BUILDING RESILIENCE IN HEALTH VISITOR STUDENTS FOR COPING WITH ADVERSITY IN PRACTICE

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Abstract

Health Visiting (the specialism of public health nursing focusing on families and children) has been under threat over the last decade, with a considerable reduction in staff establishment. This has contributed to discrepancies in practice between broad public health standards, against which health visitor education is validated, and the reality of practice that is dominated by safeguarding (child protection) work. Negative workplace experiences have coincided with this reduction in staff numbers, include growing workloads, diminishing resources, and significant organisational change. Encountering such adversity in practice can impact negatively on the functioning and wellbeing of a newly qualified health visitor.

Studies drawing on a number of salutogenic concepts and theories have identified orientations and abilities that promote the capacity to withstand adversity, and the notion of ‘practitioner resilience’ is established within the literature. However, there is a lack of research examining the whole experience of student learning and the means by which this may enhance practitioner resilience. The research question underpinning this study was: *How do student health visitors’ experiences in higher education and practice settings contribute to the development of their capacity to respond to the tensions between expectation and reality in their practice role?* In addressing this question the study explores students’ expectations of their new role and the reality of their experience, and the learning that contributed to the development of the capacity to respond to this reality.

Case study methodology rooted in a critical realist perspective allowed for the analysis of the complex, non-linear relationships between what students bring to learning, what they experience and what causes these experiences. Course documents provided the context of the planned curriculum. Data were collected from twelve participants through two series of three activity-based focus groups conducted at the beginning, middle and end of their 52-week full-time course, and semi-structured interviews carried out with six participants in the final 2 months of the same year. The longitudinal nature of data collection allowed for triangulation of data and an iterative approach to both data collection and analysis. A conceptual web of learning for practitioner resilience, drawing on resilience and transformative learning theory, emerged from initial literature review and preliminary data collection, providing a framework for data analysis.

Significant differences emerged between student expectation and experience of the health visitor role. Participants experienced greater complexity than expected, a lack of continuity with clients, a predominant focus on high risk safeguarding, a lack of autonomy in the role, and a lack of opportunity for health promotion and ‘upstream’ public health work. For some the reality of the role was “shocking”, and the emotional impact of exposure to poverty and deprivation was widely identified. However, motivation to ‘make a difference’ was increased through this exposure, and commitment to the role grew over the year. An initial preoccupation with instrumental learning gave way to the emergence of communicative learning as being central to the development of practitioner resilience. The process of ‘surviving the course’ modelled behaviour that was seen to support resilience in practice. Learning from observation of others, and reflection, helped participants to identify positive and negative influences on resilience in themselves and in their teams.

This study makes an original contribution to the field through the development of a conceptual framework combining resilience and transformative learning theory, and the application of this framework to learning for practitioner resilience. The conceptual web of learning, depicting the complex process of development of practitioner resilience, supports a social theory of resilience. The study supports the contention that resilience can be learnt through professional education, contributing new knowledge regarding how this has been achieved during a course leading to a professional qualification. The study adds to the small volume of research carried out with students and contributes new insights into the development of resilience as part of a process of transformative learning. Team dynamics and leadership are confirmed as being key to individual and team resilience, with positive outcomes emerging from practice contexts that are open, honest and trusting.
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Acronyms and Definitions

Health Visiting is one of four fields of nursing included in Specialist Community Public Health Nurse (SCPHN) registration with the Nursing and Midwifery Council (NMC) in the UK. The other fields are School Nursing, Occupational Health Nursing and Sexual Health Advisor. To be eligible to undertake a course of professional education leading to registration as an SCPHN, prospective students have to be registered with the NMC as a Nurse or Midwife.

The courses leading to registration as a SCPHN - Health Visiting are regulated by the NMC, and when undertaken full-time (as in this study) last 52 weeks. During the course students spend 50% of their time engaged in practice learning, and 50% of their time engaged in academic study. In practice they work with identified Practice teachers and mentors.

The courses of preparation run by universities are approved by the NMC and meet designated standards for public health practice. They are designed to prepare students to identify and respond to the health needs of the population in their practice area, and to work collaboratively and pro-actively to prevent ill-health and to reduce the impact of inequality and deprivation. Health Visitors provide a universal service to all families with babies and pre-school children, the extent of that service being discriminated according to the level of health need.
HV  Health Visitor

HVIP  Health Visitor Implementation Plan: a national intervention in England to increase the number of health visitors following a period of disinvestment.

NMC  Nursing and Midwifery Council: Professional regulatory body for nurses and midwives in the UK.

PBL  Problem-Based Learning

PDP  Personal Development Plan

PT  Practice Teacher

Practitioner resilience  “The ability to maintain personal and professional wellbeing in the face of on-going stress and adversity” (McCann et al, 2013, 61).

Resilience  “In the context of significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural and physical resources that sustain their wellbeing, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways.” (Ungar, 2011,10)

It is “a set of behaviours over time that reflect the interactions between individuals and their environments, in particular the opportunities for personal growth that are available and accessible.” (Ungar, 2012,14)

SCPHN  Specialist Community Public Health Nurse: Registered
qualification with the NMC. A second registration following qualification as a nurse or midwife. Includes annotation as a health visitor, school nurse, occupational health nurse or sexual health nurse.

SN  Staff Nurse

TL  Transformative Learning: ‘learning that transforms problematic frames of reference to make them more inclusive, discriminating, reflective, open and emotionally able to change’ (Mezirow, 2009b, p.22).
Learning that is not just about taking on more information or content, but also to the ‘changes in how we know’ (Kegan, 2009, p.42)
“Transformative learning suggests not only change in what we know or are able to do, but also a dramatic shift in how we come to know and how we understand ourselves in relation to the broader world” (Dirkx, 2012, 116)

TLT  Transformative Learning Theory: A collection of diverse theoretical perspectives contributing to understanding of transformative learning.
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I dedicate this thesis to my brother John, who died in 2013. He never understood why I wanted to undertake doctoral study, but he would have been proud that I have completed it nevertheless.
I declare that the research contained in this thesis, unless formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed:

Date: 8th April 2015
1. Introduction

1.1 Influences from Professional Background

As a novice researcher, I came to study for this professional doctorate from a professional background as a health visitor (HV) that began at the end of the 1970s and as a university educator since the end of the 1990s. The interaction between theory and practice has always been a prime consideration in the way that I have approached my role as a teacher, and the first four years of my involvement with education were through a lecturer-practitioner role. In the last five years I have taken on a role that requires me to work at a more strategic level with the National Health Service (NHS) and with other stakeholders, ensuring that continuing education provision enables practitioners to meet the needs of their clients who are receiving care through the modern NHS.

The studies undertaken in relation to Part 1 of the Doctorate in Education were ‘Assessing indicators of effectiveness in advanced and specialist practice nurses’ and ‘Development of leadership qualities in post-graduate students’. Although not obviously related to the subject of this study, re-examination of their contents revealed some areas that are of relevance. These include an examination of competence and capability, influences on effectiveness in practice, and also issues of leadership. Both the previous studies focused on continuing professional education, which is also a common factor with the current study.

Prior to commencing the Doctorate in Education I was chair of a national professional organisation for public health nurse teachers in the UK, and in this role was involved in lobbying for a change in policy to support the HV role in England. From contact with HVs and HV educators across the country, and also my contact with local HVs, I became very aware of the stress that disinvestment in HV education and the HV workforce was causing, and the apparent dissonance between HV practice where client interventions were being based on salutogenic, or health enhancing principles, whilst these principles were not being applied to the HVs’ own wellbeing. It was from this background that I came to this study.
1.2 Context of the Health Visitor Role

Health visiting, the specialism of public health nursing focusing on families and children, has been under threat over the last decade, suffering a considerable reduction in staff establishment and also in the student numbers supported on courses (Lindley, Sayer and Thurtle, 2011). In the last few years high profile child deaths (Care Quality Commission, 2009), and subsequently the recognition of the value of early interventions with young families, has meant that the need to reverse this trend has been acknowledged (Department of Health, 2011). Consequently, the recruitment targets for local courses more than tripled, and a major service reconfiguration was planned through the Health Visitor Implementation Programme (HVIP) (Department of Health, 2011).

All this has taken place in the context of the extreme financial constraint that has existed across all public services. This situation contributed to the discrepancies in practice between the broad, professional body public health standards, against which HV education was validated, and the reality of practice which was dominated by safeguarding (child protection) work (Lindley et al., 2011). The theory-practice gap has long been recognised as a phenomenon within professional education, and the context of the HVIP has exacerbated this divide as student HVs continued to be prepared to fulfil a wider public health role in practice, whilst the reality of working in this way was constrained until the number of substantive HV posts was increased, and the service re-designed to meet the wider public health role. This complex combination of factors resulted in the considerable potential for discrepancy between prospective HVs’ expectations and the reality of practice.

There has been increasing interest in recent years concerning the relevance of salutogenic, strengths based approaches to responding to the demands of professional roles, and the role of education in promoting these perspectives and abilities (McAllister and McKinnon, 2009; Basinska, Andruszkiewicz, and Grabowska, 2011; Adamson, Beddoe, and Davys, 2012). Although the importance of such capacity building through the curriculum has been recognised, little has been reported about how this can be achieved. However, in the last few years a growing interest in specific learning interventions within professional education and their impact on building capacity to respond to
adverse experiences has started to emerge (McDonald, Vickers, Mohan, Wilkes and Jackson, 2010; Adamson et al., 2012; Grant and Kinman, 2012; McDonald, Jackson, Wilkes and Vickers, 2012; Gu and Day, 2013). This reflects the growing interest in the relevance of theoretical concepts, such as sense of coherence, resilience, hardiness, and self-efficacy within education (McMurray, Connolly, Preston-Shoot and Wigley, 2008).

Over the period since the inception of this study the body of research into practitioner resilience has increased, extending particularly into the arena of practitioner resilience as a process. A definition of practitioner resilience has also evolved to encompass the ‘ability to maintain positivity in the face of the on-going stresses and adversity’ in practice (McCann et al., 2013, p.61).

The premise on which this study was based was that the difference in expectation and reality in role expectation had the potential to constitute adverse experience in practice, and that students therefore needed to have the resources to manage such adversity if it arose. These resources would be transferable to their role as qualified HVs and represented an important component in building resilience in future practitioners (Grant and Kinman, 2012). Research relating to students’ expectation of their HV roles is very limited and is focused on motivating factors for entry to the profession (Poulton, 2009; Whittaker et al., 2013). However, empirical and secondary research into practitioner resilience has identified a number of factors that support resilience and educational strategies to aid their development have been proposed. Some research has explored the use of specific, short interventions within the preparatory curriculum or with groups of qualified practitioners, in order to promote resilience. There has been limited research which has applied a holistic approach to ways in which the capacity to respond positively to adverse conditions in practice can be promoted through the curriculum (Hodges, Keeley, and Troyan, 2005; McAllister, 2012; McAllister et al., 2013). Whilst some studies have focussed on nurses in a variety of settings, HVs specifically have not been considered.

Negative workplace experiences, including growing workloads, diminishing resources, organisational change, and poor organisational culture, contribute to
the experience of adversity within professional life (Nordang, Hall-Lord, and Farup, 2010; Adamson et al., 2012). Adversity in the context of work is taken to include difficult or negative experiences with the potential to have an adverse impact on the functioning of the practitioner (Jackson, Firtko, and Edenborough, 2007; Adamson et al., 2012), and this can include the difficulty encountered when there is a mismatch between expectation and the reality of a professional role. Recent research has reported the occurrence of stress and burnout in nurses, social workers and teachers (Jackson et al., 2007; Castro, Kelly, and Shih, 2010), with links being made between causes and protective factors, and remedial action and responses identified (Vinje and Mittelmark, 2006; Kinman and Grant, 2011).

The importance of resilience in practitioners for the outcomes for their clients was noted by Adamson et al. (2012) and this links with current concerns and imperatives within the NHS regarding caring and compassion, which places the client/patient experience at the heart of practice (Department of Health, 2012a).

1.3 Original Contribution to the Field

This study makes an original contribution to empirical research through the development of a conceptual framework that combines resilience theory and transformative learning theory (TLT), and the application of this framework to an examination of learning for practitioner resilience. The study supports the contention that resilience can be learnt through professional education, and contributes new knowledge regarding how this has been achieved in a course leading to a professional qualification. The study adds to the small volume of research conducted with students and contributes new insights into the development of resilience as part of a process of transformative learning (TL).

1.4 Why this is an Important Issue for Health Visitor Education

The HVIP (Department of Health, 2011) has made significant investment in HV education in order to increase the number of qualified HVs in the workforce so that the health needs of children and families can be better attended to and the consequences of inequality can be reduced. Universities have also invested heavily in this education, significantly increasing the numbers of HV students.
The impact of this investment will be reduced if the wellbeing of HVs in their professional roles is not attended to. Educators need to take account of this through the process of building practitioner resilience in HV students. Research into practitioner resilience as a process is more advanced in the fields of social work (Kinman and Grant, 2011; Adamson et al., 2012) and teaching (Gu and Day, 2007, 2013); however, it is evident that the concerns that exist in health visiting are shared across the professions, discounting the additional impact of the HVIP.

The context of uncertainty and change in relation to both student HVs’ new roles and to the wider disruption caused by major change within the NHS can provide rich sources of learning, and the current situation can be seen to offer tremendous opportunities, although it may also pose significant threats. In their work as HVs the students will be required to promote health and prevent ill health through helping families to build on their strengths, maximising their health outcomes as a result (DH, 2011). Given the organisational context identified, it is important that students are also supported and enabled to recognise and build these qualities in themselves, in order that they have the capacity to maintain effectiveness in their work environment.

1.5 Influence of Sustainability and Employability Agenda

In 1995 a university in England set out to apply a whole systems health promoting approach to the university setting (Dooris and Doherty, 2009). Since then other universities have joined this initiative and recent strategy for public health in England included the ‘Healthy University’ programme, which identified collaboration with businesses and voluntary bodies as a key feature (Cawood, 2010). A core purpose of the ‘Healthy University’ initiative is to promote education for sustainable development. Sustainability is broadly understood to relate to environmental sustainability; however, it also relates to wellbeing in the dimensions of society, culture and the economy, in addition to the environment. Less well understood is the concept of sustainability in relation to the outcomes of education (UNESCO, 2005). There is a growing body of opinion that the aims of education should be broader than simply accruing knowledge and qualifications; instead it should be extended to the promotion of student
wellbeing and the development of students’ capability in relation to the things that they may encounter in a life of work.

The employability agenda for higher education also reflects the generally increasing interest concerning the ways in which all students can be better prepared for the modern world, with its expectations of flexibility and transferability (Clegg, 2005; Illeris, 2014). It would seem that this may be of particular pertinence to health and social care practitioners, due to the combination of frequent change experienced within their organisational context and the demands of working closely with vulnerable groups in the population. A critical approach to the notion of employability was suggested by Arora (2013) as the political imperatives associated with economic and policy drivers at a national and international level may displace responsibility for wellbeing from organisations and structures to the individual.

1.6 The Reason for the Focus on Resilience

A number of health promotion and public health theories and concepts, drawing on sociology and psychology, are recognised as being pertinent to achieving the wider educational goals described. These assets approaches, including resilience, have been described as contributing to a salutogenic framework (Lindström and Eriksson, 2010). Salutogenic theory (Antonovsky, 1996) focuses on the origins of positive health rather than responding to negative health (pathogenesis). As a public health nurse, salutogenic principles contribute to the way that I view health and this informed my initial thoughts on the study. Extrapolation of these theories and concepts to the context of learning was evident in the literature (Hodges et al., 2005; Judkins, Reid, and Furlow, 2006; Jackson et al., 2007; McAllister and McKinnon, 2009). Lindström and Erikson’s (2011) work, although taking these ideas further, confirmed that research was needed to explore a salutogenic approach within education. It was therefore anticipated at the outset that this study would include a critical examination of a wide range of concepts that have been implicated in learning for professional practice which fall under the salutogenic umbrella (see Appendix 1). However, it became clear that this was too complex a task to be completed within the scope of this professional doctoral study, so following a broad sweep of the research
literature relating to practitioner capacity to cope with adversity in practice, the concept identified as providing most utility in responding to the research questions posed was that of resilience.

It has been observed that resilience varies considerably between individuals (McAllister and McKinnon, 2009), and that a number of conditions that increase this ability have been identified. A growing interest in practitioner resilience has identified a key role for education in promoting these conditions (Kinman and Grant, 2011; Grant and Kinman, 2012; Beddoe, Davys, and Adamson, 2013), although the mechanisms through which this may be achieved are yet to be fully elucidated.

1.7 Inclusion of the Education Theory Perspective

Previous work for the Ed D has supported the contention that learning takes place through the ‘wholeness’ of a course, including sources other than specific taught components, thereby demonstrating the importance of the ‘hidden curriculum’. Taking this broader approach, consideration needed to be given to the learning experiences of students across the whole range of academic and practice settings. Taking a process perspective on the development of practitioner resilience implied change in the way of ‘being’ that students adopt in the world. For this reason a TL framework (Mezirow, 2009b) was appropriate due to its focus on learning as a lifelong process of change (Jarvis, 2009). TL also resonated with public health and the core purpose of health visiting to challenge norms and values that perpetuate inequality (Taylor, 2009; Mezirow, 2009a; Freire, 1970), so had an ideological fit with the professional focus of the study.

A case study approach (Stake, 1995; Simons, 2009; Yin, 2009) rooted in a theoretical framework of critical realism (Bhaskar, 1998) was employed, and data were collected through a series of focus groups and semi-structured interviews. Data collection took place over a period of eleven months, with repeated contact with the participants. This provided time to build a rapport, establish trust, and to engage with students at different points in their learning and professional role development journey. Focus groups and semi-structured
interview methods allowed narratives to be accumulated that built a picture of the overall experience of the participants learning, and the ways in which they felt that their resilience had developed and been demonstrated over the period of the course. The methods did not include any quantitative measurement of features of resilience, or pre- and post-testing using individual resilience measurement scales.

1.8 Research Aims

The research aims and questions were as follows:

1. To explore how learning in both university and practice settings contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the HV.

2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.

3. To explore the relevance of the application of salutogenic principles to curriculum design in order to support the development of resilient practitioners who can respond to the adversity encountered in practice.

As identified in the introduction, during the course of the study the scope of the study was refined to resilience and TLT, and consequently the third aim was modified to:

3a. To explore the relevance of the application of transformative learning principles to curriculum design in order to support the development of resilient practitioners who can respond to the adversity encountered in practice.

1.9 Research Question

How do student HVs’ experiences in higher education and practice settings contribute to the development of their capacity to respond to the tensions between expectation and reality in their practice role?
1.9.1 Sub-questions

i. What personal resources do student HVs see as being necessary to their ability to manage the tensions in expectations in practice?

ii. How do students’ experiences in the university and practice build their resilience to the change in role expectations?

iii. What experiences do student HVs identify from the university and practice environment that have facilitated or obstructed the development of their capacity to respond to the reality of practice?

iv. What is the relevance of salutogenic principles to students’ learning experience?

The final question was modified in the light of the change to the third aim as described above:

iv a. What is the relevance of transformative learning principles to students’ learning to build resilience?

1.10 Insider Researcher Perspectives

The Doctorate in Education requires that students will contribute to the body of professional knowledge and practice within a specific area of education, critically reflecting on the professional context in the process. It is recognised that much research undertaken within such professional doctorates can be defined as ‘insider research’ (Mercer, 2007). Indeed, within a professional doctorate it can be argued that all research is likely to be insider research, as the researcher is investigating within the parameters of their own professional arena. It was therefore important that I actively considered issues relating to insider research.

The merits of insider and outsider research can be argued positively or negatively depending on personal stance, with the degrees of insider-ness or outsider-ness often appearing complicated and unclear (Brannick and Coghlan, 2007; Gair, 2012). Mannay (2010) argued that her status as an insider researcher gave her insight into the context of the marginalised group that was
the subject of her study, as it gave her credibility within the group; conversely, this insight can be argued to undermine neutrality when approaching the participants (Darra, 2008; Sword, 1999). Mannay (2010) recognised this danger and explored in some depth the strategies that she used in order to ‘make the familiar strange.’ She used a number of visual techniques as a basis for interviews with participants, avoiding the possibility of questions that lead the participant in the direction that may have been expected by the interviewer. This strategy was reflected in the focus groups included in this study, in which a number of visually based activities were used to allow the participants to raise issues for themselves, before exploring and building shared meanings and interpretations.

Mercer (2007) similarly recognised the danger of leading participants. She described the way in which she adapted her interviewing technique by reducing her level of intervention or affirmation, which may have had the effect of leading the participants to highlight the issues that she expected to emerge. Furthermore, Mercer (2007) identified a dilemma in terms of how much an insider researcher tells his/her colleagues about the research questions on the basis that this might direct the participants in a particular direction. Academic colleagues are not participants in this study, so these challenges are not so pressing on that level. However, in gaining informed consent from the participants it was necessary to be honest about the purpose of the research. The research questions in this study were exploratory and did not indicate an expectation of specific responses; therefore, it was made clear at the outset of focus groups and interviews that this was about the participants’ own experiences and that there were no right or wrong answers.

Insider knowledge can be seen as a positive contribution to understanding the context of a study (McNiff and Whitehead, 2010), but conversely, issues of bias need to be considered, and reflexivity is suggested as a requirement to reduce this bias. Reflexivity is identified as working on two levels: epistemological reflexivity relates to the justification of the choice of research strategies and methods; whilst personal reflexivity is self-awareness and reflection in action as the study progresses, with the object of recognising and reducing behaviour or
interaction that might promote bias and threaten the veracity of the research (Dowling, 2006). Reflection in and on action (Schön, 1987) is a necessary component of reflexivity, which can be achieved through keeping a diary or field notes whilst collecting data. Within this study the use of a reflective diary and specific reflection on data collection episodes (Appendix 2), combined with reflection in action, supported reflexivity in the process of data collection (Appendix 3) and analysis (Appendix 4). Following the focus groups debriefing with a second moderator took place, and discussions on the interviews with supervisors and peers (whilst preserving the confidentiality of the participants) also supported reflexivity. These processes also enabled me to keep in mind the different roles that I held within the organisation, how these may have been perceived by the participants, and any role confusion that I may have experienced. Wearing more casual clothing, such as jeans and tee shirts was deliberately adopted, making a visual differentiation between the lecturer and research student role. Looking at data through a different theoretical lens, to ‘make the familiar strange’ (Mannay, 2010) may also reduce risk of bias. In this case this was achieved through using a theoretical lens of resilience and TL.

The above issues are important, but one stood out as especially worthy of attention in terms of insider research, that of the complex power relationships within which my study was situated. The students who were invited to take part in the study were students within the division that I lead in a school at the university. In the past I have been course leader for the course, and as such have a clear insight into the approval of the course and its development. This could be seen as an advantage; however, the predominating ethical risk with insider research involving students within a home institution was that of power imbalance. To mitigate these issues I no longer had responsibility for running the course or had day-to-day contact with the students as a pathway leader or personal tutor, consequently I did not know the students well and was not involved in the management of their course. I did teach occasional sessions on the course, contributing to the delivery of a session in one module on the course, and a session in the university induction week. However, I was not involved as a module leader or facilitator of series of action learning sets or problem-based learning trigger groups. Neither was I involved in marking the
work of the cohort involved. In addition, as I was chair of an examination board where one module from the course was normally presented, I negotiated that the results for this module be presented to a different examination board over the entire period of the study. It would have been inappropriate for me to deal with the examination board processes for students involved in this study. It was important for me to emphasise when recruiting participants that it was not compulsory to take part, that they could withdraw without penalty at any time, and that they would not be disadvantaged in anyway if they chose not to participate. Previous successful doctoral research in the school involved a colleague in a similar position, who conducted her research on students on a course related to her own professional discipline (Hall, 2001). I believe that the measures outlined above took account of the ethical issues arising from insider research in a similar way to Hall’s work.

1.11 Summary

This introduction has identified the route by which I came to the study, and identified some key relevant literature. A rationale for the study has been presented, drawing on the specific context of the HVIP, but generalising this to the context of practice, through identification of research relating to similar challenges in other professional fields. The original contributions to the field that the study makes have also been outlined.

The demands of education through the sustainability and employability agendas can be seen to contribute to the need to produce practitioners who can cope with the changeable environment of modern professional practice. An initial intention to engage with the breadth of salutogenic concepts had been identified and the narrowing of the scope to resilience has been explained. The rationale for using TLT as the educational basis for the study has been identified together with the theoretical framework underpinning the case study design and the research methods utilised. The research aims and questions have been presented. Issues pertaining to insider research have been identified and addressed.
The following chapter presents the literature review. Production of this review was an iterative process as it contributed to the initial design of the study and also to the on-going data collection and analysis. Chapter 3 examines the methodological issues and provides details of the study design and data collection methods. Ethical issues are also considered in this chapter. Chapter 4 describes the data collection process, whilst Chapter 5 describes the data preparation and development of a conceptual web of learning for practitioner resilience. This conceptual web is used as the basis for description and analysis of the data presented in Chapter 6. This is followed by a discussion of the findings in Chapter 7, and finally Chapter 8 contains the conclusions, recommendations from the study, and identifies the limitations of the work.
2. Literature Review

2.1 Introduction

The introductory chapter outlined the drivers for this study, and identified the aims and research questions. Congruent with the work of Stake (1995), the following literature review explores key issues pertinent to the case under examination and establishes their relevance to the complexity of the context. The purpose of the literature review is two-fold, to identify orienting concepts that can go on to support organisation and analysis of data (Layder, 1998) and to identify the scope and relevance of existing research findings in relation to the area under examination. The review has therefore been organised in two sections. The first section explores the theories of salutogenesis, resilience and TL in order to clarify the theoretical underpinning of the study. A rationale for narrowing the scope of the background literature from the broad church of salutogenesis to resilience theory is included, together with a brief critique of the literature relating to resilience and TL. The second section presents a critique of the existing research literature in the fields of resilience and TL, which is pertinent to the study aims and research questions, and establishes the current state of knowledge and its contribution to the study.

A literature review in the context of case study research can be seen as an iterative process (Aveyard, 2007). This facilitates response to emergent concepts in congruence with case study methodology from a critical realist perspective (Danermark, Ekstrom, Jakobsen and Karlsson, 2002; Simons, 2009). As the study progressed, the availability of directly relevant literature increased, confirming the need for an iterative approach in relation to the study context. The currency of the area of study provoked mixed feelings; feelings of excitement that the study was in a field which was generating widespread interest in professional education and practice, but also an anxiety that the contribution that I hoped to make to the field would be ‘old news’ by the time the thesis was complete. The ‘completeness’ of the literature was an issue for consideration in presenting the review. More recent research findings, identified after data collection planning was complete, are included in the discussion section of the work, and only briefly considered as a part of the literature review.
2.2 Search Strategy

The concern driving the study was the capacity of neophyte HVs to respond to the divergence between expectation and reality in their new role (Lindley et al., 2011) and the place of education in building this capacity. Literature searching therefore began with role expectation and reality in health visiting. It quickly became clear that no directly relevant research regarding HVs or the education of HV students existed. Consequently a broader range of professionals was included. Terms were widened to include nursing, and subsequently extended to professional groups across education, and health and social care. Common to the education of these professional groups was the combination of academic and practice elements, with the majority undertaking courses at the undergraduate level, but also including preparation courses at the postgraduate level.

The research questions were rooted in a supposition that difference in role expectation and reality, in common with other experiences of adversity in practice, would present challenges to the neophyte HVs for which they need to be prepared. In terms of building capacity to respond to this need, my searches initially identified ‘sense of coherence’ and resilience, hardiness and other related concepts included under Lindström and Eriksson’s (2010) salutogenic umbrella. In light of the research aims relating to the role of education in building capacity, research relating to TL and to specific teaching and learning strategies supporting development in the professional groups was also sought.

The timespan for the inclusion of literature was initially set at 10 years, allowing the identification of recent research focusing on practitioners and making links with education, as well as more established work. The iterative nature of the process meant that this time-span has extended with the timeframe of the study. Seminal texts relating to the original work in these areas were included beyond the ten year period defined.

The search strategy is outlined in Appendix 5. Boolean operators were used to combine keywords, and truncations reduced the number of searches whilst ensuring coverage. Electronic databases were searched individually and using
the ‘cross search’ facility. Individual specialist edition volumes of journals with a relevant focus were also hand searched for additional material, as were the publication histories of those identified as being contemporary writers in the field.

The search identified that the majority of studies relevant to the research aims were set in the context of resilience theory, with a smaller number of studies being based in other salutogenic theories and concepts, such as hardiness, sense of coherence, and self-tuning. These concepts hold in common strengths based approaches to professional development, with many overlapping features. A detailed critique of all the concepts identified was found to be beyond the scope of this study, therefore the decision was made to focus primarily on research in the area of practitioner resilience. Brief consideration was given to research founded in the other theoretical areas in order to gain from the contribution of conceptual eclecticism in capacity building in professional education.

Links between TLT and practitioner resilience were explored and the relevance of both to professional education and learning became apparent.

2.3 Theoretical Underpinning for the Study

2.3.1 Relevance of Salutogenic Concepts

In original work relating to stress theory carried out in the 1970s, Antonovsky identified that some women who had been subjected to extreme adversity in their lives seemed to have coped well with subsequent stress, whereas others who had apparently endured the same adversity had not (Antonovsky, 1996).

From this work emerged a theory for health termed ‘salutogenesis’. Antonovsky (1996) suggested a continuum from -ease to dis-ease, with -ease focusing on origins of health (salutogenesis) and dis-ease on responding to ill-health (pathogenesis). The theory (summarised in Table 2.1) was built around two concepts: ‘general resistance resources’, which support the capacity of the individual to manage tensions in their life; and ‘sense of coherence’, which reflects a person’s overall orientation to life. There are three dimensions
associated with the sense of coherence: comprehensibility, manageability and meaningfulness.

