

BELONGINGNESS

SAFETY & SECURITY

Figure 10.1 'Ascent to Competence' conceptual framework

Individual Factors
- Preconceptions about nursing
- Willingness to adopt the role of an unpaid 'worker'
- Resilience versus resignation
- Tendency to engage in extenuation

Contextual factors
- Orientation structure
- Consistency and structuring of mentoring
- Nurse unit managers or ward sisters
- Practice standards

Organisational factors
- Duration and structure of clinical placements
- Clinical facilitators

Interpersonal Factors
- Receptiveness of nursing staff
- Inclusion-exclusion
- Legitimisation of the student role
- Recognition and appreciation
- Challenge and support

COMPETENCE

LEARNING

SELF-CONCEPT

BELONGINGNESS

SAFETY & SECURITY

Individual Factors

Interpersonal Factors

Contextual Factors

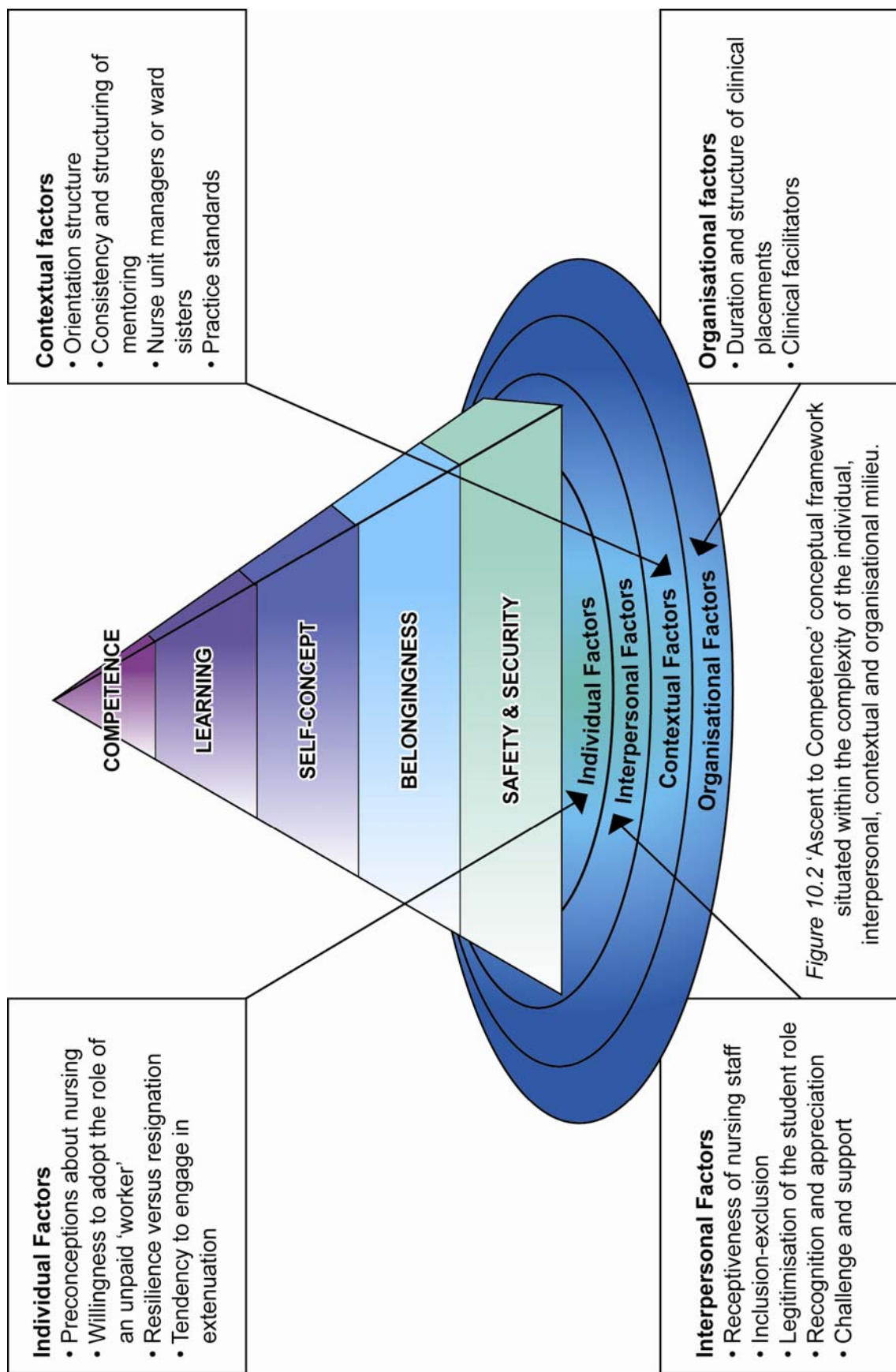Organisational Factors

Figure 10.2 'Ascent to Competence' conceptual framework situated within the complexity of the individual, interpersonal, contextual and organisational milieu.

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10.2.5 Safety and security

When students began each new clinical placement, they focused initially on seeking information that would allow them to cope in their new and unfamiliar surroundings. Information that did not relate directly to helping them meet their basic needs for safety and security within a short time frame was mostly left unattended. At this stage students were often challenged by a fear of the unknown, and for many this was a period characterised by uncertainty, anxiety and dependency. Anant (1967) proposed that when people are placed in strange situations, with a lack of clarity about what to do, where to go or who to talk to, they are likely to become anxious. Nolan (1998) and Brodie (2005) also identified the anxiety surrounding the beginning of clinical placements as a factor that dominated students' thoughts and hindered their progress. While all the students I interviewed described the commencement of placements as a time of apprehension and uncertainty, individual attributes such as self-efficacy, resilience and adaptability moderated their experience to a degree.

Clinical units or wards that were committed to the facilitation of successful clinical placement experiences recognised the immediacy and importance of addressing students' basic needs for safety and security by orientating them to their surroundings, key personnel and basic routines. A planned orientation session indicated a state of readiness and receptiveness to students; it clarified the staff's expectations of them and allowed the students to begin to feel comfortable in the environment and at ease with the staff. Although the need for a planned orientation to each new area of practice has been recognised by previous researchers (Brodie et al., 2005; Champion, Ambler & Keatinge, 1998; Clare, White, Edwards & van Loon, 2002; Elcock, Curtis & Sharples, in press), these research findings do not always translate into practice. In Lathlean and Myall's (2006) study, less than half of the students surveyed reported that they had an orientation in each new clinical placement area. In this study similar results were evident.

Once students' basic needs had been met they began to settle in and feel more comfortable with the staff and the routines specific to the ward or unit. The duration of the settling-in phase varied, but most students suggested that a minimum of two to four weeks was needed. While the ideal duration of clinical placements is subject to debate, many authors have expressed concerns about the efficacy of short placements that do not provide enough time for students to settle in and feel secure in preparation for

learning (Champion et al., 1998; Clare, Edwards, Brown & White, 2003; Elliot, 2002; Hart & Rotem, 1994; Kiger, 1992; Mallik & Aylott, 2005; Mannix, Faga, Beale & Jackson, 2006; Nolan, 1998).

The process of settling in was negatively impacted by students' perception that their safety and security in the clinical environment was threatened. This included not only physical safety but also psychological and emotional safety. Although true of all of the placements described by students, this was particularly relevant to mental health placements, a finding that is supported by the literature (Charleston & Happell, 2005; Clinton & Hazelton, 2000; Hayman-White, 2004; Stevens & Dulhunty, 1997). Additionally, in line with Griffin's (2004) research, horizontal violence or bullying from staff undermined students' feelings of safety and security. Staff who were unwelcoming, hostile, indifferent, dismissive or unfriendly exacerbated the students' anxiety, adversely affected their ability to settle in, and impeded their ascent through the hierarchy.

Recommendations for practice

- The assumptions, educational philosophies, policies and practices that underpin the duration and structure of clinical placements should be carefully reconsidered. In some cases this may mean the development of alternative placement models that utilise fewer placements of longer duration in order to facilitate students' socialisation to the clinical environment, in preparation for learning to nurse.
- Students should be provided with a short but comprehensive orientation at the commencement of each clinical placement.
- Attention should be given to the development of students' communication and assertiveness skills and the teaching of strategies (such as cognitive rehearsal[2]) that would help to prepare them for potentially confronting situations such as horizontal violence.

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[2] Cognitive rehearsal is described by Griffin (2004) as a method of mentally processing and practising effective responses to unpleasant triggers (such as horizontal violence) in order to develop and integrate effective coping skills into one's repertoire of behaviours.

10.2.6 Belongingness

Once the students' need for workplace safety and security had been met, they were then able to move to the next level of the hierarchy, where their primary motivation became consolidation of interpersonal relationships in order to progress from feeling like an outsider to becoming an integral member of the nursing team. This is in accord with Hagerty et al.'s definition of belonging as "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of the system or environment" (1992, p. 173). Hagerty et al. (1993) also found that when people feel connected and actively involved with the other members of a group, they experience a sense of comfort, wellbeing and anxiety reduction. This was played out in the experiences of the students in the current study.

Most students believed that the legitimacy of their place as learners in the clinical environment was determined by the quality of the interpersonal relationships forged with their nursing colleagues and by the receptiveness, acceptance, support and interest demonstrated by those nurses. This finding extends upon previous work by Nolan (1998), who asserted that until students feel accepted by the staff and assured that they have a valid place in the team they remain preoccupied with fitting in and their progress is negatively impacted. Similarly, Champion et al. (1998) and Hemmings (1993) examined the importance that students and graduates attributed to achieving the status of insider in each new clinical area, and found that until these beginning nurses felt confident that they had a place in the team they could think of little else but fitting in. In the current study students sought connectedness and collegial, friendly, comfortable and cooperative working relationships with their nursing colleagues. Their aim was to find a legitimate place in the clinical environment and meaningful involvement as they learned to care for patients. The degree of belongingness students experienced determined to a large extent how motivated they were, how well they participated and how much satisfaction they gained from the placement with respect to the goal of becoming a nurse. There is a similarity between these findings and those of Winter-Collins and McDaniel (2000), who also identified a strong association between the quality of interactions and relationships with co-workers, belongingness and job satisfaction.

Belongingness was also related to a perception of harmony or congruence between the students' personal and professional values and those of the team with whom they were

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working. When students felt a dissonance between their own values and those of the staff, they reported feeling alienated and disillusioned and often emotionally and psychologically disengaged, and they distanced themselves. This finding is consistent with Brodie et al.'s (2005) and Kiger's (1992) assertions that environments with perceived poor standards of care have a negative impact on student's placement experience and on their desire to be part of the team.

The nursing staff who students worked with on a day-to-day basis exerted the greatest influence on their sense of belonging and learning, and either facilitated or undermined their experience of belongingness, a finding that is consistently upheld in the literature (Champion et al., 1998; Dunn & Hansford, 1997; Nolan, 1998). The commitment of nursing staff to students' experience of belonging was indicated by the quality and consistency of the support provided through facilitative interpersonal relationships and the extent to which students were included and involved in the work of the nursing team.

 A designated mentor during this phase had a significant influence on students' experience of belongingness, as this allowed them to build relationships based on mutual understanding and respect. Mentors facilitated students' entrée to clinical environments and helped them to forge effective relationships with the nursing staff. This finding is supported by a wide body of literature on mentoring (Andrews, Brodie, Andrews, Wong & Thomas, 2005; Champion et al., 1998; Langridge & Hauck, 1998; Workman, 1998). Many students suggested that the quality and consistency of the student–mentor relationship determined whether they fitted into a clinical placement and felt accepted by the staff. They commented that without the sense of collegiality and connectedness they received from working with a regular mentor, they often felt left out and as if they were on the periphery of the clinical team.

Similarly, the influence of the ward manager was crucial to students' experience of belongingness. Clinical managers who were accepting, supportive, and inclusive strengthened students' perception of being welcomed and accepted as members of the nursing team and influenced the attitude of staff towards students. This finding is in accord with the literature that attests to the key role that ward managers play in creating positive clinical learning environments (Dunn & Hansford, 1997).

Unfortunately, in complex and highly pressured work environments such as healthcare organisations, ensuring that students feel comfortable and helping them fit in is not always given a high priority. For the students in this study, a diminished sense of belonging, or alienation, resulted in a range of deleterious consequences. Students who did not feel as if they belonged reported feeling isolated, lacking in motivation, disempowered, anxious or distressed. Some students participated and contributed very little until they felt accepted and confident of their place in the team; others worked very hard, even redefining their supernumerary status, thinking that to be seen as a worker was a strategy that would heighten their chance of acceptance by the nursing team. Similar findings have been described by Joyce (1999) and Parahoo (1992), who reported that students often feel emotionally blackmailed into working hard to earn their right to acceptance into the team. Elcock et al. (in press) concurred, suggesting that students frequently become "an extra pair of hands" as a strategy to ingratiate themselves with the nurses they work with and to be included as a member of the team, even if it meant that the quality of their clinical learning experience was compromised.