Table 2.1: Components of salutogenesis

<table>
<thead>
<tr>
<th>Theory of Salutogenesis</th>
<th>Sense of coherence (orientation to life)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General resistance resources:</strong> (pre-requisite to sense of coherence)</td>
<td>1. <strong>Comprehensibility:</strong> Life is understandable with explanations and reasons for occurrences. Information is clear not chaotic.</td>
</tr>
<tr>
<td>Resources in the person and their environment that support capacity to manage tensions and prevent transformation into stress. Physical, material, social, emotional, cognitive, hereditary, beliefs, knowledge, meaning of life, self-knowledge, self-esteem, purpose.</td>
<td>2. <strong>Manageability:</strong> Resources are available to manage the demands and tensions, flexibility in choices</td>
</tr>
<tr>
<td>Comprises three dimensions</td>
<td>3. <strong>Meaningfulness:</strong> This is the motivational dimension. Demands are challenges that are worth expending time and energy in responding to.</td>
</tr>
</tbody>
</table>


Salutogenesis takes a positive approach, focusing on the strengths and resources that individuals have to support them through the demands of life. It is an approach that is widely applied in public health, my professional discipline and that with which participants in this study were engaging.

Many other concepts, beyond the sense of coherence, have been identified in the literature, which focus on the origins of health. These assets based approaches, which include resilience, hardiness, empowerment, self-efficacy and emotional intelligence, have been included in a framework termed the ‘salutogenic umbrella’ (Lindström and Eriksson, 2010, p.55). It can be argued that the inclusion of a multiplicity of concepts under the ‘salutogenic umbrella’ is not helpful to the perpetuation of salutogenesis as a distinct theory; equally, it can be argued that the perspectives offered by each
constituent theory or concept can illuminate the multiple issues that affect the emergence of positive outcomes (or health) resulting from challenging experiences.

Significant overlap of the constituent elements, attributes, and resources is evident between these concepts, and therefore, it might be suggested, between processes that can contribute to their development. Lundman et al. (2010) recognised this overlap between concepts and attempted a theoretical analysis of resilience, sense of coherence, hardiness, purpose in life, and self-transcendence, with the aim of gaining ‘an overarching understanding of inner strength’ (Lundman et al., 2010, p. 254). This analysis did not advance understanding of how resources can be promoted, and demonstrated limited value in the comparison of concepts. Greater value may be derived from using the resources (identified across the range of concepts) promoting capacity in practitioners to respond to adversity, as a pragmatic basis for establishing links with learning experiences.

Lindström and Erikson (2011) considered the theoretical relevance of salutogenesis to education programmes on the basis that healthy education would support the development of the ability to make healthy judgements and decisions in the workplace, a desirable response to adversity. Indeed a number of health promotion and public health related theories and concepts, drawing on sociology and psychology, have similarly been recognised as having relevance to achieving wider educational goals. At the outset of this study I planned to consider the application of the breadth of salutogenic concepts to capacity building to withstand adversity in practice. However, it soon became clear that it was beyond the scope of this study to adequately critique all of the concepts that have been identified under the salutogenic umbrella. Recent work in the resilience field had moved its application to practitioners forward and identified a role for education, and the nature of this role needed further clarification. The decision was therefore made to focus on resilience as the salutogenic element of the underpinning theory.
2.3.2 Resilience Theory

In the literature relating to the response of individuals to adversity, resilience is widely described as being the ability to ‘bounce back’ after an encounter and it is observed that some do this much more successfully than others (McAllister and McKinnon, 2008). The construct of resilience in the context of human responses has been conceptualised and interpreted in many different ways in research spanning over five decades. This has given rise to criticism of the concept and its application as an underpinning construct for research (Luthar, Cicchetti, and Becker, 2000).

Engineering science uses the term ‘resilience’ to denote plasticity and the property of materials to return to their original state having been subjected to external influences, whilst environmental science describes it as the capacity of systems to withstand challenges to their stability (Ungar, 2012). This plasticity and resistance to disruption is reflected to some degree in the application of the concept to humans, although this definition is not consistently applied and research is approached from different theoretical perspectives.

Shaikh and Kauppi (2010) organise meanings attributed to resilience into two clusters; those rooted in psychology, and those rooted in sociology. Within each cluster there are variations in approach, with a greater diversity of conceptualisations relating to psychology than to sociology. Those derived from a psychology root identify specific factors that contribute to the resilience of individuals, with research in this area being heavily influenced by positivism. These range from personality traits (Kobasa, 1979; Connor and Davidson, 2003), through positive adaptation in the face of identified risk or adversity (Masten, 2001), protective factors (Rutter 1990), processes involved in changing the level of risk or compensation against risk factors through asset building (Masten, 2001), the dynamic process of adaptation through transitional stages of development and coping responses during periods of adversity (Luthar et al., 2000; Masten 2001), to the recovery of functioning after a period of adversity.

Hart, Blincow and Thomas (2007) took a more common-sense approach to explaining the diversity of interpretation, classifying resilience as ‘popular’, ‘real’
or ‘inoculated’. ‘Popular’ resilience they contend (p.9), reflects the breadth of ‘normality’, the ability that we nearly all have to deal with the ups and downs we encounter in everyday life. Of greater importance they suggest, are the other two interpretations. ‘Real’ resilience (p.10) refers to understanding the differences in the experience of individuals in similar predictive circumstances as they live their lives. For Hart et al. (2007) the interest lies in exploring what it is that has provoked a better than expected outcome for some, that is, the protective mechanisms or processes. In referring to ‘inoculated’ resilience (p.11), the suggestion is that some experience of adversity can provoke an ‘immune response’ in an individual against future exposure to adversity, in much the same way that inoculation against an infectious disease can confer immunity to developing that disease in the future (Hart et al., 2007; Davydov et al., 2010).

Luthar et al. (2000) refer to resilience as ‘a dynamic process encompassing positive adaptation within the context of significant adversity’ (p.543). Masten (2001) suggests that people are not described as resilient unless they have been exposed to adversity and reacted positively in the face of this adversity. Individual internal resilience properties are required, and these are tested when adversity is experienced. In the context of my study, it is proposed that adversity is widely encountered in the professional role, and that it is desirable to pro-actively build capacity in health practitioners to respond to such adversity when it arises. Capacity may be built within the individual or within the context in which they operate, or in both. Models of resilience discussed so far concern individual resilience. In order to consider resilience beyond individual capacity it is necessary to explore its definition in relation to social theory.

At the interpretative end of the research continuum identified by Shaikh and Kauppi (2010), fall the sociological conceptualisations of human agency and resistance, and survival. Ungar (2012) developed the notion of the social ecology of resilience, though this still focuses predominantly on individual ecologies rather than wider ecological systems. The notion of agency denotes the active involvement of individuals in determining their own destiny (Archer, 2000) and as such is key to positive outcomes in the face of adversity. In
addition, a sociological interpretation of resilience can, I suggest, draw upon
notions of emancipation and empowerment (Freire, 1970), moving away from
ideas of learning as filling empty vessels and towards resilience through self-
determination. Both agency and empowerment may therefore contribute to
capacity building to promote practitioner resilience.

Much research in relation to resilience has focused on individuals and the
qualities and attributes that exist or can be developed within those individuals.
This has contributed to the criticism of resilience theory, which through applying
a neo-liberal approach lays responsibility for the problems encountered at the
doors of the individual (Bottrell, 2009). Bottrell (2009) argues that the social
context in which individuals are placed, including cultural influences,
relationships and social processes, needs to be included in conceptualising and
analysing resilience. She favours the development of a social theory of
resilience. Adversity, Botrell (2009) contends, can be a collective rather than an
individual experience, embedded in the organisational or community context.
Similarly, Trzesniak et al. (2012) suggest that resilience may be applied to wider
systems, of which organisations and teams may be examples. In this instance,
they suggest, resilience is not the ‘sum of the parts’ contributed by individuals,
but has different causal powers, a perspective congruent with critical realism.
Understanding at this level therefore requires the movement in research
approaches away from individual adaptation and protective processes, towards
those promoting understanding of the complex processes and interactions that
promote resilience, both in individuals and the organisations or communities
within which they are situated. Mapping of the ecological system within which
an individual is situated can aid the understanding of context and processes at
an individual level (McAllister and McKinnon, 2009; Ungar, 2012), however
scope of influence and complexity is widened when considering open systems
that lack defined boundaries.

This variability in definition reflects four waves of resilience research that have
by turn been concerned with protective factors, understanding processes that
account for these protective factors, promotion of protective factors through
prevention and intervention, and an ecological approach that takes account of
processes working within and across levels to promote resilience (Masten and Obradovic 2006). The ecological approach takes greater account of the dynamic processes and structures of society, though Hart and Gagnon (2014) identify that this remains concerned with an individually centred ecological system. Most recently Hart and Gagnon (2014) have proposed a fifth wave of resilience research. Approaching resilience from a social justice perspective they recognise and challenge the neo-liberal displacement of responsibility for resilience and consequent reduction of inequality in health from governments to the individual, and argue that focus on individuals obscures the deficiencies in structural responsibility. Hart and Gagnon’s (2014) argument comes from the perspective of disadvantage as adversity. Within the context of practitioner’s own resilience adversity may or may not be linked to disadvantage in the practitioner (Maunder, Peladeau, Savage, and Lancee, 2010) but the same principles of structural responsibility for health outcomes of the workforce, and the impact of these on clients, apply. The political dimension of the public health role of the HV emerges here in relation to structures that sustain inequality and poor health outcomes in their clients, and those that challenge their own health outcomes as practitioners. Hart and Gagnon (2014) call for resilience research demonstrating political awareness and an emancipatory dimension that looks beyond individuals and takes account of political and economic contexts.

With the historic research focus on resilience relating to children in contexts of adverse childhood experience, promoting resilience has become a desired outcome in the education of children and young people, and many interventions have been implemented in pre-school and school settings in an effort to address the impact of children’s circumstances on their resilience (Hart and Heaver, 2013). The role of all health professionals in promoting health equity is recognised (Allen, Allen, Hogarth and Marmot, 2013), and in health visiting is a specific objective of the HVIP. Outcomes of such intervention are of benefit to children and their families, but also contribute to the country’s economy through promoting routes out of poverty thus reducing reliance on state benefits and support.
Recently there has been growing interest in practitioner resilience, particularly in relation to health, social care and education professionals, and the vulnerability that they may experience in their roles. A role for professional education in promoting practitioner resilience has consequently been identified (Hodges et al., 2005; Judkins et al., 2006; Jackson et al., 2007; McAllister and McKinnon, 2009; Kinman and Grant, 2011; Adamson et al., 2012; Grant and Kinman, 2012). The literature review that follows examines the research in this area that is of particular relevance to the design and execution of this study.

In the realms of practitioner resilience, the definition of adversity follows a different path to the existing work with vulnerable groups in society. Previous research has indicated that many entering the caring professions have experienced adverse personal circumstances (Maunder et al., 2010). In addition, they may experience vulnerability through the contexts in which they work, expectations of their employers and society, and vicariously through exposure to the experiences of the populations and communities with whom they engage (Tabor, 2011). McCann et al. (2013) defined professional resilience as ‘the ability to maintain personal and professional wellbeing in the face of on-going stress and adversity’ (p.61). It can therefore be anticipated that adversity for practitioners is bound together with context and processes, the scope of which will be explored in the following section. Taking this and the preceding discussion into account the working definition of resilience that I adopted was that of Ungar.

“In the context of significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural and physical resources that sustain their wellbeing, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways.” (Ungar 2011,10)

It is “a set of behaviours over time that reflect the interactions between individuals and their environments, in particular the opportunities for personal growth that are available and accessible.” (Ungar, 2012,14)
Ungar’s (2012) definition encompassed a view beyond the individual that was inclusive of the context of professional learning and practice. I acknowledge the criticism of an individual focus on resilience, though the focus of my study on the learning of a small group of students meant that the individual perspective was likely to predominate. The definition of McCann et al. (2013) provided application to the specific context of practitioner resilience.

The diversity of the definitions and conceptualisations of resilience has been seen to be problematic when empirical data are collected within a positivist paradigm, as consistency and uniformity of the definition underpins reliability and validity in the comparison of such studies (Luthar et al., 2000). However, this consistency is not an imperative in the application of qualitative methodologies, which take account of the experiences of actors in their own worlds. These are discursive approaches that allow consideration of the complexity of interaction and non-linear causation in the context of real life (Bottrell, 2009; Adamson et al., 2012).

A number of conditions that increase individual resilience have been identified through research across the range of psychological interpretations, and the value of paying heed to the attributes and qualities promoting resilience in health and education professionals has been identified to a varying extent (Vinje and Mittelmark, 2006; Gallos, 2008; Gillespie, Chaboyer, and Wallis, 2009). These can be used to prompt exploration of what helps and hinders individuals in responding to the challenges of professional practice, especially when such challenges are experienced as adversity. From the perspective of professional learning, this provides a springboard to explore how these conditions (including qualities, attributes, skills and strategies) may be learned or developed. Professional preparation comprises a complex web of processes through which the learner is prepared for practice. Identification of those processes that enable students to respond positively to challenges encountered is an appropriate basis for exploring practitioner education. The complexity of both the context and the individual learners’ experience of that context is a good fit with the definition of resilience as multi-dimensional and socially constructed (Gu and Day, 2007; Adamson et al., 2012). This also carries greater resonance
than notions of personality traits and predispositions, which might be taken to suppose limited opportunities for development.

Research into practitioner resilience indicates what has to be developed in order that the capacity to respond to adversity may be built, and proposes sources of this capacity. It does not however fully address how resilience may be built through the process of a professional education course, the critical component of the research aims of this study.

2.3.3 Transformative Learning Theory

Since the 1960s adult learning theory has evolved from a number of theoretical roots. Freire (1970) focussed on emancipatory learning, using the promotion of literacy in deprived population groups in Brazil to raise political consciousness. Knowles (1980), influenced by the earlier humanist psychological therapy based work of Carl Rogers (1969), proposed his theory of andragogy, which differentiated adult learning from learning in childhood, and identified the centrality of self-directed learning and experiential learning. Maslow (1970), also from a humanist psychology background, identified a hierarchy of psychological need with the ultimate achievement of ‘self-actualisation’, which has had a lasting influence on approaches to adult education. The concept of Transformative Learning (TL) was introduced by Mezirow in 1978 (Mezirow, 2009b) and subsequently formalised as a theory of TL (Mezirow, 1991). TL has since become well established as a basis for adult education; although a range of theoretical perspectives are now established alongside Mezirow’s original theory across the diverse academic range of its proponents. An in depth critique of the wide literature on TL is beyond the scope of this study, but effort has been made to identify some differences emerging from the varying theoretical perspectives. Dirkx, Mezirow, and Cranton (2006) agree that though their theoretical perspectives are different, their understandings of TL are complimentary rather than mutually exclusive. Mezirow’s conception of TL was the predominant orientation in approaching this study, drawing upon influences from emancipatory and humanist approaches. The approach of Dirkx, influenced by Jung through the field of depth psychology, takes a different perspective on the process of learning. However, his focus on a lifelong process
of individuation associated with the development of confidence and empowerment (Dirkx, 2000), may also have potential for links with the development of resilience, although following this through in the data collection process would require skills in managing the unconscious thoughts of the participants. Maintaining an overview of the diversity of the perspectives on TL is reflected in Cranton and Taylor’s (2012) suggestion that it is helpful to identify commonalities between these perspectives in a ‘unified’ (p.12) theory of TL, rather than seeking to differentiate between them.

Mezirow defines TL as

‘learning that transforms problematic frames of reference to make them more inclusive, discriminating, reflective, open and emotionally able to change’ (2009b, p.22).

He includes cognitive, affective and conative (or motivational) dimensions in his use of the term ‘frame of reference’.

TL is founded on the premise that adults’ beliefs, assumptions and prejudices can be challenged through the process of education, resulting in significant change in their frames of reference. Mezirow initially referred to these frames of reference as ‘habits of mind’, only later adopting the term ‘frame of reference’ as this broader term allowed inclusion beyond the cognitive domain (Illeris, 2014). He suggested that an example of such a frame of reference that would benefit from challenge and consequent change could be the negative perception of individuals or groups outside the learners own group (Mezirow, 2009a). In his constructivist approach, Mezirow takes the position that individuals’ expectations are derived from past experience, taking for granted the ‘truth’ of these expectations until they are challenged or variation from the expected norm is exposed. If learning is transformative, then variation from the expected norm will be assimilated into a revised frame of reference, or put another way, a different way of knowing (Kegan, 2009); if it is not then the original ‘truth’ will remain unchanged (Cranton and Taylor, 2012). In the absence of challenge the prejudices and stereotypes that are carried will be perpetuated. Therefore it can be seen that TL allows for challenge to the prevailing views that perpetuate
inequity within society, and change in epistemology or our way of knowing (Kegan, 2009). TL may take place through instrumental or communicative learning, the former relating to hypothetico-deductive learning and the latter to understanding the perspective and meanings of others regarding the ideas being communicated (Mezirow, 2009a).

Illeris (2009) suggests that TL, as identified by Mezirow (2009a), leads to fundamental changes in the self. When Kegan (2009) refers to TL he refers to learning that is not just about taking on more information or content, but also to the ‘changes in how we know’ (Kegan, 2009, p.42). Kegan has expressed concern that the term has been applied to any form of change taking little account of this epistemological requirement. Kegan (2009) contends that informative learning can take place where the bank of knowledge is increased, but in the absence of TL this is not then translated into increased capacity in relation to such things as creativity, abstract thinking, or problem solving. These characteristics, Flores et al. (2010) suggest, are central to critical thinking, and are identified as components of resilient or higher order thinking (Fazey, 2010).

Mezirow’s theory of TL identifies ten ‘phases of learning’ during the transformative process, which were derived from his original 1978 study of women returning to higher education.

1. A disorienting dilemma
2. Self-examination
3. A critical assessment of assumptions
4. Recognition of a connection between one’s discontent and the process of transformation
5. Exploration of options for new roles, relationships and action
6. Planning a course of action
7. Acquiring knowledge and skills for implementing one’s plan
8. Provisional trying of new roles
9. Building competence and self-confidence in new roles and relationships
10. A reintegration into one’s life on the basis of conditions dictated by one’s new perspective

(Mezirow, 2009b p.19)
These phases may not be experienced sequentially, and more likely they are experienced through a spiral where the elements are visited and re-visited over time (Apte, 2009). However, for epistemic change to occur a ‘disorienting dilemma’ needs to be present around which the other elements build.

Taylor (2009, p.4) reports that three elements were originally identified that are core to teaching for TL: individual experience, critical reflection and dialogue. The individual experience of each learner, including prior experience and experience during the learning programme, provides the basis for beliefs, assumptions and prejudices that will be critically examined through the learning process. Critical reflection includes reflection on content, process and premise (Illeris, 2014). Frequently prompted by the ‘disorienting dilemma’ phase of learning described by Mezirow, this allows for an in-depth critical exploration of the assumptions and beliefs embedded in the individual as a result of their previous experience (Taylor, 2009). Critical reflection can revolve around reasoning processes and judgements, without taking account of the political and power dimensions of critical theory. Kreber (2012) however, distinguishes ‘critical’ reflection from other representations of reflection and critical thinking through connection with the political and social objectives of critical theory, drawing in the wider social application of TL beyond the predominating individual perspective. A central contributor to TL, dialogue provides essential interaction, including dialogue both ‘with the self and others’ (Taylor, 2009, p.9). This is the arena in which critical reflection is enacted and deeply held norms and feelings are questioned. Taylor suggests that dialogue is not so much an analytical debate, presenting arguments and counter arguments, but instead involves trusting communication, often with high levels of personal disclosure.

Subsequently, three further elements have become evident: holistic orientation, awareness of context and an authentic practice (Taylor, 2009, p.4). Holistic orientation emphasises the inclusion of affective and social dimensions in addition to the cognitive, allowing the exploration of ‘other ways of knowing’ linking with the potential for epistemological shift identified by Kegan (2009). One of the criticisms of Mezirow’s theory is the perceived limitation to cognitive learning with the exclusion of the affective domain, although his definition of
frame of reference clearly indicates that this is not now the case (Mezirow 2009b). A further area of contention is the perceived limitation of Mezirow’s TL to the individual context, due to the limited attention given to wider social change. Again it is suggested that Mezirow did consider these issues, although it is accepted that his primary interest was in TL from the individual perspective (Cranton and Taylor, 2012). An awareness of context as a contributor to promoting TL brings into play the breadth of the individual, social and political context in which the learner is placed. Context can provide both support and barriers to change occurring through TL (Taylor, 2009). The final element identified by Taylor as a contributor to TL is authentic relationships. Genuine, trusting relationships need to exist within the learning environment in order that honest discussion (including self-disclosure) may take place. Authenticity in the relationships developed provides the bedrock for TL, and emphasises influence beyond the individual to the psycho-social context.

Mezirow et al. (2000) and Cranton (2006) discussed the place of learner-centred teaching in relation to TL, but Taylor (2009) identified that what this means in practice has been poorly addressed through research. He raises the question of whether the core elements of TL are in fact the same as the core elements of learner-centred teaching. Teachers with different theoretical perspectives on TL may conceptualise their role as a teacher differently, and Taylor (2009) questions how this, in turn, affects their conceptualisation of learner-centred teaching.

This exploration of TLT demonstrates its relevance to this study. The application to adult learning is clearly relevant on a superficial level, but taking into account the association of TL with challenging inequality and prejudice, the depth of this relevance becomes more apparent. This is a critical perspective in HV education, where a key objective in practice is the reduction of health and social inequality. Experience with working with HV students indicates that assumptions regarding social and health inequalities are often deeply held at the outset of the course, and that in order to move forward in the role these have to be challenged and frames of reference shifted.
This section has explored the literature relevant to both the ‘what’ and ‘how’ of learning for capacity building in HV students. Brief critiques of resilience and transformational learning theory have been presented in order to establish their relevance to the research aims and design. This provides the context for the following section, which reviews the research literature relating to practitioner resilience in the context of the research aims of this study.

2.4 Practitioner Resilience

2.4.1 Experience of Adversity in Professional Practice

Negative workplace experiences, including growing workloads, diminishing resources, organisational change, bullying and poor organisational culture, contribute to the experience of adversity in professional life (Nordang et al., 2010; Jackson et al., 2011; Adamson et al., 2012; Hunter and Warren, 2014). Adversity in the context of work is taken to include difficult or negative experiences with the potential to have an adverse impact on the functioning of the practitioner (Jackson et al., 2007; Adamson et al., 2012). This can be anticipated to include the difficulty encountered when there is a mismatch between expectation and reality of professional roles, and is implicit in the literature relating to attrition in health professions. Kyriacou and Kunc (2007) conducted a study of students and newly qualified teachers explicitly concerning their expectations of teaching. The authors observed that, in common with earlier research about teacher retention, positive or negative experience of four factors: school management, time pressures, pupil behaviour, and having a happy private life, which included issues relating to work-life balance (p.1253), tended to be linked with corresponding positive or negative views about the teacher role. However, this was not always the case, and some teachers who had negative experiences in these areas continued to view their role as a teacher positively. This difference can also be observed in health and social care practitioners, prompting the question why some are able to manage the adversity they encounter positively and others are not.

Resilience has been suggested as a mechanism protecting against the negative impact of such adversity, and its application to professional practitioners has therefore come under scrutiny.
2.4.2 Defining and Understanding Practitioner Resilience

As identified in the previous section of this review, much work on resilience has been related to developmental psychology, and attributes and predispositions that have supported individual resilience. The work of Luthar et al. (2000) and Masten (2001) however, supports the notion of resilience as a process, and Ungar (2012) proposed the construct of social ecology in representing a scaffold of elements within a system of interactions that support resilience. Bottrell (2009) suggested the notion of collective adversity and of a social theory of resilience, both of which are also relevant to resilience as a process rather than a series of traits or attributes.

Practitioner resilience in the health professions has recently been defined as ‘the ability to maintain personal and professional wellbeing in the face of ongoing stress and adversity’ (McCann et al., 2013, p.61). Gu and Day (2013) in considering teacher resilience, suggested that it is ‘the capacity to maintain equilibrium and a sense of commitment and agency in the everyday worlds in which teachers teach’ (p.26). Both of these definitions emphasise process and infer the inclusion of emotional and social dimensions of resilience.

Understanding practitioner resilience as a process, and in the context of organisations, underpins the research aims of this study. Three key research studies, reported in six papers, are now presented that have contributed to moving this understanding forward. Two of these studies are in the professional context of social work (Kinman and Grant, 2011; Grant and Kinman, 2012; Adamson et al., 2012; Beddoe et al., 2013) and one study is in the field of education (Gu and Day, 2007, 2013). Hunter and Warren’s (2014) recent study of midwives in the UK is also briefly included here due to the relationships between identity and resilience development, but this paper is more widely included within the later discussion chapter. Further papers, including those of Vinje and Mittelmark (2006) and Gillespie et al. (2007) relating to nursing, are also presented. Whilst there are differences in the papers between the professions studied these have in common close contact with ‘clients’ across the population and the need to be aware of the influence of socio-economic inequality and its possible impacts on outcomes.
The context of public service is shared across the professions in the UK and Australasia with the attendant impact of public scrutiny and expectation, and the financial implications of being managed from the public purse. All three fields carry historical associations with ‘training’ but are now educated through higher education settings combining at least graduate level study with education in practice. A recent literature review by McCann et al. (2013) confirmed 15 factors as promoting resilience that were common to both nurses and social workers. A further 18 factors were not explored in studies of both professions so a comparison was not possible. The factors that were common to nursing and social work were: gender, experience, work-life balance, humour/laughter, hope/optimism, beliefs/spirituality, professional identity, control, family support, friend support, colleague support, mentors/role models, making a difference, and culture (McCann et al., 2013, p.75-76). On this basis extrapolation, exercised with a degree of caution, of the research findings from the UK and Australasia across organisational contexts appeared appropriate. Research from the US at the level of individual resilience could also be included in nursing, although organisational features may need to be considered more critically due to the differing approaches to the provision of public and private services.

The importance of emotional influences was central to Kinman and Grant’s (2011) UK study regarding the development of emotional and social competence for practitioner stress resilience. The aims of their study, which was conducted with 240 student social workers, focussed on the roles of ‘emotional intelligence, reflective ability, social competence and empathy’ (p.265) as predictors of individual resilience to stress, relationships between resilience and psychological distress, and ‘whether resilience mediated the relationship between emotional competencies and psychological distress’ (p.265). Emotional intelligence, popularly associated with Goleman (1996), is a contested concept in theoretical research with identified constituents ranging across ability, personality, and other factors, such as resilience and motivation (Smollen and Parry, 2011). Research in this field is predominantly in the positivist paradigm, and this was reflected in the study design of Kinman and Grant (2011), which utilised validated self-report scales to examine contributory
aspects of emotional intelligence. Psychological distress was also measured and correlated with measurements of the aspects contributing to emotional intelligence, i.e. reflective ability, empathy and social competence. A matrix clearly presented the correlation of the data collected through each scale. Multiple regression analysis, controlling for age and gender as possible confounding variables, was undertaken to expose links between emotional competencies and the prediction of resilience.

Emerging from this analysis were insights into the potential of empathy in mitigating or potentiating stress in the social work role. A distinction was made between ‘empathetic concern’ and ‘empathetic distress’, the former being contained within appropriate professional boundaries and supporting a positive response in practice, while the latter breaks through the healthy personal/professional boundaries resulting in psychological distress that is potentially damaging to both client and practitioner. This highlighted the need for practitioners to be supported in developing the emotional dimensions of personal/professional boundaries through their educational preparation. Overall, the study’s findings provided evidence of emotional competence and reflective ability as being predictors of resilience, as demonstrated through lower levels of psychological distress. The contributions of reflection and reflexivity to practitioner resilience are confirmed elsewhere (Jackson et al., 2007; Fazey, 2010), as is the relevance of social and emotional competence (Rajan-Rankin, 2013). Kinman and Grant’s (2011) study was significant due to the statistical correlation of variables supporting the identification of predictors of practitioner resilience, and particularly in the context of my research, in its focus on students’ learning and preparation for practice.

In introducing their study, Adamson et al. (2012) suggested that resilience is centred more on the emotional aspects of mitigating stress than cognitive problem solving approaches. Adamson et al. (2012) drew on the findings of a small scale qualitative study undertaken with social workers practising in the health care and non-statutory social work services in New Zealand, in combination with previous resilience literature, in order to construct a theoretical framework to aid the understanding of the wider system influences on
practitioner resilience. In common with this study, the authors identified the applicability of resilience theory used in the practitioners work with their clients to the social workers own responses to their experiences of adversity in practice.

Adamson et al.’s (2012) qualitative study was designed in response to interest in moving away from a deficit perspective on stress and workplace pressures to a positively framed approach to support practitioner resilience, a position congruent with the salutogenic approach that underpins my own approach to professional education and practice. The role of education in developing resilient practitioners was central to the study design, although data were collected from qualified practitioners. Participants fell into three categories; practice in health care, practice in mental health, and practice as student supervisors. The student supervisors’ interviews focused on the experience of working with students, whereas those with the other two groups focused on their own experiences. Students were not included in the study so my study contributes a different practitioner perspective. In addition to their practice experience criteria participants were self-defined as resilient and accessed through their professional leads. The student supervisors were identified through the university student supervision networks, and were both experienced social workers and had supervised at least five students. Twenty-one individual semi-structured interviews provided narratives of the perceptions of resilience in the participants’ professional role.

Thematic analysis was used to analyse the transcribed interviews, and the emergent themes were then combined and organised within a map defining practitioner resilience. The three domains of the resilience map; self, mediating factors, and practice context, were drawn from the background literature forming a theoretical framework for the analysis of the emerging themes. The findings falling into each of these domains are summarised in Table 2.2 overleaf.
### Table 2.2: Summary of Adamson, Beddoe and Davys’ Resilience Map

<table>
<thead>
<tr>
<th>Self</th>
<th>Mediating factors</th>
<th>Practice context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal health or ill-health as a resource</td>
<td>Resilience as a process including ‘relational, professional and systemic factors’</td>
<td>‘Reading the environment’ culture and organisational context.</td>
</tr>
<tr>
<td>Maturity (not age)</td>
<td>‘Sound work-life balance’</td>
<td>Balance of autonomy and presence of management support.</td>
</tr>
<tr>
<td>Spiritual belief → hope</td>
<td>Developmental learning from age and experience in the role</td>
<td>Positive organisational and management support.</td>
</tr>
<tr>
<td>Remembering past success</td>
<td>Learning how far to push and when to let go</td>
<td>Systems approach to organisation.</td>
</tr>
<tr>
<td>Hope / seeing a different future</td>
<td>Adversity as an opportunity to learn</td>
<td>Balancing act between uncertainty, support and structures.</td>
</tr>
<tr>
<td>Humour as a counterbalance</td>
<td>Resilience not a static state ‘fluid and flexible’</td>
<td></td>
</tr>
<tr>
<td>Choice: whether to stay</td>
<td>Ability to stay passionate and grounded in role, seeing clients as individuals and looking at situations with ‘fresh eyes’</td>
<td></td>
</tr>
<tr>
<td>A degree of control</td>
<td>Affirmation from client</td>
<td></td>
</tr>
<tr>
<td>Internal moral and ethical codes</td>
<td>Able to put personal issues on one side, recognising and maintaining professional boundaries.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervision and being able to discuss difficulties.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of professional identity: purpose, values and vision in, and of, the role.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Knowledge, education and theory.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adamson et al. (2012, pp.10-16)
A recent study by Rajan-Rankin (2013) examined the development of emotional resilience from a phenomenological perspective, again in the professional field of social work. Critical incidents were used as the focus for participant narratives regarding how they had managed adversity within their lives. For some these incidents occurred while they were students, for others at an earlier point in their lives. The narratives reinforced the position that individuals coming into the caring professions have often experienced significant adversity in the past, and are congruent with the position in TLT that past experience needs to be attended to as a starting point, or the initial anchor, on the bridge to learning (Kegan, 2009). Empathy, self-awareness and social support emerged from the narratives as important resources in promoting resilience, reinforcing the findings from Adamson et al. (2012) and Kinman and Grant (2011). The importance of self-identity was stressed as an important factor in the management of emotion.

Hunter and Warren’s (2014) very recent study with a group of qualified midwives in the UK confirmed the findings of previous studies, but more interestingly added to the relevance of identity in the context of building resilience. In their study, which involved 11 experienced midwives in an on-line discussion group, with the findings subsequently examined by an expert reference group, the identity of midwives as a professional group sharing a sense of belonging and commitment to their role was seen as important in developing resilience. The social dimensions of resilience were also confirmed through the dynamic of peer support, which was recognised as being mutually beneficial to the resilience of those both offering and receiving the support.

Vinje and Mittelmark (2006) reported a small qualitative study drawing on data from nine community nurses. Though not based in resilience theory, the study made useful links though contributory concepts under the salutogenic umbrella. The initial study had included the participants as individuals perceived to have high levels of job engagement. The definition of job engagement used by the authors was that of Schaufeli, Salanova, Gonzàles-Romà and Bakker (2001) ‘positive, fulfilling, work-related state of mind that is characterised by vigour, dedication and absorption’ (Vinje and Mittelmark 2006, p.36).
However, the nurses’ original narratives exposed individual histories of near burnout experiences, so the interviews had been extended to examine how this had been avoided. The study was useful in identifying actions that had been taken by nurses in their own self-care, demonstrating learning from experience and the ways in which behaviours and approaches had been modified. This was presented as a model of ‘self-tuning’ that promoted coping in the face of adversity in practice. The processes identified in ‘self-tuning’ included six active coping strategies, although the emphasis was on the emotional and philosophical elements of the strategies more than on the practical actions. The strategies were:

- Striving to be a realistic idealist,
- Engaging in meaningful activities alongside nursing,
- Ensuring a place for silence and withdrawn peace,
- Solving emotional problems,
- Learning from experience and ability and willingness to undertake major change,
- Existential curiosity monitoring and self-tuning

(Vinje and Mittelmark, 2006, pp.40-42)

Although the illustrations from the participant narratives indicated connections with activity, the orientation was evidently more to do with the way in which the individual perceived and interacted with the context than the activity in itself. For example, work-life balance wasn’t simply about doing something outside of work but more the meaningfulness of that activity. Significant attention was given to allowing ‘space’ for quiet and calm. The empirical findings, although from a very small study and set in a Scandinavian context, provided a useful link between factors promoting resilience extrapolated from the theoretical literature, and the real context of professional practice.

Gillespie, Chaboyer, Wallis and Grimbeek, (2007) devised and tested a theoretical model of resilience that was developed from a review of the wider resilience literature, a previous concept analysis by the authors, and an ethnographic study of work-place culture, in order to establish variables that influence practitioner resilience in the workplace. Five constructs of hope,
coping, self-efficacy, workplace culture, and demographic influences (p.428) were included in the framework, which were further subdivided to give twelve variables in all. The sample of 1430 participants was randomly selected from operating room nurses in Australia. Similarly to Kinman and Grant (2011), a number of measurement scales were used in respect of each of these constructs in a positivist approach to the study. Some scales, such as the Connor-Davidson resilience scale (Connor and Davidson, 2003), had been previously validated, whilst others were constructed, critiqued and piloted as a part of this study. A response rate of 53% was achieved as 770 participants returned their completed surveys, which were then analysed through multiple regression analysis. Hope, self-efficacy and coping emerged as the variables most highly correlated with resilience. Modest correlations with control and competence were also noted in the analysis. These factors did not account for all resilience, and the authors recognised that other influences were at work but these remained unidentified. The study examined coping from a problem based rather than an emotional focus, which was recognised by the authors as a potential issue, subsequently supported by Kinman and Grant (2011) and Adamson et al. (2012). Age, education, experience and years of employment were not significantly correlated with resilience.

Castro et al. (2010) suggested that individual agency enabled the use of a number of strategies to address the adversity faced by novice teachers in practice. Their study explored these strategies and the resources the teachers needed to be resilient in their new roles. The authors hoped to contribute new knowledge to the relationship between resilience and retention of new teachers. Fifteen newly qualified teachers participated in the study, all worked in socio-economically challenging contexts of the public school system in the US. Due to difficulties in recruitment and retention in the profession, not all of the participants had been prepared through the usual graduate entry process. The description of challenges in the US public education system appeared to resonate with experience in the state systems in the UK. Four strategies emerged from the data: help-seeking, problem-solving, managing difficult relationships, and seeking rejuvenation and renewal (pp.625-7). In all of these areas the researchers looked for connections between individual agency and
resilience. Whilst evidence of agency was provided, in that the teachers took the initiative and responsibility for developing strategies to cope with their negative experiences, these did not always suggest a positive emotional outcome for the teacher. The discussion seemed to reflect a functional approach to stresses in the workplace, with the existence of ‘buffers and allies’ suggestive of witnesses, ‘avoidance’ of passing decisions on to others, and ‘collecting documentation’ as a strategy for dealing with difficult people akin to disciplinary processes. Whilst all of these behaviours may be important in the learning of new teachers, practitioner resilience as: ‘the capacity to maintain equilibrium and a sense of commitment and agency in the everyday worlds in which teachers teach’ (Gu and Day, 2013, p.26) seems to require the emotional aspects of negative workplace experiences to be addressed within whatever strategy is applied. However, exploration of individual agency merits further consideration in relation to resilience as a process, and is consistent with Clegg’s (2011) perspective on changing demands in identity formation in the current socio-cultural context.

A proportion of secondary research in the field of practitioner resilience has focussed on identifying factors relating to individuals coping with adversity within particular occupational groups. Research regarding the occurrence of stress and burnout in health professionals has been drawn on in this process, and analysed and extrapolated through literature reviews in the context of the demands of specific occupational groups (Jackson et al., 2007; Zander, Hutton, and King, 2010; Hart, Brannan, and de Chesnay, 2012; McCann et al. 2013). Jackson et al. (2007) examined personal resilience and relationships with strategies for responding to workplace adversity in nurses. They argued that rather than only considering resilience in nurses as a reaction to adversity, a proactive approach to developing the capacity to respond in stressful circumstances should be taken. Five areas of need were identified and strategies were suggested for their development, which are helpful in considering the construction of learning experiences. These are summarised in Table 2.3.
McCann et al. (2013) reviewed the literature with the aim of clarifying processes and factors that promote practitioner resilience. The factors common to nursing and social work were detailed earlier in this section. These confirm the contextual and socio-emotional influences on resilience already discussed, but do not appear to take full account of organisational influences (Gu and Day, 2007; Adamson et al. 2012). Hart et al.’s (2012) review focussed on resilience in nurses and drew together factors contributing to individual resilience.

From the empirical work reviewed, and through cross-referencing with the identified literature reviews, a comprehensive range of resources supporting resilience has been compiled. Factors drawn from the wider practitioner resilience literature are summarised in Table 2.4. My study is not concerned with these individual factors influencing resilience in isolation, but because they link with the process of resilience development through the potentially transformative learning experience of a course leading to a professional qualification as a HV. Grouping the resources under the three components of sense of coherence is helpful in making links for student learning at three levels: understanding what is going on, resources that may be available for support, and influences on motivation to become a HV and to persist in the role.
Table 2.4: Resources for resilience mapped against the three dimensions of sense of coherence

<table>
<thead>
<tr>
<th>Comprehensibility (understanding)</th>
<th>Manageability (resources)</th>
<th>Meaningfulness (motivation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-efficacy (belief in ability to control events in life which have significance to individual)</td>
<td>Flexibility, Adaptability, Creativity, Self-esteem (feelings of own value), Self-confidence, Level headedness, Curiousness, Trust, Open-minded, Self-understanding, Resourceful, Self-discipline, Co-operation, Prioritisation, Abstract thinking, Problem solving, Belonging to a social group, Strong peer / social support, Maintain life balance, Healthy lifestyle activity, Find support when needed, Independent thinking, Empathy, Sense of humour / laughter, Social intelligence, Enabling spirituality, Coping</td>
<td>Motivation, Optimism, Commitment (to self and work), Purpose, Building positive relationships, Self-direction, Taking control (internal locus of control), Control, Challenge, Perseverance, Courage (capacity to move into situations when feel fear or hesitation), Being (taking time for self by allowing self just ‘to be’), Meaningfulness, Hope, Positive identity, Planning for the future, Emotional intelligence</td>
</tr>
<tr>
<td>Reflection / reflexivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical thinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasticity: ability to think critically and creatively in order to adapt to context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding meaning in adversity</td>
<td></td>
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</tbody>
</table>

Little is written about the expectation of the HV role, but research has focused on the motivation aspects of the decision to become a HV. Poulton (2009) carried out a small survey study with a cohort of Specialist Community Public Health Nurse (SCPHN) students in Northern Ireland. For these students the highest rated factor was their involvement in health promotion, followed by working in the community, moving on in career, working in a more social model of care, and working in a multi-disciplinary manner. Further findings were published by Whittaker et al. (2013) in the final stages of the data collection period of this study and these are therefore considered within the discussion chapter of this thesis.

### 2.4.3 Practitioner Resilience as a Process in Organisational Systems

The context of public services in the UK, including the NHS, is one of high public scrutiny, expectation, and often criticism, combined with frequent and far-reaching organisational change. Participants in the study by Adamson et al. (2012) identified the need for organisational and managerial support in promoting a culture that supports resilience in practitioners. Additionally, Grant and Kinman (2012) identified the risks of focussing on individual resilience within organisational contexts that have been identified to promote stress through their structures and mechanisms. In terms of this study, it is important to be clear on the influence of organisational context on processes supporting or undermining practitioner resilience, as the participants’ learning is facilitated in the higher education and practice/organisational contexts. Equally, they are being prepared for work as HVs within the context of the NHS and have to meet their professional responsibilities and accountability within that organisation.

Gu and Day (2007) examined the role of resilience in teachers in responding to the changes and challenges that they may experience through their careers. Their study conceptualised resilience in teachers in terms of the maintenance of positive role modelling to their pupils, sustaining teacher motivation and commitment through the challenges of their practice, and in the links between the motivation of teachers and positive outcomes for their pupils. This holds true for professionals in other fields of health and social care (Edward and Warelow,
2005; Judkins et al., 2006; McAllister and McKinnon, 2009; Kinman and Grant, 2011; Adamson et al., 2012).

A large scale mixed methods Department for Education and Skills (DfES) sponsored study examined the variation in teachers’ work, lives and effectiveness (VITAE) (Day et al., 2006) and provided the data for Gu and Day (2007) analysis of teachers’ resilience. The longitudinal four-year study included 300 teacher participants at different stages in their career trajectory (including the newly qualified) from 100 schools across seven local authorities. The overall aim of the study was to examine teacher effectiveness, and the study involved two semi-structured interviews each year with the teachers over the four-year period. In addition, school leaders and students were interviewed at various stages, and documentary analysis was performed in areas such as pupil attainment and test results.

In the context of the VITAE project, resilience was equated to the capacity of the teachers to maintain motivation and commitment. It was identified that the teachers’ identities fluctuated over time, affected by dimensions of school (situated), outside school (personal) and professional influences that changed in nature and balance over the timespan of their practice. The challenges posed by these fluctuations in identity, required resilience in the teacher in order to maintain motivation and commitment to their roles. Relationships between identity and resilience have also been proposed in the work of Rajan-Rankin (2013) as described in the previous section. Three ‘scenarios’ were identified in the VITAE project as a framework against which the severity of adversity encountered could be positioned (Day, Kington and Gu, 2005). In scenario 1 the three dimensions were balanced and manageable, in scenario 2 there was a dominance of one or two dimensions but supportive internal or external influences made this manageable, and in scenario 3 there was serious disruption in all three dimensions that would require significant support from internal or external sources. Hence scenario 3 equated to the most extreme adversity that tested to the greatest degree the resources available to support a positive outcome. Gu and Day (2007) tracked three teachers’ experiences where the severity of their adversity fell within scenario 2, and their experiences
were analysed to identify the influences helping and hindering teacher resilience and demonstrate processes involved in teacher resilience. A number of organisational influences emerged as sources of adversity. Mediating factors were identified in the individual teachers' context that countered this adversity and supported their motivation and commitment to their role, and these are summarised in Table 2.5.

**Table 2.5: Organisational adversity and mediating factors in maintaining teacher motivation and self-efficacy**

<table>
<thead>
<tr>
<th>Adversity in organisational context</th>
<th>Mediating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>School leadership issues:</td>
<td>Support from colleagues /collegiality</td>
</tr>
<tr>
<td>• lack of affirmation and leadership from school head</td>
<td>Good pupil behaviour</td>
</tr>
<tr>
<td>• poor departmental leadership</td>
<td>Change in leadership</td>
</tr>
<tr>
<td>Lack of support from parents</td>
<td>Promotion of positive teaching culture</td>
</tr>
<tr>
<td>Poor work-life balance</td>
<td>Career progression / increased responsibility in role</td>
</tr>
<tr>
<td>Target driven teaching in opposition to own philosophy of learning</td>
<td>Positive teacher pupil relationships</td>
</tr>
<tr>
<td>Poor pupil behaviour</td>
<td>Deliberate alteration to work-life balance</td>
</tr>
<tr>
<td>Students enjoying learning</td>
<td></td>
</tr>
</tbody>
</table>

Source: Gu and Day (2007)

The benefit of this longitudinal study is that it has tracked individual teachers’ experiences in their organisational context, identifying the personal, professional and organisational factors that have enabled them to maintain their motivation for, and their self-efficacy in, their role. It also introduces the notion of maintaining balance in the face of adversity, and the threat posed by negative experiences occurring simultaneously in different areas of a practitioner’s life. A perspective of resilience as a process that is open to influence or change is apparent, highlighting the relationships between three dimensions of the teachers’ identity. In common with Adamson et al. (2012) and Kinman and Grant (2011), the importance of leadership, emotional and social dimensions on practitioner resilience are clearly identified. Beddoe et al. (2013) expanded on the educational relevance of the study by Adamson et al. (2012) to further confirm understanding of the contribution of the organisation to practitioner
resilience in social work, identifying the impact of supervision, peer support, professional development opportunities, organisational culture and valuing the profession (p.104).

Organisational resilience, as a concept, is primarily associated with the ability of organisations to survive in the face of challenge and change (Kantur and Arzu, 2012), often in financial and market contexts. Human resources make a predominating contribution to the health, education and social care organisations, and the resilience of the workforce (at all levels) to withstand challenge and change is intrinsic to an organisation’s survival, indicating the wider impact of practitioner resilience and the relevance of a health promoting culture in the workplace.

2.4.4 Education and the Promotion of Practitioner Resilience

There has been increasing conviction in recent years regarding the role of education in promoting the capacity in students to respond to the demands of professional roles (McAllister and McKinnon, 2009; Basinska et al., 2011). The need for this has been reinforced in the empirical studies presented in this review. Although some targeted learning interventions in professional education and their impact on building capacity to respond to adverse experiences have started to emerge (McDonald et al., 2010, McDonald et al., 2012), little has been written about how this can be achieved through holistic, coherent curriculum design.

Hodges et al. (2005) argued strongly for the development of resilience through education, and considered curriculum design from this perspective. In their theoretical paper they suggest that the application of the Human Becoming School of Thought (HBST) (Parse, 1992) to curriculum design demonstrates links with resilience through engaging with students’ philosophies and identity in their professional roles. Hodges et al. (2005) explain that the application of Parse’s model to education centres on the facilitation of learning through the lived experience of student-tutor interactions. The object, they suggest, is to promote creative, flexible, reflective practitioners who can think ‘outside the box’ thus enabling them to work in innovative ways with clients and colleagues to address problems that are encountered. Such an approach therefore links with
the development of resilient practitioners who are able to respond to the stresses encountered in professional life. The mechanism suggested is continuing dialogue between students and tutors, which enables challenge and facilitates co-construction of meaning. This reflects tenets of TLT, through dialogue comprising of critical reflection and self-disclosure in the examination of personal norms and beliefs (Mezirow, 2009b; Taylor, 2009). However, the strategies for teaching and learning identified in their paper, with the exception of problem-based learning in the ‘mobilising transcendence’ dimension, appear to reflect teacher lead strategies to promote classroom interaction and dialogue (Hodges et al., 2005, p.552), whereas the TLT notion of student centred learning is open to wider interpretation (Taylor, 2009).

Strategies for the development of practitioner resilience through professional education are outlined in the recommendations of Beddoe et al. (2013), building on the study undertaken by Adamson et al. (2012). Beddoe et al. (2013) categorise factors affecting resilience as being related to the individual, the organisation and to education, whilst accepting that most are of direct relevance to professional education. There are contributors, for example reflection, that are widely included in educational programmes, but the development of students’ individual resources, as already identified, is also clearly of importance during the learning process. This is congruent with the perspective of Hodges et al. (2005), whereby learning should include the social emotional and existential dimensions of learning, in addition to cognitive processes involved in gaining specific subject knowledge. The social and emotional aspects, and the relational influences experienced in practice, are challenging but vital for professional education and the feelings of students, as these provide a critical dimension in their learning experience.

Grant and Kinman (2012) drew on the findings from their earlier study (Kinman and Grant, 2011) to develop ‘a series of wellbeing days’ (p.612) for inclusion in their social work curriculum. The areas covered contribute to most of the strategic areas identified by Beddoe et al. (2013). Table 2.6 summarises the strategies recommended for education as identified in the literature. There is a high degree of congruence in these strategies with the features of TLT. This
study will explore how these relate to the students’ experience of learning and the activity that has contributed to this.

**Table 2.6: Summary of strategies for education promoting resilience**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognise previous challenges and ways of coping</td>
<td>Hodges et al. (2005), McAllister and McKinnon (2009), Grant and Kinman (2012) Beddoo et al. (2013)</td>
</tr>
<tr>
<td>Build knowledge and understanding of resilience and self-care</td>
<td>McAllister and McKinnon (2009), Grant and Kinman (2012) Beddoo et al. (2013)</td>
</tr>
<tr>
<td>Build clear role identity</td>
<td>McAllister and McKinnon (2009), Beddoo et al. (2013)</td>
</tr>
<tr>
<td>Develop skills for reflection and supervision</td>
<td>Grant and Kinman (2012) Beddoo et al. (2013)</td>
</tr>
<tr>
<td>Role model positive professional culture</td>
<td>McAllister and McKinnon (2009), Beddoo et al. (2013)</td>
</tr>
<tr>
<td>Promote dialogue between students and teachers</td>
<td>Hodges et al. (2005), McAllister and McKinnon (2009)</td>
</tr>
<tr>
<td>Promote peer support</td>
<td>Grant and Kinman (2012)</td>
</tr>
<tr>
<td>Development of leadership skills</td>
<td>McAllister and McKinnon (2009)</td>
</tr>
</tbody>
</table>

**2.5 Summary**

This chapter has presented the process by which TLT and resilience were identified as the theoretical concepts underpinning the examination of capacity building in student HVs through their learning experiences. Theories of TL and resilience have been analysed, and the concept of resilience as a process for education established. The dearth of research relating to HVs has been exposed, and the limited perspective on the application of the process of developing resilience through holistic approaches to education identified confirming the value of undertaking this study. Contextual, social and emotional influences on resilience have been identified, confirming the complexity of relationships and the scope of issues that may emerge. Identification of
strategies and resources for building resilience from practitioner resilience studies provides an evidence base for activity to be undertaken in the focus groups.
3. Methodology

3.1 Introduction

In this chapter I explore the philosophy of critical realism (Bhaskar, 1975), its fit with my own epistemological position and with the context of professional education in the field of health visiting. I examine case study methodology as the overarching strategy applied to the study design, and focus group and semi-structured interview methods within the context of the study. I discuss the design and planning of the focus group activity and outline for the interviews, mapping this against the research aims and questions in the process. I then explore the approach to data analysis, ensuring consistency with the critical realist approach, using the thought operations of induction, deduction, abduction and retroduction of Danermark et al. (2002). I establish the need for a conceptual framework to support this process, drawing on resilience and TLT. The process of developing this framework is covered in detail in Chapter 5.

The process that I followed to gain ethical approval is identified and the measures taken to ensure that the study process took account of this are clarified in relation to the recruitment of participants and their experience during the conduct and reporting of the study.

3.2 Establishing an Ontological and Epistemological Position

A medical model based in positivist ontology has historically dominated health care, valuing random control trials as the basis by which practice should be developed and evaluated (Nairn 2012; Porter and O'Halloran, 2012). The dominance of quantitative research was challenged during the ‘paradigm wars’ (Denzin and Lincoln, 2011) of the 1980s and interpretative approaches are now commonly applied to examining the process of nursing and education (Pawson, 2012). However, debate surrounding the veracity of differing ontologies and epistemologies is on-going in the research texts, particularly in relation to social science research. Dualisms of quantitative versus qualitative, or positivist versus interpretivist approaches continue to be the focus of such debate (Danermark et al., 2002). Such dualisms may detract from the development of
research that is most beneficial to the development of knowledge in relation to
the understanding of causal mechanisms and applicability for practice.

3.3 Critical Realism

The philosophy of critical realism, described by Denzin and Lincoln (2011) as an
anti-positivist movement, emerged in the 1970s at a time when the domination
of empirical positivist ontology was being challenged. Critical realism has its
roots in the work of Bhaskar (1975), whose development of a new philosophy of
science drew on the influence of his doctoral supervisor, Harré. Bhaskar (1975)
presented a detailed description of his philosophy, described in his initial work
in the field of science as transcendental realism, and in his later work relating to
human sciences as critical naturalism (Bhaskar, 1989), with the two terms
subsequently being merged in the term critical realism (Collier 1994). Bhaskar
challenged positivist notions of ontology, which he perceived as
anthropocentric. He observed that the identification and definition of scientific
laws was achieved through the social action of humans to explain what had
been observed or experienced by them. This action was comprised of controlled
experiments excluding influences in the wider system. He argued that such an
approach limited the existence of knowledge to that which could be
demonstrated through human experience, and did not take account of other
possible elements in the wider system that may have also had an influence. In
contrast, and reflecting the ‘transcendental’ component of his philosophy,
Bhaskar contended that phenomena exist regardless of whether or not people
recognise that they are there, so distinguishing the world from what we know
about the world (Sayer, 2000). For example, to argue that the earth’s rotation
around the sun did not exist before being demonstrated by Copernicus would
be fallacious, as it was recognition that did not previously exist rather than the
earth’s rotation itself. Bhaskar referred to this as ‘epistemic fallacy’ (Bhaskar,
1975).

Bhaskar argued that there are three domains of ontology, or ‘theory of what
exists’ (Sayer, 2000, p.10). The first of these is the empirical domain, including
what humans’ experience. A further two domains were also identified: the actual
domain, where events that are experienced in the empirical domain take place,
and the real domain of structures and mechanisms which generates these events. These overlapping domains emphasise the complexity of causal relationships; a mechanism could generate an event that in turn could be experienced (or observed). Within the domain of structures and mechanisms, Bhaskar (1978) further identified a series of strata, which sequentially tracked downwards through the causal mechanisms. An example that he used to illustrate this was the explanation through several strata of the chemical reaction between sodium and hydrochloric acid:

**Stratum I:**  \(2\text{Na} + 2\text{HCl} = 2\text{NaCl} + \text{H}_2\)

Explained by

**Stratum II:** Theory of atomic number and valency \hspace{1cm} Mechanism 1

Explained by

**Stratum III:** Theory of electrons and atomic structure \hspace{1cm} Mechanism 2

Explained by

**Stratum IV:** Competing theories of sub-atomic structure \hspace{1cm} Mechanism 3

(Bhaskar, 1978, p. 169)

This example identifies that ‘laws’ in science are only as good as the currency of knowledge allows, and are therefore subject to development, change or revision. In critical realism this knowledge is therefore referred to as a ‘tendency’ rather than the absolute nature that the term ‘law’ suggests (Sayer, 1981). This illustration explains the stratified and changing nature of knowledge that is supported through critical realism. Furthermore, mechanisms may be known or unknown, visible or unseen. They may need to be exposed and may ‘emerge’ through tracking causation, but even if they do not ‘emerge’ then they still exist. Further still, the existence of structures and mechanisms does not mean that they are necessarily active as there may be particular conditions for them to become active, although they have the potential to bring about an event, that is they have ‘causal power’. This may be summarised as conditions + causal power leads to outcome (Sayer, 1981; Chapter 5 in Archer et al., 1998).
The principles of critical realist philosophy illustrated thus far have been applied to knowledge within the field of natural science but in his later work on critical naturalism, Bhaskar (1989) examined its relevance to human science. In doing this he explored the relationship between society and the individual, and suggested that there was a dynamic, symbiotic, relationship between the distinct entities of individual and society, with the individual being socialised by the norms and expectations of society and society being either reproduced or transformed through the actions of individuals. Thus Bhaskar suggested that society is both a condition and an outcome of human agency (Collier, 1994). This relationship is illustrated in Figure 3.1 from Bhaskar’s book *The Possibility of Naturalism* (Bhaskar, 1989).

**Figure 3.1: The transformational model of the society/person connection**

*Source: Bhaskar (1989, p.36)*

The conceptualisation of stratification in critical realism was illustrated earlier in relation to the production of sodium chloride. In considering the application of critical realism to the social world the range of strata in the real domain of structures and mechanisms extends beyond the physical and chemical to the biological, social and psychological. Within the physical and chemical strata observing specific interaction between individual elements is manageable. However, progression through the biological, psychological and social strata becomes an unrealistic proposition. Archer (1998) argued that critical realism acknowledges and allows for the difference in ontology in relation to the physical and the social world. In the natural sciences an experimental approach
can artificially create a closed system, where one variable can be manipulated whilst the rest of the system is kept constant, but social systems cannot be kept closed in this manner. Archer (1998) explains that even if it were possible to close a system to outside influence (extrinsic closure), the people contained within such a system would not be ‘controllable’ and through human characteristics of reflexivity and creativity would change the ways in which they respond, thus prohibiting ‘intrinsic closure’. Open systems therefore present a greater challenge in developing knowledge of causality due to what Archer describes as the ‘riddle of structure and agency’ (1998, p.191); however, the stratification of causal structures and mechanisms that is a feature of critical realism, does allow for the complexity of causation that exists within social contexts.

A causative chain may be tracked through the three domains of reality (the empirical, the actual and the real), where the conditions imposed by generative mechanisms (in the real domain) trigger an event (in the actual domain) and influence agency/experience (in the empirical domain). It is possible that generative mechanisms are unidentified precluding clear tracking of causation through the strata, though antecedents to events and experience may become clear in this process. The lack of continuity, through susceptibility to change, in the social domain leads Bhaskar to suggest that the object of study in social research should be relational as ‘in social life only relations endure’ (Bhaskar, 1989, p.25). As already identified, causal powers invested in structures and mechanisms require certain conditions in order to be activated, the occurrence or non-occurrence of these conditions results in a variation in response to what appears to be the same circumstances. This provides a perspective on the variation of experience of resilience across a social group, perhaps indicative of Archer’s riddle of structure and agency identified previously.

In approaching this study from a critical realist perspective, I took a position in which the world was taken to be ‘out there’, whether or not all its structures and mechanisms had been recognised as such, and in which social activity or interaction was implicated in the production of knowledge. Social and physical structures are not unchangeable or unchanging but they do constitute a single
world. The epistemology of critical realism, the way in which sense is made of this world, is not fixed but instead is affected by the social and historical contexts of the individuals experiencing it (Nairn, 2012). My position in undertaking this study was that this world, including the environments of university, practice and personal learning, was ‘out there’ and had a degree of commonality across the student cohort. Social, historical and educational orientations that the students held in common and individually affected the way in which they experienced the world (the empirical domain). The events of the actual domain varied between students, and knowledge of underlying structures and mechanisms in the real domain and the conditions under which they were triggered may have been known, unknown or unrecognised. The research aims and questions of the study related to the identification and explanation of causal relationships in the complex environment in which the curriculum was situated, and it was hoped that drilling down through the strata of the ontological domains might provide a contribution to establishing causality.

3.4 Consideration of Alternative Theoretical Frameworks

Understanding complexity theory, seen by some as an emerging paradigm relevant to education research (Cohen, Mannion, and Morrison, 2007), was developed through Stage 1 of my doctoral studies. Complexity theory holds that even a minor interaction between any of the large number of influences occurring in complex open systems can lead to the emergence of consequences, some of which may be unanticipated or unintended. Causation within such systems is non-linear, involving the whole system and the reactions within it, rather than a straightforward linear causation between single elements in the system (Mason, 2009; Morrison, 2009). The application of complexity theory in education research can allow for the recognition of the unique experiences of students within the context of the education process (Biesta, 2010).

The literature confirms the relevance of complexity theory to professional education, where academic and practice worlds combine in a complex open system. In designing this study, complexity theory was seriously considered to underpin the research design, as the concepts of non-linear causation through
multiple interactions occurring within the system, and notions of emergence and unintended consequences resonated with the focus of the study. Positive and negative feedback mechanisms, features of complexity theory, are also likely to be a part of students’ experience both in university and in practice, and could be explored within such a study. Where the application of complexity theory became more problematic was in the size and scope of a study that could be completed as the second stage of my doctoral studies. In applying complexity theory to the design of the study I would have needed to collect data from the multiple stakeholders involved with the student HVs during the year of their course, and this was simply not practical. Using critical realism to guide the study still allowed me to look for the emergence of consequences and to try to discover some of the non-linear causal mechanisms, whilst containing the study and focusing on the experience from the students’ perspective alone.