Of significant concern is the finding that students who felt insecure, vulnerable, isolated or ostracised were more willing to conform and less likely to rock the boat by questioning nursing practices that they felt uncomfortable with. The findings from this study are supported by a body of literature on the issue of group conformity that attests to the fact that conformity and compliance are sometimes viewed as strategies to enhance one's chance of inclusion and to be seen as an insider (Baumeister & Leary, 1995; Clark, 1992; Mooreland & Levine, 1989; Williams & Sommer, 1997). In the nursing literature the tendency for students and graduates to view conformity as matter of survival has also been emphasised (Champion et al., 1998; Hart & Rotem, 1994; Nolan, 1998). These studies reiterated that the decision to conform and comply was a calculated one that students thought would increase their chance of acceptance and inclusion. For many students in the present study, their need to belong and to be accepted into the team took precedence over the quality of care they provided and their need to learn, a finding that reinforces previous research (Hart & Rotem, 1994; Hemmings, 1993; Tradewell, 1996).

10.2.7 Self-concept

When students felt their place in the team was secure and they had a strong sense of belonging, they were then able to ascend to the next level of the hierarchy, where being recognised and respected for their valuable contribution to patient care and to the work of the team assumed importance. At this level it was students' self-concept that was the major focus. It was evident from the students' accounts that their self-concept was not static but evolved in response to their perception of how they were viewed by other members of the healthcare team. Feeling that they had a legitimate and valued role and being acknowledged as capable confirmed that the team valued them and was intrinsically rewarding. When students were trusted with additional responsibilities, their confidence and motivation were strengthened. Opportunities to work with increasing levels of independence allowed students to feel validated and appreciated, and they became more confident of their place in the team. In Champion et al.'s (1998) study beginning nurses described similar experiences and perceptions, saying that the staff's appreciation and recognition were essential for their feelings of self-worth and progress. These perceptions

have been echoed by the participants in other studies (Hart & Rotem, 1994; Nolan, 1998). In a large study undertaken by Brodie et al. (2005), feeling valued, recognised and appreciated was so important to students that it was identified as the chief determinant of their future employment decisions.

Although students longed to be acknowledged and appreciated, they often felt that the value of their contribution was overlooked. When they were not trusted with a level of responsibility commensurate with their skills and scope of practice, they felt unappreciated. In unwelcoming and unreceptive clinical environments, students often felt they were a nuisance, an intrusion or an imposition. This had a strong and negative impact on their feelings of self-worth. For some it led to feelings of inadequacy, inferiority and diminished self-worth, as they internalised the views expressed by the nursing staff. Students sometimes felt guarded, timid and self-conscious as a result of their poor self-concept. These findings are in accord with those reported in the psychology and social science literature, where poor self-concept was shown to be a consequence of feeling as if one doesn't belong (Baumeister & Leary, 1995; Baumeister & Tice, 1990; Hagerty & Williams, 1999; Maslow, 1987; Twenge, Baumeister, DeWall, Ciarocco & Bartels, in press).

A negative self-appraisal prevented many students from moving up to the next level of the hierarchy and undermined their confidence to actively engage in learning opportunities, although their degree of resilience, efficacy and other individual characteristics moderated the severity and extent of this experience.

Recommendations for practice
- Students should be encouraged to assume increasing levels of responsibility and autonomy commensurate with their skills and experience.
- Students should be acknowledged for their contribution to patient care and to the work of the nursing team.
- Clinical education and academic experiences should aim to promote the attainment of a positive and realistic self-concept, as this affects students' performance and learning.

10.2.8 Learning to nurse

At the next stage of the hierarchy, the development of clinical knowledge and skills, through immersion in patient care and working beside effective role models, was the students' primary motivation. Undoubtedly, most students acquire some knowledge and skills in most clinical contexts and at most levels of the hierarchy. However, the goal of clinical education is to maximise student's learning in each clinical environment in order to produce nurses who are competent, confident, and fit for practice (Levett-Jones & Lathlean, in press). In this study the relationship between belongingness and motivation for learning emerged as a critical and recurring theme. Students who felt accepted, secure of their place in the team and recognised for the valuable contribution that they made actively embraced new learning experiences with confidence. Moreover, students who experienced a strong sense of belonging felt enabled and empowered to negotiate specific objective-related learning opportunities and confident to ask questions and challenge practice. These findings correlate with those of Hart and Rotem (1994), who found that nursing students felt more at ease to ask questions when assured of their acceptance by nursing staff and confident of their place in the team.

Self-directed learning is an essential vehicle for developing a commitment to lifelong learning (Nolan & Nolan, 1997). In this study it became evident that clinical environments that were supportive, inclusive and receptive strengthened students' self-efficacy and allowed them to be more self-directed in their approach to learning. While students embraced opportunities to extend themselves, they were able to do so only to the extent that they felt secure of their place in the environment and supported by the nursing staff they were working with. In addition to being supported students also said that it was important for them to be challenged by the staff they worked with. When staff invested time and interest in the students' growth and learning, it showed students that they were valued and that their learning was important.

In Dunn and Hansford's (1997) study, it was the registered nurses that students worked with who were considered to be the most significant influence on students' ability to be autonomous and self-directed. When students were secure in the knowledge that the nurses they worked with were committed to their professional development, they focused on learning rather than being preoccupied with trying to fit in. Conversely, nurses that were neither receptive nor facilitative of students' learning had a negative and at times long-

lasting impact on students' confidence and capacity to become actively involved in experiential learning opportunities. Hadja (1961) claimed that alienation results in anxiety, a lack of motivation and a lack of direction, and this was certainly evident in the students' accounts of their placement experiences. The anxiety and apprehension resulting from being excluded, resented or rejected often interfered with students' motivation to engage in clinical learning. This is in accord with Nolan's finding (1998) that fear and anxiety associated with feeling unwanted or unaccepted impeded students' learning. This is not surprising, as stress and anxiety—consequences said to derive from a diminished sense of belonging, are frequently cited as barriers to learning (Kleehammer, Hart & Fogel Keck, 1990; Lindop, 1999; Lo, 2002; Timmins & Kaliszer, 2002). Additionally, studies from the psychology and social science literature suggest that the anxiety caused by a diminished sense of belonging produces a short-term impairment in cognitive performance and reduces intelligent thought (Baumeister, Twenge, & Nuss 2002). Baumeister and Leary (1995) add that people can become so preoccupied with attempting to understand interpersonal relationships, particularly when those relationships do not fulfil their belongingness needs, that their ability to learn can be reduced.

Clinical placements are specifically designed to provide authentic opportunities for students to learn in meaningful ways that are conducive to the attainment of competence in preparation for their future practice. As students progress through their nursing program, they need the freedom and security to test out their knowledge and skills, both with the support of their colleagues and in an increasingly self-directed manner. In this study belongingness was seen to be a pivotal precursor to optimal clinical learning.

Recommendations for practice
- Students should be helped to recognise the influence they exert over their own clinical learning. They should be taught how to apply the principles of self-directed learning gained in academic settings to their learning in the clinical milieu.
- Students should develop their own context-specific learning objectives in preparation for clinical placements. During their placements they should be encouraged to negotiate learning opportunities that facilitate achievement of their objectives, as well as to capitalise on the serendipitous learning opportunities that present themselves.
- Clinical and academic staff should be mindful that learning can be impeded by the anxiety and apprehension that often results from a diminished sense of belonging.

10.2.9 Competence

When the other needs in the hierarchy have been addressed, students move towards a realisation of their full potential; this means that the attainment of a beginning level of competence is now possible. Competence is a rather broad concept that has been considered from the narrowest of perspectives as "a list of tasks to be completed" through to the more complex and abstract definition of "an ability to demonstrate an appropriate level of professional practice in a variety of contexts" (Girot, 1993 p. 85). Nursing students are expected to achieve a generally agreed beginning level of competence before registration. Australian students are deemed competent according to the Australian Nursing Council National Competency Standards for the Registered Nurse (2005). Students from the UK must achieve standards of proficiency[3] in the practice of either adult nursing, mental health nursing, learning disabilities nursing or children's nursing (Nursing and Midwifery Council, 2004c). Both sets of outcome standards define a combination of skills, knowledge, values, attitudes, behaviours and abilities appropriate for a beginning practitioner.

For nursing students the attainment of competence is the primary purpose of their clinical learning. The Ascent to Competence conceptual framework does not presume to provide a recipe for the certain achievement of competence. Instead it posits a set of interrelated constructs that together create a scaffold that supports and strengthens students' ascent to a position where the actualisation of a beginning level of competence becomes possible. However, competence is a multidimensional and multilayered phenomenon. In the Ascent to Competence framework competence is not considered to be an end-point, but a series of stages, with students expected to achieve at least a novice or beginner level of competence before registration. In some respects the stages of competence I refer to are not dissimilar to Benner's (1984) conceptualisation of skill acquisition, where she describes five layers of proficiency: novice, advanced beginner, competent, proficient and expert.

Benner (1984) also notes that students entering a new clinical environment are not the only beginners or novices. Any nurse entering a clinical setting in which they have limited

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[3] The standards of proficiency for the first level of the nursing register were initially defined as competencies in SI 2004/2546 (Nursing and Midwifery Council, 2004a)

experience may return to the stage of being a novice until they become familiar, confident and comfortable in the environment and with the patients and the staff. In many respects competence is situational and context-specific. Students, or more experienced nurses for that matter, will recommence their ascent up the hierarchy many times during their professional journey of lifelong learning. Thus, although the model emerged from the findings of a study specific to nursing students, it may well be useful beyond its application to students and the nursing profession.

From the students' accounts it was apparent that, caught up in the midst of the semi-structured chaos that characterises much of contemporary health care and driven by the need to belong, it was often difficult for them to remain focused on their primary goal of becoming a competent nurse. Yet the development of competence does not happen serendipitously; simply undertaking a clinical placement does not necessarily lead to the development of students' clinical competence, just as being in a healthcare environment does not guarantee learning (Levett-Jones, 2007). This conceptual framework proffers that students progress to a stage where attainment of competence is possible only after their previous needs for safety and security, belongingness, healthy self-concept and the need to learn to nurse have been met. Additionally, a complex matrix of related factors underpins students' attainment of beginning level competence. Foremost among these factors are: the determination and active participation of students; the support, interest and commitment of academic and clinical staff; clinical environments that are receptive to, inclusive of and invested in students' progress; and organisational and regulatory policies and processes that facilitate the students' learning and the attainment of competence.

Recommendations for practice

Nurse regulatory authorities charged with the responsibility for accrediting nursing programs should take into account that nursing programs that do not explicitly incorporate strategies to facilitate students' experience of belongingness and their ascent through the hierarchy may be less effective at preparing competent beginning practitioners.

For nearly two decades in Australia and the UK, complaints that graduates are not able to "hit the floor running" have been cited. Numerous justifications, explanations and arguments have been provided for the apparent deficiency in graduates' clinical

confidence and competence. The Ascent to Competence model reconceptualises these problems from a fresh perspective, and by exploring the relationship between belongingness, learning and competence offers some new insights into these multidimensional and long-standing problems.

10.3 Personal reflection

Self-awareness of the researcher is essential. An understanding of the researcher's own historicity and situatedness helps to develop this self-awareness. As a nurse educator and later as an academic, I have been involved with nursing students and new graduate nurses for many years. As a director of clinical education I undertook a study tour reviewing clinical placement models in Australia and the UK and I have been involved in a range of projects seeking to improve the quality of clinical placements. The local or insider knowledge that I gained was advantageous in conceptualising and designing the study, but it also coloured my thinking and perspectives. As I began this study I was conscious of the need to suspend my biases and preconceptions. In an effort to ensure that my own values and beliefs were not imposed upon the analysis, I maintained a journal to record and reflect upon my perspectives and emerging understandings. This was an effective strategy in many respects. However, despite my commitment to maintain an open mind, in truth it was not until I was engaged in the pilot study that I realised that my perspectives and understandings were, in many respects, limited and superficial. As I reread my journal now I am surprised at the number of times I wrote statements beginning with phrases such as, "I didn't realise"; "contrary to what I expected" and "I was intrigued by". Until this stage I had presumptuously felt that I had a reasonable understanding of student's clinical placement experiences. The pilot study generated such illuminative and meaningful data that I was taken aback and became, for want of a better term, a more naïve researcher. The research journey took on a new and exciting momentum and I became open to and welcoming of the new insights that were emerging. Many, many times I had reason to question and re-evaluate the legitimacy of my previously held understandings as I unpacked new meanings from the data. In this process, I became particularly conscious of the importance of allowing the perspectives of the participants to dominate throughout the analytic and interpretive phase, rather than my own; it was their story that needed to be told, and they were the people best equipped to tell it.