As can be seen from the initial literature review, much of the research relating to the development of practitioner resilience, hardiness and sense of coherence, has taken a positivist stance, with methods including quasi-experimental (Siu, Spence, Laschinger, and Vingillis, 2005), random control trial (Warnecke et al., 2011) and survey approaches (Kinman and Grant, 2011). Various interventions have been applied with the intention of increasing participants’ resources or responses, and their success measured by applying a number of rating scales as pre- and post-tests to the participants. Such an approach can demonstrate whether or not an outcome has been achieved, but even with complex statistical analysis gives little indication of the reasons for a particular outcome. As such it makes a limited contribution to understanding causality, or why there is a different impact for different participants. In addition, this approach takes an individualistic approach to resilience, and approaches the topic from a deficit perspective. In this study I wanted both to understand what it is in the students experience that contributes to building their capacity to respond to tensions in their professional lives, which may be about strengths that they already have or develop and responses to negative experiences, rather than taking a position that assumes a deficit that can be remedied by a particular intervention. I also wanted to try to uncover and understand the complex causal relationships at
play, and the experience of the students and their constructed meanings, which was in direct conflict with these positivist approaches.

3.5 Application of Critical Realism to the Study Design

Denzin and Lincoln (2011) are dismissive of critical realism, appearing to see it as an apolitical epistemology, and voicing concern on the adverse impact on social science of conflating philosophy and social science theory. However, Danermark et al. (2002) contend that the historical position where ontology and epistemology guiding social science research has been largely grounded in theory, has missed the point that research design is strongest when the philosophical position of the researcher permeates the research, a point reinforced by the notion of scaffolding the research process (Crotty, 1998). Critical realism does not prescribe the methods that should be used in research, but rather provides parameters by which to assess the appropriateness of existing methods (Danermark et al., 2002).

Longhofer and Floersch, (2012) in considering research in social work practice, suggested that critical realism challenges us to understand what happens and why it happens or does not happen, thus illuminating the theory-practice (or as they refer to it the phenomenological-practice) gaps. Praxis, they argue, is the process by which theory is integrated into the activity of practice (p.9), and takes place in a complex open system with multiple theoretical and practical influences that operate at different levels within that system. The term phenomenological-practice gap is used to emphasise the place of human experience in this process. Social work is rooted in the social policy context of welfare, and health visiting in health policy and the discipline of public health. Although the roots of the roles are distinct, both share the complexity of contributory academic disciplines, and both contribute to health and social wellbeing in their client group.

3.6 Critical Realism and Case Study Methodology

I chose case study methodology to investigate the research questions, as it is a good fit with a critical realist approach that allows the recognition of multiple influences within a whole system and the emergence of alternative
perspectives. This is supported in the literature that describes case study as a research approach (Simons, 2009) or overarching strategy (Yin, 2009) for gaining knowledge of the world as defined by the research aims (Denzin and Lincoln, 2011). It facilitates the exploration of complex real life problems (Anthony and Jack, 2009) and allows for non-linear approaches to causality. Case study allows the researcher to ask ‘how’ and ‘why’ in examining contemporary events (Yin, 2009). Simons (2009) supports the contention that it is suited to dealing with the complexity of education and practice, allowing for the uniqueness of the case under examination. In critical realist terms, a case study approach allows the exploration of what has to be in order for an event or experience to occur (Bhaskar, 1989).

3.6.1 Definition of a Case Study

The characteristics of case studies are categorised in a number of ways by different authors, but held in common are the notions of a “functioning specific” or “bounded system” (Stake 2008). The limits or boundaries of the system are defined but porous, with the effect that the interactions within it are also affected by external influences, and are consequently complex. A case study strategy from a critical realist perspective therefore provided an appropriate framework for the study as multiple sources of learning were examined and interactions between them anticipated. These may have been complex and possibly unique to the case and to participants within the case. Stake (1995) distinguishes between intrinsic case study, that is a case in which the researcher has an intrinsic interest, and instrumental case, that is one in which the case study is being used as a means (or instrument) to assess achievement of the questions posed, for example how successful a recently introduced system is in practice.

The ‘case’ was a HV course within my home university, where the students have practice placements across the county. Participants were drawn from students commencing the course in the academic year 2012-13. This was a single case, not seeking comparison between cases, or replication, but exploring issues in the context of students undertaking one course. The boundaries of the case were the practice and university system within which the HV students’ preparation took place. The decision to limit the study in this way
was three-fold. Firstly HV courses, although meeting national standards, do not have a shared curriculum so each is unique. Secondly, pragmatically the study needed to be undertaken within the constraints of full-time work plus doctoral study, so the time taken to travel to alternative sites would have been unachievable. Use of telephone interviewing and on-line focus groups was considered, but experience of the former in previous Ed D work was that the interview data did not give the richness of the personal interviews. I also did not feel confident that students with the heavy workload associated with this course would engage with on-line focus groups. Finally as the students are NHS employees, access through multiple employing organisations would be complex.

3.6.2 Case Study as a Methodology

Case study as a methodology differs from the use of a case study as a means of teaching or demonstrating an application in a particular situation or scenario, instead providing an overarching strategy for conducting research. In a traditional hierarchy of research methodology, case study has been seen as being suitable for exploratory studies, but not for establishing the ‘truth’ and causative relationships (Yin, 2009). Flyvbjerg (2011) agrees with Yin (2009) in contesting this view, and supports Gerring’s (2007) contention that the more academics try to clarify, the more the definition of case study methodology becomes murky and indistinct. Instead, Flyvbjerg (2011) suggests a common sense definition that places the emphasis on the defining factor as studying an individual unit with an identified boundary, which is much more helpful.

Flyvbjerg (2011) identifies five distinct areas of criticism of case study as a methodology (p.302). These relate to the value attributed to generalised theoretical knowledge, limitation to the exploratory stages of a study, the generalisability of findings from case study research, researcher bias, and the generation of knowledge and theory from specific case contexts.

The first of these relates to the nature of knowledge and the value ascribed to positivism in the creation of knowledge. Flyvbjerg (2011) identifies disagreement on this point as far back as the ancient philosophers, when Aristotle refuted the ideas of Plato and Socrates through his assertions that
case knowledge was fundamental to knowledge overall. The notion that statistical 'proof' is the only means by which knowledge can be created would exclude all qualitative social research methodology, and has been displaced in recent research literature, which recognises the validation of findings through hypothetico-deductive analysis, as well as through statistical analysis (Ruddin, 2006). On this basis the generalisability of findings would also be contested across qualitative methodologies, as these are predominantly based on the examination of specific cases and contexts. From a critical realist perspective, the complexity of an open system is recognised, as is lack of consistency in the experience of those involved in the system. As effects may vary according to the circumstances in which they occur, critical realism refers to tendencies rather than laws (Collier, 1994; Danermark et al., 2002). Danermark et al. (2002) identified that a qualitative case study is well positioned to identify such tendencies.

Although findings from case study research such as this study may not be applicable to all courses and contexts in which HV students are prepared for their professional qualification, there may be issues emerging that are of relevance to those involved with other courses. Consequently, readers can examine the findings to identify areas of commonality and difference, and make their own decisions regarding the applicability of the study to their context (Stake, 1995), in a process referred to as ‘naturalistic generalisation’. Lincoln and Guba (1985) use the term ‘transferability’ to reflect the difference from statistical generalisability.

Limitation to the exploratory phases and the problems associated with using a single case to generate theory, are both refuted by Flyvbjerg (2011) and also by Ruddin (2006), who refers to Galileo dispelling Aristotle’s theory of gravity through the contribution of a single case. Flyvbjerg (2011) and Lincoln and Guba (1985) argued that the appropriate response to these criticisms is to ensure that the depth of reporting demonstrates the rigour of the approach and makes the derivation of the findings transparent.

An alternative approach for this study could have been to use ethnography, as this would have allowed the participants to be observed in the contexts in which
they learned (Cohen et al., 2007). Participant observation would have avoided self-reporting and reliance on students’ memories, but the diverse range of places and contexts within which students learned would have made the management of such a study very difficult, and ‘becoming invisible’ during interactions in multiple settings would have been a significant challenge. Ethical considerations would have been much wider as the needs and interests of a wide range of professional groups, and of course clients, would need to have been taken into account. Using a case study methodology allowed the use of different methods that provided data from both individuals and groups, within the time and financial resource constraints, needed to respond to the research aims of the study.

3.7 Research Methods

Critical realism takes the stance that mixed methods grounded in both quantitative and qualitative perspectives can be used, rather than working exclusively within one paradigm. This is seen as adding value to the research that is precluded by the dualisms frequently debated in relation to social research (Danermark et al., 2002). The methods used however must ‘fit’ with the ontological and epistemological position, with proponents of critical realism preferring to describe a design as intensive (based in one paradigm) or extensive (crossing paradigms) (Danermark et al. 2002).

Case study approaches utilise a range of methods for data collection. An intensive design, including a series of activity-based focus groups and individual semi-structured interviews, was planned with data collection over the period of a year. This combination contributed to the robustness of the research by allowing the triangulation of the data obtained. Table 3.1 below, summarises the data collection process through the study. The content of course handbooks and documents provided background information on the expectation of the curriculum delivery. Plans for focus group activity are included in Appendix 6 and a draft interview schedule in Appendix 7. With case study design there is capacity to amend or add alternative methods of data collection as the study unfolds. An alteration to timing and content of the third in the series of focus groups was necessary, but did not require further ethical clearance.
Table 3.1 Summary of data collection

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timing</th>
<th>Participants</th>
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</thead>
<tbody>
<tr>
<td>Focus group 1a</td>
<td>September 2012</td>
<td>5 out of 6 invited participants attended: Alice, Becky, Clare, Jess, Holly</td>
</tr>
<tr>
<td>Focus Group 1b</td>
<td>September 2012</td>
<td>All 6 invited participants attended: Nicola, Dawn, Georgie, Brigid, Laura, Katie.</td>
</tr>
<tr>
<td>Focus Group 2a</td>
<td>February 2013</td>
<td>5 out of 6 invited participants attended: Alice, Becky, Clare, Jess, Jo</td>
</tr>
<tr>
<td>Focus group 2b</td>
<td>February 2013</td>
<td>All 6 invited participants attended: Nicola, Dawn, Georgie, Brigid, Laura, Katie.</td>
</tr>
<tr>
<td>Focus Group 3a</td>
<td></td>
<td>These groups were planned for June 2013. Participants did not want to attend at this time and requested a different time be arranged.</td>
</tr>
<tr>
<td>Focus group 3b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>July 2013</td>
<td>Becky</td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>July 2013</td>
<td>Dawn</td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>July 2013</td>
<td>Jo</td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>July 2013</td>
<td>Laura</td>
</tr>
<tr>
<td>Focus Group 3</td>
<td>August 2013 at participant request</td>
<td>6 out of 12 participants invited attended: Dawn, Brigid, Laura, Becky, Clare, Jo</td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>August 2013</td>
<td>Clare</td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>August 2013</td>
<td>Jess</td>
</tr>
</tbody>
</table>

3.7.1 Focus Groups

Focus groups have been used in academic and market research since the early twentieth century (Colucci, 2007), with use of the focused interviews first being included in social research by sociologist Robert Merton (Merton and Kendall, 1946). Focus groups were initially used to test a series of hypotheses devised through prior analysis of the context of the participants’ shared experience. Since then their application has diversified and they are used as an initial exploratory phase of research in both positivist and interpretivist paradigms, for example as the first stage for exploring question focus and wording for surveys (Kidd and Parshall, 2000; Barbour, 2005), as a component of mixed methods approaches (Barbour, 2007; Flick, 2007), or as a single method of data
collection (Flick, 2007; Kreuger and Casey, 2009). Focus group method can therefore fit with research from a wide variety of epistemological standpoints, and is a versatile tool for use in qualitative research (Kidd and Parshall, 2000).

In this study I used a series of focus groups in conjunction with individual semi-structured interviews. I examined the course periodic review documents to review the context and philosophy of learning. This mixture of methods placed within a case study strategy allowed breadth of exploration of the case in question, and is a strategy often used in education research (Wilson, 1997). The methods did not triangulate in the sense of confirming data from multiple standpoints, as achieving consensus was not an identified outcome of the study (Barbour, 2007). However, triangulation in the sense of examining the complexity of the issue from a number of perspectives could be achieved through this combination of methods (Flick, 2007). Wilson’s (1997) experience of researching sensitive topics, in contrast to Kreuger and Casey’s (2009) assertions, suggests that focus groups can provide a safer environment in which peers can challenge each other than an individual interview situation where the challenge has to come from the interviewer. The sequencing of focus groups and interviews allowed for the emergence of issues and experiences that could then be followed up at an individual level, allowing the complexity of issues to be explored. Three focus groups, spaced at around four month intervals over the academic year, were planned. These focussed on exploration of the participants’ opinions and experiences in relation to the relevance of their learning experiences to development of their capacity to deal with the reality of practice. Sources of learning were anticipated through examination of the curriculum, but may also have been hidden or unanticipated, forming part of the hidden curriculum. The use of focus groups can help to access difficult to reach information through their discursive and interactive nature, so helping to unpick learning occurring through the hidden curriculum (Barbour, 2005) in addition to gaining opinion on experience of the taught curriculum.

Across the literature the terms focused interview, group interview and focus group discussion, are used synonymously (Barbour, 2007). Although argument may be made for the use of each of these different terms, what is held in
common across the literature is the defining nature of focus groups. That is, they facilitate the exploration of the experience and opinions of the participants, they are discursive, and they take place in a non-threatening environment. Focus groups are not undertaken to achieve a consensus, rather they allow differing views and opinions to be voiced and explored (Barbour, 2007; Kreuger and Casey, 2009). Strength of the focus group method is that it not only allows the identification of what people think, but can also draw out why they think as they do (Morgan, 1993). Therefore, the skill of the moderator who facilitates the focus group is critical to optimal data collection. I have previous experience of moderating focus groups, and understood the need to ask open-ended questions, to probe for clarification and encourage discussion between the participants. Providing safe and comfortable physical and emotional environments is central to promoting interaction between participants. The rigour of a focus group as a method therefore depends on careful planning of the conduct of the group (Barbour, 2007).

Previous experience of focus groups had been positive, although only single groups had been held rather than a series of groups. On all occasions I had worked from a schedule that formed a framework for the group (Kreuger and Casey, 2009). On one occasion I used an activity as the focus of the group and, in congruence with Kreuger and Casey (2009) and Collucci (2007), found that this was an effective way to engage participants in discussion with each other. Where I had used questioning alone as the framework for the group it was more difficult to avoid participants directing their observations through me, rather than interacting with each other and discussing areas of similarity and difference between their opinions. It was important to make clear this expectation to the participants when introducing the purpose and process of the group.

The use of a series of three groups, building sequentially on the outcomes of each, was a new experience for me. Tensions between the need to present the intended format of the focus groups for ethical approval against the principle of flexibility of case study methodology, responding to what emerges as the study progresses, was challenging. Success and enjoyment of using activity as a basis for the groups provided the solution. The activities were planned in
advance, although these allowed for flexibility in focussing questions depending on the outcomes of the previous focus group(s) in the series. Appendix 6 provides a summary of the planned activities mapped against the research aims and questions.

### 3.7.2 Moderator Roles

The presence of two moderators ensured that the different voices within the focus group were heard and enabled the taking of field notes during the course of the discussion. There are differences of opinion regarding who should take the role of the moderator (McLafferty, 2004). In this instance I acted as the first moderator of the focus groups, with the role of the second moderator being taken by a colleague. One outcome of doctoral research is to refine the research skills of the novice researcher, including those of data collection. Understanding the context of the students’ learning, as an insider, gave me credibility and an inside knowledge of professional terminology and behaviour. Researching as an insider also carries a range of challenges, which I have previously discussed in Section 1.1. Close involvement with the narrative of the participants enabled me to become situated in the data, which was beneficial in the process of data analysis. The second moderator wrote field notes on one page of a notebook with space for me to record observations and reflections on the opposite page. This enabled me to concentrate on following and facilitating the discussion, whilst allowing the opportunity for debrief following the groups including reflection on the process and outcomes, and an external view of my effectiveness as a facilitator.

### 3.7.3 Semi-Structured Interviews

Qualitative research interviews are widely recognised as being a conversation with a purpose. Kvale and Brinkmann (2009) see the interview as literally an ‘inter-view’ (p.2); that is a conversation between two people constructing an understanding or interpreting the experience of the subject under discussion between them. Interviews can be unstructured, the participant telling their story independent of any questioning by the interviewer, or semi-structured. In the latter an interview guide provides a basic framework of questions that the interviewer wants to address in the course of the interview (Cohen et al., 2007)
in order to gain the perspectives required to answer the research questions. In this study the semi-structured interviews followed the focus groups, so they were an opportunity to pick up on issues emerging from the iterative analysis of the data. They were also an opportunity to discuss issues in more depth from a participant’s individual perspective, and to talk about things that they may not have felt comfortable talking about in a group. The use of a topic guide allowed me to think through the essential content of the interview and the way in which the questions might be phrased in order to avoid interviewer bias (Cohen et al., 2007). In common with questioning in the focus groups, I needed to be open to the views of the participants and to ask open questions, avoiding any suggestion of right and wrong answers. Moving through areas identified in a topic guide required a varying amount of questioning from me as the interviewer, as sometimes the conversation flowed to cover the material naturally and at other times more prompts were required. This flow was directed through encouraging noises, probes to develop understanding or to clarify a particular area (Birley and Moreland, 1998), or through the introduction of new topics (Whyte, 1982). A topic guide can lead to important areas being excluded if they are not in the guide, however if the interviewer is flexible in using the guide and allows the interviewee sufficient space to move through the interview then this difficulty can be avoided (Cohen et al., 2007).

I think I was reasonably successful in this area, as when I listened to the recordings the questions that came to mind were subsequently asked by me or answered by the participant without prompting. The use of probes allows the researcher to focus the interviewee on details that further explain how they see the world and to clarify any apparent contradictions in what they say (Kvale and Brinkmann, 2009). Again I think this was reasonably successful, although the time available for the interviews was a limiting factor in relation to how far this could be followed through. The development of a topic guide, with questions and associated prompts mapped to the research questions, formed a critical part of the design phase (Kvale and Brinkmann, 2009) and this is presented in Appendix 7.
Knowing how many interviews to undertake when conducting qualitative research is not an exact science. Kvale and Brinkmann (2009) suggest that this should be the number needed in order to yield the information that is required. In a quantitative study clearly sample sizes need to be assessed in relation to overall populations and the numbers required for reliable statistical testing. In qualitative research numbers are usually assessed in relation to the yielding of new data, with the point at which this ceases to happen being referred to as saturation. Kvale and Brinkman (2009) observe that this often falls between 5 and 25, depending on time and resources available, and the added value from further interviews. In this study the aim was to undertake approximately six semi-structured interviews.

Ethical issues are discussed later in this chapter, and in common with the focus groups, included preserving anonymity throughout the processes of transcribing and reporting, taking particular care with the quotes used in research reports. Confidentiality is easier to control in the context of an individual interview than in a focus group with multiple participants.

3.8 Data Analysis

Critical realism allows for the examination of non-linear relationships in causation, and the potential for the emergence of structures with new properties when existing entities combine (Elder-Vass, 2010). As such, a linear method of data analysis appeared incongruent. Instead a spiral view of data analysis (Levett-Jones and Lathlean, 2008), dipping in and out of the data and allowing a stepping back and the re-visiting of thoughts as further data and reflection contributed to the process, seemed more appropriate. Consequently Stake (1995) and Simons (2009) suggest that although a specific time may be identified in the timeline of the case study methodology where analysis is prioritised, the process of sense making is ongoing.

Danermark et al. (2002) identified that within critical realism there are four methods, or ‘thought operations’, through which meaning can be inferred from the data; these are induction, deduction, abduction and retroduction. In this context Danermark et al. (2002) take ‘inference’ to mean both applying
deductive logic in judging whether the conclusions drawn are consistent with the premises on which they are based, and thinking or arguing that allows the application of knowledge from one situation to another. This includes taking knowledge from the observation of the specific into the domain of developing knowledge about more general structures. Danermark et al. (2002, p.79) identified that:

‘Scientific inference, in the sense of thought operations, involves different ways of reasoning, interpreting and drawing conclusions without following strictly formalised rules. Here the researchers’ powers of abstraction, as well as imagination and creativity, can be crucial.’

Induction involves drawing on similarities in the data, leading to the identification of patterns. These patterns may be applicable to other contexts through the process of generalisation, as already discussed. Deduction involves reaching logical conclusions about what is presented in the data based on established knowledge (Danermark et al., 2002; Flick, 2007). Whilst induction and deduction are referred to in relation to wider approaches to social research, the processes of abduction and retroduction are specifically identified within critical realism.

Abduction involves gaining new understanding through analysing and interpreting something against a conceptual framework. This allows a new perspective to be gained on a particular phenomenon. Chapter 5 includes details of the conceptual framework I developed from TLT and resilience theory to support this process.

Retroduction involves breaking the occurrence of a phenomenon down further, aiming to be able to move from describing what has occurred to describing what must exist in order for it to take place (Collier, 1994; Danermark et al., 2002).

The process of abstraction is seen as central to drilling down to mechanisms in causality through the domains and strata of critical realism. The thought processes of abstraction allow the mental isolation, as opposed to physical manipulation, of an aspect of social relations from the concrete evidence. Danermark et al. (2002) identified the specificity of abstraction in critical realist
terms that involves isolating particular structures that are involved with the social phenomenon under examination. Subsequently, more structures may be examined as the examination proceeds. Lawson (1998) argues that the level of abstraction varies according to the level of generality of the question that is being asked, dictated by the ‘vantage point’ of the questioner. The more specific and narrow the question the more specific the concepts that need to be abstracted in order to further explore causation. This seems to me to represent a kind of mental gymnastics that allows for the disaggregation and examination of contributory concepts to causation, whilst preserving the overall complexity of the social context.

A combined approach to data analysis was taken in the study design, incorporating all the ‘thought operations’ described above, drawing inductive and deductive inferences from the data, and exploring phenomena against the conceptual map of practitioner resilience. To achieve this the process included the six stages of the explanatory model of Danermark et al. (2002, p.109): description, analytical resolution, abduction or theoretical re-description, retroduction, comparison between theories and abstractions, concretisation and contextualisation. In this process I started working with the data through the description of the concrete, moving on to breaking the data down and interpreting the elements in the context of wider theoretical concepts, firstly through the application of the conceptual framework, and secondly by drawing on wider theory, before returning to the concrete through bringing the analysis back to the context of the research aims. The process was supported through reference to field notes and researcher reflections. Reflexivity is recognised as an important contributor to rigour in social research (Cohen et al., 2007), including that based in critical realism (Longhofer and Floersch, 2012), although this is not made explicit in the model that Danermark et al. (2002) presented. The description, analysis and interpretation of the data took place on a continuous basis, allowing adjustments to the data collection and an on-going exploration of the theory to support the findings that emerged (Simons, 2009).

Reporting of the detail of moving from the descriptive to the analytic in data analysis in qualitative research studies sometimes lacks clarity within the
literature, as thematic analysis and content analysis are often poorly
discriminated (Vaismoradi, Turunen, and Bondas, 2013). Vaismoradi et al.
(2013) align thematic analysis with the analysis of narrative and life stories, and
content analysis with the exploration of phenomena. In both instances,
however, they perform this through the detailed coding of small chunks of text
by the researcher. In contrast, Glaser and Laudel (2013) outline an approach to
qualitative content analysis that constructs a set of categories informed by
theory related to the study, and use these as the basis for extracting information
from the data. As time progresses these categories can be modified or
extended according to the need emerging from the data. Use of an identified set
of categories in this way addresses the criticism of a lack of transparency and
the reliability of the construction and assignment of codes in qualitative data
analysis. In all its forms the analysis of qualitative data involves description,
analysis and interpretation, although the involvement of theory in the
interpretation process may vary. Whilst theory may emerge inductively from the
interpretation of data in grounded theory based research, it plays a varying role
in the interpretative process in other qualitative research approaches (Gibbs,
2007; Simons, 2009), and it is through the middle stages of the model proposed
by Danermark et al. (2002) that this occurs. Theory influences interpretation,
though in congruence with Glaser and Laudel (2013) the researcher needs to
remain open minded as to the continuing relevance of that theory as the
interpretation of the data progresses (Sandelowski, 2010).

The use of theoretical frameworks for data analysis in qualitative research is not
universally accepted, but Gibbs (2007) supports such an approach suggesting
that theory and concepts can be used to check out ‘hunches’ (p.5) to see how
they map against existing theory. However, the use of conceptual frameworks is
clearly supported when working within a critical realist framework through the
process of abduction (Danermark et al., 2002). The use of a conceptual
framework does not exclude the emergence of new categories not included in
the original framework, nor does it compel the researcher to stay with that
framework as the analysis unfolds (Sandelowski, 2010). This is also congruent
with Stake’s (1995) position that in making sense of data in case study research
the researcher identifies areas that are familiar and fit with previous knowledge
alongside areas that have not previously been encountered and have then to be understood in the complexity of the case.

In this study I developed a conceptual framework amalgamating theory and findings from the literature review in the light of initial data collected from the first focus groups. My purpose in doing this was to place the data collected in the context of established theory, presented in a new way, with the hope that insights might be gained regarding how that theory might be helpful in understanding education for practitioner resilience. The conceptual framework was used to structure the analysis of the participant interviews and focus group data, and to aid the process of drawing content appropriate to the research questions from the mass of data collected (Miles and Huberman, 1994; Simons, 2009). This iterative process allowed deductive, inductive, abductive and retroductive approaches to the data to be employed (Danermark et al., 2002).

Using a framework in this way had the potential to make explicit the existence of the double hermeneutic, that is the approach to the transcribed text from the participant and the researcher perspectives, both of which contribute to meaning-making (Brogden, 2010). Reflexivity of the researcher is essential in maintaining an awareness of the impact of the double hermeneutic on what is identified as emerging from the data.

A single case study does not comprise a strong base for generalisation against other cases, although much of what is learnt may be general in nature and therefore of wider interest to readers with experience of other cases. Others can incorporate what is learnt through the experiential process of ‘naturalistic generalisation’ (Stake, 1995, p.85) identified earlier. Naturalistic generalisation from a case study, Stake (1995) suggests, requires that the processes by which the research is undertaken, the context and data gathered, and the analysis of that data must all be made explicit in the written report of the study, in order that the reader may make a valid judgment of its applicability.

3.9 Managing the Data

The focus groups were audio recorded and transcribed (see following section for ethical considerations). Video recordings were also taken to help me to
situate myself within the context of the groups when looking back some time later. They were also helpful in identifying participants where this was not clear from the audio recording, and to pick out interactions between participants where required. The audio recordings were retained and provided the main source for analysis as I found listening to the spoken word situated me closer to the context of the narrative of the participants and allowed it to ‘live’. I returned to the written word to highlight quotes that would add richness and authenticity to my reporting of the findings. Transcribing took account of laughter (and other interjections), occasions where two people spoke at once, and of pauses. Detailed recording of inflections and speech patterns was not included, as this was not congruent with the research aims (Belzile and Öberg, 2012). The semi-structured interviews were also transcribed verbatim and the narratives of the participants subjected to thematic analysis with reference to the conceptual map in the same manner as the focus groups.

Belzile and Öberg (2012) observe that although there is agreement on the interactive nature of the focus group method, this is rarely evident in the analysis of focus group data. This has been the source of some criticism of the focus group method (Wibeck, Dahlgren, and Öberg, 2007). Belzile and Öberg (2012) suggest that the extent to which interaction needs to be included as an outcome of data analysis is dependent on the epistemological stance of the researcher and the methodology employed, and needs to be planned in the design stages of a study. A continuum of the relevance of interaction as an outcome of the study places the focus on content at one end of the continuum, and a predominant focus on interaction at the other end (Belzile and Öberg, 2012, p.469), thus enabling a match between the use of the focus group method and the purpose of the research.

The epistemology of critical realism, the way in which sense is made of the world, is not fixed but is grounded in social and historical contexts of the individuals experiencing the world. The principles of critical realism are situated within three domains: the real, the actual and the empirical (Bhaskar, 1978). The implications of critical realism for understanding causal relationships dictate that what actually happens in an interaction cannot be explained without taking
the context of that interaction into account. Within that context the concept of emergence is central in applying a critical realist perspective. Social or physical structures can emerge from interactions (Cruickshank, 2012; Longhofer and Floersch, 2012) as different elements in individuals and the context are exposed to each other (Elder-Vass, 2010).

3.10 Ethical Considerations

3.10.1 Ethical Approval

Ethical approval for the study was gained through the Tier 2 faculty research and ethics governance committee (FREGC) arrangements at my University of Brighton. The students were employed on training contracts by local trusts, so guidance was sought regarding whether ethical approval was also required through the NHS research governance processes (IRAS). Confirmation was received that this was not required. Following approval through the University process I approached the Research and Development lead for the local NHS Trusts. The interviews and focus groups were not taking place on Trust premises, nor were the students participating during the hours that they were committed to working in practice placements. This meant that they were not classified as NHS participants so no further approvals were required. The documentation required for ethical approval is included in Appendix 8.

3.10.2 Ethical Considerations in Recruitment

Participants were recruited from a cohort of thirty-five HV students. Access to the students was agreed through the Head of School and the course leaders. Letters were sent in August 2012 to all of the students enrolling for the beginning of the academic year 2012-2013, including participant information and consent forms, and an invitation to participate (Appendix 8: 8.4, 8.5, 8.6). Those interested in participating were asked to bring completed consent forms in to the university during the induction week and a box was provided from which I could collect them. Twelve students volunteered to take part in the study, and completed and submitted their consent forms. This was a welcome response, and avoided the risk of coercion through repeated approaches for recruitment.
I had made provision in the participant information to limit the number of participants if necessary, but decided that as data collection was longitudinal there might be some drop-off in engagement over the year. I therefore decided to run two series of focus groups in parallel, with six participants in each. I would then offer an invitation for individual interviews to all the participants with the aim of achieving six interviews. I felt this offered the best opportunity for maintaining the cohesion of the focus groups, following individuals through the process, and safeguarding the integrity of the study over its duration.

All twelve participants were invited to participate in an interview. I sent out this invitation twice as I had insufficient response from the first contact, but made no further contacts except to agree arrangements for the interviews. Six of the participants volunteered. Participant information made it clear that they were free to withdraw from the study at any time without any adverse consequences. The consent form and participant information made it clear that if they withdrew during the process of the study any data collected already would be used in the final analysis. None of the students actively withdrew from the study, although the third focus group was re-arranged at the students’ request as at the original planned time they had just finished their assessed work and did not want to come in to the university. Six students responded and took part at the re-arranged time.

3.10.3 Ethical Considerations for Data Collection

The data collection processes needed to be safe for the participants, and to allow all of their voices to be heard. Ground rules were established at the outset of the first group, and re-visited on each subsequent occasion, requiring the respect of individual views and opinions. Moderation of the focus group ensured that the different voices within the focus group were heard.

In both the interviews and focus groups there was always a possibility that material might be disclosed that indicated that an individual was either at risk in some way, or that behaviour that breached required codes and standards had occurred. In the participant information, in the focus group ground rules, and at the beginning of the interviews, the limitations of confidentiality were made clear.
Informed consent given at the beginning of the study was confirmed at the beginning of the first focus group. It was not anticipated that the material covered in either the focus groups or interviews would be distressing, however this possibility could not be ignored. In the event that participants became distressed the recording would have been suspended, and the activity terminated if either the participant or researcher deemed it appropriate. As students, the participants could access counselling support through student services if necessary. As an experienced practitioner accustomed to working with clients with varying vulnerabilities and health needs, I could also have directed them to other sources of support and guidance relevant to the issues identified. I would not have provided any counselling or professional advice in the course of the study.

Focus groups and interviews took place within the university outside academic and practice teaching hours, at intervals over the period of the course. The timing was scheduled to avoid points at which students were experiencing high workload due to the submission of assessed work. Summaries of the focus group transcriptions and preliminary analysis of the data from focus groups was taken back to the participants for discussion and verification. Transcripts of individual interviews were made available to the participants for confirmation. The use of quotes from focus groups and interviews was explained to the participants so that they were aware of this when checking the content of transcripts.

Any study that uses peoples’ resources and goodwill needs to be justifiable. It was hoped that this study would be helpful in the development of future curricula benefitting course design and organisation. If the means by which capacity can be built to be resilient in practice could be identified, this would be of benefit to the participants themselves and their employing organisations. In addition, from previous work for my doctoral studies I identified that the process of being involved with the study and the reflection that participation required could in itself be beneficial to the students’ understanding of the outcomes of the educational process, and their personal development through this. This was confirmed by some of the participants in this study.
3.10.4 Confidentiality, Privacy and Data Protection

The identity of the participants was protected throughout the research process. The focus group ground rules requested that information disclosed within the confines of the group was not discussed outside. This relied on the integrity of the participants, but as all were on a professional register with the Nursing and Midwifery Council (NMC) their code of conduct required them to maintain confidentiality unless their duty of care dictated that it was in the interest of safety to disclose information to an appropriate body (NMC, 2008). This expectation and interpretation of the bounds of confidentiality extended to the context of the research and was clearly stated in the ground rules set for the focus group activity and at the beginning of the interviews. Identification of the limits of confidentiality allowed action to be taken if a participant disclosed poor practice or safeguarding issues that required me to act in accordance with my own code of professional conduct as a nurse. Anonymity and confidentiality was protected throughout the transcription, storage, and analysis of data, and also during the reporting of findings. Data were kept securely and processed on a private computer accessed only by myself. The use of data was explained to participants and the circumstances in which raw data would be shared with supervisors identified. The principles of data protection required by the university ethics processes were adhered to.

3.11 Participants

The focus groups brought together students in the same cohort of a one-year full-time course. Authors are divided regarding the desirability of participants being known to each other or having pre-existing relationships prior to participating in focus groups (Kitzinger, 1994; Kreuger, 1994). In this instance the study aims defined the pool of prospective participants. In addition, as the focus groups were spread over a period of nine months, relationships between the participants developed over the period of data collection. It was not possible to predict the group dynamics but hierarchies, negative and power relationships may have existed (Barbour and Schostak, 2005), which I, as moderator, needed to be cognisant of if the groups were to be productive.


3.12 Summary

In this chapter I have explored the theoretical framework of critical realism and its application in the complex context of this study. I have justified the choice of case study as a methodology, and the applicability of the focus group and semi-structured interview method. I have described the planning of the data collection activity and the approach to data analysis through adoption of the strategy proposed by Danermark et al. (2002). I have outlined the principles and processes of data management. Ethical approval was established and I have applied this approval in the specific context of the participants in this study, and the data that were collected from them.

In the following chapter I describe the data collection process, including the pilot study and the data collection period of the study.
4. Data Collection

4.1 Introduction

This chapter details my engagement with the data collection process, combining learning from the research literature in the last chapter with the practice of data collection. I describe and reflect on the pilot activity for the focus groups and identify the way in which learning from this was transferred to the focus groups in the study. A total of five focus groups were undertaken during the study, together with six semi-structured interviews.

This chapter takes a reflective approach to the data collection process through both focus groups and interviews. This allows me to demonstrate how reflexivity in the research process supported the robustness of the data collection process, and the development of my data collection skills.

4.2 Participant Biographical Information

Some basic information was collected from the participants by means of a short pro-forma given at the end of first focus group. In retrospect this was not the best timing for the distribution as the participants did not all return the form as requested and follow-up requests had to be made. One participant withdrew from the course before the study was completed and complete data were not obtained, although some data were available from her narrative through the focus groups. The data were gathered to provide a participant profile in order to identify whether there was any obvious bias in the self-selected sample. The dimensions included were age, professional qualifications gained and longevity in the profession, previous roles as nurses or midwives, level of academic qualification, and length of time since most recent study. The participant biographical data are presented in Chapter 5.

The participants were all female; health visiting is a female-dominated profession with few men taking on the role. Although it would have been good to include a male perspective in the study, my experience of having one man in the pilot group highlighted the challenges in maintaining the confidentiality of a lone male participant who was the only man in the cohort. There is also some
evidence that gender affects the language and focus of discussion (Barbour, 2007), a dimension that it was not possible to include.

4.3 Focus Groups

4.3.1 Pilot Activity

The piloting of the activity could not practically mirror the longitudinal perspective, as the student cohort available to test the activity was at the end of their course of study. Instead, the purpose of the pilot was to test whether the activities facilitated the depth of discussion needed to obtain data pertinent to the research questions. Data collected in the pilot were not included in the study, although the activity of recording and transcribing was piloted to identify any issues with data capture.

Two activities were tested in the pilot: drawing, to help to pin down views of the role, both in terms of expectations and reality; and a ‘hierarchy’ exercise to focus the participants on qualities and attributes, and skills and strategies linked with resilience identified from the literature (see Section 2.4.3). I had previously used drawing with students in the classroom to help them identify what they were bringing to the course, and their expectations. I had also use a hierarchy exercise in previous teaching to help students to explore their attitudes and beliefs to child abuse. In both contexts these strategies had been successful in promoting discussion, so I decided to apply them as activities in data collection. For the third focus group the original plan was to look at specific stories/anecdotes that identified and unpicked valuable learning experiences. In the event, the timing and format of focus group 3 was completely changed, and this is discussed later in this chapter.

Key points from the pilot activity are summarised here, together with the implications for the main study. I piloted the first two activities with a group of students who had completed the same course as the main study participants.

Talking retrospectively about students’ experiences was unsurprisingly problematic (Kreuger and Casey, 2009), as they either said they didn’t know or talked in terms of progression from their previous role. The problem here may have been that they didn’t remember, or that they had moved on in their
transition to the role so their initial conceptions of the HV role were no longer relevant. It may also have been that they were saying what they felt would be expected of them at that stage on their programme.

The drawing activity did not produce such rich discussion in the pilot as in my previous experience of this kind of exercise. This may have been because I was asking the participants to do more than one thing at a time; that is to distinguish between their expectations and their experience of the reality of practice, and to identify how this made them feel. The participants seemed to have difficulty in conceptualising the issues they were identifying in terms of a ‘drawing’ or ‘picture’. In the pilot I was anxious that the students shouldn’t just produce a list of expectations, as I felt that this would result in a descriptive outcome. However, re-visiting the work of Kreuger and Casey (2009), and the experiences of Colucci (2007), I recognised that this could provide the means of moving from the easy to the more difficult (Kreuger and Casey, 2009), and both stimulate discussion and give an impression of the magnitude of the issue (Colucci, 2007).

Using a series of focus groups in the main study helped to address these findings from the pilot group. This allowed the participants to look at their situation at each stage of the process, providing a contemporaneous view. The activities were also modified allowing movement from the easy to the more difficult as the focus groups built upon each other, using written description of the expectations of the role in the first focus group, and moving to more imaginative conceptualisations through drawing during the second groups.

Comparison and change was followed up in relation to each activity in the subsequent focus group, a process including initial data analysis checking with the participants.

The group with whom the pilot activity was undertaken was large (15 participants) and exploration of ideas was limited through the participants tending to put forward their own individual view rather than contributing to a group discussion of issues raised. This experience reinforced the view that when a topic is complicated a smaller group size allows more time for a deeper
exploration and is more likely to lead to success (Kreuger and Casey, 2009). The size of groups in the main study was affected by recruitment. Although a group of eight seemed from the interaction within the pilot to be the optimum size, ultimately two groups of six were arranged so that all of the twelve volunteers could be included within the study. It was hoped that this smaller group size, combined with the series of focus groups, would build trust and enable the participants to be confident that they could be honest rather than saying what they thought was expected as seemed to be an issue in the pilot.

The hierarchy exercise with the cards was more engaging and provided the opportunity to test out which worked best as triggers for discussion (Colucci, 2007). This exercise promoted better interactions between the participants and all became engaged in the process, however both the length of time needed for the activity and the use of the word ‘hierarchy’ were challenging. The number of cards used in the second activity in the first focus groups was reduced allowing more time for discussion. The choice of cards used was guided by those used successfully in the pilot activity whilst also aiming to preserve the scope of emerging ideas.

The mode of presentation of the cards was changed, replacing the term ‘hierarchy’ with ‘rating’ as this allowed different elements to be placed in the same position, whereas ‘hierarchy’ unhelpfully suggested an ordering of factors. A guide was placed on the table scoring the rating from 1-10, the higher score indicating greatest value, to aid placement of the cards. The cards were taken one by one, by the participants in turn, rather than being shared out between them. This allowed time to be taken for discussion as needed, and for all to engage in this rather than preparing to talk about the cards they had been given. The list of terms used is detailed in Appendix 9, with those taken forward into the main study shown in bold type.

In the pilot insufficient time was devoted to the learning experiences that had enabled the development of the students, and whether these were part of the taught or hidden curriculum. The series of focus groups in the main study
allowed greater opportunity for this exploration, with follow up during the semi-structured interviews.

4.3.2 Organisation and Management of the Focus Groups

The study followed twelve participants over the year of their course and involved them in taking part in focus groups at three points over this period. Six participants were subsequently interviewed individually using a semi-structured format. The data collected from each focus group were built upon and revised by the participants at subsequent groups. The data collection process is summarised in Table 3.1 and an audit trail is presented in Appendix 3.

Six participants were included in each of two focus groups. The first focus groups were important in setting the scene and atmosphere for the series of focus groups. The room was prepared in advance so that when the participants arrived they were made to feel welcome. The focus groups were ‘piggy-backed’ (Kreuger and Casey, 2009) onto other sessions the participants were attending at the university, in order to minimise disruption to their busy lives and to maximise attendance. Some refreshments were provided appropriate to the time of day. The social activity of eating is thought by some to promote engagement with the group, but also demonstrates an appreciation of the time and effort being expended by the participants (Barbour, 2007).

The groups were held in rooms within the university where we could sit around a table. There was no material on the walls that could influence the discussion (Barbour, 2007) and the rooms were well lit and had sufficient space for the group. The second moderator sat away from the table so that her writing did not distract nor did she physically get in the way of the activity. A table was necessary for the activities to be undertaken, and experience from the pilot study was that although informal, getting the whole group to sit on the floor was not practical.

At the beginning of the first focus group I explained the conduct of focus groups and established ground rules to ensure respect for individual views and opinions. I wanted to create an environment whereby the participants could be honest about their thoughts and experiences, and where they would be
prepared to discuss these, exposing areas of agreement and difference. I hoped that the time invested in stressing the lack of a ‘right’ answer and the value of their individual views at the outset would pay off in terms of honest contributions over time. Issues of insider research have been examined in Section 1.10. Taking these into account, it was made clear that the research was not about whether the course was good or bad, but about how they experienced learning over the period of time that they were on the course. Although I was not a member of the course team, I was aware that the participants knew that I had a senior role in the School in which the course was situated, and I did not want this to inhibit discussion or create bias during data collection. The benefit of being familiar with the course and the setting was that they knew I understood the context of what they were discussing, and that as a HV I had knowledge of the language of practice that they were developing.

Confidentiality was discussed, and in line with the ethical approval gained (see Appendix 8.3), was agreed within the parameters of professional regulation. Thus if issues arose that indicated unsafe practice for either the participant or someone else I would then need to raise this with them in order that an appropriate response was made. The discussions held within the room were to stay between the participants and me. I confirmed the purpose of the research, although the participants had previously received information about the study and provided their consent during the recruitment process. I outlined the format of the focus group at the outset of each group, emphasising the desirability of discussion between the group members, and the expectation that they might not all agree or have the same experiences.

4.3.3 Focus Group 1

The first focus groups with six invited participants in each, took place three weeks into the course. The timing and plans for the focus groups are detailed in Appendix 6. I prepared guides for each of the sessions (Appendix 10), which initially included a fairly detailed ‘script’ to facilitate explanation and questioning. As my confidence and knowledge of the groups grew, so the level of written detail decreased and the guides moved away from a more structured questioning route towards a wider topic guide (Kreuger and Casey, 2009). The
participants were randomly assigned to each of the groups: five participants attended focus group 1a (one was unable to attend) and six to focus group 1b. At this stage of the course students had attended a one-week university induction, and two weeks of practice induction. They had therefore all had some exposure to the HV role through observation in their practice placements. Some of the students had previously worked as staff nurses in health visiting teams, and for some this was their first experience in a health visiting setting.

Two activities were undertaken in the first focus groups, which I had mapped against the research questions (Appendix 6). The first activity focused on establishing the expectation of the participants of their role as a HV, in order that any differences between expectation and reality might be exposed. This was achieved through writing on flipchart paper, either in terms of lists of activities or drawings. This gave time for the individual participants to think and to get some thoughts ‘out there’ for discussion. Moving away from the emphasis on conceptualisation through drawing used in the pilot group, these first focus groups were more successful, and all of the participants actively engaged with the process. Areas of similarity and difference could be established, as all members of the group were writing or drawing simultaneously, thus avoiding the possibility of false agreement that might have occurred if one person had given an opinion that others then had to agree or disagree with. Part of my role as the moderator was to help establish trust within the group so that individual participants felt able to challenge each other’s views and to present differing opinions. Open questioning around the content of what had been written and drawn allowed the exploration of issues, and differences in expectation to be exposed.

The second activity was also adapted from the way that it was used in the pilot group. The cards (see Appendix 9) were placed in a backpack using Lindström and Eriksson’s (2010) analogy of carrying resources through life to be used when required. The number of cards in the backpack was smaller than the number of cards distributed around the group during the pilot session. The cards were coloured yellow to flag qualities and attributes, or green to flag skills and strategies. This was done to try to help capture any distinctions about what
could be learned or developed and what might be innate. The participants then took one card at a time and all joined in with the discussion regarding that particular element. When the discussion was completed for a particular card the backpack was passed to the next participant, and a further card was extracted for discussion. This allowed greater discussion, focussing on one issue at a time. Not all of the cards were discussed in the time allowed, and the resources covered varied between the two groups.

At the end of the session I discussed the process with the second moderator, and made some notes alongside those made by her during the session. This allowed reflection of the way that I had facilitated the group, as well as the interaction of the participants and emerging thoughts.

The audio recordings of the groups were transcribed by me, using ‘F5 transcription’, a free software package available on-line that allows the controlled playback of audio recordings, and a brief summary of the transcripts was prepared for verification with the participants at the beginning of the next group. In addition to verification this served as a link between the two groups, with the aim of maintaining focus on the purpose of the study.

### 4.3.4 Focus Group 2

The second focus groups were undertaken at the end of February and the beginning of March. Five participants took part in group 2a (one of whom had been unable to attend the first group) and all six returned to group 2b. The plan for the second focus groups is also presented in Appendix 6.

The second moderator was the same for group 2a, but a different colleague undertook the role with group 2b. Combined with the fact that the room was different from the initial meeting place for this group, this had potential to undermine the stability of the group. As a doctoral student relying on the support of colleagues and goodwill regarding the availability of rooms, there was little I could do about this, since the window of opportunity for meeting with the participants was non-negotiable. Fortunately, the group did not seem concerned by the change, although the second moderator (who was not known to the participants) did note that one member of the group seemed to keep
looking at her. The reason for this never became apparent, and the discussion seemed unaffected.

I presented a verbal summary of the outcomes of focus group 1 to each group. The groups agreed that the representation of what had happened in their respective groups was fair. Looking back on the expectations of the role the participants had identified and the simplistic nature of their observations, they then explored the complexity and depth of the role in the light of their experience over the first semester. They acknowledged the limited knowledge base from which they had made their initial assessment of the role.

I was much more relaxed with both groups, and felt this was reflected in the way that I facilitated the discussion within the groups. The participants seemed to gel as a group and no difficult relationships were apparent that adversely affected the discussion, or that seemed to inhibit trust or honesty. Developing the researcher relationship with participants over a period of time was a new experience for me, as in previous work I had only encountered participants on a single occasion. As I got to know them through their disclosure of experiences across the range of their learning, I needed to strike a balance in what I offered to the relationship and what I took, whilst avoiding the risk of imposing my own views. They were offering their trust and openness, in addition to making my study viable, and I really valued their contributions. At times I wondered if I spoke too much in the groups, but when reflecting on this felt that I needed to give something back in our interaction rather than expecting them to do all the giving. I made conscious efforts to maintain open questioning, to leave periods of silence to allow the participants to think about their responses, and to use questioning to clarify and confirm what they were saying.

4.3.5 Focus Group 3

Focus group 3 was originally scheduled to take place in June after the final submissions of the participants’ modular assessments. However, when I came to contact the students to confirm arrangements it became clear that they did not want to engage at that point in time. Various reasons were cited, which suggested that they were exhausted from their efforts to complete the assessed work, but it was also made clear to me that there was a willingness to take part
in individual interviews over the following months, and that a later date for the final focus group would also be acceptable.

The third focus group was therefore re-scheduled for the last day that the students were to attend the university at the end of their period of consolidation of practice. The session was timed for an hour and a quarter, the maximum time available prior to their timetabled sessions. Although I would have liked a longer session with the participants, I could not take them out of their practice placements to attend, and ‘piggy backing’ on other sessions had been successful in gaining attendance in the past. One factor with the unsuccessful session scheduled in June was that it required attendance on a day that the participants did not otherwise have to be in the university.

An invitation to attend was extended to the 10 students who remained engaged with the course; one had intermitted, and one had withdrawn from study. Six participants volunteered to take part in the focus group, three from each of the original groups. This balance was particularly welcome as it allowed representation across the groups for this final activity.

Feedback from the previous groups was achieved through the circulation of a poster of work in progress presented at the International Community Conference on Nursing Research (ICCNR) in March 2013 (see Appendix 10.1). I also agreed with the participants that the preliminary analysis of the focus groups would be circulated to them as this progressed.

In the final focus group I had planned to look at the influence of specific learning experiences on building capacity in the neophyte practitioners. The initial plan had been to look at these in a group setting and then to follow up in individual interviews. However, case study research allows for significant flexibility in the conduct of a study, responding to issues as they emerge. I did not plan to introduce an alternative method of data collection, but what this offered was the opportunity to situate the final focus group at the end of the course and within the timeframe of conducting the individual interviews. This allowed checking back and forth between individual experiences and the wider experience of the group. The individual interviews allowed me to dig deeper into participants'
experience, and to identify ideas regarding the scaffolding of learning and any relationships with the development of practitioner resilience. These ideas, combined with the iterative analysis of earlier focus group data alongside the conceptual web of learning, provided a stream of statements that could be used in a final focus group activity. This activity grew from an idea of a colleague, who had successfully used a Jenga™ game to explore resilience with groups of adolescents in the criminal justice system (Crozier, 2013). In his case, the building was of individual resilience in young people, and in this case I was interested in how a range of learning experiences could contribute to building practitioner resilience. The activity had the potential to provide some ideas for a clear way forward in professional education curricula.

A series of statements were stuck onto the outside of the blocks of a garden tower building game, as indicated in the photograph shown in Appendix 11.3. A photograph of the full range of blocks is also included. These statements were based on comments made by the participants earlier in the study, and drew on ideas from the literature and the development of the conceptual framework. The statements were intended to promote discussion, enabling the participants to make connections between developing resilience and their learning experiences, and to identify whether these were similar or different across the sample. The activity could not be piloted as it was devised at a late stage during the study when subjects for piloting were not available. However, as the statements were rooted in data collected from the participants during the study they provided a logical progression from the earlier activities. The blocks were randomly positioned within the tower.

This activity had the scope to allow blocks with statements linked with unhelpful learning experiences to be removed from the tower, and the tower to be reconstructed to identify a helpful sequence of learning. The time available for the activity was not sufficient to allow this, although the activity did engage the participants in interesting discussion. Experience of using this approach suggested that it could be adapted to different contexts of learning about practitioner resilience. To complete all stages of the process would probably have required a session lasting three hours.
4.4 Individual Semi-Structured Interviews

I undertook semi-structured interviews with six of the participants. For five this was during their period of consolidation of practice at the end of the course, and for the sixth participant, who had intermitted from the course at the end of Semester 1, she had just returned to commence Semester 2 with the next cohort of students. This student was keen to continue to participate in the study, and though she was not at the end of the course, she could offer the valuable perspective of someone who had encountered a level of adversity such that she needed to intermit.

The interview schedule is presented in Appendix 7, where the guide questions are mapped against the research questions. Five of the interviews were carried out in the university at a time convenient to the interviewee. Where students came in to the university specifically for the interview, I reimbursed their travel costs, although they did not know in advance that I was going to do so as I did not want to appear coercive. One interview was carried out away from the university, as the student did not have sufficient time to make the journey to the university at the end of her working day. For this student I arranged to meet her in a public place, but where we could have a private conversation without risk of being overheard. The interview took place outside her working hours, and away from her workplace, both conditions of my ethical approval. I spoke with my supervisors and the chair of the faculty ethics and governance committee (FREGC) about these alternative arrangements, following the advice given by the Chair of the FREGC and confirming the arrangements I had made with the participant’s Head of School to ensure that risks for the student and myself were minimised.

The interviews followed the focus groups, so the participants and I were known to each other and had already established a rapport. Despite this, I reiterated the purpose of the research and their consent was re-confirmed through their attending the interview. I revisited the aims of the study and the way in which I would maintain confidentiality and anonymity through the reporting process at the beginning of the interviews. The ground to be covered in the interview had
been informed by the focus groups, but I kept an open mind about any other topics they might want to cover.

As I was only planning to interview six participants, I decided that data from the first interview would be included, rather than treating it as a separate pilot. In the event there were no issues emerging from the use of the interview guide in that first interview, and the full transcript contributed to the data. In fact, the first interview was straightforward as the participant was very open and offered a lot of material spontaneously. She was also happy to offer further clarification and detail when I needed to confirm my interpretation of her narrative. I adapted the way in which the guide was used with each interviewee according to the ‘flow’ of their narrative. I was careful to use open questions throughout, tried not to speak too much whilst still participating in the ‘conversation’, and to avoid using interjections that would signify approval or disapproval of what was being said.

The interviews lasted 60-75 minutes, and at the end of each interview I gave the interviewee the opportunity to add any further insights that had not been covered and that they felt were important. However, little was offered at that stage. I also asked some of the participants if they had enjoyed being involved or got anything out of the process. It was gratifying to hear that they had found the process useful and interesting; although this did make me wonder to what extent being involved in the study had contributed to their learning for resilience. On reflection this was a question I could have asked, but I missed the opportunity.

My engagement with the data collection process was supported through reflection and reflexivity, helping in both increasing my awareness of applying the techniques, and in reminding me of the need to maintain an open mind to what was being presented. The preceding text includes some elements of reflection, but further material is included in Appendix 2.

4.5 Background Context from Course Documentation

A detailed analysis of course documents was not undertaken, but an overview of the structure and content of the course was obtained from module templates,
and course and module handbooks. This included the identification of the learning and teaching strategies used within the course.

4.6 Summary

This chapter has provided details about the data collection process through a series of activity related focus groups and semi-structured interviews. Twelve participants were involved with two sets of two focus groups and of these six took part in the fifth and final focus group. The flexibility available through case study methodology had to be applied in the timing and organisation of the final focus group, but in the event this probably worked better than the original plan, as it took place on the final day of the participants’ involvement in the course.

Six individual semi-structured interviews took place during the final weeks of the course, allowing an exploration of individual experiences in more depth. Again, flexibility was applied in relation to the organisation of one of the interviews, where the participant was very keen to contribute, but could not get to the university to be interviewed. Appropriate steps were taken to obtain advice in order to safeguard both the participant and myself in revising these arrangements.

I had conducted both focus groups and semi-structured interviews before, but no two situations are the same so a high degree of reflexivity was applied throughout. Overall, data collection proceeded in a straightforward manner, and the participants engaged enthusiastically in both the focus group and interview settings. It was an enjoyable experience for me, and appeared to have been for the participants as well.
5. Introduction to the Data: Presentation and Analysis

5.1 Introduction

Having described the process of data collection, in this chapter I report the processes of authentication and transforming of the data into a medium that facilitated content analysis. Biographical information is used to introduce the participants. In this section an overview of the participant characteristics is presented, but as I wanted to ensure that the participants ‘lived’ through the analysis pseudonyms are applied in the subsequent chapters.

I go on to detail the development of the conceptual framework required for the data analysis. This is presented as a web of learning in which I have synthesised resilience and TLT within the domains of critical realism. Taking a creative approach to the presentation of the framework has allowed me to demonstrate the complexity I have encountered in the process of understanding and interpreting the data.

5.2 Authentication of the Data

I verified the data and preliminary analysis with the participants at a number of stages during the study, in order to ascertain that my interpretations of discussion within the focus groups and individual interviews were authentic. Focus group outcomes were shared through summaries of content and a conference poster, as detailed in the focus group data collection in Section 4.3. The participants agreed with these interpretations whilst recognising that their understandings were changing as they developed in their new roles. These comments particularly related to the recognition of the complexity of the role.

I sent individual interview transcripts to the participants concerned and invited them to respond with any clarifications or corrections. I received responses from two participants with a small number of minor clarifications. In addition, I shared the initial emerging themes mapped against the conceptual framework (along with an explanation of the conceptual framework development) with participants following completion of the data collection phase. One participant acknowledged this preliminary analysis but did not offer any further comments.
5.3 Data Preparation

All the focus groups and interviews were transcribed verbatim. I transcribed the first focus groups, but paid for professional transcription for the later focus groups and interviews. I chose to do this as time was a limited resource that was required for other elements of the study. The concern in taking this approach was that engagement with the data would be reduced; however, I compensated for this by listening to the audio recordings when travelling to and from work each day, allowing for repeated exposure to the spoken words of the participants.

Transcripts provided me with a complete record of the interactions as they took place, using the language of the participants. Written word however does not ‘live’ in the same way as the spoken word, and I found that listening to the audio recordings grounded me in the context of what was being said (Gibbs, 2007). Gibbs (2007) suggests that interviews may be selectively transcribed with the analysis being carried out predominantly, or exclusively, from the audio recording. The disadvantage of this approach is the potential to lose the context provided by the complete transcription, and a reliance on memory in returning to sections of the data as ideas develop and transform over the period of analysis. Given the iterative approach to the study, this could have been a particular problem. In addition, an incomplete transcript of the focus groups may not have been helpful in identifying the impact of the interactions between the participants, so I decided to have both complete transcripts and audio recordings available to support the data analysis process.

Although the transcripts were, in the main, produced for me, they needed to be organised so that I could manage the tracking of participants’ narratives. With the interview transcripts this was easily managed as only the participant and I were involved in each interview and line numbers could be inserted throughout the document. For the focus group I organised the transcripts into a table format in order to align the participant names, the contributions they made, and my notes. This was a time consuming process, and having completed the exercise I realised that line numbers could not be utilised within the documents. However, it did save the frustration of contributors and contributions falling out of
alignment when notes were inserted. In this case page numbers and initials were substituted for line numbers for tracking purposes.

5.4 Development of a Conceptual Framework

As discussed in the last chapter the thought process of abduction, indicative in a critical realist approach, is supported by examining the data against a conceptual framework, which allows new perspectives to emerge (Danermark et al., 2002). My conceptual framework needed to take into account both the critical realist perspective and the underpinning theoretical areas that contributed to the study. From my experience as a practitioner and the review of the literature, I identified the main theoretical contributors as TLT and resilience. There are significant areas of overlap between the requirements for TLT and the strategies suggested in the literature for promoting resilience through education, and these were summarised in Table 2.6. The stories from the data I collected had similarities with previously told stories in other studies (Adamson et al., 2012; Whittaker et al., 2013). However, through analysing these narratives against a new conceptual framework combining different insights (Danermark et al., 2002) there was the potential that a degree of ordering of causal mechanisms within the social and psychological strata might emerge (Collier, 1994), which would illuminate relationships between learning and resilience. Ordering was unlikely to be applied down through the strata however, as the depth of data collection in this small study would not support this.

5.5 Developing the Conceptual Web of Learning for Resilience

The iterative process (Bassey, 1995) of developing this framework, drawing on the work of Adamson et al. (2012) and McAllister (2012), brought TLT and resilience research findings together and crystallised my ideas concerning the relationships between the different theoretical influences on the study, and the experience and narratives of the participants. It supported data collection in addition to providing categories from which data analysis could move forward (Danermark et al., 2002; Glaser and Laudel, 2013). The framework was
presented in diagrammatic form (Figure 5.1) as this kept in my mind both the process and complexity of context that are evident in the area of study.
Figure 5.1: Conceptual web of learning for practitioner resilience
Contextual elements in open system of practice

Individual student

Process of transformative learning
Critical realism recognises intransitive entities, that is the objects or things we study, including structures, mechanisms and associated causal powers; and transitive entities, which include the theories we produce about these objects (Sayer, 2000). The intransitive objects remain constant though the transitive theory which may change over time. In congruence with critical realism, the framework included things that are experienced (events in the domain of the actual) as well as things that might cause what is experienced (in the domain of the real).