The main question that framed the interviews with the students was "Can you tell me about your clinical placement experiences?" I believe that it is significant and somewhat disappointing that the participants' interactions with their patients did not figure more strongly in their stories. Certainly, it seemed that for most students the consolidation of interpersonal relationships with nursing staff took precedence over the establishment of therapeutic relationships with their patients. The need to fit in and be accepted appeared to weigh more heavily on the students' minds than learning to care for patients, particularly until they felt they had a secure place in the team. However, as discussed in Chapter 6, the exception to this was when students' placements were in contexts where the general standards of practice challenged their professional and personal values to such an extent that they became distressed and disengaged. These experiences were often described in great detail.

I found the participants' descriptions of poor nursing practice to be one of the most personally and professionally challenging aspects of this study. Before starting to collect data, I was aware of the need to maintain my identity as a researcher. I had anticipated potential situations in which I might feel tempted to slip back into my role of academic or to offer guidance/counselling to the students I was interviewing. I had also considered the possibility of recognising, during the course of an interview, a students' need for help and I had planned the actions I would take, were the situation to arise. However, I was less prepared for the students' descriptions of incidences of poor practice that they had witnessed. I was particularly concerned about two issues: (1) the incidents of poor practice described by students (as presented in Chapter 6), and (2) the emotional and psychological wellbeing of the students who had been involved in or witness to such practice. While I made no attempt to counsel, guide or advise the students, I did ensure that each had sought and obtained appropriate support and opportunities for debriefing. Most had discussed the issues with their facilitators or link tutors and one student had sought professional counselling. With regard to poor practice, as a professional nurse committed to quality care I was greatly concerned by the students' stories, even more so because I felt that I was not in a position to really do anything. Although I suspected that the stories told were probably not isolated incidences, I did not feel I could reveal any of the confidential information that had been shared with me. These ethical tensions remain unresolved, even though I was encouraged that these quite inexperienced students had

identified and meaningfully reflected on examples of poor practice. While this did not alleviate my concern, it did provide a measure of reassurance.

10.4 Strengths and limitations of the study

There are limitations inherent in all research methods. Some researchers (for example: Cherryholmes, 1992; Creswell, 2003) suggest that a mixed-method approach allows the limitations of one method to neutralise or cancel out the biases of other methods. I do not fully subscribe to this claim, as I believe that the potential for alternative explanations and insights is possible even when more than one method of data collection is used. I do suggest, however, that using mixed methods as I have done in the present study allowed one methodological stance to enhance and inform the other by presenting different slices of reality, and provided a more comprehensive understanding of the phenomenon of belongingness. Nevertheless, the quantitative and qualitative methods employed had limitations and these are now discussed.

The response rate for the BES–CPE was satisfactory at sites 1 and 2 but relatively low at site 3, although at all sites the sample was considered to be representative of the population. It is acknowledged that even a good response rate does not necessarily protect against bias. As with any survey, there is a possibility that participants may differ in character or attitudes from non-participants, and one could speculate that those with strong views regarding their own experience of belongingness and clinical placements may have been more likely to respond to the survey. Whether these views are positive or negative, or are derived from positive or negative experiences is unknown. In this study I suggest that the wide range of mean BES–CPE scores, the acceptable response rate and the opportunity for all current third-year students to participate in the survey minimised the influence of the varying characteristics and views of the respondents.

However, the opportunity to participate in the study was available only to those students who were enrolled in the nursing programs at the time of the study. Therefore those who had withdrawn in the previous three years had no opportunity to express their views. Given the attrition rates at each of the universities, there were a reasonable number of untapped perspectives that may have impacted upon the findings. The extent to which this is significant cannot be ascertained but should be taken into consideration. It should also be

noted that, although fairly typical of the student cohorts from which they were drawn, the survey participants cannot be assumed to be necessarily representative of a larger population outside the study contexts, as they were predominantly white, English-speaking women. Furthermore, because the vast majority of participants were from Australia and the UK, this may limit generalisability to other cultures and countries.

An additional limitation of the BES–CPE is that survey data were based on self-report. Responses obtained in this manner may be subject to social desirability that may bias answers towards more acceptable norms. It was anticipated that the anonymity provided by offering online submission of questionnaires would improve the likelihood of participants responding candidly to the survey. Additionally, as the survey focused on the clinical placement experience only, the effect of other significant environments/relationships was not accounted for, although these environments/relationships may indeed affect levels of belongingness.

To keep the qualitative findings in perspective, it is important to note that the sample was relatively small, with participants totalling 18. This is in keeping with qualitative methods where the purpose is both to add new insights that stimulate debate and discussion around the issues and to enhance transferability by providing faithful and detailed descriptions of the phenomenon. Furthermore, the interviews elicited the students' personal perceptions or slant on the issue of belongingness and as such may not always be a complete reflection of the situations described, although in many respects the students from the three sites shared similar perspectives and described similar experiences. The recurring nature of the themes depicted in the transcripts enhanced the credibility of the study.

Throughout the qualitative interviews I was aware of the potential influence that I, as the researcher, might have on the views expressed by the participants. This was particularly true of the interviews undertaken with students from site 1, where I held an academic position. To lessen the risk of bias I ensured that I had not and would not in the future engage in a teaching relationship with any of the participants. The extent to which my presence as the interviewer influenced these students cannot be determined, yet the candid nature of the students' accounts and the consistency between the experiences described by students from the three sites provided a measure of reassurance.

Another limitation arose from the fact that data collection, analysis and interpretation were undertaken by a single individual, and that the possibility of my influence existed at virtually all stages of the process. On the one hand, this may have contributed to the coherence of the study; on the other, it implies potential bias. In an attempt to guard against bias and to strengthen the dependability of the findings, emerging themes were verified by two independent researchers, both co-supervisors in the study. This checking of intersubjective agreement was undertaken to enhance auditability. It should also be noted that saturation of the categories identified during analysis was achieved through a coherent schema of interrelated theoretical themes, as evidenced in the preceding chapters, and that no readily apparent "outliers" prompted me to further interrogate the data set.

One of the study strengths not yet mentioned is the multi-site, cross-national case study approach, which was adopted not only to explore the concept of belongingness but to gain a comparative perspective. Stake (2000) suggests that similarities and differences between case study sites and between the participants' perspectives allow greater generalisation and lead to improved understanding and theorising. Certainly, the opportunity for an examination of contrasting sites brought valuable insights to the study, which may not have been possible had another design been selected. Of note was the finding that belongingness defies national and contextual boundaries, and that the experiences and perspectives of the participants from all sites were, in many respects, remarkably similar, despite the differences in the health and higher education systems.

10.5 Recommendations for further research

In exploring belongingness, the intention was to aid understanding by promoting dialogue, disentangling complexities and raising the level and focus of debate. I believe that in this regard the study has achieved its aims. However, the implications of belongingness for individuals, workplaces, and for the nursing profession are diverse and far-reaching and should continue to be explored and debated.

This study highlights several issues requiring further research. The study clearly indicated that belongingness is pivotal to the quality of nursing students' clinical placements and to

their learning. Ongoing research is needed to expand on this area of study. If nursing academics are to ensure that graduates emerge as confident and competent professionals able to deal with the problems and pressures of professional practice, and clinical leaders are to reinforce this in practice environments, then belongingness needs to be actively fostered, purposefully studied, and assessed to provide baseline measures for decision-making.

Educational institutions would benefit from the use of a quantified yardstick, such as the BES–CPE, with which to measure belongingness as one way of evaluating the efficacy of programs, placements and partnerships between higher education and health services. Replication studies with a diverse range of samples are needed in order to determine the reliability and validity of the BES–CPE with other populations. Suggestions for further research include additional cross-cultural studies using samples from different countries and further exploration of the phenomenon of belongingness in nursing and other professional groups. Additionally, as interpersonal relationships with nursing colleagues are a key factor in students' perception of the quality of clinical placements, further research is required to define the best methods to prepare, support and recognise registered nurses who assume a mentorship role.

Researchers have recently begun to focus their attention on the relationship between peoples' individual attributes and their need to belong. This work is in its infancy and further studies are needed to develop a complete model which more fully delineates how peoples' characteristics and contextual situations impact their experience of belongingness. This research would be of some use in allowing vulnerable individuals to be identified before they are lost to the profession.

Currently there is a paucity of empirical evidence on best-practice principles for clinical placements and a dire need for further research (Clare et al., 2003). Numerous evaluative studies have been undertaken, although to date, a clear set of generic guiding principles for clinical placements have not emerged. While it is important to retain the different philosophical approaches to the preparation of a nurse that various programs in the UK and Australia offer, it is critical that clinical education models are informed by sound research and best-practice principles. The role of regulatory authorities should not be ignored in the debates about appropriate clinical placement principles, as they are the gate

keepers of the standards required to achieve registration. However, for regulatory authorities to support best-practice principles, they must be convinced that these principles are based upon supporting evidence. A body of evidence is therefore needed from which to develop best-practice principles. While much work still needs to be done, this study has contributed new knowledge that can inform this debate.

10.6 Final words

Two decades ago Melia (1987) described the socialisation experiences of hospital-trained nurses in the UK. She identified "getting the work done", "learning the rules" and "fitting in" as dominant strategies used by students to survive in practice. These strategies are not dissimilar to those adopted and described by the students in the current study. It is disturbing that two studies, separated by an extensive period of time and focusing on what are, in many ways, disparate systems of nursing education, could identify problems in clinical education that are of such a recurring nature. Without doubt, nursing education has made enormous progress over the last 20 years, but I question whether progress in the clinical education of nursing students is commensurate with the advances seen in theory-based learning. While a number of students in this study had what appeared to be positive and productive clinical placement experiences, where they learnt to assume a level of responsibility for their learning, far too many experienced placements where their learning was not optimised and their goal of becoming a competent and confident professional was negatively impacted.

I advocate that, in recognition of the significance that students attribute to belongingness and the demonstrated influence it has on their learning, there is a need for strategies that enhance students' belongingness and social wellbeing when undertaking clinical placements, so that they can direct their energy and attention towards learning to care for patients. Optimising the quality of clinical placement experiences in this way is critical, but complex in its realisation. Success is dependent upon a number of factors: effective collaboration between higher education and health services; practice and learning environments that, regardless of the complexity, remain responsive and flexible to the diverse professional and personal needs of nursing students; the development of effective interpersonal relationships between all stakeholders involved; and students who are adequately prepared for the complexity and challenges inherent in contemporary clinical

practice and cognisant of the influence they exert over their own clinical learning. This study has demonstrated that the actualisation of these goals is not only possible but in many environments has already been realised. The challenge for those concerned with optimising students' clinical placement experiences is to examine learning environments and processes that facilitate students' experience of belongingness and to explore ways to re-create these across health services and within diverse groups.

I view the findings from this study as a contribution to the search for better understanding and perhaps better conceptualisation of belongingness as it relates to clinical placements. This study seeks to join with other emergent perspectives of belongingness to form part of the larger developing picture of the phenomenon. It also marks an important phase in my continuing interest and concern for improving the quality of what I consider to be the most important component of nursing education, the clinical placement. At this stage, true to my commitment to allow the participants' perspectives to prevail, I call upon Monique to add her final words to this thesis:

> *Everybody needs to belong, to feel accepted, especially in the work environment or learning environment. And I want to feel like part of the team, to be involved and included. Then I can focus on the job of learning—and isn't that what I'm there for?* (10: 500–503)

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Appendices

Appendix 1
BES–CPE Questionnaire

Belonging

Implications for Third Year Nursing Students in Australia and the UK

Part I: Online Survey

Please follow the directions below to complete the online survey.

Step 1: Read Online Survey Information

The first stage of the research project is the online, anonymous survey. To download and read the information about the survey, click the button below:

[Download Survey Information]

Belonging
Implications for Third Year Nursing Students in Australia and the UK

Belongingness Survey

This survey is structured in two parts:

1. Information about you
2. Information about your clinical placement experiences

Many questions will involve simply clicking on a button. A few will invite you to select from a drop down list of possible answers or to type a few words.

1: Information about you

For the following questions please select the option that best describes you.

Which University / Campus / Locality / Clinical Partner Hospital are you a student of?

Please select... ▾

What academic program are you enrolled in?

Please select... ▾

How old are you?

Please select... ▾

What gender are you?
○ Male   ○ Female

Is English your native language?
○ Yes   ○ No

What is your country of origin?

What academic program are you enrolled in?

Have you any nursing experience apart from that included as part of your current academic program?
○ Yes   ○ No

Are any of the members of your immediate family nurses?
○ Yes   ○ No

[Continue >>]   [Exit Survey]

Belongingness Survey

2: Information about your clinical placement experiences

Over the next three pages, you will find a list of statements. Read each statement and then select the response that best indicates **how often the statement is true for you**.

For example, if you eat desert after dinner almost every night you would select '*Often True*'. If you rarely eat desert you would select '*Rarely True*'

For each question:

- **Please answer every item**, even if one seems similar to another one
- **Answer each item quickly**, without spending too much time on any one item.
- **Think generally about your clinical placement experiences** when considering your responses to the questions, or if this is difficult **reflect on your last clinical placement experience**.

In the statements below, '*placement/s*' refers to your supernumerary clinical placement experience as a nursing student, and '*collegues*' refers to clinical staff in the area of your placement.

01	I feel like I fit in with others during my placements	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
02	It is important to feel accepted by my colleagues	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
03	Colleagues see me as a competent person	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
04	Colleagues offer to help me when they sense I need it	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
05	I make an effort to help new students or staff feel welcome	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
06	I view my placements as a place to experience a sense of belonging	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
07	I get support from colleagues when I need it	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
08	I am invited to social events outside of my placements by colleagues	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
09	I like the people I work with on placements	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
10	I feel discriminated against on placements	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True

[<< Page 1]   [Continue >>]   [Exit Survey]

The UNIVERSITY of NEWCASTLE
AUSTRALIA

Belongingness Survey
3: Information about your clinical placement experiences (cont.)

11	I offer to help my colleagues, even if they don't ask for it	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
12	It is important to me that someone at my placement acknowledges my birthday in some way	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
13	I invite colleagues to eat lunch/dinner with me	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
14	On placements I feel like an outsider	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
15	There are people that I work with on placements who share my values	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
16	Colleagues ask for my ideas or opinions about different matters	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
17	I feel understood by my colleagues	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
18	I make an effort when on placements to be involved with my colleagues in some way	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
19	I am supportive of my colleagues	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
20	I ask for my colleagues' advice	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
21	People I work with on placements accept me when I'm just being myself	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
22	I am uncomfortable attending social functions on placements because I feel like I don't belong	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True

Belongingness Survey
4: Information about your clinical placement experiences (cont.)

#	Statement	Responses
23	When I walk up to a group on a placement I feel welcomed	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
24	Feeling "a part of things" is one of the things I like about going to placements	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
25	There are people on placements with whom I have a strong bond	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
26	I keep my personal life to myself when I'm on placements	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
27	It seems that people I work with on placements like me	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
28	I let colleagues know I care about them by asking how things are going for them and their family	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
29	Colleagues notice when I am absent from placements or social gatherings because they ask about me	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
30	One or more of my colleagues confides in me	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
31	I let my colleagues know that I appreciate them	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
32	I ask my colleagues for help when I need it	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
33	I like where I work on placements	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True
34	I feel free to share my disappointments with at least one of my colleagues	○ Never True ○ Rarely True ○ Sometimes True ○ Often True ○ Always True

[<< Page 3]   [Submit Form]   [Exit Survey]

Belonging

Implications for Third Year Nursing Students in Australia and the UK

Thankyou...

...your survey has been submitted!

Thankyou for taking the time to complete this survey. Your input is valued and greatly appreciated.

Interview Invitation

Would you consider taking part in the second stage of the research project? Students will be interviewed and asked to share their perspectives and experiences of belonging.

Your decision to participate is completely voluntary. At this point, there are two ways to proceed:

[Download Interview Information] - Information on how to participate further in the study is provided in the document.

[Exit Website] - Leave the website. Bookmark this page now should you reconsider at a later time.

Appendix 2
SPSS Command Syntax File

* Read data from Excel.
* Remember to amend path name for file when working on different computers.
* /FILE='C:\My Documents\Consulting\Health\Nursing & Midwifery\Tracy Levett-jones\Survey Stage 2\survey-data-stage2-17.7.06#combined and corrected.xls' .

GET DATA /TYPE=XLS
  /FILE='f:\Statistics\Survey Stage 2\survey-data-stage2-17.7.06#combined and corrected.xls'
  /SHEET=name 'survey-data-stage2-20060704'
  /CELLRANGE=full
  /READNAMES=on
  /ASSUMEDSTRWIDTH=32767.

* Recode all questions from text values into range 1 to 5.
RECODE Q1 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q2 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q3 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q4 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q5 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q6 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q7 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q8 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q9 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q10 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q11 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q12 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q13 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q14 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q15 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q16 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q17 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q18 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .
RECODE Q19 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-true'='5') .

```
RECODE Q20 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q21 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q22 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q23 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q24 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q25 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q26 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q27 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q28 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q29 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q30 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q31 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q32 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q33 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
RECODE Q34 ('never-true'='1') ('rarely-true'='2') ('sometimes-true'='3') ('often-true'='4') ('always-
true'='5') .
EXECUTE .

* Recode other variables - from the Excel data labels to simple numeric codes.
RECODE  Program  ('Bachelor of Nursing'='1')  ('Diploma in Nursing'='2') ('Advanced Diploma in
Nursing'='3').
RECODE  Location
('University of Newcastle - Callaghan Campus'='1')
('University of Newcastle - Gosford'='2')
('University of Newcastle - Port Macquarie Campus'='3')
('University of Queensland - Ipswich clinical partner hospital'='4')
('University of Queensland - Princess Alexandra clinical partner hospital'='5')
('University of Queensland - unspecified hospital' = '11')
('University of Southampton - Portsmouth locality'='6')
('University of Southampton - Isle of White locality'='7')
('University of Southampton - Winchester locality'='8')
('University of Southampton - Basingstoke locality'='9')
('University of Southampton - Southampton locality'='10').
RECODE  AgeGrp  ('19-22'='1') ('23-25'='2') ('26-30'='3') ('31-40'='4') ('41-50'='5') ('51-60'='6')
('61+'='7') .

RECODE  Gender  ('Male'='1')  ('Female'='2').
RECODE NativeEnglishSpeaker ('Yes'='1') ('No'='2').
RECODE  PrevExp ('Yes'='1')  ('No'='2').
RECODE  FamExp ('Yes'='1')  ('No'='2').
RECODE  Location ('1'=1) ('2'=1) ('3'=1) ('4'=2) ('5'=2) ('6'=3) ('7'=3) ('8'=3) ('9'=3) ('10'=3)
('11'=2) INTO  Site .
```

```
RECODE  COB  ('Australia'=1) (ELSE=2) INTO COB2 .
VARIABLE LABELS COB2 'COB - 2 groups'.
VALUE LABELS cob2 1 'Australia' 2 'Other'.
EXECUTE .

* Recode COB into 4 groups.
STRING COB3 (A17).
RECODE COB
('Australia'= 'Australia')
('Brunei' = 'Asia')
('Cambodia'='Asia')
('China'='Asia' )
('Czech Republic'='Other')
('France'='Other')
('Germany'='Other')
('Korea'='Asia')
('Malaysia'='Asia')
('New Zealand'='Other')
('Papua New Guinea'='Other')
('Philippines'='Asia')
('Singapore'='Asia')
('South Africa'='Other')
('Tonga'='Other')
('UK'='UK')
('USA'='Other')
('Zimbabwe'='Other')
into cob3.
Execute.


* ----------------------------------------------------------------------------------------.
* REMEMBER THIS MANUAL STEP HERE.
* Using Windows interface in Data set variable view convert all string variables to numeric.
* Hint: convert first variable, say Q1 to numeric and then copy and paste the numeric attribute to the
rest.
* Remember to convert location, campus, etc too before running the value labels beneath, BUT
NOT COB!.
* THE FOLLOWING CODE WILL NOT WORK WITHOUT THIS MANUAL STEP FIRST.
* ----------------------------------------------------------------------------------------.


* Reverse coding for certain questions.
NUMERIC Q10r Q14r Q22r Q26r (F1.0).

COMPUTE Q10r = 6-Q10 .
COMPUTE Q14r = 6-Q14 .
COMPUTE Q22r = 6-Q22 .
COMPUTE Q26r = 6-Q26 .
EXECUTE .

* Set up value labels for the simple numeric codes above to turn them into more helpful and short
names.
VALUE LABELS Program 1 'BN' 2 'DipN' 3 'AdDipN'.
VALUE LABELS Location 1 'Site 1-1'  2 'Site 1-2'  3 'Site 1-3' 4 'Site 2-1' 5 'Site 2-2'  11 'Site 2-?' 6
'Site 3-1'  7 'Site 3-2' 8 'Site 3-3' 9 'Site 3-4' 10 'Site 3-5'.
VALUE LABELS Site 1 'Site 1' 2 'Site 2' 3 'Site 3'.
VALUE LABELS AgeGrp2 1 '19-22' 2  '23-25-61+'.
```

VALUE LABELS   Gender 1 'Male'   2 'Female'.
VALUE LABELS   NativeEnglishSpeaker 1 'Yes'   2 'No'.
VALUE LABELS   Q1 to Q34 1 'never true' 2 'rarely true' 3 'sometimes true' 4 'often true' 5 'always true'.
VALUE LABELS   Q10r Q14r Q22r Q26r 5 'never true' 4 'rarely true' 3 'sometimes true' 2 'often true' 1 'always true'.
VALUE LABELS   AgeGrp 1 '19-22' 2 '23-25' 3 '26-30' 4 '31-40'   5 '41-50'   6 '51-60'   7 '61+' .
RECODE AgeGrp (1=1) (2=2) (3=2) (4=2) (5=2) (6=2) (7=2) INTO AgeGrp2.
EXECUTE .

* Variable labels.
VARIABLE LABELS
Q1 'Q1 I feel like I fit in with others during my placements'
Q2 'Q2 It is important to feel accepted by my colleagues'
Q3 'Q3 Colleagues see me as a competent person'
Q4 'Q4 Colleagues offer to help me when they sense I need it'
Q5 'Q5 I make an effort to help new students or staff feel welcome'
Q6 'Q6 I view my placements as a place to experience a sense of belonging'
Q7 'Q7 I get support from colleagues when I need it'
Q8 'Q8 I am invited to social events outside of my placements by colleagues'
Q9 'Q9 I like the people I work with on placements'
Q10 'Q10 I feel discriminated against on placements'
Q11 'Q11 I offer to help my colleagues, even if they don't ask for it'
Q12 'Q12 It is important to me that someone at my placement acknowledges my birthday in some way'
Q13 'Q13 I invite colleagues to eat lunch/dinner with me'
Q14 'Q14 On placements I feel like an outsider'
Q15 'Q15 There are people that I work with on placements who share my values'
Q16 'Q16 Colleagues ask for my ideas or opinions about different matters'
Q17 'Q17 I feel understood by my colleagues'
Q18 'Q18 I make an effort when on placements to be involved with my colleagues in some way'
Q19 'Q19 I am supportive of my colleagues'
Q20 'Q20 I ask for my colleagues' advice'
Q21 'Q21 People I work with on placements accept me when I'm just being myself'
Q22 "Q22 I am uncomfortable attending social functions on placements because I feel like I don't belong"
Q23 'Q23 When I walk up to a group on a placement I feel welcomed'
Q24 'Q24 Feeling "a part of things" is one of the things I like about going to placements'
Q25 'Q25 There are people on placements with whom I have a strong bond'
Q26 "Q26 I keep my personal life to myself when I'm on placements"
Q27 'Q27 It seems that people I work with on placements like me'
Q28 'Q28 I let colleagues know I care about them by asking how things are going for them and their family'
Q29 'Q29 Colleagues notice when I am absent from placements or social gatherings because they ask about me'
Q30 'Q30 One or more of my colleagues confides in me'
Q31 'Q31 I let my colleagues know that I appreciate them'
Q32 'Q32 I ask my colleagues for help when I need it'
Q33 'Q33 I like where I work on placements'
Q34 'Q34 I feel free to share my disappointments with at least one of my colleagues'
Q10r 'Q10r I feel discriminated against on placements'
Q14r 'Q14r On placements I feel like an outsider'
Q22r "Q22r I am uncomfortable attending social functions on placements because I feel like I don't belong"