I conceptualised the wider system as a web, with multiple threads and connections, but one that is also open to the influence of broader external forces. The threads in a spider’s web are both strong and flexible, but are also vulnerable in adverse conditions. There is thus an element of unpredictability inherent in the system of a web reflective of the context of professional practice.

**5.5.1 Structures and Mechanisms Providing the Context**

Set within the web, and providing the context in which the study is placed, were a series of grey shapes. These identified structures and mechanisms that exist in the open system of practice that bring about, or have the potential to bring about, what is experienced (in relation to building capacity) by the individual students within the system; referred to in critical realist terms as the ‘real’. Structures in critical realism may be social, mental or cognitive, including for example gender, age, social-class, political, or organisational structures. These entities are unobservable in themselves but have causal powers with the potential to bring about events. The components included were drawn from the organisational context and mediating factors included by Adamson et al. (2012) in their resilience map, and from wider literature relating to practitioner resilience identified through the literature review. By the very nature of the domain of the real, there may have been influences that were not known so were not included. Some of the elements included could be seen both in relation to the domain of the real and the actual, for example ‘team dynamics and coping mechanisms’ and ‘supervision’. Danermark et al. (2002) recognised that, in the context of social research, activities can be viewed both as objects
(intransitive) and as products of the activities (transitive). The rationale for the inclusion of these entities here, rather than in the domain of the actual, was as components of the organisational structure that may have casual powers in triggering the events encountered, as an object rather than a product.

Placed in the context of this wider system were two loosely concentric ‘pathways’. Although arranged in this manner, the different components may or may not have been experienced sequentially. The threads in the web connected all of the elements through straightforward or more complex routes, and these connections might have been experienced sequentially or there may have been repeated iterations of some experiences, or little or no connection with others.

5.5.2 Including Transformative Learning Theory

The central pathway, depicted in red, related to the facilitation of TL through the learning experiences of the course. The ‘actual’ in critical realist terms, this domain included events that had taken place, whether or not they have been recognised (by the participants) as having done so. This pathway drew on the STAR framework, which was devised in relation to nurse education by McAllister (2012) and also on the wider work of Mezirow (2009a), on which the STAR framework was itself based. The purpose of this pathway was to focus attention on the existence or application of TL principles.

The STAR framework identified three phases in TL: sensitise, to the human context and issues of the role; take action, link instrumental knowledge with context and action; and promote reflection, challenge habits of mind and preconceived ideas, and allow new frames of reference to emerge (McAllister 2012, p.46). These phases were identified as four of the components of the TL pathway. The third phase, promote reflection was divided in my framework. The reflective element was re-worded as a separate element, ‘promote critical self-reflection’, as this is key in Mezirow’s (2009) seminal work. Reconstruction of ‘habit of mind’, or frame of reference, was represented as a different component. This was because it has been recognised that even where TL
approaches are taken, frames of reference are not necessarily changed, and transformation may not take place (Kegan, 2009).

I included two other components in this pathway by drawing on wider work relating to TL. The creation of knowledge was clearly important to students in a new area of professional practice, and emerged from the outset in the focus groups, but from a TL perspective this relates to both instrumental learning and communicative learning. The taking action component of the STAR framework clearly addresses this, but for the purposes of this study the ‘creation of (instrumental) knowledge’ in the first instance benefitted from being made explicit. The remaining component was that of ‘self as a foundation for learning’. Kegan (2009) identified the importance of recognising where the learner is at, and taking them along at a pace that is appropriate for them as an individual. This is equated to leading them across a bridge, and establishing a foundation for that bridge; clear recognition of the learners’ starting point is seen as key.

5.5.3 Student Experience of Learning

The second of the ‘pathways’ (depicted in blue), was the pathway of the individual learner moving through the experience of the course. This pathway, the ‘empirical’ in critical realist terms, was concerned with what was heard, seen or experienced by the student as they went through the process of learning from the course. Identified along this pathway were a number of attributes and characteristics that the individual carried with them that may have influenced their perception of what they heard, saw and experienced. In one sense these may have been causal powers in their own right, with the potential to trigger what existed in the domain of the real (Sayer, 2000), and in another sense they reflected the resources to support human agency in the experience of building resilience (Archer, 2003). Pragmatically they were included here as a part of the individual student experience, but there was overlap in the open system of practice with contributions to the real. These elements were drawn from resilience map by Adamson et al. (2012), and supported through reference to the wider literature, specifically Hart et al. (2003), Hammond (2004), Edward and Warelow (2005), Jackson et al. (2007), McAllister and McKinnon (2009),
Lundman et al. (2010), and Kinman and Grant (2011). These attributes should not be regarded as exclusive, but it was not practical to include all the characteristics identified in literature in relation to individual resilience. The initial focus groups identified the perceived importance of reflection and reflexivity, and adaptability and flexibility, dimensions that are also evident in the TLT (Illeris, 2014).

Danermark et al. (2002) identified the support of creativity and imagination in the process of abduction, and although I had not consciously taken this on board during the early stages of the development of the conceptual framework, on reflection I think this is evident in the production of the web. The individual student and the learning experience actively interact rather than passively running along side by side. The threads of the web represent the complexity of this interaction and the lack of linearity in the process, as the elements may not always take place sequentially, but may be visited and re-visited over time, forming multiple links between the three domains depicted. In this manner the possibility of downward causation through the strata is also included (Danermark et al., 2002). The strata indicative of critical realism are difficult to depict, although the cycles are dynamic and repeated with no designated start and end points, so as the relative position of the learner and the context changes over time differing properties may emerge through the multiple layers and sectors of the web.

5.6 Transforming the Data

As identified in Chapter 3, I analysed the data through content analysis using the categories derived from my conceptual framework. I became familiar with the data through both reading the text and repeatedly listening to the audio recordings. Carrying out the descriptive phase in this manner helped me to preserve the context in which participants’ comments were made. Extracts of the transcripts are included in Appendix 12.

As data analysis proceeded, I printed transcripts on different coloured paper to aid tracking and the sequencing of data. As analysis was on-going with data collection (see the data analysis audit trail: Appendix 4), focus group analysis
proceeded first, taking extracts from the transcripts and relating them to the three domains of the conceptual framework. The transcripts of the individual interviews were then cut up and physically distributed between the components identified in the conceptual framework, enabling me to draw together related data. Data collection from the semi-structured interviews resulted in a large volume of data, not all of which were relevant. Exclusion of this ‘noise’ (through physically cutting it out) reduced the volume of material to be handled and ensured that the focus remained on responding to the research questions (Glaser and Laudel, 2013).

The following section presents the descriptive phase of the data analysis, introducing the participants and the development of the conceptual framework. The participants’ views and experiences are related to each of the domains of the conceptual framework, alongside the integration of contextual content from the course validation documents. The following chapter engages with the interpretative and discursive process of the analysis.

5.7 Introducing the Participants

Brief biographical information was requested from each of the twelve participants, and was obtained from all but one. This participant provided some of the information through her contribution in the focus groups, but did not provide her complete biographical data before she withdrew from the course. All participants were female, which is unsurprising given the gender balance of the workforce where male HVs comprise only 1% of the workforce (Department of Health, 2012). All of the participants were white and had English as their first language. Students of other ethnic origins and male students were registered on the course, but did not volunteer for the study.

One participant was qualified as a midwife, nine as nurses, and two held qualifications as both a nurse and a midwife.
The age distribution of the participants (Figure 5.2) was evenly spread across the age range, although none of the participants was under 26. The number of years of experience of the participants in nursing or midwifery related roles ranged widely, from 1 to 23 years, although the age of the participant was not necessarily indicative of longevity in a nursing or midwifery role, as shown in (Figure 5.3). Throughout the HVIP there has been movement towards encouraging and accepting young applicants directly from their initial nursing qualification. I have heard concerns expressed that these young applicants may find coping with the role more challenging, so this might have offered an added dimension to the data collection.

**Figure 5.2: Age distribution of participants**

The age distribution of the participants (Figure 5.2) was evenly spread across the age range, although none of the participants was under 26. The number of years of experience of the participants in nursing or midwifery related roles ranged widely, from 1 to 23 years, although the age of the participant was not necessarily indicative of longevity in a nursing or midwifery role, as shown in (Figure 5.3). Throughout the HVIP there has been movement towards encouraging and accepting young applicants directly from their initial nursing qualification. I have heard concerns expressed that these young applicants may find coping with the role more challenging, so this might have offered an added dimension to the data collection.
Figure 5.3: Age of participants against years in nursing and midwifery roles

Four of the participants were undertaking the course as a Post-graduate Certificate at Level 7, and the remaining eight as a BSc (Hons) at Level 6. The progress of two participants on the course was interrupted; one returned after a period of intermission. This participant completed an interview after her return, which was still within the data collection timeframe of the study. I was very grateful for her willingness to continue with the study, as it provided an opportunity to speak with someone whose resilience had been significantly challenged. Eight of the participants had completed academic studies in the previous two years, with the remaining three having last studied five, six and seven years previously. Four of the participants had previous experience of working in a health visiting team as a staff nurse. It is widely suggested that resilience is not experienced or exhibited in the same way by different individuals (Ungar, 2012), therefore the diversity of the sample offered a welcome opportunity to explore the perspectives of a diverse, albeit small, range of individuals who had the common goal to practice as HVs.

Throughout the analysis the participants are referred to by a name allocated by myself during the transcription process. This preserves their anonymity whilst maintaining a perspective on them as individuals, rather than as numbers within.
the study. The participants were offered the opportunity to suggest an alternative pseudonym if for any reason they felt the one allocated was inappropriate.

5.8 Summary

The creative process of synthesising the philosophical and theoretical influences underpinning my study into a conceptual framework for data analysis was challenging. This chapter has described the process, and presented a conceptual web of learning that encapsulates the complexity I encountered through the study. The following chapter uses this framework, through the application of content analysis, to focus disparate influences into a number of themes as part of a process to abstract key concepts for discussion.
6. Presentation of the Findings: Description and Analysis

6.1 Introduction

This chapter moves forward content analysis of data from the focus groups and interviews. I have organised the data description and analysis in three pathways reflecting each of the domains within the conceptual framework: exposure to the HV role in the real context of practice, organisation of learning, and experience of becoming a HV. I have drawn on the narrative of the participants to illustrate experience in each of the domains of the conceptual framework, and on the theoretical conceptualisation of the framework to illuminate that experience. In this way the complexity of the context in which the participants were placed is described and deconstructed against the backdrop of the theoretical perspective. Throughout the chapter quotes are identified by line number from individual interviews, or by focus group. Chapter 7 will advance analysis through abstraction of ideas from these preliminary stages and discussion in the context of wider theory, before Chapter 8 pulls the analysis back to the concrete (Danermark et al., 2002), drawing conclusions and identifying possible implications.

6.2 Applying the Conceptual Framework

My aim in undertaking this study was to explore the contribution of learning to building capacity in students to respond positively to the reality of practice. This was focused through the differences between expectation and reality of the HV role. A number of elements were identified in the conceptual web of learning having varying levels of interconnectivity. As content analysis of the data proceeded I aggregated categories from the conceptual framework into broad themes under the headings of the three domains, and these are identified in Table 6.1 overleaf.
Table 6.1: Organisation of categories from the conceptual framework into pathways and broad themes emerging from the content analysis

<table>
<thead>
<tr>
<th>Domain</th>
<th>Element of conceptual framework</th>
<th>Cluster theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real: Structures and mechanisms in the context of practice Exposure to the HV role in the real context of practice</td>
<td>Adverse experience</td>
<td>Identification of expectation and reality</td>
</tr>
<tr>
<td></td>
<td>Organisational and policy context</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contradictions and dilemmas</td>
<td></td>
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<tr>
<td></td>
<td>Wider socio-economic context</td>
<td>Challenges emerging from the structures and mechanisms</td>
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<tr>
<td></td>
<td>Team dynamics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moral and ethical codes</td>
<td></td>
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<td></td>
<td>Peer support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team dynamics and coping mechanisms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervision</td>
<td>Social contributions to building individual and collective resilience</td>
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<td></td>
<td>Work-life balance</td>
<td></td>
</tr>
<tr>
<td>Actual: Facilitation of transformative learning The organisation of learning</td>
<td>Self as a foundation for learning</td>
<td>Starting points</td>
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<td></td>
<td>Sensitise</td>
<td></td>
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<tr>
<td></td>
<td>Create knowledge</td>
<td>Scaffolding learning for resilience</td>
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<tr>
<td></td>
<td>Take Action (including Active learning)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promote critical self-reflection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transformation: re-constructed habits of mind</td>
<td>Endings</td>
</tr>
<tr>
<td>Empirical: Learners experience of the course Experience of becoming a health visitor</td>
<td>Passion for role</td>
<td>Creating an identity</td>
</tr>
<tr>
<td></td>
<td>Positive identity</td>
<td></td>
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<tr>
<td></td>
<td>Awareness of personal and professional boundaries</td>
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<td></td>
<td>Humour</td>
<td>Learning from negative experience</td>
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<td></td>
<td>Hope</td>
<td></td>
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<td></td>
<td>Memory of past success</td>
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<tr>
<td></td>
<td>Maturity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reflective and reflexive</td>
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<tr>
<td></td>
<td>Adaptability and flexibility</td>
<td>Health Visitor as a chameleone</td>
</tr>
<tr>
<td></td>
<td>Imagination and creativity</td>
<td></td>
</tr>
</tbody>
</table>

Original in colour
According to critical realism, in open systems there is necessarily a relationship between the three domains of the real, the actual and the empirical. Structures and mechanisms (the real) have causal powers in respect to both events (the actual) and experiences (the empirical), and events have causal powers in relation to experiences (Bhaskar, 1975). Therefore, in analysing the data there are interactions and overlaps between structures and mechanisms, events and experiences, with the participant experience evident in all domains. These overlaps are evident in the following analysis.

6.3 Domain 1: Exposure to the Health Visitor Role in the Real Context of Practice

From the categorisation of the data three broad areas emerged for this domain.
1. Identification of expectation and reality, encompassing the adverse circumstances, organisational and policy context, and contradiction and dilemma elements. 2. Challenges emerging from the structures and mechanisms, including the wider socio-economic context, team dynamics, and moral and ethical codes. 3. Coping and response mechanisms, drawing on peer support, team dynamics and coping mechanisms, supervision, and work-life balance.

6.3.1 Identification of Expectation and Reality

At the beginning of the study the participants had a varied level of knowledge concerning the HV role. For some this was based on their own experience of HVs and realising the actual scope of the role came as a surprise.

Becky 62:

“[I saw her] just being there to give support and advice and information. I would see her at clinic and I had a completely different view on health visiting to what it actually is. So I did get a bit of a shock.”

Four participants drew on their experience of working as staff nurses (SNs) in the HV team. For others their knowledge and expectations of the role were based on the policy and publicity material about the HVIP that they had looked at during the application process. Between them, the participants were able to
identify many of the areas of work that the HV would be involved with, although at the outset this was task oriented and showed little understanding of the multi-professional working involved (see Appendix 11.1 for flip charts from focus groups 1a and 1b). Those who had been SNs in a HV team had greater insight into the range of professionals they would be working with, but still saw the role as a series of tasks. By the time of the second focus group all of the participants were recognising the complexity of the role, marking a shift away from the expected task-orientation.

Clare: FG2a 4

“… I had been [in] a staff nurse role with the health visitors before, that had been [the] focus … you did the tasks. Whereas .. looking back now, I can see that you were skimming along the top really. And having had the insight into attachment, and resilience and you know … you can see how we work differently and how it is such a bigger picture.”

Although the participants expected to be involved with health promotion at individual and group level, there was limited expectation of their involvement in community development work. Dawn knew in theory that working with communities was an expected outcome of the HVIP but openly acknowledged her lack of understanding of this aspect of the role:

Dawn: FG1a 3

“Definitely a push to build capacity ……..I'm not completely fully sure that I understand what building capacity means.”

Participants were also recognising that the role was not all ‘nice’ and that there were many challenging elements where they were required to make judgments and speak out where there were concerns over standards of care and parenting.

Jess: FG2a 8

“It is quite difficult you know. It is not … ‘hello well let’s weigh the babies and have a nice talk’. 

123
There are actually ….. difficult parts to the job. […] right at the forefront talking about quite difficult things with families.”

The influence of the wider socio-economic context on the participants’ developing HV role was not always anticipated. The interventions focussing on a social, rather than a medical, model of care became clear to Dawn but were a surprise to Jo.

Jo: 195

“There is more on the social side of things – what we used to think of as social worker’s role. So the inequalities and the housing and the people who live in pretty poor conditions, you are far more involved with that side of things and trying to link in with other departments, than I had quite anticipated.

…. I had probably thought it would be more health orientated. But it is the whole thing – social and everything.”

In the first focus groups the participants identified the way in which they expected to be working as HVs, and the skills that they would need. This is depicted in the word clouds shown in Figure 6.1 and Figure 6.2, which reflect the relative frequency with which each element was identified.

Figure 6.1: Participants’ expectations of how they would be working as health visitors
A significant expectation of the role was of facilitative working that included continuity in relationships with clients. However, this was not evident in the patterns of practice observed by most of the participants, where the balance of work was on high-risk situations and child protection. This high profile of safeguarding work was recognised as differing from expectation by some, although those who had been in SN roles were more aware that this would be the case.

Becky: FG1a 9

“..and I go out on placement and there’s all this child protection, safeguarding, domestic violence, and it’s like …wow - ok. They do other things than the nice things and going round and weighing babies.”

Exceptionally, Nicola was working in a team where the impact of increased HV numbers was beginning to be felt, where some continuity with babies in the first six months of life was beginning to re-emerge as a routine pattern of contact. However, the broader public health role that the students were being prepared for was not being seen in practice, despite the indicators for this work being
clear. This was confirmed by Georgie, who also observed that the balance of work that she had expected from the role was not what she was experiencing.

Georgie: FG2b 8

“…..yes of course it is about health promotion and inequalities, but then that is also linking in to safeguarding. And that [safeguarding] seems to be the majority of the things that are going on .. and just kind of completely blanks out everything else that is on that paper”.

The focus on high-risk work impacted on how the students’ learning about ‘the normal’ routine health visiting work was being facilitated in practice. In most cases ‘normal’ families and situations were being identified specifically for the students in order to gain experience of routine, low risk work. The participants had expected this work as a part of their role but once they were competent in this area of practice they appeared to be taking the ‘normal’ on to alleviate the workload of the qualified HVs, something that they had not expected and that sometimes threatened their own wellbeing in the process.

Georgie: FG2b 15

“I am doing the new birth visits and the six week checks. But it is hard not to sometimes feel a little bit overwhelmed as well. ……… because they [HVs] can’t do the ‘normal’ because they have so many other things going on, I am taking that on now. And I am starting to sort of … each time they say – ‘what have you got going on this week?’ – I know it is because they want me to do something of theirs.”

The definition of adversity in practice has previously been identified as difficult or negative experiences with the potential to have an adverse impact on the functioning of the practitioner (McCann et al., 2013). Jackson et al., (2007) and Adamson et al., (2012) contend this includes the wider system of the team or organisation. The reality of the team and organisational context of practice quickly became evident to the participants who spoke of excessive workloads and of the manifestation of stress in the qualified HVs.
Laura: 1584

“… there is one health visitor who will just come into work and start crying…. for no apparent reason at all. I have seen another health visitor just sort of spinning around in the middle of the floor, kind of having a bit of a breakdown, with the stress.”

The reality of the movement of staff and changes in caseloads in response to risk assessment and adverse events was identified and recognised as creating further stress.

Becky: 719

“… People are being moved bases and then they get moved again, pretty quickly. And it puts a stress on everyone, because you are trying to work with someone new, or they are trying to work with people they have never met before, in an office they have never worked in.”

Challenges also arose from the policy and organisational context of the HVIP that had resulted in larger numbers of students than usual in practice teams. Issues relating to practice teacher (PT) availability for support and being used as a ‘pair-of-hands’ to alleviate the workload in the team were identified to a greater extent than expected. Issues also arose around the availability of practice learning opportunities for participants that were central to the development of specialist public health practice skills. Although the participants did not criticise the response from their HV colleagues, it was clearly of significance in accessing appropriate learning experiences. Laura identified this when accessing specialist areas for short observation visits.

Laura: 677

“I was made to feel ‘well we can give you an hour and that is it’ […] [I was] made to feel unwelcome a couple of times by people. You know, there was more of ‘you have got to come’ but you know… it is not that important.”

In the rollout of the HVIP it was anticipated that the extra numbers of students qualifying would quickly start to increase the number of qualified HVs in the
workforce. However, the unintended consequences of the demands of the programme were the premature retirement and decisions to leave due to the additional workload stress created through its implementation. This resulted in no improvement in workload, and an increasing number of students. There was therefore additional anxiety about the further increase in the number of students expected in the next academic year, of which the participants were fully aware.

Clare: 941

“The pressure that is putting on, on top of the case load and then the fact that actually we are not coming out and being extra to requirements we are still plugging gaps in staff.

It is just about balanced but it is not going to take too much to tip people over the edge.”

There were also practical issues arising from the increasing numbers in respect of the availability of accommodation.

Becky: 702

“.everyone is worrying about where all these health visitors are going to actually go, because the office spaces everywhere are so small.”

The relevance of the work environment was also recognised in relation to healthy workspaces, and the changes to the organisation of the service that had seen HVs removed from GP surgeries and the primary care team. This brought them into larger teams that worked corporate (shared) caseloads across larger populations. This also impacted on the expectation of multi-professional working identified earlier (Figure 6.2)

Laura: 1428

“.where they are locating the teams all into one patch all the time, you are not getting those little bases around GP surgeries that there used to be. So you are not forming the same relationships with the GPs and other people, that you used to have.”
Jo contrasted the working environment in two different teams that she had worked in, identifying that the second was a much more positive team despite the fact that the client group were significantly more socially and economically deprived and so potentially more stressful to work with.

Jo: 596

“In the first team] physically we didn’t have a desk, we had to sort of hot-desk or seats. I didn’t have access to a computer. They were under a lot more stress.
The [second] team has more of an optimistic and upbeat approach to each other. And it is a nicer building so it is airy and bright and it is more conducive to a more positive outlook. So that is how it seems to me. Whereas the other place was pretty dull and depressing ……And it wasn’t a pleasant building to be in, and to work from.”

The policy change relating to the HVIP was therefore having a very obvious impact in practice. The participants identified that it was acknowledged by their colleagues that the increased numbers of qualified HVs would ultimately improve the opportunities to work across the spectrum of public health need, rather than focusing on the high risk safeguarding situations. However, this met with mixed reactions: excitement at the opportunities it would present, concerns about where the ‘extra bodies would be put’, the demands that would be placed on them for preceptorship and support, and a lack of motivation to engage with the wider public health aspects of the role. The participants also reported pessimism in HV colleagues about the abilities of their newly qualified colleagues in practice.

Laura: 628

“…although I think they are quite excited about having more people in the profession, they are also very concerned about the quality of the training. And, you know, how people will be when they come out from training and how much support they will need.”
In addition to dealing with their own expectations, the participants were carrying the weight of expectation of their colleagues that they were the solution to the problem, but were worried that they would not be enough to turn the situation around.

Laura: 512

“...people have big expectations of us and so much money is being poured into us – whether we can actually mobilise the workforce to achieve everything that we have got to achieve – I don't know.”

The need for whole system organisational support to implement policy change was identified but there was a lack of conviction that this would happen.

The impact of on-going organisational change in the NHS also had the potential to affect the teams. An increasing focus on target driven commissioned services was seen as a negative influence, contributing to feelings that much of the work undertaken was not recognised or valued. The prevailing climate of financial constraint and decreasing funding across the public services also contributed to a decrease in other health and social care services that affected the availability of services to support HVs in their work with clients.

In summary, a number of contradictions or tensions between expectation and reality emerged that the participants and the wider HV workforce were exposed to, which were either obviously negative or had the potential to be experienced as adversity. These included:

- Change of perspective from a ‘nice’ role to one which was ‘difficult’ and complex
- Expectation of facilitative work through continuity with families against reality of limited contact
- Expectation of support from colleagues as students and as qualified staff against reality of qualified HV colleagues under stress and with limited availability and perhaps motivation to provide this support
• Recognition of the potential of increased HVs to increase the scope of public health work with reality of lack of engagement

6.3.2 Challenges Emerging from the Structures and Mechanisms

The structures that played a role in challenging the expectations of the students appeared to be socio-economic status, inequality, prejudice, autonomy and political influences. Professional ego (Hart and Freeman, 2005) and gender also seemed to be a challenge in some aspects of participants’ experience.

Socio-economic status and the inequality arising from this had an obvious impact on the participants. Although all were qualified nurses or midwives and would have been exposed to inequality in health through their previous roles, they were nevertheless affected by the experience of seeing the impact of this inequality on the everyday lives of the families they were working with.

Brigid: FG3 6

“[..] it has given me an insight into families. Addressing … the issues with them, and helping them.. within their family lives. It has been quite an emotional time.”

Contrasting experiences with that of previous roles broadened the participants’ perspectives and challenged their beliefs, but Clare also identified that she didn’t want this to affect her underpinning moral compass regarding what was and was not acceptable.

Clare: 1170

“… the reality for other people, compared to what I was used to, has been quite shocking […..] So actually coming into [my HV student placement] … it is a lot different. And yes, my beliefs and understanding of how some families work, have changed completely. But I am still aware: I don’t want to get to the point where my threshold has changed too much, if that makes sense.”

Prejudice was evident in several of the participants, and the beliefs that underpinned this were challenged through their exposure to families in their
student HV role. Becky identified that she had previously made judgements comparing her own work ethic with that of other low income young mothers, but now realised that these judgements lacked foundation. Jess, by contrast, was challenged in the assumptions that she made about the circumstances of those who were well off.

Jess: 550

“There was a mother that was in a massive house. Grounds, gates … and her child was subject to child protection, because [the mother] had an alcohol problem […] that family would probably have everything that they […], they didn't have any money worries. However, they couldn't look after the child's basic needs by keeping that child safe. […] When you look from the outside in they would be fine, and you couldn't imagine that going on here. But actually it did.”

Becky identified that she didn’t think her underpinning values had changed; she just hadn’t previously recognised them. In contrast, Jo was clear on her own values and beliefs but had identified the need to learn to put these on one side when considering her professional responses to families. Awareness of dissonance between personal and professional expectations was important in managing the threshold of ‘good enough’ care.

Jo: 1045

“I am conscious that I don’t try and put my own values on to them. But on the other hand I need to make sure that the children are safe and healthy. …..that is when I would have my nurse’s hat on or my health visitor’s hat. And give them the choices of a healthy lifestyle.”

Alongside these challenges, the realisation that health inequalities, identified as an issue many years ago persisted in the present day, presented a practical and political incentive in the HV role. For Jo this was a result of seeing what her theoretical learning really meant in practice.
“When we looked [in class] at health inequalities and the Black Report…, and Wilkinson … they were just policies – quite dull things, and they were a long time ago. And then here I was looking at health inequalities. And it is like a cycle that the politicians talk about ……. But actually it is still happening ………It is still going on and you just have to try and get in there, and if you can make a small difference, for me, that has got to be worthwhile.”

Dawn identified how learning in the university had influenced her reading habits and political awareness, and how she was challenged to restore the original political role of the HV.

Dawn: 1840-1857

“I think the public health [module] was good. I think that really did help me think outside the box actually. Because I started to look at politics and I started reading the New Statesman. [giggles]……I would never have picked up that! Or even the Economist, you know! […] actually I started to read it. So yes, it has helped me to really look at politics, and where health visiting is. […] that is something that we could be really be strong on again – actually shaping policy.”

It was interesting that the exposure to socio-economic deprivation acted to build motivation in the role. This supported the participants’ desire to ‘make a difference’, which was voiced throughout the study. Recognition of having done so was a positive influence on the participants’ resilience and motivation to persist in their role.

Dawn: FG3 22

“It does make you quite determined to do something about it actually. It motivates you...”

The long-term nature of HV work could be an added challenge to resilience, as participants recognised that in many aspects of their role ‘making a difference’
could not be achieved quickly, however recognising small gains could be helpful.

Jo: FG3 16

“And if we can chip away […] but I think if we do start with small little bits, it will have a ripple effect. You are not going to change it overnight.”

The relationship between policy and the reality of practice was recognised in different ways. One aspect was the rejuvenation of the public health role of the HV through implementing national policy within local organisations, which was again seen as a slow process.

Nicola: FG2b 12

“… the potential is there but we need to be able to build the momentum. But it is quite hard […] We are just treading water at the moment and we are not getting to the other side. So hopefully – but it is going to take a long time, it is not going to happen overnight.”

The implementation of change within the organisation of the NHS, particularly the way in which services are commissioned, was seen as a challenge to the autonomy of practitioners, as the service was prescribed and perceived as denying the HVs the opportunity to decide the best way to respond to their clients’ needs. This loss of autonomy threatened the internal locus of control within the HV teams, with a tangible impact on the team.

Georgie: FG2b 38

“People feel very let down that there is not any choice, and that they do not have a say in anything, they are just being told.”

In contrast, the use of policies and guidelines, which could challenge professional autonomy in decision-making, was seen as helpful in legitimising the challenge of clients’ actions and behaviours. This may be to do with confidence in the role in raising difficult topics, but it may also indicate a lack of confidence and awareness in working from the client rather than the professional agenda (Hart and Freeman, 2005).
Jo: 1082

“I can point out what is … what I think is the right thing in accordance with regulations as well.”

The tension between exercising professional judgement and following policy and guidelines to meet employer expectations was highlighted by Dawn, illustrated in relation to following the lone worker policy. This was perhaps not unsurprising at this novice stage of their professional role development.

Gender is commonly identified as a social structure with causal powers to bring about events in social contexts. Health visiting is a profession dominated by women, and as such provides a gendered approach to work with clients. Within the data there were few references to men as part of the family unit with mothers, children and babies being predominantly identified as the recipients of the service, with some more general references to parents and carers. Interestingly, although fathers were rarely specifically mentioned in the data, on two occasions when there were issues of power and control they were evident. The first related to a situation where Clare felt a father was not being truthful, and that if she did not challenge this then it would have implications for the power balance in their future relationship.