Q26r "Q26r I keep my personal life to myself when I'm on placements".

```
*----------------------------------------------------------------------------.
* Calculate scale scores.
COMPUTE connect_pr = (q1+q2+q14r+q17+q21+q23+q24+q25+q33)/9.
COMPUTE connect_ag = (q5+q18+q26r)/3.
COMPUTE connect_nb = q15.

COMPUTE esteem_pr = (q3+q4+q7+q12+q16+q29+q30)/7.
COMPUTE esteem_ag = (q11+q19+q20+q28+q31+q32)/6.
COMPUTE esteem_nb = q34.

COMPUTE con_est_pr = (q6+q8+q10r+q22r+q27)/5.
COMPUTE con_est_ag = q13.
COMPUTE con_est_nb = q9.

* Scale totals.
COMPUTE connect = ((q1+q2+q14r+q17+q21+q23+q24+q25+q33) +(q5+q18+q26r) + q15)/(9+
3+1).
COMPUTE esteem = ((q3+q4+q7+q12+q16+q29+q30) + (q11+q19+q20+q28+q31+q32) +
q34)/(7+6+1).
COMPUTE con_est = ((q6+q8+q10r+q22r+q27) + q13 + q9)/(5+1+1).

COMPUTE pr = ((q1+q2+q14r+q17+q21+q23+q24+q25+q33) + (q3+q4+q7+q12+q16+q29+q30) +
(q6+q8+q10r+q22r+q27))/(9+7+5).
COMPUTE ag = ((q5+q18+q26r) + (q11+q19+q20+q28+q31+q32) + q13)/(3+6+1).
COMPUTE nb = (q15 + q34 + q9)/3.

* Grand total.
COMPUTE belonging = mean(q1 to q9,q10r,q11 to q13, q14r, q15 to q21,q22r, q23 to q25,q26r,q27
to q34).
Execute.
```

* After calculating the above scales manully adjust the number of decimal places to 1 or 2 in the
variable view of the data table.

```
VARIABLE LABELS
connect_pr  'Connectedness - Passive/Receiving'
connect_ag  'Connectedness - Active/Giving'
connect_nb  'Connectedness - Neutral/Both'
esteem_pr 'Esteem - Passive/Receiving'
esteem_ag 'Esteem - Active/Giving'
esteem_nb 'Esteem - Neutral/Both'
con_est_pr 'Connectedness/Esteem - Passive/Receiving'
con_est_ag 'Connectedness/Esteem  - Active/Giving'
con_est_nb 'Connectedness/Esteem - Neutral/Both'
connect 'Connectedness - total'
esteem 'Esteem - total'
con_est 'Connectedness/Esteem - total'
pr  'Passive/Receiving - total'
ag  'Active/Giving - total'
nb  'Neutral/Both'
belonging 'Grand total'.

*----------------------------------------------------------------------------.
```

* Remember to ammend path name for file when working on different computers.
* Tracy's computer.
SAVE OUTFILE='f:\Statistics\Survey Stage 2\Survey Stage 2\survey stage2 combined.sav' .
 /COMPRESSED.

* Kim's computer.
*SAVE OUTFILE='C:\My Documents\Consulting\Health\Nursing & Midwifery\Tracy Levett-jones\Survey Stage 2\survey stage2 combined.sav' .
 /COMPRESSED.

* --.

* Carry out missing value anlysis.
MVA
  Location Program AgeGrp Gender NativeEnglishSpeaker PrevExp FamExp Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10
   Q11 Q12 Q13 Q14 Q15 Q16
  Q17 Q18 Q19 Q20 Q21 Q22 Q23 Q24 Q25 Q26 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 COB
  /MAXCAT = 25
  /CATEGORICAL = COB
  /TPATTERN NOSORT PERCENT=0 .

* Explore the data - tables and graphs.

* Nominal variables.
FREQUENCIES   VARIABLES=Location Program Gender NativeEnglishSpeaker COB COB2 PrevExp FamExp
/ORDER= ANALYSIS /FORMAT=DFREQ /BARCHART PERCENT.

* Ordinal variables: Age groups in age order rather than most frequent first.
FREQUENCIES
  VARIABLES=agegrp
  /BARCHART PERCENT
  /ORDER= ANALYSIS .

DESCRIPTIVES
  VARIABLES=Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10r Q11 Q12 Q13 Q14r Q15 Q16 Q17 Q18 Q19 Q20
  Q21 Q22r Q23 Q24 Q25 Q26r Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
  /STATISTICS=MEAN STDDEV MIN MAX .

FREQUENCIES
  VARIABLES=Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10r Q11 Q12 Q13 Q14r Q15 Q16 Q17 Q18 Q19
  Q20 Q21 Q22r Q23 Q24 Q25 Q26r Q27 Q28 Q29 Q30
  Q31 Q32 Q33 Q34
  /ORDER= ANALYSIS .

CROSSTABS
  /TABLES=COB BY NativeEnglishSpeaker
  /FORMAT= AVALUE TABLES
  /CELLS= COUNT
  /COUNT ROUND CELL .

* Save output as frequency tables.

```
*---------------------------------------------------------------------------.
* Belonging analysis.
* Variables with 3 or more groups.
CTABLES
 /VLABELS VARIABLES=AgeGrp belonging DISPLAY=DEFAULT
 /TABLE AgeGrp > belonging [MEAN COMMA40.2, COUNT F40.0]
 /CATEGORIES VARIABLES=AgeGrp ORDER=A KEY=VALUE EMPTY=INCLUDE.

GRAPH
 /ERRORBAR( CI 95 )=belonging BY AgeGrp .

UNIANOVA
 belonging  BY AgeGrp
 /METHOD = SSTYPE(3)
 /INTERCEPT = INCLUDE
 /PRINT = DESCRIPTIVE
 /CRITERIA = ALPHA(.05)
 /DESIGN = AgeGrp .

UNIANOVA
 belonging  BY COB
 /METHOD = SSTYPE(3)
 /INTERCEPT = INCLUDE
 /PRINT = DESCRIPTIVE
 /CRITERIA = ALPHA(.05)
 /DESIGN = COB .

* Variables with 2 groups.

T-TEST
 GROUPS = COB2(1 2)
 /MISSING = ANALYSIS
 /VARIABLES = belonging
 /CRITERIA = CI(.95) .

T-TEST
 GROUPS = Gender(1 2)
 /MISSING = ANALYSIS
 /VARIABLES = belonging
 /CRITERIA = CI(.95) .

T-TEST
 GROUPS = NativeEnglishSpeaker(1 2)
 /MISSING = ANALYSIS
 /VARIABLES = belonging
 /CRITERIA = CI(.95) .

T-TEST
 GROUPS = PrevExp(1 2)
 /MISSING = ANALYSIS
 /VARIABLES = belonging
 /CRITERIA = CI(.95) .

* Save output as t-test & ANOVA belonging.
*---------------------------------------------------------------------------.
```

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*belongingness table. (NB. No. 10, 14, 22 and 26 use reverse scored items).

* Connectedness - Passive - Receiving.
DESCRIPTIVES
  VARIABLES=Q1 Q2 Q14r Q17 Q21 Q23 Q24 Q25 Q33
  /STATISTICS=MEAN STDDEV .

*Connectedness - Active - Giving.
DESCRIPTIVES
  VARIABLES=Q5 Q18 Q26r
  /STATISTICS=MEAN STDDEV .

*Connectedness - Neutral - Both.
DESCRIPTIVES
  VARIABLES=Q15
  /STATISTICS=MEAN STDDEV .

*Esteem - Passive - Receiving.
DESCRIPTIVES
  VARIABLES=Q3 Q4 Q7 Q12 Q16 Q29 Q30
  /STATISTICS=MEAN STDDEV .

*Esteem - Active - Giving.
DESCRIPTIVES
  VARIABLES=Q11 Q19 Q20 Q28 Q31 Q32
  /STATISTICS=MEAN STDDEV .

*Esteem - Neutral - Both.
DESCRIPTIVES
  VARIABLES=Q34
  /STATISTICS=MEAN STDDEV .

*Connectedness and Esteem - Passive- Receiving.
DESCRIPTIVES
  VARIABLES=Q6 Q8 Q10r Q22r Q27
  /STATISTICS=MEAN STDDEV .

*Connectedness and Esteem - Active - Giving.
DESCRIPTIVES
  VARIABLES=Q13
  /STATISTICS=MEAN STDDEV .

*Connectedness and Esteem - Neutral - Both.
DESCRIPTIVES
  VARIABLES=Q9
  /STATISTICS=MEAN STDDEV .

*---.
* TOTALS.

* Connectedness - Passive - Receiving.
DESCRIPTIVES
  VARIABLES=connect_pr
  /STATISTICS=MEAN STDDEV .

*Connectedness - Active - Giving.

```
DESCRIPTIVES
 VARIABLES=connect_ag
 /STATISTICS=MEAN STDDEV .

*Connectedness - Neutral - Both.
DESCRIPTIVES
 VARIABLES=connect_nb
 /STATISTICS=MEAN STDDEV .

*Connectedness - Total.
DESCRIPTIVES
 VARIABLES=connect
 /STATISTICS=MEAN STDDEV .

*Esteem - Passive - Receiving.
DESCRIPTIVES
 VARIABLES=esteem_pr
 /STATISTICS=MEAN STDDEV .

*Esteem - Active - Giving.
DESCRIPTIVES
 VARIABLES=esteem_ag
 /STATISTICS=MEAN STDDEV .

*Esteem - Neutral - Both.
DESCRIPTIVES
 VARIABLES=esteem_nb
 /STATISTICS=MEAN STDDEV .

*Esteem - Total .
DESCRIPTIVES
 VARIABLES=esteem
 /STATISTICS=MEAN STDDEV .

*Connectedness and Esteem - Passive- Receiving.
DESCRIPTIVES
 VARIABLES=con_est_pr
 /STATISTICS=MEAN STDDEV .

* nb. Connectedness and Esteem - active/givng and neutral/both only have one item. i.e total will be
the seme as above.

*Connectedness - esteem - Total.
DESCRIPTIVES
 VARIABLES=con_est
 /STATISTICS=MEAN STDDEV .

*Passive - receiving - total.
DESCRIPTIVES
 VARIABLES=pr
 /STATISTICS=MEAN STDDEV .

*Active - giving - total.
DESCRIPTIVES
 VARIABLES=ag
 /STATISTICS=MEAN STDDEV .
```

```
*Neutral - both - total.
DESCRIPTIVES
 VARIABLES=nb
 /STATISTICS=MEAN STDDEV MIN MAX .

*Belonging - total.
DESCRIPTIVES
 VARIABLES=belonging
 /STATISTICS=MEAN STDDEV .

*-------------------------------------------------------------------------.
*Reliability - Cronbach's Alpha.

* Connectedness - Passive - Receiving.
RELIABILITY
 /VARIABLES=Q1 Q2 Q17 Q21 Q23 Q24 Q25 Q33 Q14r
 /FORMAT=NOLABELS
 /SCALE(ALPHA)=ALL/MODEL=ALPHA.

*Connectedness - Active - Giving.
RELIABILITY
 /VARIABLES=Q26r Q18 Q5
 /FORMAT=NOLABELS
 /SCALE(ALPHA)=ALL/MODEL=ALPHA.

*Esteem - Passive - Receiving.
RELIABILITY
 /VARIABLES=Q3 Q4 Q7 Q12 Q16 Q29 Q30
 /FORMAT=NOLABELS
 /SCALE(ALPHA)=ALL/MODEL=ALPHA.

*Esteem - Active - Giving.
RELIABILITY
 /VARIABLES=Q11 Q19 Q20 Q28 Q31 Q32
 /FORMAT=NOLABELS
 /SCALE(ALPHA)=ALL/MODEL=ALPHA.

*Connectedness and Esteem - Passive- Receiving.
RELIABILITY
 /VARIABLES=Q10r Q22r Q6 Q8 Q27
 /FORMAT=NOLABELS
 /SCALE(ALPHA)=ALL/MODEL=ALPHA.

*-----------------------------------------------------.

* Factor Analysis.
* Initial exploration - PCA.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
  Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
  Q10r Q14r Q22r Q26r
 /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT UNIVARIATE INITIAL CORRELATION SIG EXTRACTION
```

```
 /PLOT EIGEN
 /CRITERIA MINEIGEN(1) ITERATE(25)
 /EXTRACTION PC
 /ROTATION NOROTATE
 /METHOD=CORRELATION .


* Try extracting 9 factors.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r  /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(9) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .

* Try extracting 8 factors.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r  /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(8) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .

* Try extracting 7 factors.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r  /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(7) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .

* Try extracting 6 factors - FA.
```

FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(6) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .

* Try extracting 5 factors.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(5) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .

* Try extracting 4 factors.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(4) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .

* Try extracting 3 factors.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)

```
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(3) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .

* Try extracting 2 factors.
FACTOR
 /VARIABLES Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11 Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21
Q23 Q24 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34
 Q10r Q14r Q22r Q26r  /MISSING LISTWISE /ANALYSIS Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q11
Q12 Q13 Q15 Q16 Q17 Q18 Q19 Q20 Q21 Q23 Q24
 Q25 Q27 Q28 Q29 Q30 Q31 Q32 Q33 Q34 Q10r Q14r Q22r Q26r
 /PRINT INITIAL EXTRACTION ROTATION
 /FORMAT BLANK(.3)
 /PLOT EIGEN ROTATION
 /CRITERIA FACTORS(2) ITERATE(25)
 /EXTRACTION PC
 /CRITERIA ITERATE(100)
 /ROTATION VARIMAX
 /METHOD=CORRELATION .


* Calculate scale scores.
COMPUTE connectedness = (q8+q13+q16+q25+q28+q29+q30)/7.
COMPUTE active = (q2+q5+q11+q19+q20+q31+q32)/7.
COMPUTE esteem2 = (q1+q3+q4+q7+q9+q17+q21+q23+q27+q33+q10r+q14r)/12.
EXECUTE .
```

* After calculating the above scales manully adjust the number of decimal places to 1 or 2 in the variable view of the data table.

```
*Connectedness.
DESCRIPTIVES
 VARIABLES= connectedness
 /STATISTICS=MEAN STDDEV .
EXECUTE .

*Esteem2.
DESCRIPTIVES
 VARIABLES= esteem2
 /STATISTICS=MEAN STDDEV.
EXECUTE .

DESCRIPTIVES
 VARIABLES= active
 /STATISTICS=MEAN STDDEV .
EXECUTE .

esteem

DESCRIPTIVES
 VARIABLES=Q1 Q3 Q4 Q7 Q9 Q17 Q21 Q23 Q27 Q33 Q10r Q14r
 /STATISTICS=MEAN STDDEV .
```

connectedness

```
DESCRIPTIVES
 VARIABLES=Q8 Q13 Q16 Q25 Q28 Q29 Q30 Q26r Q15
 /STATISTICS=MEAN STDDEV .
```

active

```
DESCRIPTIVES
 VARIABLES=Q2 Q5 Q11 Q19 Q20 Q31 Q32
 /STATISTICS=MEAN STDDEV .
```

Appendix 3
Interviewer behaviour code

Interviewer behaviour	Yes	No	Some-times	Mostly
Interview preparation				
Asks the participant if they have any questions.				
Ensures that the participant has signed their consent form.				
Helps participant to understand their role.				
Helps participant to understand the interviewer's role.				
Explains purpose of study.				
Asking interview questions				
Reads the question as exactly as printed on interview schedule.				
Reads the question making only minor modifications of the printed version, bur does not alter frame of reference.				
Reads the question but makes significant modifications of the printed version which alter the frame of reference.				
Asks a question that should have been skipped.				
Does not ask a question but instead makes a statement about the response he/she anticipates.				
Probing and clarifying				
Makes up in own words a probe (query) which is not directive.				
Repeats respondents' response or part of it.				
Confirms a frame of reference by responding correctly and in a non-directive manner.				
Makes up a probe which is directive, limiting or changes the frame of reference of either the question or the potential response.				
Either repeats questions or responses incorrectly or gives incorrect summary of respondent's response.				
Either interprets question by rewording it or confirms a frame of reference incorrectly.				
Fails to probe after an inadequate answer.				
Inappropriate interviewer behaviours				
Interrupts participant.				
Gives personal opinion or evaluation.				
Pace and voice inflection				
Ask question too slowly.				
Asks question too fast.				
Reads question with expression.				
Reads question with a rising inflection at the end.				
Reads question with voice dropped so that it sounds like a statement.				
Recording				
Turns tape on and off as appropriate.				
Finalises interview				
Asks the participant if they would like to choose a pseudonym.				
Asks the participant if they would like a copy of their transcript.				
Acknowledges contribution of participant to the study.				

Adapted from Cannell, Lawson and Hausser (1975).

Appendix 4
Pilot Study Report

Demographic characteristics of participants

The pilot study was conducted at site 1, campus 2. The population size was 61. Of these students, 41 Bachelor of Nursing students completed the survey, giving a response rate of 67.21 per cent. The sample was representative of the population in terms of age and gender. Each demographic characteristic was tested using a one sample chi-squared test in which the population frequencies were taken as the expected values for comparison with the sample values. The following results were obtained: Age $\chi^2(4, N = 41) = 2.4$, $p = .66$); gender $\chi^2(1, N = 41) = .13$, $p = .72$).

The majority of pilot study participants, or 90.2 per cent, were female ($n = 37$), compared to 9.8 per cent male ($n = 4$). Their ages ranged from 20 to 50 years. School leavers, or participants in the 19–22 age group comprised 31.7 per cent of participants ($n = 13$). Mature age students, those aged 23 and above, comprised 68.3 per cent ($n = 28$).

The majority, or 62.5 per cent of the participants identified Australia as their country of birth ($n = 25$). A significant number, 20 per cent, identified one of a group of Asian countries as their country of birth (n = 8). In this group the majority of participants were from China ($n = 5$). A small number of students came from a range of other countries. For 22 per cent of the participants English was not their first language ($n = 9$). Table A.1 contains a summary of the demographic characteristics of the participants from site 1.

Table A.1 Demographic characteristics: pilot study participants (site 1, campus 2)

	Sample *n*	Sample per cent	Population	Per cent[1]
Sample composition (*n* = 41)			(*N* = 61)	
Age (*n* = 41)				
19–22	13	31.7	22	36.0
23–25	5	12.2	6	9.8
26–30	8	19.5	11	18.0
31–40	10	24.4	16	26.2
41–50	5	12.2	4	6.6
51–60			2	3.3
Gender (*n* = 41)				
Female	37	90.2	56	91.8
Male	4	9.8	5	8.2
English as first language (*n* = 159)				
Yes	32	78		
No	9	22		
Country of birth (*n* = 40)				
Australia	25	62.5	38	62.3
Asia[2]	8	20.0	Note [4]	
Other[3]	7	17.5		

[1] Not all percentages add to 100 due to rounding.

[2] Asia: Brunei, China, Korea.

[3] Other: New Zealand South Africa, Tonga, UK.

[4] *Note:* combined statistics for Asian and Other categories, i.e. international students (*n* = 23, 37.7%).

Research question 1

With respect to the clinical placement experience, to what extent do third-year nursing students from three different sites experience belongingness?

To answer this question the mean BES–CPE scores for each question were computed. Mean and standard deviation for BES–CPE scores for each item are demonstrated in Table A.3. Answer choices for the BES–CPE were based on a 5-point Likert Scale, with 1 = never true, 2 = rarely true, 3 = sometimes true, 4 = often true and 5 = always true.

Research question 2

With respect to the clinical placement experience, which of the following variables influence nursing students' experience of belongingness?

- *Gender*
- *Age*
- *Country of birth*
- *English as a first language*

Hypotheses

1. There is no relationship between belongingness and gender.
2. There is no relationship between belongingness and age.
3. There is no relationship between belongingness and country of birth.
4. There is no relationship between belongingness and English as a first language.

Hypothesis 1

Hypothesis 1 posited that there is no relationship between belongingness and gender. Independent t tests were conducted and the mean BES–CPE score for the total sample of men (M = 3.77, SD = .20) was not significantly different from that for women (M = 3.45, SD = .41). The assumption of normality was met, and with α set at .05, no statistically significant t value was found, t (41) = 1.55, p = .13 (two-tailed). The 95 percent confidence interval for the difference between the means was 0.1 to 0.74. Thus, hypothesis 1 was supported. There is no relationship between belongingness and nursing students' gender.

Hypothesis 2

Hypothesis 2 posited that there is no relationship between belongingness and age. The mean BES–CPE scores for the six age groups: 19–22, 23–25, 26–30, 31–40, 41–50 and 51–60 years were analysed with a one-way analysis of variance (ANOVA) and the result was found not to be statistically significant $F(4, 36) = 0.90$, $p = .47$. Descriptive statistics are shown in Table A.2. Thus, hypothesis 2 was supported. There is no relationship between belongingness and age.

Table A.2 Mean BES–CPE scores for age groups: pilot study

Age group	*M*	*SD*	*n*
19–22	3.59	.25	13
23–25	3.34	.46	5
26–30	3.44	.50	8
31–40	3.54	.50	10
41–50	3.24	.23	5
Total	3.48	.40	41

Hypothesis 3

Hypothesis 3 posited that there is no relationship between belongingness and nursing students' country of birth. The categories for country of birth were Australia ($n = 25$, 62.5 per cent), UK ($n = 3$, 7.3 per cent), Asia ($n = 8$, 20 per cent) and Other ($n = 4$, 9.7 per cent). Asia included Brunei, China and Korea. The Other category included New Zealand, South Africa, Tonga and the UK. Using α = .05, the ANOVA result was found not to be statistically significant, $F(4, 36) = 2.3$, $p = .08$. Thus, hypothesis 3 was supported. There was no relationship between belongingness and country of birth.

Hypothesis 4

Hypothesis 4 proposed that there is no relationship between belongingness and English as a first language. Independent *t* tests were conducted and the mean BES–CPE score for participants for whom English was a first language ($M = 3.45$, $SD = .41$) was not significantly different from that of participants for whom English was not a first language ($M = 3.58$, $SD = .36$). The assumption of normality was met, and with α set at .05, no

statistically significant *t* value was found, *t* (41) = 0.87, *p* = <.39 (two-tailed). The 95 per cent confidence interval for the difference between the means was 0.44 to 0.17. Thus, hypothesis 4 was supported. There was no relationship between belongingness and country of birth.

Reliability statistics

Reliability analysis from piloting the instrument revealed a Cronbach's alpha of 0.9. Although the size of the pilot study sample (*n* = 41) limits the strength of validity and reliability testing, there was no indication that the instrument was not rigorous and would not be appropriate for the main study.

Table A.3 Mean and standard deviation for BES–CPE scores: pilot study

		M	SD	N
Q1	I feel like I fit in with others during my placements.	3.59	0.71	41
Q2	It is important to feel accepted by my colleagues.	4.41	0.71	41
Q3	Colleagues see me as a competent person.	3.95	0.71	41
Q4	Colleagues offer to help me when they sense I need it.	3.59	0.74	41
Q5	I make an effort to help new students or staff feel welcome.	4.46	0.71	41
Q6	I view my placements as a place to experience a sense of belonging.	3.68	0.99	41
Q7	I get support from colleagues when I need it.	3.78	0.72	41
Q8	I am invited to social events outside of my placements by colleagues.	1.83	1.00	41
Q9	I like the people I work with on placements.	3.61	0.63	41
Q10r	I feel discriminated against on placements.	3.80	0.90	41
Q11	I offer to help my colleagues, even if they don't ask for it.	4.10	0.78	40
Q12	It is important to me that someone at my placement acknowledges my birthday in some way.	1.90	1.13	40
Q13	I invite colleagues to eat lunch/dinner with me.	2.80	1.26	40
Q14r	On placements I feel like an outsider.	2.98	0.97	40
Q15	There are people that I work with on placements who share my values.	3.50	0.64	40
Q16	Colleagues ask for my ideas or opinions about different matters.	2.85	0.98	40
Q17	I feel understood by my colleagues.	3.20	0.85	40
Q18	I make an effort when on placements to be involved with my colleagues in some way.	3.88	0.72	40
Q19	I am supportive of my colleagues.	4.35	0.58	40
Q20	I ask for my colleagues' advice.	4.45	0.64	40
Q21	People I work with on placements accept me when I'm just being myself.	3.63	0.77	40
Q22r	I am uncomfortable attending social functions on placements because I feel like I don't belong.	2.83	1.06	40
Q23	When I walk up to a group on a placement I feel welcomed.	3.13	0.72	40
Q24	Feeling "a part of things" is one of the things I like about going to placements. *(Continued)*	3.39	0.95	41

Q25	There are people on placements with whom I have a strong bond.	3.27	1.05	41
Q26r	I keep my personal life to myself when I'm on placements.	2.32	0.91	41
Q27	It seems that people I work with on placements like me.	3.73	0.55	41
Q28	I let colleagues know I care about them by asking how things are going for them and their family.	3.46	0.95	41
Q29	Colleagues notice when I am absent from placements or social gatherings because they ask about me.	2.93	1.12	40
Q30	One or more of my colleagues confides in me.	3.07	0.98	41
Q31	I let my colleagues know that I appreciate them.	4.12	0.78	41
Q32	I ask my colleagues for help when I need it.	4.54	0.64	41
Q33	I like where I work on placements.	3.49	0.68	41
Q34	I feel free to share my disappointments with at least one of my colleagues.	3.49	0.95	41

Appendix 5
Advertising Flyer

WHAT DOES IT MEAN TO BELONG?

To all third-year nursing students

My name is Tracy Levett-Jones. I am a PhD student who is interested in understanding how third-year nursing students think and feel about their clinical placement experiences. I am seeking to explore your experiences in two ways:

1. By inviting <u>*all*</u> 3rd year nursing students to complete a short, anonymous, online survey.
2. By interviewing a small number of interested 3rd year nursing students.

Please select the **Download Survey Information** button to find out more about the first stage of the research project – the surveys.