Clare: 1405

“Yes, for me I felt that I had to address that, because […] actually I couldn’t let him treat me like an idiot because then our relationship would have been really unequal, if that makes sense.”

In a second, less specific incident, men were mentioned when discussing the idea of the ‘locus of control’ within the focus group. This indicated both the stereotyping of men, but also manipulation in the relationship with clients suggesting the dominance of the professional ego (Hart and Freeman, 2005).

FG1 24

Holly: “Make them feel like they’re in control, but you’re suggesting, putting things in their head”

Jess: “Just like men” [laughter]
Becky: “Yes make them feel like it’s their idea”.

This interaction was perhaps an indication of the influence of the gendered nature of the workforce on the experience and expectations of the role. In addition, Clare’s observation confirmed the contradiction between a role that was enabling, supportive and ‘nice’, and one that required the HV to speak out to, and about, clients. Unfortunately, the lack of male participants meant that the gender perspective was not open for further exploration in this study.

6.3.3 Social Contributions to Building individual and Collective Resilience

As previously identified (Figure 3.1), Bhaskar (1989) suggests reciprocity in the relationships between society and individuals: society socialising the individual and the individual acting to reproduce or transform the structures and mechanisms of society. I see the socialising structures and mechanisms, and the response of individuals in perpetuating or challenging these social structures, to be relevant to understanding the building of resilience. Social interaction was identified as key to the participants’ resilience during the course. The importance of contact with the student peer group was clear, and the contribution of this interaction in these contexts to building resilience through shared experience was made explicit. Dawn and Brigid drew comfort from this shared experience.

FG3 8

Dawn: “It is good to know that other people are experiencing the same or similar things.”

Brigid: “That was comforting”

Dawn: “[I] take a lot of comfort from that. And because you talk about it, you build a certain degree of resilience in that shared experience.”

Laura identified that informal peer support during time spent together in the university was as important, or more so, than formal learning experiences in enabling students to cope with the demands of the course.
Laura: FG3 8

“…..you are kind of offloading stuff that has happened to you, or how you are feeling or things like that[…] You know sometimes I think those [times] are more valuable than the learning, within that day”

Jo distinguished between ‘learning’ and ‘picking it up’ from others, but she spoke of drawing strength from the social processes of encouragement by others and hearing about their experiences of managing difficulties.

Jo: FG3 9

“[…] at times you think oh god this is awful and I can’t manage. And then somebody says ‘come on, look what you have done, this is great so let’s pull you through’. And you learn or you pick up other peoples’ strength. I am not sure if that is a learning thing or just support. But you sort of learn from other peoples’ management of their crisis or problem. And you pick it up, and you think that is a good idea, and OK I will try this or … so you sort of pick up from each other.”

Brigid went on to explain how she had been enabled to become more open through this process of social support from her student peer group, and that this ‘openness’ was key to becoming more resilient. This discussion was related to an element of the Jenga™ tower activity relating to the statement: ‘I can create safe emotional places in practice by…..’ (Appendix 11.3). Dawn spoke about this ‘space’ as being something that was created within the individual, and Nicola referred to it as part of an internal toolkit.

Dawn: FG3 10

“The concept of a ‘safe place’ […] in a sense you create that space inside yourself. It is not an external space it is an internal space – for me it is definitely an internal space. And that is developed I think from the shared experience, from support and from peers. And support from the teams you are working with, and your mentor and PT as well.”

There was agreement from several of the participants that they could transfer this increased ability to be open into the context of practice.
The concept of ‘openness’ had relevance for individual and team resilience in a number of ways. The stress that team leaders were under was evident in the data, although it was clearly felt that if the teams were to be resilient then their team leaders also needed to be open to seeing what was happening within their teams and in responding to what they saw.

Jo: FG3 43

“But do you think that the team leader [is] not recognising what is going on in their team? […] it comes from the top and it filters down – but if they are too busy or if they are not interested, or whatever it is, that can make a big difference can’t it.”

Jo, who had experienced differing leadership in two placements, identified positive behaviour by her current team leader indicating openness to seeing and responding to what was happening in her team.

Other social processes were evident in the data that appeared to contribute to the development of the participants’ resilience as individuals and to the resilience of their teams. Reference has previously been made to the part played by the participants in managing the overall workload of the team by taking on the more routine work as they became competent to do so. Although resisted by the participants on one level, on another this seemed to have a positive effect through building confidence and capacity, resources recognised within the literature review as supporting practitioner resilience.

Georgie: FG2b 21

“…it is a nice feeling […] that they have given you that responsibility and that they feel that you understand and you can go and do the role.”

Inclusion in meeting the demands made on the team also appeared to promote a sense of belonging, again recognised in the literature review to support resilience, and ‘being in it together’ along with an element of quid pro quo.
Laura: FG2b 20

“Which […] is why you kind of give a little bit of attention to those visits that you [don’t] particularly want to, because you are aware that they are stressed and stretched. And you know, even though it is not a learning opportunity for you, you will help the team out. […] So, if I do that for you now, it will free up time that I can spend with you this afternoon. So it is kind of a bit of give-and-take.”

However, within this socialisation process into practice some of the participants also identified the need to learn to say ‘no’. Becky saw this in relation to advocacy by HV colleagues in support of the team to managers, thus contributing to the resilience of the team.

Becky: 748

“Some people are very good at saying to a manager – ‘actually no this is not going to happen because there is no capacity for it’. And they are really forward in actually saying – ‘no’.”

Becky then went on to voice concern that although she had been able to say ‘no’ in previous roles, she did not feel she would be that assertive in the HV role at that point, but that this was something that she would learn to do. This learning would take place through becoming confident in the HV role.

Other participants referred to learning as individuals to say ‘no’ to the wider teams demands, drawing on their experience of inappropriate work allocations as students. Jo spoke about how she felt when she missed writing up a set of notes, a time when reflection had been key to her gaining insight into how she could have promoted her own resilience, through saying no.

Jo: 411

“I actually reflected on one particular incidence at my previous placement. ….they were very understaffed and they gave me all the new births […] I was sort of pressured to ‘get on with it’ ……. I was expected to help them out. I was happy to do that and felt very much that I wanted to contribute as well. But it was too much.
… I had all these reports to write [...] and I missed out one of the notes [...] So the lesson to learn was that [when I was] tempted to say – ‘oh yes I will do that’ [...] I should have said – ‘actually I can’t do that’.”

Saying ‘no’ was therefore identified as a resilient move by the participants, both in their context as team members, and in the context of promoting the wellbeing of the team through standing up to the demands of the organisation.

Supervision was a further social structure in place to support students, provided formally by PTs and mentors, and informally by HV colleagues. It also provided a social interaction with others to facilitate reflection, in addition to the individual reflection undertaken by participants. Openness appeared to add to vicarious vulnerability in the sense that being ‘open’ in practice exposed the participants to being trusted by their clients with more challenging information. At the same time however, this openness on the participants’ part also promoted the trust and honesty essential to effective clinical supervision, and so supported the mechanism through which they could manage the impact of what they had experienced.

Mechanisms for the supervision of participants HV colleagues appeared to vary in format and accessibility. Supervision as a resource to support individual and team resilience was widely recognised, with the proviso that there needed to be trust and honesty in order to promote the openness in the relationship that would provide a positive and effective supervision experience.

Laura: 878

“I have had clinical supervision in the past…and I think that I didn’t really use it properly, … it was somebody that I didn’t really trust.

… I am more able to know now, what I want from it, perhaps than I did in the past.”

Other challenges were also posed during the participants’ experience as students on the course that were felt to provide a ‘test-bed’ for their capacity to respond to the adversity they encountered. The workload from the course, managing the work-life balance, and conflicting demands, required them to use
a range of personal skills and resources in order to survive. Laura described
this with reference to the exercise rating qualities and attributes in the first focus
group (Appendix 11.1).

Laura: FG2b 44

“[..] the course is very short. And everything is all in at once, and you
have to ..prioritise ... you have to.. problem solve and you are having to
[..] focus on one thing and have a purpose. So you are using this
within the course – otherwise you wouldn’t get through it....
But the support network is very challenging at the moment. You know,
you have got a PT, but mine is divided into about five pieces at the
moment. [...] Look at it – prioritisation – every-day you are thinking ‘what
do I have to do now?’ ‘Today I need to do that – that is number one on my
list’. [...] So you are using the flexibility and problem solving. Self-
esteeom is hopefully being built by you getting positive results from your
assignments: and getting feedback from your PT.
Perseverance – is definitely there isn’t it, because ..we’re doing that!”

Issues with team leadership and relational problems within teams could also
undermine resilience. One example was where teams had been amalgamated
and were not being managed by their team leader to work as one new team.

Brigid: FG3 41

“We had four teams come into one. .... they had to come and start
working as a team answering the phone [for each other] which they
refused to do –[they were taking their own work] and just leaving, and not
coming back. [...] my team lead [. . just didn’t] challenge it, and she just let
it ride. And people were getting upset and people were getting
disgruntled.”

Dawn also identified problems with team dynamics where the team leader
appeared unable to move a situation on and where she felt the resilience of the
team was undermined. The deficit in the team’s resilience perceived by Dawn
was linked to specific leadership behaviour, as the method and timing of
communication was felt to be a significant contributor to the lack of team feeling and resilience.

Dawn: 1082

“There is no team feeling in the team I am working at….. She [team leader] is very good at identifying when people shouldn't be doing something that they have done. [……] sometimes she has challenged them in front of other people and I have felt very uncomfortable about that. [……] and I wouldn't necessarily use the sort of language which she uses either. I might try a different way.”

In a different team, where difficulties in team dynamics also existed, techniques learnt to support clients were sometimes seen to provide tools to enable positive responses. Clare identified the “impressive” negative impact of one team member on the rest of the team and the way in which her PT had applied a behavioural technique (used with clients to support parenting) to manage this.

Clare: 710

“[My PT] says that she adopts a very ‘positive parenting’ type of role within the team[…] tending to leave the bad behaviour until it reaches an unacceptable level and then we do a bit of time out. [laughter] And then come back to positive praise again.”

Jess also described the high workload and potentially stressful working conditions in her team but identified that there was no sickness due to stress, something she attributed to the support in the team mediated through talking between themselves and with their team leader, and going out socially together. This seemed to promote the resilience of her team in combination with supportive behaviour from the team leader, who herself exhibited some resilient attributes.

Jess: 278

“She is very level headed…… she is there – and she is approachable. You don’t feel that you are interrupting if she is doing something. She
makes time to answer any questions. And if you email her something she always gets back to you, which is really important.”

Clare confirmed the positive contribution of such responsive behaviour.

Clare: FG2a 35

“...the team seemed to thrive on our team leader. She was flexible, and she listens to people and she acknowledges the issues that are there, and she stands up for people, and she deals with things straight away.”

In Jess’s situation the longevity of the team seemed to be a positive contribution to the team dynamics, which is in contrast with Dawn’s placement where being part of an established team did not promote cohesion.

These observations of team leader styles and mechanisms in practice were of great importance in applying the participants’ learning about leadership, and understanding the impact of this on the resilience of teams and individuals. As important as seeing positive role modelling was also learning how not to do things.

Dawn: 1076

“Some of the time I have learnt what not to do.”

Within the participants accounts there appeared to be an undercurrent of existing HVs looking for a ‘way out’, with an impact that might pose a threat to the resilience of the new HVs. Retirement from the existing HV workforce was identified as an issue, together with people leaving because they were unhappy with the current state of affairs.

Becky: FG2a 36

“The team leader in my area, she had just been along to the team meetings, and she sort of told us … she has applied for another job back in the hospital. And things are dire and she would never do this job ever again.”
This had some congruence with Jess and Jo’s comments at the outset of the study regarding ‘leaving’ as a strategy when things become too difficult. This could be seen as a resilient move in terms of managing the adversity faced, or could be seen as an outcome of a lack of resilience in having to move away from the situation due to a lack of capacity to respond to adversity. Experienced HVs were looking out for new roles, and there was a feeling on the part of some that the new HVs would be excluded from the new focus on broader public health in favour of their more experienced colleagues.

Laura: 556

“And I know that people have been [nervous laugh] looking on the jobs website to see what is coming up. And they are very excited about the thought of the new roles.”

Dawn compared the relationship between individual and collective resilience to herd immunity, a phenomenon associated with immunisation where a certain level of uptake in the population is required in order that immunity is conferred on the whole population. She observed however, that with resilience a single ‘unimmunised’ person could threaten the resilience of the herd.

Dawn: FG3 46

“It’s a bit like herd immunity. You get that, you know, when everybody is resilient and you get that protective factor. But actually one practitioner who has not got resilience and who is struggling can affect the whole […….] everybody else, in some way, perhaps.”

Laura observed that from what she had seen, negative response to adversity in practice manifesting through stress related illness, was responded to by her organisation at an individual level, rather than looking at the root causes.

Laura: 1647

“I think it is very much – ‘well we will get you to occupational health.’ ‘You go to your GP and then we will get you to occupational health’. Rather than kind of thinking about what is underlying it all really. Taking the problem away rather than addressing the issue.”
Discussions about the work-life balance occurred in both the focus groups and individual interviews. The need to take a break, whether as part of the working day or as part of a broader work-life balance strategy, was recognised by all the participants. This seemed to be equated to taking a deep breath in order to come back with fresh eyes and renewed energy, thus contributing to resilience.

Dawn: 923

“..when you are not winning something, and when you are in a lose-lose situation (chuckles) then sometimes just stopping what you are doing or recognising that actually I need to stop and I need to go out and walk around the block and come back again. It can be helpful.”

A range of physical and leisure activities, and the importance of family and other social supports were identified. Participants described how the time demands of the course had impacted upon some of these activities, but felt they would resume on qualification. Jo pointed out that particular effort needed to be made to engage with this activity.

Jo: 1128

“I also go to the gym and I go and do something physical. […] But it is an effort to have to do it, because I actually wanted to sit and flop and do nothing, but I went .. and I felt so much better.”

6.4 Domain 2: The Organisation of Learning

This domain is concerned with the way in which the students’ learning was organised and occurred. The validated curriculum was central to this including learning in the university (denoted as theory) and learning in practice settings (practice). Table 6.2 (overleaf) is drawn from the course documents, and summarises the course structure and content, mapping the modules against teaching and learning strategies employed in the different components of the course.
In the modules where ‘large and small group strategies’ are identified, a variety of approaches were utilised, including keynote lectures, seminars, reflective activity, and small group work. Periods of induction and consolidation of practice are identified. The course ran over the period of a full calendar year, and was 50% practice and 50% theory based.
Students undertaking the BSc (Hons) route took the modules at Level 6 and the Post-graduate Diplomas students at Level 7. The modules marked ‘L6&7’ in Table 6.2 were taught by shared delivery. In most of these modules the content was the same, with differentiation evidenced in the level of the learning outcomes and expectation of the assessments. The exception to this was the Child Protection module, which was a Level 6 module undertaken by all the students as a basis for child protection practice.

The university induction included a wellbeing afternoon, designed to introduce students to a number of activities that might promote their wellbeing during and after the course. Activities included mindfulness, yoga, creative writing, and hand massage.

A Practice Teacher (PT), who undertook summative assessment of practice oversaw each student’s practice learning. (See Appendix 14 for alternative models of PT supervision.) The practice induction included two-weeks observation in their allocated placement to become orientated to the HV role. This was followed by a ‘skills’ week within the university where a number of PTs taught practical skills to the student group. These included communication skills, managing difficult situations, child development and teaching skills.

The personal development plan (PDP), a summary of which is presented in Appendix 15, was a document kept by the student designed to support their individual learning throughout the course. This included a self-assessment by the student at the outset, and learning contracts to be agreed between the student and PT, and where applicable, the mentor. An action plan for each module was also included within the PDP to identify learning opportunities that would support the module. The final sign off by the PT of fitness for practice and registration was included at the end of the document.
6.4.1 Starting Points

This theme emerged from the categories of 'self as a foundation for learning' (Kegan, 2009) and 'sensitise', the component derived from the STAR framework (McAllister, 2011), which were included in the conceptual framework. Extracts were elicited from the data that illustrated the variety of experiences that were brought to the course by the different participants through their individual personal and professional experience, and the relevance of these to their learning and development for the HV role. The exposure of the participants to the reality of the role, already explored in relation to structures and mechanisms, also contributes to this theme. Here however, the focus is on the organisation of learning, including the way that participants may have been enabled to assume new views or perspectives.

All of the participants unsurprisingly voiced a desire to become a HV, although the move seemed serendipitous for some, as the opportunity arising through a HVIP advert for a fully funded HV course included with their pay slip. Participants ranged widely in age, education and experience, (Figure 6.1 and Figure 6.2) and they also appeared to come from a range of social backgrounds. From the focus group and interview data a variety of motivations for coming into health visiting emerged. Some participants, like Jo and Becky, spoke of needing a change in the direction of their career, whilst for Jo the opportunity to undertake a Masters level study was also a strong motivation.

Jo: 38

“I was looking to do some extra learning for me. I had done my degree and I wanted to do some more learning.”

In contrast, Becky identified that she had found academic learning difficult in the past, so came to the course with less confidence regarding the academic demands of the course.

Becky: 877

“I have never been very academic. The nurses training I sort of scraped everything.”
For Clare, who recognised the drive she had to move from ‘knowing what’ to ‘knowing why’, the course was about gaining the knowledge that would give her the perspective she needed to move from a SN to a HV role.

Clare: 169

“I wanted that underpinning knowledge about why you are doing things and how to work with people in different ways. That is what drove me on to doing it.”

Several of the participants therefore brought with them a desire to engage further with education, although their ability to take on academic study varied. Sessions were included as part of the planned curriculum to refresh students’ academic skills and readiness to learn. These sessions, in the induction week, included content on reflection, academic writing and an update on electronic literature searching. A session was also included on establishing honest relationships with clients and agenda setting, recognising the place of learning within the student/client relationship.

Personal experiences had sensitised the participants to opportunities offered through the scope of the HV role. Three of the participants specifically identified their own experience of post-natal depression and two of these disclosed significant ongoing mental health problems. Becky’s experience of mental health problems had led to her involvement with social services, an experience in which she had felt unsupported and frightened.

Becky: 284

“I got quite poorly […] with my depression and I ended up with social services involved with me. … I wasn’t allowed my [children] for about two weeks by myself. They dropped it all and they said, ‘this looks fine’. […] it was awful and it was the worst time of my life […] but now, when I go to see people, I think I can support them. Obviously I am not going to tell them that it happened to me but I can sort of support them and maybe guide them and help them in a way that maybe someone else can’t.”
Jess as a young mum felt unable to disclose her post-natal depression to HVs who she perceived as judgmental and out of touch with her generation.

Jess: 90
“..I would want to be different and more on their [the young people’s] wavelength.
..I didn’t really want to talk to them [HVs] too much because I found them judging me. I had depression when I had my daughter, but I didn’t tell my health visitors. I thought they would take the baby away. I was young and I was worried so I didn’t tell anybody. My mum knew, and we kept it in the family.”

Laura spoke about how her position as an older, first-time, working mother left her isolated and raised her awareness of the needs of other groups who were marginalised by the organisation of services albeit for other reasons.

Laura: 170
“…it might be that you are from a different country, or an older or a really young mum........... what was it about those mums that made them different? And in what ways would they need perhaps additional support, than perhaps other mums would need, who had their peer groups around them?”

For all three participants their own experiences were a motivating force to make a difference in the experience of others in similar positions. Both Becky and Laura also identified their own vulnerabilities as contributing to their resilience in their HV role. For Laura this was with respect to her age and experience.

Laura: 1267
“..as you move into your forties, you kind of realise that you are actually a grown-up now and you can’t hide anything anymore! [laughter]
And actually life is there for living and you have just got to get on with it. And no, there is no point in being down-beat about anything really much for very long.”

Becky saw her mental health issues as contributing to her resilience as she was able to recognise her ability to win through against the odds.

Becky: 411

“I think of how far I have come […] And I just think, you know, a year-and-a-half ago, I was in that situation and now … well now I have passed my degree and I am out there to help people now. And I think it is a real achievement.”

For Becky and Jess the disclosure of their past experience to their personal tutor and subsequent inclusion of their PTs in this confidence, allowed them to be supported through difficult times during the course. For Becky this happened at the beginning of her practice placement, whilst for Jess it didn’t occur until she was in crisis, with her reluctance to disclose her difficulty with the course mirroring the same reluctance she had felt to disclose her own post-natal depression. The importance of building openness as a resource to support resilience, recognised in earlier discussion in this chapter, appears to be reinforced by Jess’s experience.

Jess: 989

“There came to a point when I think my PT realised that I was quite stressed out and said – ‘are you OK?’ And I said ‘I am not actually, I am really struggling’.”

Having taken time out through intermission, Jess returned to study with a positive strategy for completing the course.

Exposure to socio-economic disadvantage has been identified as a threshold concept resulting in the participants gaining a new view of inequality (Section 6.3.2). Dawn and Jo had had experience of populations in overtly socio-economically deprived areas of the world, Dawn through living abroad and Jo
through working with a charity. These experiences contributed to their motivation to become HVSs through recognition of the privilege that they and their families enjoyed.

Despite her experience overseas and the fact that she had worked as a community midwife, Dawn was surprised at the level of deprivation encountered in her practice area. Clare shared this surprise and identified the on-going nature of sensitisation in relation to socio-economic deprivation, recognising the continuing impact through the course and into the final period of consolidation.

Clare: 217
“..growing up where I grew up and having the childhood that I had, and then going and working with families [...] that realisation that actually there are a lot of children living in those situations and that you end up working with them. [...] that could be a bit of a shock I think, especially in consolidation more, when you are picking up more of those families and working with them.”

Several participants specifically identified the emotional impact of crossing this threshold, but identified how they were helped to cope through peer support.

Brigid: FG3 7
“….my peers on the course – I think we have supported each other. [...] we have we have formed a more of an honest relationship with each other.”

Reflection and role modelling by colleagues in practice were also identified as helpful in learning how to manage these feelings.

Clare: 344
“Seeing other people work, and listening to how other people talk, really helps I find for me. And then the talking about things afterwards, so like I was saying about the informal supervision in the office. [...] And hearing how people respond helps, if they have been in that situation as well: and reflecting back on it with others.”
Starting learning from where the student is requires them to recognise their own starting point. The PDP was designed to encourage students to achieve this at the beginning of their course and at other points throughout the year. Interestingly, when asked whether they had been helped to make this assessment no-one mentioned the PDP or the self-assessment and learning contract requirements within it, although this would have had to have been completed and submitted for them to complete the course.

Laura and Clare, who had both gone into the SN role as a stepping-stone to becoming a HV, spoke about their experience as HV SNs and how their PTs had helped to link this with their learning in transferring from that role to a HV. Both were open to the change in perspective, which evidently helped them in transforming their thinking.

Clare: FG3 28

“I had that conversation with my PT… ‘we had to unpick all the stuff you did as a staff nurse [...] to kind of move you forward as a health visitor’.

[PL: How did she unpick it..?]“By using reflection and the way you approach your visits..... if you are going to do an antenatal visit then not being sticking rigidly to the [assessment] triangle but taking what is coming from the mother and letting the visit develop that way. …. [that way] it has got more of a health visitor type of approach, in that you are picking up on the needs and going with those..”

However for Holly, who had been a SN in a HV team for an extended period of time and only participated in the first focus group, it seemed that she might find it less easy to be open to this change in perspective than other participants. When responding to the questions and issues raised she seemed to be more concrete in her thinking and embedded in a task-oriented role within the HV team. This was exhibited through being very definite in her interpretations, showing a preference for working with guidelines and giving the ‘right’ information. Despite having made it clear at the outset that there were no right or wrong answers, Holly showed discomfort with questions that were open to
interpretation. For example when discussing whether the participants could learn to become more flexible, whilst others were happy to range around the idea Holly seemed to need a definite question to answer.

Holly: FG1 22

“Are we talking about flexibility within working hours, or changes to your role, or.. I'm not quite with you..”

When discussing ‘purpose’ she found the concept difficult, perhaps because it was more abstract.

Holly: FG1 18

[PL: Why is it difficult?] “I don't know. Cause it doesn't seem as specific as the others it's not such a strong word. or phrase. I don't know it's not as powerful ..”

Although this may have been due to a lack of confidence, it might also have been important that the position from which she was starting her learning was made explicit. However, as she did not continue to participate in the study this could not be followed up.

6.4.2 Scaffolding Learning for Resilience

In this cluster theme I draw on data relating to the ‘create knowledge’, ‘take action’ and ‘promote critical reflection’ elements from the conceptual framework, pulling together narrative that links the facilitation of TL and promoting resilience. Scaffolding learning refers to the way in which learning experiences build upon each other through the course, and this occurred in both a planned and informal manner. It was quite evident that although time on the course was clearly distributed 50:50 between university and practice learning environments, most of the conversation during focus groups and interviews related to experiences in the practice world. This was despite open questioning about experience across the scope of theory and practice. Returning to the critical realist domains, the ‘actual’ (in this case the ‘facilitation of TL’ domain of the conceptual framework) has already been identified as that which actually takes
place, whether or not it is recognised as having done so. Some activity that might have been anticipated to be recalled was not mentioned. It seems likely that this was known by the participants to be happening at the time, but that its relevance to the topic under investigation was not recognised. Noticeable by their absence were comments on strategies to promote wellbeing that were included in the induction week, and the use of the PDP as a tool for individualising learning needs and progress. A specific opportunity was provided to talk about the experience of different learning and teaching strategies, and some data emerged from this. Reference to modules and strategies for delivery was contextualised with reference to the course documents as an additional data source, and is included in this discussion.

In the first focus groups there was considerable preoccupation with ‘knowledge’. This was unsurprisingly related to the knowledge that was required in a new specialist area of practice.

Clare: 1660

“I think, probably when you start the course, it is that knowledge that you want, isn’t it? ……. it is knowing how to make a bottle up, and how much weight they [babies] should put on in a week and all that kind of thing.”

Similarly, Jess spoke about her feelings about the gap between her existing field of practice and her new speciality of health visiting.

Jess: 139

“I don’t think I realised the extent of child development knowledge that you need. And sometimes I find that quite daunting, coming from a mental health background.”

A number of the participants identified that the evidence base for practice was constantly changing, so knowledge was as much about knowing where to get up to date information as about learning it in the first place.

Laura described how the modules built on each other and the way in which the continuity of tutors contributed to this building process.
Laura: 341
“… you can build one on top of the other and you kind of mould it together … that [first] semester perhaps makes you look at things in a different way. … the next semester…they [the tutors] are sort of bringing this in and ‘we talked about this previously and let’s just refresh it’. And I do remember perhaps that theory, or … that particular session … and looking at things in a different way for each semester.”

Becky described the way that the scaffold of learning was filled in as she progressed through the course:

Becky: 1308
“…sort of bricks, yes, it all … it is all gone into place now. A bit like ‘Jenga’ I suppose – with rewind. So you have got all these holes and now you can fill them all in, with all the work you have done.”

The participants identified the need for this instrumental knowledge before being able to move into the ‘take action’ phase involving learning spaces to put into practice newly gained knowledge and skills. This involved testing out what they had learnt intellectually and practically, and reflecting on the relationships between the knowledge they had gained (instrumental knowledge) and how they were able to use that knowledge (communicative knowledge). The idea of building through a series of bite-sized chunks was voiced a number of times by different participants. Jo used this to describe the incremental nature of combining instrumental and communicative learning, and reflection, and the way in which this related to building confidence in the HV role.

Jo: FG2a14
“It is … learning and going out and maybe doing a little bit on your own and coming back and discussing it and having … well that is another bite-sized chunks. Learning new things and you can gather in the knowledge and it gives you the confidence.”

Clare also described how she saw the process of melding theory and practice.
Clare: 1592

“Well they are two sides of the same coin really, aren’t they […] because if you know the knowledge, but you don’t know how to use it properly, in an evidence based way, and … or how to find out where to find that knowledge, then it doesn’t work really does it…”

Learning theory in isolation from practice was therefore of limited value. Jo found the activity of looking at research findings dull until she was able to make the link with something useful in practice.

Jo: 940

“[…] all the different types of research that you can do… I found it very dull. Whereas when I did my practical side, it was for a purpose. … here is this that I have produced – it is useful. People find it very easy to read and it is a good … it is of benefit for lots of people. So it seemed to be a practical thing to do, which I like to do.”

Taking specific instrumental learning into the communicative domain was discussed by some of the participants in the way in which they learned to manage the ‘difficult’ parts of the job, thus contributing to their ability to ‘make a difference’, which supported resilience in their role. Clare described how she was able to learn to promote clients engagement with her. The content of skills week and the early interventions module was implicated here, but communicative learning is identified through the action of applying her learning in practice.

Clare: 252

“[…] the work around the ‘strengths based approach’ and working in that way has helped as well, actually. And encouraging families to … (thoughtfully) encouraging families to open up if that makes sense? Using those skills that we have picked up, and from working with our PTs about communication, and giving people the chance to open up, because you feel that you are more confident in your skills, to hear what they are going
Similarly, Laura talked about the way in which she had used De Shazer’s (2007) miracle question⁴ in a situation where she was having difficulty moving the client on, even though this felt like a “very odd concept” when it was taught as part of the content of a module.

Laura: 1140

“I was thinking – ‘well how can I ever use that in practice?’
But I did go and see one lady and I thought – ‘actually I am going to try it because she just seems absolutely perfect’ – and I used it, and I met her the next week and she was beaming.
She said – ‘I was thinking about what you said about the miracle thing, and I thought actually I am going to do it and I am going to change’. And I thought, well that actually did work really well.”

Different modules on the course utilised different teaching and learning strategies. Overall, participants felt that there was a high level of student involvement in organising their own learning. Most of the time this was planned, but on occasion a few participants felt they were left to ‘get on with it’. One example was given by Dawn.

Dawn: FG3 40

“I think because of the way the team was at the time, she [PT] …….just kind of left me to do my own thing a lot of the time, really. And my learning needs were very much secondary to what was going on elsewhere. …… you have to know – and fortunately I did know what I wanted to do and get

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⁴ A strategy central to ‘Solution Focussed Brief Therapy’ that asks, if a miracle occurred during the night while the person was sleeping that meant that a problem no longer existed, how would they know when they woke that the miracle had happened. The intention is to help the client to focus on what would need to change in order for a solution to the problem to be found.
out of it. And I was able to achieve that. By self-motivating myself for that and not having needed too much from her. … She wasn’t available.”