Appendix 6
Survey Information Statement

Professor Margaret McMillan
Faculty of Health
The University of Newcastle
University Drive
Callaghan
NSW, 2308
Phone: (w) 02 4921 6783
Facsimile: 02 4921 2020
Margaret.McMillan@newcastle.edu.au

Tracy Levett-Jones
School of Nursing and Midwifery
The University of Newcastle
University Drive
Callaghan
NSW, 2308.
Phone: (w) 02 4921 6599
(m) 0414 277 510
Facsimile: 02 49216301
Tracy.Levett-jones@newcastle.edu.au

Survey Information Statement for the Research Project:

Belonging, implications for third-year nursing students.

Researchers:

Professor Margaret McMillan (Chief Investigator) Faculty of Health The University of Newcastle	Professor Judith Lathlean (Co-Supervisor) School of Nursing & Midwifery The University of Southampton
Tracy Levett-Jones (PhD Student) School of Nursing and Midwifery The University of Newcastle	Dr Isabel Higgins (Co-Supervisor) School of Nursing and Midwifery The University of Newcastle

You are invited to take part in the research project identified above which is being conducted by Tracy Levett-Jones from the School of Nursing and Midwifery at the University of Newcastle. Tracy Levett-Jones is conducting the research as part of her PhD under the supervision of Professor Margaret McMillan, Professor Judith Lathlean and Dr Isabel Higgins.

Why is the research being done?
- *The purpose of this research is to explore the experience of belonging, as it relates to the clinical placement experience, from the perspective of third-year nursing students.*
- *Information gained from this study will inform policy makers, and has the potential to improve the clinical placement experiences of nursing students.*

- *Previous research has shown that "belonging" is a fundamental and pervasive human need and yet nursing students' experience of 'belonging' has not been adequately explored.*

Who can participate in the research?
- *We are seeking <u>all</u> third-year nursing students to participate in this stage of the research project.*

What choice do you have?
- *Participation in this research is entirely your choice.*
- *Whether or not you decide to participate, your decision will not disadvantage you in any way.*
- *If you decide to participate but later change your mind you can discontinue your participation part way through or at the end of the survey by selecting the **Clear Form** button.*

What you will be asked to do?
- *If you decide to participate you will be asked to complete one online anonymous survey that should take approximately 5–10 minutes.*
- *Completion of the survey does NOT obligate you to agree to undertake an interview, which is the second stage of the research project.*

What are the risk and benefits of participating?
- *We cannot promise you any personal benefit from participating in this research, neither are there any foreseeable associated risks.*

How will your privacy be protected?
- *All surveys will be completed anonymously online and returned to a secure site accessible only to the researchers.*
- *Each survey will be numerically coded for data entry purposes.*
- *No identifying personal information will be recorded on the surveys.*
- *IP addresses will be removed from the surveys by appropriate software prior to the survey results becoming accessible to the researchers*
- *While the study is underway survey data will be kept on my home computer and backed up on a USB drive that will remain in my possession. These files will be password protected and only the researchers will have access to this data.*
- *On completion of the study all computer files will be transferred to the USB drive and stored in a locked cabinet in the School of Nursing and Midwifery at the University of Newcastle for a period of five years. At the end of the five-year period data on the USB drive will be erased.*

How will the information collected be used?
- *Results from this study may be published both in my PhD dissertation and in scientific journals.*
- *You are welcome to a copy of the summary of the findings of the study. The findings will be available within two years and will be sent to you upon request. Please contact the researchers by e-mail, phone or mail to request the summary of findings.*

What do you need to do to participate?
- *Please read this Information Statement and ensure that you understand its contents before you begin the survey.*
- *If there is anything you do not understand, or if you would like to obtain further information about the project, you can contact one of the researchers.*

- *If you accept the conditions of the consent statement listed below and select the **Go to Survey** button, this will be taken as your indication that you are willing to take part in this research.*
- *You may refuse to proceed by selecting the **Exit** button below.*
- *You are able to decline to participate in any section by not making a response and can discontinue your participation part way through the survey by selecting the **Exit Survey** button.*
- *When the survey is complete select the **Submit Form** button to send the survey anonymously to a secure site.*

I acknowledge

- That I have read and understand the Information Statement
- I understand that the project will be conducted as described in this Information Statement.
- I understand that the aggregated results will be used for research purposes and may be reported in scientific and academic journals.
- I agree to participate in the above research project and give my consent freely.

Thank you for considering this invitation.

Tracy Levett-Jones (PhD Student)
School of Nursing and Midwifery
The University of Newcastle

Professor Margaret McMillan (Chief Investigator)
Faculty of Health
The University of Newcastle

Select the *Go to Survey* button to accept the statements above and to go to the survey.

Select the *Exit* button to close the website.

THANK YOU FOR TAKING THE TIME TO

COMPLETE THIS SURVEY

Would you consider taking part in the second stage of the research project where students will be interviewed and asked to share their perspectives and experiences of belonging?

Your decision to participate is completely voluntary.

Select the **Exit Website** *button* to exit the system now.

Select the **Download Interview Information** button to find out more about the interviews.

Appendix 8
Interview Information Statement

Professor Margaret McMillan
Faculty of Health
The University of Newcastle
University Drive
Callaghan
NSW, 2308
Phone: (w) 02 4921 6783
Facsimile: 02 4921 2020
Margaret.McMillan@newcastle.edu.au

Tracy Levett-Jones (PhD Student)
School of Nursing and Midwifery
The University of Newcastle
University Drive
Callaghan
NSW, 2308.
Phone: (w) 02 4921 6599
(m) 0414 277 510
Facsimile: 02 49216301
Tracy.Levett-jones@newcastle.edu.au

Interview Information Statement for the Research Project:

Belonging, implications for third-year nursing students.

Researchers:

Professor Margaret McMillan (Chief Investigator) Faculty of Health The University of Newcastle	Professor Judith Lathlean (Co-Supervisor) School of Nursing & Midwifery The University of Southampton
Tracy Levett-Jones (PhD Student) School of Nursing and Midwifery The University of Newcastle	Dr Isabel Higgins (Co-Supervisor) School of Nursing and Midwifery The University of Newcastle

You are invited to take part in the research project identified above which is being conducted by Tracy Levett-Jones from the School of Nursing and Midwifery at the University of Newcastle. Tracy Levett-Jones is conducting the research as part of her PhD under the supervision of Professor Margaret McMillan, Professor Judith Lathlean and Dr Isabel Higgins.

Why is the research being done?
- *The purpose of this research is to explore the experience of belonging, as it relates to the clinical placement experience, from the perspective of third-year nursing students.*
- *Information gained from this study will inform policy makers, and has the potential to improve the clinical placement experiences of nursing students.*

- *Previous research has shown that belonging is a fundamental and pervasive human need and yet nursing students' experience of belonging has not been adequately explored.*

Who can participate in the research?
- *We are seeking third-year nursing students to participate in the research project.*

What choice do you have?
- *Participation in this research is entirely your choice.*
- *Only those students that give their informed consent will be included in this project.*
- *Whether or not you decide to participate, your decision will not disadvantage you in any way.*
- *If you do decide to participate, you may withdraw from the project at any time without giving a reason.*

What you will be asked to do?
- *If you decide to participate you will be asked to participate in one audiotaped interview conducted by Tracy Levett-Jones and lasting approximately 40 minutes.*
- *During the interview you can turn the tape off at any time.*
- *During the interview I will ask you to share your experience of clinical placements.*
- *The tapes will be transcribed and the data used for analysis.*
- *You will be able to review the recording and/or transcription to edit or erase your contribution if required.*
- *Interviews will be conducted in private, at a date, time and place of mutual convenience.*

What are the risks and benefits of participating?
- *We cannot promise you any personal benefit from participating in this research, neither are there any foreseeable associated risks.*

How will your privacy be protected?
- *All information that you provide will remain confidential.*
- *Within written records all names, including those of healthcare facilities, will be altered and you will be asked to choose a pseudonym.*
- *Individual participants will not be identified in any reports arising from the project.*
- *An experienced person well versed in the ethics of research will undertake the transcription of the audiotape. They will be required to sign a Promise of Confidentiality Agreement prior to the transcription.*
- *During the study computer records will be given a password and all names and contact details will be kept separate from records.*
- *While the study is underway data will be kept on my home computer and backed up on a USB drive that will remain in my possession and be password protected.*
- *All paper records and tapes will be kept in a locked cabinet in my home.*
- *Only the researchers will have access to this data.*
- *At the completion of the interviews all participants' contact details will be destroyed.*
- *At the completion of the study all computer files be transferred to the USB drive and stored with the paper records and tapes in a locked cabinet the School of Nursing and Midwifery for a period of five years.*
- *At the end of the five-year period data on the USB drive will be erased, the tapes destroyed and paper-based records shredded.*

How will the information collected be used?
- *Results from this study may be published both in my PhD dissertation and in scientific journals.*
- *Individual participants will not be identified in any reports arising from the project.*

- *You are welcome to a copy of the transcript of your interview which will be available within two months, and/or a copy of the summary of the findings of the study. The findings will be available within two years and will be sent to you upon request. Please contact the researchers by e-mail, phone or mail to request the summary of findings.*

What do you need to do to participate?
- *If there is anything you do not understand, or if you would like to obtain further information about the project, you can contact one of the researchers.*
- *If you are prepared to participate in the interview, please contact the researchers and provide your preferred contact details.*
- *Please be advised that only a limited number of interviews will be conducted.*
- *The researcher will contact participants selected to take part in an interview to arrange a mutually convenient date, time and place for the interview and will send the consent form by mail or e-mail.*
- *Read this Information Statement and be sure you understand its contents before you sign the consent form.*
- *Send your completed consent form to Tracy Levett-Jones prior to the interview.*
- *You are reminded that you can change their mind at any time and are not obliged to take part in the interview if you do change your mind.*

Thank you for considering this invitation.

Tracy Levett-Jones (PhD Student)
School of Nursing and Midwifery
The University of Newcastle

Professor Margaret McMillan (Chief Investigator)
Faculty of Health
The University of Newcastle

Appendix 9
Consent Form

Professor Margaret McMillan(Chief Investigator)
Faculty of Health
The University of Newcastle
University Drive
Callaghan
NSW, 2308
Phone: (w) 02 4921 6783
Facsimile: 02 4921 2020
Margaret.McMillan@newcastle.edu.au

Tracy Levett-Jones (PhD Student)
School of Nursing and Midwifery
The University of Newcastle
University Drive
Callaghan
NSW, 2308.
Phone: (w) 02 4921 6599
(m) 0414 277 510
Facsimile: 02 49216301
Tracy.Levett-jones@newcastle.edu.au

Consent Form for the Research Project:
Belongingness, implications for third-year nursing students.

I have read and understand the Interview Information Statement.

I understand that the project will be conducted as described in the Interview Information Statement, a copy of which I have retained.

I agree to participate in the above research project and give my consent freely.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I understand that my personal information will remain confidential to the researchers.

I have had the opportunity to have my questions answered to my satisfaction.

I consent to:

- Participate in one audiotaped interview lasting approximately 40 minutes.
- The interview transcript being used for research and publication purposes.

Print Name:

Signature: Date:

Phone Number:

E-Mail:

Address:

Appendix 10
Figure A.1 Flow chart—data collection process

Study advertised on university website used by 3rd year students.

Interested students can access and download the Survey Information Statement by selecting the *Download Survey Information* button.

After reading the Survey Information Statement students can either exit the system by selecting the *Exit* button or proceed to the Survey by selecting *Go to Survey* button. This makes the online survey available.

Participants can discontinue their participation part way through the survey by selecting the *Exit Survey* button. When the survey is complete, the participant selects the *Submit Form* button to send the survey to a secure site.

On completion of the surveys, participants will be invited to take part in an interview. Participants can either decline and exit the system by selecting the *Exit Website* button or access and download the Interview Information Statement by selecting the *Download Interview Information* button on the website.

The Interview Information Statement advises those participants who are prepared to take part in an interview to provide their preferred contact details to the researcher.

The researcher will contact those participants randomly selected to take part in an interview and send them a consent form. A date, time and place for each interview will be negotiated.

Participants will be advised to send their completed consent form to the researcher prior to the interview. Interviews will last approximately 40 minutes and be recorded with the permission of the participant.

Appendix 11
Interview Schedule

The interviews will be semi-structured and occur at a time, date and place of mutual convenience to the participants and the researcher.

With the participant's permission the interviews will be audiotaped. The interviews should take approximately 40 minutes.

The aim of the interviews is for students to:

- describe their understanding of belonging as it relates to their clinical placement experiences
- identify factors that impact upon their sense of belonging, and
- identify the consequences of belonging and not belonging.

Open-ended questions may take the following forms:

- Can you tell me about why you decided to become a nurse?

- Can you tell me about your clinical placement experiences?

- Can you describe a clinical placement experience where you felt as if you did belong?

- Can you describe a clinical placement experience where you felt as if you did not belong?

Appendix 12
Transcription Guidelines

Type in size 12 font, and leave a wide margin (40–45 mm) on the right side.

Title each interview transcript with relevant information as given on tape or written on the label:

e.g.   Tape 1—Version 1

R Researcher Levett-Jones

P Participant Number 1

Date 19.9.05

- Number the pages of the transcript
- Use a new line for each turn in conversation (when one person starts to speak, or when another responds).
- Identify who is speaking by using **R** (for researcher) and **P** (for research participant).
- Number each turn in conversation in chronological order (starting with 1, and working down).
- Delete any names that could identify individuals, hospital etc by using initials only (e.g., Dr D [not Dr Denham]; nurse/sister B [not Sister Benton]; my brother J [not my brother Jack]; M hospital [not the Mater Hospital]; in S [not in Sydney] etc.).

Use the following symbols to indicate pauses, emphasis etc as these appear in the verbal interview:

- Use **bold type** to indicate when words are spoken loudly, or emphasised strongly.
- Use — (long dash) to indicate a short pause of 2–4 seconds.
- Use quotation marks (" ") to indicate when the person speaking is quoting someone else (e.g. So he said "No, I don't agree with that", and we could not talk him out of it.)
- Use the statement **[interview stopped]** in bold text in brackets on a separate line to indicate that the interview was interrupted or stopped for a time
- <u>Underline text that you are not sure has been transcribed accurately (</u>e.g. if you cannot hear or understand exactly what was said, or are not sure of the correct spelling).
- Underline and place in brackets if you are unable to hear at all (e.g. So he <u>said</u> <u>[unable to hear] and</u> that made him mad.)

Appendix 13
Transcriptionist's Promise of Confidentiality Agreement

I, …………………………………………., am aware of the importance of maintaining the confidentiality of the information that may be revealed to me during transcription of the interviews from Tracy Levett-Jones' research project. I am aware that during these transcriptions I may be privy to information about individuals that is of a private and personal nature. I realise that by signing this document, I promise not to reveal any of the information contained in any of these interviews to any other person.

Signed: …………………………………………

Date:……………………………..

Witnessed: ………………………………………

Date: ……………………………

Appendix 14
Ethics approval letters

150306

Ms Tracy Levett-Jones
School of Nursing and Midwifery
The University of Newcastle
University Drive
Callaghan
NSW, 2308.

15th March 2006

Dear Tracy

Re: **Committee Decision: Internal Ethics Reference Number: SONAM003/2006**
Belongingness: Implications for third year students in Australia and the UK

Thank you for your response of 24th February 2006 to the School of Nursing & Midwifery Internal Research Ethics Committee, in relation to your application to proceed with your research study in the School.

On behalf of the Committee, I can confirm that each of the points raised by the committee on the 9th February 2006 have been satisfactorily addressed in your response.

I can therefore confirm that the research study is formally approved to proceed according to your proposal and details as specified in the application to the School of Nursing & Midwifery Internal Research Ethics Committee.

May I take this opportunity to wish you every success with your study.

Yours sincerely

Dr Sue Latter
Reader
Deputy Chair of the School of Nursing & Midwifery Internal Ethics Committee

The UNIVERSITY of NEWCASTLE
AUSTRALIA

HUMAN RESEARCH ETHICS COMMITTEE

Certificate of Approval
for a research project involving humans

Applicant

Chief Investigator/Project Supervisor: (First named in application)	*Professor Margaret McMillan*
Co-Investigators/Research Students:	*Dr Isabel Higgins* *Professor Judith Lathlean* *Ms Tracy Levett-Jones*
Project Title:	*Belongingness: Implications for third year nursing students in Australia and the United Kingdom*

In approving this project, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the *National Statement on Ethical Conduct in Research Involving Humans, 1999,* and the requirements within this University relating to human research.

Details of Approval

HREC Approval No: *H-079-0705*	Date of Approval: *20 July 2005*
Approval valid for: *3 years, or until project ceases, whichever occurs first.*	Progress reports due: *Annually*

NOTE: Approval is granted subject to the requirements set out in the attached document *Approval to Conduct Human Research* and any additional comments or conditions noted below.

20 July 2005
Approved subject to a satisfactory response to issues identified by the Committee.

4 August 2005
Response received and accepted.
Approval confirmed.

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Signed for the Committee: _____

Ms Susan O'Connor
Human Research Ethics Officer

From: <L.Bird@admin.uq.edu.au>
To: Tracy Levett-jones
CC: e.davies@nursing.uq.edu.au
Date: Wednesday – August 31, 2005 7:54 AM
Subject: RE: recruiting nursing students from UQ
Mime.822 (2673 bytes) [View] [Save As]

Tracey

I have read your survey material and am happy to approve for the survey to
proceed.

Cheers

Linda Bird
Academic Registrar
Phone: 3365 2224

-----Original Message-----
From: Tracy Levett-jones [mailto:Tracy.Levett-jones@newcastle.edu.au]
Sent: Tuesday, 16 August 2005 5:19 PM
To: l.bird@admin.uq.edu.au
Subject: recruiting nursing students from UQ

Dear Linda
Elizabeth Davies (Head, Nursing Program, Faculty of Health Sciences) advised
me to contact you as the UQ "gatekeeper" regarding the possibility of
recruiting 3rd year nursing students as one of the cohorts for my PhD
project.

I have ethics approval from the University of Newcastle Human Research
Ethics Committee (HREC), approval number H-079-0705 and Elizabeth has
reviewed my proposal and I have her full support.

Could you tell me what the process it to seek approval or what information
you require as Elizabeth did not feel that I would require ethics approval
from UQ.

kind regards
Tracy

Tracy Levett-Jones
Director of Clinical Education
Lecturer
School of Nursing & Midwifery
Faculty of Health
University of Newcastle
Ph: 49 216599 (Callaghan)
   43 202312 (Gosford) Mobile:0413277510
Tracy.Levett-jones@newcastle.edu.au

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Appendix 15
Table A.4 Missing value analysis

	n	*M*	*SD*	Missing		No. of extremes(a,b)	
				Count	Per cent	Low	High
Location	366	5.02	3.719	0	.0	0	0
Program	365	1.55	.839	1	.3	0	0
Age group	355	2.50	1.519	11	3.0	0	0
Gender	364	1.90	.295	2	.5	.	.
First language English	364	1.08	.275	2	.5	.	.
Previous nursing experience	322	1.40	.490	44[1]	12.0	0	0
Family member with nursing experience	325	1.73	.443	41[2]	11.2	0	0
Q1	366	3.86	.707	0	.0	0	0
Q2	364	4.56	.616	2	.5	1	0
Q3	363	3.93	.680	3	.8	.	.
Q4	366	3.69	.773	0	.0	1	0
Q5	366	4.49	.669	0	.0	1	0
Q6	366	3.70	.941	0	.0	5	0
Q7	365	3.77	.768	1	.3	1	0
Q8	364	2.47	1.214	2	.5	0	0
Q9	365	3.70	.640	1	.3	3	0
Q10	366	2.19	.937	0	.0	0	0
Q11	356	4.09	.706	10	2.7	5	0
Q12	356	2.14	1.214	10	2.7	0	0
Q13	355	3.01	1.102	11	3.0	0	0
Q14	362	2.79	.975	4	1.1	0	17
Q15	362	3.63	.572	4	1.1	0	0
Q16	364	3.20	.872	2	.5	14	0
Q17	364	3.43	.733	2	.5	3	0
Q18	364	4.05	.666	2	.5	.	.
Q19	363	4.23	.635	3	.8	1	0
Q20	362	4.41	.622	4	1.1	1	0
Q21	363	3.78	.732	3	.8	3	0
Q22	362	2.89	1.081	4	1.1	0	0
Q23	359	3.32	.770	7	1.9	5	0
Q24	359	3.66	.958	7	1.9	7	0
Q25	360	3.39	.916	6	1.6	9	0
Q26	359	3.50	.878	7	1.9	2	0
Q27	360	3.81	.614	6	1.6	.	.
Q28	362	3.51	.933	4	1.1	12	0
Q29	354	3.11	1.059	12	3.3	0	0
Q30	363	3.08	.979	3	.8	0	0
Q31	360	4.04	.711	6	1.6	7	0
Q32	358	4.44	.686	8	2.2	4	0
Q33	363	3.70	.774	3	.8	1	0
Q34	363	3.44	.948	3	.8	10	0
COB	366			0	.0		

a Number of cases outside the range (Q1 - 1.5*IQR, Q3 + 1.5*IQR),
b. indicates that the inter-quartile range (IQR) is zero.
[1,2] Note: 41 of these participants were in the pilot study and were not provided with these items on the questionnaire

Appendix 16

Table A.5 Rotated component loadings without suppression for belongingness variables

Factor				Components 1	2	3
1	Q7	I get support from colleagues when I need it.		0.71	0.16	0.12
1	Q21	People I work with on placements accept me when I'm just being myself.		0.69	0.23	0.23
1	Q1	I feel like I fit in with others during my placements.		0.68	0.31	0.10
1	Q14r	On placements I feel like an outsider.		0.67	0.37	-0.14
1	Q10r	I feel discriminated against on placements.		0.65	0.01	-0.01
1	Q2	When I walk up to a group on a placement I feel welcomed.		0.65	0.31	0.08
1	Q4	Colleagues offer to help me when they sense I need it.		0.65	0.09	0.09
1	Q33	I like where I work on placements.		0.61	0.12	0.27
1	Q9	I like the people I work with on placements.		0.61	0.21	0.21
1	Q17	I feel understood by my colleagues.		0.57	0.49	0.05
1	Q27	It seems that people I work with on placements like me.		0.56	0.25	0.26
1	Q3	Colleagues see me as a competent person.		0.54	0.23	0.26
	Q22r	I am uncomfortable attending social functions on placements because I feel like I don't belong.		0.48	0.47	-0.13
1	Q24	Feeling "a part of things" is one of the things I like about going to placements.		0.44	0.39	0.24
	Q6	I view my placements as a place to experience a sense of belonging.		0.34	0.31	0.33
2	Q30	One or more of my colleagues confides in me.		0.16	0.73	0.14
2	Q13	I invite colleagues to eat lunch/dinner with me.		0.04	0.64	0.17
2	Q8	I am invited to social events outside of my placements by colleagues.		0.33	0.62	-0.07
2	Q28	I let colleagues know I care about them by asking how things are going for them and their family.		0.05	0.61	0.30
2	Q16	Colleagues ask for my ideas or opinions about different matters.		0.42	0.60	0.00
2	Q29	Colleagues notice when I am absent from placements or social gatherings because they ask about me.		0.32	0.60	0.06
2	Q25	There are people on placements with whom I have a strong bond.		0.43	0.59	0.15
2	Q34	I feel free to share my disappointments with at least one of my colleagues.		0.34	0.47	0.05
2	Q15	There are people that I work with on placements who share my values.		0.16	0.44	0.18
2	Q26r	I keep my personal life to myself when I'm on placements.		0.13	0.32	-0.06
	Q12	It is important to me that someone at my placement acknowledges my birthday in some way.		-0.27	0.29	0.19
3	Q20	I ask for my colleagues' advice.		0.16	-0.02	0.71
3	Q31	I let my colleagues know that I appreciate them.		0.14	0.16	0.68
3	Q32	I ask my colleagues for help when I need it.		0.22	-0.04	0.66
3	Q19	I am supportive of my colleagues.		0.17	0.23	0.65

3	Q11	I offer to help my colleagues, even if they don't ask for it.	0.08	0.00	0.61
3	Q5	I make an effort to help new students or staff feel welcome.	0.05	0.16	0.52
3	Q2	It is important to feel accepted by my colleagues.	-0.08	-0.05	0.50
3	Q18	I make an effort when on placements to be involved with my colleagues in some way.	0.10	0.35	0.49

Appendix 17

Table A.6 Themes re-presented in the narratives of belongingness and alienation

Participant/ narrator	Themes
Leanne	Enhanced self-concept Future employment decisions Inclusion/exclusion Receptiveness of nursing staff Optimal clinical learning Nurse unit managers or ward sisters Tendency to engage in extenuation Resilience versus resignation Legitimisation of the student role
Laura	Legitimisation of the student role Inclusion/exclusion Receptiveness of nursing staff Future employment decisions Optimal clinical learning Recognition and appreciation Joy at work
Sarah	Preconceptions about nursing Practice standards Clinical facilitators Tendency to engage in extenuation
Ann	Consistency and structure of mentoring Optimal clinical learning Challenge and support Self-efficacy Recognition and appreciation
Abby	Conformity and compliance Enhanced self-concept Inclusion/exclusion
Nicole	Recognition and appreciation Optimal clinical learning Enhanced self-concept Consistency and structure of mentoring Duration and structure of clinical placements Challenge and support Self-efficacy