The public health project module, and the research evidence in practice module used problem-based learning (PBL) and work-based learning (WBL) strategies that required a high level of student participation and autonomy. These two strategies emerged as being particularly helpful to the students in a number of ways. The skilled facilitation of the PBL strategy used in the public health module was seen by Jo to contribute to being led further into broadening her perspective and becoming enthused with the reality of public health practice. This motivated her to address inequality, and in her description it is almost possible to ‘feel’ the space that the students were being given to think.

Jo: 1497

“And [module leader], was very enthusiastic about her subject. And she sort of … she opened a door for you to go through, but she didn’t necessarily drag you through it or push you through it. She sort of opened and watched you go through and make … and ‘oh yes of course this is what links in with that’

[…] I found that her influence was very positive for me.”

Laura identified how the PBL approach allowed space for students to challenge each other’s assumptions and beliefs.

Laura: 381

“And [sigh] you get some people who have very, very forthright opinions. …… [chuckles] and yes, we have challenged each other, but within the safety of that group. Knowing that it is confidential what goes on in-between in that group. […] I think [the tutors] have left it to us to do it in some ways. They were there to police, but if we said – ‘well hang on I don’t agree with you there’ – we were able to challenge each other.”

Reflection was a significant component of theoretical learning and was widely identified as an integral part of the way in which the participants tested out their learning in practice. This was not a one off event but continuing and intertwined
with their actions. Jo made connections between using the ‘Johari window’ as an exercise in self-awareness and critical self-reflection, both elements of emotional intelligence (Goleman 1996).

Jo: 380

“… when you look at reflective pieces and you are looking at and you are critiquing somebody else’s role or performance or how you think that has gone or how teams interact, and all those sorts of things, I think you need to look at yourself. You need to have a good understanding of what makes you tick in order to then take that next step and look at how other people tick.”

The participants spoke about reflection in very different ways; Becky having seen it as a chore in the past, Clare as something she ‘loved’ and how she used different models and a reflective diary, whilst Jo spoke about her reservations concerning the use of formal models. All described the ways in which reflection had changed for them, the influences on this, and the ways in which they now used reflection.

Becky: 1379

“At first, reflection was … [bored voice] ‘Oh god’ – you know … sit down and write about what has happened and how I felt. And it was a real chore. […] But now I think I do it in my head. Or I will do it may be with my colleague about a situation which has happened.”

Dawn: 568

“When things look quite chaotic, [my mentor] is quite good at actually drawing the separate issues out […]. It has helped me tremendously to actually re-look at … so ok, if I was going to do that again how would I tackle it? What would help me? And that is the resilience part of it.”

Jo: 1251

“I have certainly had to do much more of it. […]
I quite often will reflect on things anyway, but I don’t necessarily follow a model to do it. … I have been thinking more in-depth I suppose, about things.

I quite like things that flow…things that follow a flow I tend to sort of start at one point and go round. But you could actually jump in at any point, rather than things in a line.”

Sometimes there was a degree of dissonance when reflecting with more experienced colleagues. Both Dawn and Becky identified that they would do something differently next time, despite being told that they had ‘done the right thing’.

Becky: 1391

“It was just to do with a dog – a ‘staff’ that took a liking to me. And we ended up having to leave because this dog wouldn’t leave me alone. […] We should have said ‘fine we will come back when the dog is not here’. We could have dealt with that a lot differently and that was my view. But she is a health visitor, and she saw it differently to me.”

These extracts are drawn from a wide range of references concerning the use of reflection, including its importance in enmeshing theory and practice, and in ‘becoming’ HVs. It was clear that the participants engaged in reflection in all contexts of their learning, and that spaces were created both for them and by them in order for this to take place. Reflective space was not always labelled as such as the reference to peer support earlier also described a reflective process through describing what was happening, learning from others’ experiences, and seeing other ways of doing things. Dawn discriminated between reflecting with colleagues and hearing other’s stories, identifying the additional benefit of storytelling in linking theory and practice.

A further form of personal private reflection seemed important. There were several instances in the data where participants referred to ‘talking to themselves’. Although referred to as “a bit batty” by Jo, this emerged as a significant way of actively talking themselves through a difficult situation,
reminding themselves of past success, and convincing themselves that they could get past the problem and succeed.

Jo: FG2a 13

“I had to have a sort of conversation with myself .. – ‘look think about what you have done in the past and you could do that’ ‘so this is just another thing - skill that you are learning’.”

During the third focus group the participants were given the opportunity to suggest when and how the planned ordering of content might have aided scaffolding their learning in relation to promoting resilience. No suggestions were made at that point, but later during the interview with Clare, she observed that a session on resilience applied to role transition in the taught content of the ‘Developing practice’ module, had been very good but would have been better delivered in skills week in order to help students understand what they were likely to experience over the coming year.

Clare: 1875

“ […] it would have been really good to have done right at the beginning of the course. So … that when you were going through that journey, and maybe you are struggling, you can think well actually that is perfectly normal.”

Role modelling was evidently important in the participants’ learning, both in terms of learning what to do and what not to do in their practice with clients, and in promoting resilience in themselves and their teams.

Jess: 344

“Watching other people: how not to do things and how to do things. There is someone in the team that is quite challenging […] So, I have seen the way she acts with people and it is certainly a way I would not want to be.”

Laura identified the benefit of seeing many different HVs carry out their role.
Laura: 707
“I actually went out with lots of different health visitors and [...] that was really good because then I could kind of find my own feet with the things – and think what was good about that visit? And what I enjoyed and how that felt to me as, you know, as an outsider just watching the relationship develop between the client and the health visitor.”

Clare felt that she had learnt about resilience from the role modelling of her PT, however she said it was difficult to put into words.

Clare: FG3 20
“.. my PT, I have seen her model resilience – and the support of the team. And talking things through and seeing how she sees the same situation and how she breaks it down, and deals with it herself, if that makes sense – and that has helped… It is [...] her way of managing her caseload and allocating her time. And her justification of how she plans to take families forward, if that makes sense……?”

6.4.3 Endings
The selection of ‘endings’ as the title of the theme relates to the ‘transformation: reconstructed habits of mind’ category in the conceptual framework, which allows that the level of transformation that occurred in the participants cannot be assumed. In the same way that the notion of resilience cannot be assumed to apply to all in the same way, so it cannot be assumed that all students will be ‘transformed’ in the same way (or indeed at all) by a programme that may have the potential to facilitate such change. The participants identified the course as part of a lifelong learning process, and that the end of the course meant the beginning of ‘being’ a HV. This was evidenced in the second focus groups where a number of analogies emerged which described the participants’ feelings about becoming a HV. In one group sporting analogies of hurdles and reaching the finishing line were used to describe feelings about the experience of the course itself, whereas optimism and opportunities were related to the new growth of Spring and an open door of opportunity in the role that awaited them. In the other group the overall analogy was one of balance between the weight
of factors promoting and undermining their resilience (see photographs in Appendix 11.2).

As she progressed through the course, Jo, who had seemed more strategic in her choice of health visiting as a career move, appeared to become more committed to the role.

Jo: 199

“I think I have just embraced it as part of the job, and really enjoyed it. Probably more than I had thought I would.”

Becky, who had initially been shocked by the role, spoke of how her feelings and her commitment to the role had changed.

Becky: 79

“I love it, but it is very different to how I thought it would be. And very different to how other people think health visiting is.”

169

“[…] all the way through I have known that it was the best decision I ever made, and I wish I had done it sooner.”

Clare echoed this depth of personal fulfilment from the role.

Clare: 458

“Oh yes, I love it. I wouldn’t do anything else really. ..It is just … I think it is the best job in the world really. The impact, through the early interventions, and especially if it is one family like that family I spoke about. And their relationship has improved for that child and for mum. And then that makes it worth doing, doesn’t it?”

Transformation in TLT, was related to transformed frames of reference by Mezirow (2009), a fundamental permanent change in being. However, thinking may be transformed in the absence of such a fundamental change in being. The participants talked of the changes in themselves in a number of ways, recognising differing scope and depth of change. All those involved in the third focus group, and in the semi-structured interviews recognised a degree of
change in themselves, which could be associated with a transformation in their thinking and the beginnings of a transformed identity to that of a HV. Transformation in their being, in the sense of change in underpinning values and moral frameworks, was evident to a lesser extent. Vignettes of the individual participants and perceptions of the ways in which they have changed are presented below to illustrate the extent of transformation.

**Becky**

Becky came onto the course with a very limited knowledge of what the HV role entailed and had been shocked at what she found. However, as identified above, she embraced this difference and loved the new role. Becky felt that she had “changed completely” (965) over the period of the course, a change that she viewed as positive and that had also been observed by her PT, personal tutor and her parents.

“I feel like a professional. I feel that I have ‘bettered myself’ from doing the course.” (988)

There were a number of changes associated with these feelings. At the forefront of these was a perception that both her written and spoken use of language had changed. These changes in her written language had increased her confidence in her academic ability, which had been confirmed through her raised level of academic achievement.

“I never, ever thought I would be able to do a project like that. […] my mum proofread my work, and she said looking from the sort of learning agreement, and the rationale, to the evaluative report – she said it was amazing the actual wording that I was using had come on so much. So she was quite surprised. And I was quite surprised as well.” (855)

Her cognitive skills appeared also to have improved, as she expressed an increased ability to understand what she was reading and studying, and to make links with her practice. These changes had far exceeded her expectations. Becky felt that her spoken language had also changed, and that she was able to adapt the language she used according to the context in which
she was speaking, making information accessible to professionals and clients from a range of backgrounds.

“I find that I speak differently as well, to people. I find that my language that I use is different. Although, when I am out at work, if I am talking to someone who is very educated I will speak very professionally. But then I will go into another house, where it is a young mum, and she is ‘here alright’ … and I don’t talk pointedly, but I play it down a bit, and actually I talk normally.” (943)

She saw confidence as key to the changes in herself, although she obviously did not see herself as invincible.

“[…] I think my confidence, because I know that I can actually do it. I know I can write an essay. And I got ‘A’s for my practical side and my report writing. I know that I can do it .. I need to keep reminding myself that I can do it.” (972)

Becky also felt that the way that she saw things had changed, and that she now saw the way that she had cared to her own children differently. She attributed this change to an increased knowledge of theory and its application in practice. She was very proud of her achievement and her self-belief appeared to have grown significantly alongside her confidence. For Becky, being ‘a professional’ was important.

“It means a lot because hopefully I can be a role model to my children or other people that maybe I help.” (1341)

The response of ‘hard to reach’ clients to her as a professional, also built Becky’s self-belief, and helped her to recognise the way in which she was ‘making a difference’.

“..it was like … wow … she is a young mum and she didn’t really engage fully beforehand, and she actually feels that she can talk to me. And I thought that is a real achievement, so that felt really good.” (527)
Becky felt that she had been able to build her own way of being a HV through taking what she wanted from seeing a range of colleagues practising.

“And I think it is knowing that actually I can take bits off that person, and bits off that person, and put it all together. And that is how I work – that is my way of working.” (1699)

In the process of becoming a HV Becky had identified two significant resilient moves. The first was to recognise the limits of what she could do and to be open about this.

“I think it is recognising that actually – don’t push yourself too far. There is no point in pushing it too far, because anything could just make you go back.” (652)

The second was a surprise to Becky, as she found she had become ‘hooked’ on academic study and she was motivated to do more in the future.

“. we went out for a meal with work last night to celebrate me and another student passing…. I found myself saying – ‘I have really enjoyed the studying!’ and I went ‘Argh! What have I said?’ My mum has already said– ‘I know you are going to do more studying’. And I was like (excited) - ‘I know’.” (1146)

Although she clearly enjoyed the study now that she had gained confidence that she could do well and had found value in it, it also served as a resilient move through distracting her from elements of her personal life that were potentially detrimental to her mental health.

“It also keeps me busy at home, because [I] separated two years ago this month, and in the evenings if [the children] are at their dad’s it is just me at home. And it is a bit lonely and then that is when my brain starts going on overload.” (1171)

A significant driver for Becky’s successful completion of the course was her desire to please others by her performance; in fact this exceeded her desire to
do well for herself. External reinforcement was therefore a contributor to her resilience. She observed that she had not changed in this respect.

“I have always been like this: I want people to be proud of what I have done and who I have become.” (1057)

Brigid

Brigid laughed when she saw the statement ‘I’m exactly the same as I was at the beginning of the course’ on one of the blocks of the Jenga™ tower. She summarised the change in herself as follows:

“I think I know myself a lot better [...] I think as a nurse, you think that you are caring, but I think this role as a student health visitor has really kind of enhanced my own ‘knowing’ [...] I have found more resilient qualities within myself when things haven’t gone well. And to build upon them, and I have had to really dig deep within myself.” (FG3)

In terms of learning about herself Brigid identified “motivation.. to keep going”, and like Becky, recognising her limitations. The experience of the year was likened to a juggling or delicate balancing act between the activity of the course and her personal life, and also in respect of helping clients balance the demands made upon them. It was an “emotional time” and Brigid doubted she would “ever go back to the way I was before.” The emotion was illustrated through her description of provision of a food parcel to a family and the children’s reaction.

“I ordered a food parcel for a family that were struggling, and had no money to feed the children. And when I collected it, because they didn’t have any transport to collect the food parcel [...] just taking it into the home and seeing the children gather around the bags of food. And I … it was just a very, you know, not moving but just …. To see children actually take an interest was … whereas they were playing, you know, and they stopped playing to come.” (21)
Openness and honesty with herself and in her relationships with peers, colleagues and clients, appeared key to Brigid’s learning and ultimately to her resilience, something that has already been identified.

A further feature of the way in which Brigid had changed seemed to be in the way that she had become more adaptable. At the outset she had used the word ‘chameleon’ to characterise a HV, and in the final focus group she suggested that the participants now resembled:

“those little transformer models. You know those little toys and … and all these little gadgets come out and then they pop back in again.” (34).

The implication seemed to be that she could now pull out the resources to cope with things as they arose, and then put them back away when they were no longer needed, an interesting analogy in resilience terms.

**Clare**

Although Clare had been a SN in a HV team the reality of the role had still been a shock to her, although like Becky she was extremely positive about the role.

“I have absolutely loved it. It has been a real shock as well … especially in consolidation where I have picked up more complex families. ‘More challenging’, as my mentor and PT would say – ‘the ones that make your hair stand on end’.” (193)

She had successfully made a major change from the SN to the qualified HV role, and adopted a strength-based approach to working with families. Her description of the way in which she had changed is quite unassuming but actually identifies some fairly major shifts in her thinking, not least of which is an appreciation of the wide context of public health practice.

“I think yes [I have changed]—I feel more confident within the role. And taking those things on doesn’t scare me as much as it did. I don’t find it so overwhelming, but I am aware of the other issues and seeing the bigger picture, which maybe I wasn’t aware of before.
And the other issues, that are [...] going to impact as well on the situations that you find yourself working in [...] are clearer for me I think.” (1704)

Clare had earlier identified the way she felt about learning to speak up and out for a child.

“……you are there for the child. And to challenge those parents …
But it is hard. …… going to your first child protection meeting and having to stand up and …… give your voice about what is happening and what needs to happen. It is hard – it is hard.” (332)

However, it was clear from her narrative that she had learned to be open and honest with clients, and had identified specific techniques to enable this to happen. In addition, she had found herself in an intimidating situation with a client and had spoken out, challenging the assertions that were made but which were clearly not true, a measure of her growth in confidence and her self-belief in her role as a HV. Of this she said:

“[...] would I have done that at the beginning of the course? I don’t think I would have done because I just felt possibly intimidated by him. But not by the end of it! [laughter]” (1431)

Dawn

Dawn was initially uncertain as to whether she had changed over the course. She identified differences in how she felt, but asserted that her values were unchanged.

“Have I changed? I don’t think my values have changed. I think my values have remained true. I think I am in a happier place professionally now – I know I am. I am a much happier person I think.” (1319)

She observed that her skills had developed and that these were transferrable across roles. As identified earlier, there were changes in Dawn’s awareness of inequality and deprivation, and its impact that motivated her to work for change, and promoted an interest in the political potential of the professional role. These
were all indications of a degree of transformation of her thinking. Although Dawn did not identify changes to her values, she recognised authenticity within the HV role.

“I think it has helped me be true to myself actually. ……It is actually feeling that I am living an authentic life true to my own values and my own self. And I am able to recognise that as a professional as well.” (1363)

Similarly to Becky, Dawn identified that she had drawn on the observations of a number of HVs, particularly in relation to their communication skills, in developing her own way of being a HV.

“I often think … well I like that bit, but I don’t like that bit. So I will take … I quite like that bit so I will take what I have seen of that, but I will leave the other bit behind. So it is almost a pick-and-mix, really. And that is how I think I have developed.” (699)

Jo

Jo also did not feel that her values had changed over the course. From the outset Jo had been aware that she needed to avoid imposing her beliefs and standards on others, and it was evident that this was going to be an important part of her adjustment to working with families across the social spectrum. This was the area in which she identified she had changed, although there was clearly still a dissonance between her personal values and what she would accept in her professional role.

“I think I have become more aware of what I think about how other people live their lives, and maybe a bit more accepting and less judgmental… I have learnt to think about ‘what is good enough’. Whereas it might not be good enough for me, but I recognise that actually that is their choice. So possibly less judgmental, but feeling that I can actually do something positive.” (1155)
It was difficult to draw from Jo’s narrative the ways in which her skills had developed, although she was clear that her confidence had increased and she had felt supported in the following ways:

“Well I feel like I know what I am doing a bit more [chuckles] which is always a good thing. There is the knowledge, and the fact that I have passed my exams and they [the HV team] have been very positive and they have encouraged.” (569)

She had clearly gained knowledge of new areas of practice and had made the transition to the HV role. Jo felt that she had been able to draw upon many aspects of herself and her past experience to the role. In a similar way to Dawn and Becky, who also recognised that they could bring together their own way of ‘being’ a HV from their observations of others in the role, Jo commented that she valued the opportunity to bring ‘herself’ as a personality to the role.

“[…] you can bring your personality more to what you do, and interact more with people. [In previous roles] there was no room sort of to express yourself particularly as a type of person you might be…. I think there is a lot of leeway to draw on who you are and what you believe in, and then just to sort of work with that and with what you are doing and adapt it. And thinking on your feet and every time you go into a new situation: you have to think something new, every single time.” (FG3)

Laura

Laura’s experience of personal change through the experience of the course was mainly evidenced in her narrative through anecdotes regarding role transition from a HV SN to the qualified HV role. Laura was very stoical about the difficulties she had faced in the HV role, expressing this as part of life. She appeared to have been the most aware at the outset of the reality of the HV role of all the participants.

However, one feature of her narrative was that some aspects of the role scared her and that this still persisted to some extent, although the focus of the fear
had changed. Initially, fear was expressed in relation to how she would become knowledgeable as a HV.

“I think that is probably what scared me the most about doing the course, was the thought that I would then have to be able to voice my opinion. And I didn’t know quite how I was going to get that opinion.” (471)

In part, this related to how she would gain an understanding of how the team was controlled and how to manage her own workload, something that emanated from her experience of a large ‘chaotic’ team whilst working as a SN. At the end of the course she recognised that she had gained this knowledge and experience, and that this fear had been reduced.

“…now I know how it is controlled and [work is] allocated [...]. And certainly in the team that I am going to now, it seems that will be managed quite well. I can gain some confidence from it really. It doesn’t scare me quite so much as it used to.” (491)

Laura felt her confidence had increased in association with the knowledge and skills she had gained, and being able to put these into practice, particularly in relation to leadership. She expressed this as the feeling that she had greater authority in her professional role. This was illustrated by how she now managed in the child protection arena, where the increased authority seemed to contribute to her being able to speak out.

“Yep the confidence to say … I guess perhaps [...] sitting in the child protection arena when you go to conferences. And thinking – ‘well I have got this valid voice and I do need to speak up’ – so perhaps it is that, more than anything else, that has brought that to the fore.” (994)

Although all of the participants spoke at some point about putting the child at the centre of their thinking, it was interesting that Laura, like Clare, specifically linked with this with developing a ‘voice’. This also had some resonance with Becky’s observations concerning the development of her ‘professional’ language when considered in the context of Laura’s explanation below.
Confidence and authority extended beyond the work with clients to the way in which Laura now felt she could engage with others in group supervision. This was important in relation to resources for her personal resilience, but also as a contribution to the team’s resilience. Mezirow (2009a) refers to transformation as either epochal or incremental. ‘Epochal’ change he describes as “involving dramatic or major changes” (Mezirow, 2009a, 23) in an individual’s point of view, either in relation to the objective (task oriented) nature of the problem or the subjective context in which the problem exists. Although the changes described by Laura did not seem ‘epochal’, an incremental increase in confidence and professional authority was a profound and important change, in someone who had an acknowledged quiet personality, coming into a role that required the ability to deal with a high level of challenge from both clients and within the organisation.

Drawing on these vignettes the extent to which ‘frames of reference’ had changed through the participants’ learning experiences is clearly variable, and the epochal nature of change was not generally evident in the participants in the sense of a sudden cataclysmic change. However, the participants had undergone, apparently successfully, a major change through their role transition. They identified that their underpinning values had not changed, but their awareness, and in Dawn’s case her ability to be true to these values through her role, had in general increased. All of the participants, however, had changed in relation to their prejudices and stereotypes about socio-economically deprived groups within the population. For Jo this was limited to the way in which she managed her own beliefs, learning to adopt a more non-judgemental approach to families and not imposing her own values and beliefs. For other participants a more fundamental challenge to their beliefs concerning poverty and the lifestyles of those in poverty had taken place. These changes

“I think it is because in that arena, in the child protection arena, you are speaking for that service. And you will be the only person in that service. And you will have met the family under different circumstances. So, it is having that valid voice for that service, and being the expert in that service.” (1008)
had come about through exposure to families experiencing deprivation and the spaces created in their learning to reflect on these experiences and to meld theory and practice together.

The greatest transformation seemed to have occurred with Becky, where her sense of self appeared to have completely changed and was associated with becoming a ‘professional’. Transformation in thinking was more widely evident, and it seemed that this had contributed to the participants’ ‘ways of being’ as novice HVs. The potential for combining critical reflection and practice activity in embedding transformation in thinking was clear, although the necessary opportunities for action and reflection in wider public health working through community capacity building were not evident. The need for life-long learning to sustain the role as a qualified HV was recognised by all.

**6.5 Domain 3: The Experience of Becoming a Health Visitor**

As previously identified, experience is relevant across all three domains of critical realism. The extracts that have been used to illustrate each of the categories of the conceptual framework thus far have demonstrated the participants’ experience within the domains of the real and the actual. In this section the focus is specifically on experiences relating to the categories in the empirical domain of the conceptual framework, linking with participants’ experiences in and of themselves, rather than their experience in relation to the context of their learning or the organisation of the curriculum.

**6.5.1 Creating an Identity: It’s Not Just Weighing Babies**

Initially, participants struggled to define what a HV was, observing that there was a lack of understanding across the public and fellow professionals. When talking about knowing their ‘purpose’ as a resource in the first focus groups, the participants found this a difficult concept and something that they had not explicitly considered in the past. It was also difficult to pinpoint their purpose in the HV role when they did not fully understand what that role was about.

Holly: FG1a 15

“I don't quite KNOW what the role was .. so I don't really know..”
Despite this difficulty, participants thought that it would be important that they did know their purpose, and without knowing this they would not be effective, perhaps getting bound up in the moment and losing focus on what they were trying to do.

Clare: FG1a 17

“Can't really do it can you without really believing in it.. why you're there and your purpose for being there.. …”

Georgie: FG1b 20

“..it can be difficult sometimes not to get caught up in yourself, and lose sight of what you doing and why you are here.”

The participants also observed that HVs themselves interpreted the role differently.

Jo: 749

“I think as individuals everybody is [different]….they are autonomous practitioners and they have their own motivations”

This lack of consensus, combined with the context of change, appeared unhelpful to the participants in establishing their own identity in the role. Three of the elements of the conceptual framework in particular seemed to contribute to allowing them to work their way through this ‘fog’ and forge their own role identity in the role: ‘passion for role’, ‘positive identity’, and ‘awareness of personal and professional boundaries’. The following commentary presents extracts from the data in an attempt to build a picture of how this occurred and its relevance to the individual practitioner’s resilience.

Clare identified that there was something in her sense of self that drew her to working in the community. Although she found it difficult to verbalise what this was, she was able to give a clear account of her identity in the HV role that had crystallised for her over the period of the course.
Clare: 1166

“My identity as a health visitor … it is public health and to encourage … you know that public health side of it: and working with families ensuring that the children are safe: and building that relationship to engage the parents in bringing up their children, and supporting them and challenging them with that.”

Dawn and Becky both identified the way in which achieving and recognising gains with children and families contributed to their passion for the role. In addition, for Becky the challenge of getting reluctant families to engage was very much a part of her purpose.

Becky: 457

“I have got families that don’t want to engage with us and it is getting those mums on board. And now I get a text, on my work phone, saying ‘Can I see you?’ and ‘Can we meet up? And yes we can. And we will have a chat and yes, it is getting them on board and actually wanting to talk to you.”

Most of the participants spoke of the way in which commitment was integral to them keeping going. For Becky and Dawn this was a commitment to the role, whilst for Clare doing anything else was unthinkable, although she observed there were others on the course for whom this was not the case. Jess’s commitment was to finishing the course rather than to the role, and it seemed that half way through the course she hadn’t transitioned into her new role identity, still referring to her past role as “my area”.

Jess: 958

“I would say even when I was off [intermitted from the course], I knew I was coming back and I wanted to come back, because there is commitment as well. I have signed into this, and I do want to finish it.”

It was evident from the outset that a lack of knowledge on the part of friends and colleagues, and the expression of a negative image of the HV by others,
cast its shadow at a time when participants were trying to construct a positive identity for themselves.

Becky: FG3 15

“When you mention the health visitor they go – errgh – it is such a negative thing about health visitors and they are coming in to inspect your home.”

Indeed, Jess, as has been identified earlier, had a negative view of HVs from her own experience that may have presented additional difficulties when creating a positive identity for herself in her new role.

The conflicting perceptions of the role had the potential to present a challenge to identity formation: the extent and responsibility of the challenging elements of the work might confirm the value of the role on a professional level, whereas the perception of the HV as interfering in family life supported a negative stereotype. Conversely, the simplistic view of the role of a HV as ‘weighing babies’, resulted in little professional value being applied to the role; however, this was acceptable as a ‘nice’ thing to do.

These contradictory positions and the lack of a clear identity for prospective HVs to work from as a basis from the outset could be problematic. Perhaps, however, having to explain the complexity of the role to others might have been helpful in building their own identity through verbalising the scope and purpose of the role.

The responses of clients to the participants’ practice also appeared important in relation to identity. Although the lack of ‘plaudits’ from clients was pointed out as a difference between health visiting and other fields of nursing or midwifery practice, most of the participants identified ways in which positive feedback from their clients had contributed to their feeling that they had ‘made a difference’ and confirmed the way in which they practised as a part of their identity as a HV. For Clare this was clearly expressed in relation to strengths-based practice.
Clare: 371

“[The] mum of the child said – ‘oh thank you for everything you have done’ – and I said ‘well no actually I didn’t do anything’. She had all the answers in herself and she had done it all herself.

But she said ‘well actually unless you had asked those questions I wouldn’t have done it’.”

The participants came to the course with their own personal identities, and professional identities established in their previous roles. Jo spoke of the way in which her identity was no longer defined for others by what she wore.

Jo: 989

“When I used to put my navy blue dress on, or my uniform, people would know immediately who I was. And…. it wouldn’t matter initially whether I was any good at what I did, they would automatically give me a certain amount of respect, because of the uniform that I was wearing. But I am not wearing one now.”

For some their experience of being with families was derived from their personal experience as parents, rather than their previous professional roles. Part of their identity building was therefore to transition the way in which they related in that context from a personal to a professional basis. Recognising the difference in the basis of these relationships supported them in building an identity as a professional rather than a friend.

Dawn: 752

“I often would say – ‘well you know when mine were little’. And actually I try not to do that now […] I think it is more helpful to really concentrate on them.”

Clare tried to capture what it was about the public identity of the HV that encouraged parents to approach them rather than the GP. Putting the difficulty in getting an appointment with the GP aside, she described the relationship with the HV as follows:
Clare: 1236

“It is informal but professional. … you are nearer – on the same level…..professionally … you are more accessible I think, to them.”

From the data there were therefore many disparate elements that contributed to the participants building their identity as HVs. This was unsurprisingly influenced by elements from all three domains. In the initial stages of the study participants struggled with identifying what their ‘purpose’ would be as a HV. As they progressed through the year this seemed to become clearer for them, but making their identity in their new role explicit still appeared challenging.

6.5.2 Learning from Negative Experience

Participants identified many negative experiences in relation to Domain 1 of the conceptual framework. As a part of the planned delivery of the course, Domain 2, there were fewer negative experiences, but these still occurred. Here my focus is on how humour, hope, memory of past experience, maturity, and reflection and reflexivity contributed to the participants response to negative experiences.

Dawn observed that negative experiences could both enhance and ‘zap’ resilience, the path taken being determined by the way in which the experience was responded to or managed. Reflection was particularly important in this process.

Dawn: FG3 11

“It is what happens with that negative experience.
If you have a negative experience … that you are not supported in, you know I think that can be really detrimental. It can reduce your resilience and it can zap it away rather than build on it, so it is definitely the support that you get from that and the reaction and the reflection that you do.”

The inclination to reflect on the negative was identified by many with a lesser tendency to reflect on what went well. Although good experiences were recognised as having occurred they were not dwelt on. For Becky the experience of looking at her work with others had always been something she
disliked. Whilst she still found this difficult, she had learned over the period of the course to reflect openly with others and was finding this helpful.

Becky: FG3 12

“I have always been one of those people who hate people looking at my work when I am sat there. […] Now I feel more comfortable in saying to someone – ‘I didn’t do this’.”

Jess thought that self-esteem was a valuable resource in coping at times when clients did not value the intervention of the HV. At these times it would be important to be able to maintain perspective on her worth. Jess seemed particularly vulnerable in this respect, and it appeared at this early stage that her experience with her own HV dominated her view.

Jess: FG1a 16

“I think it’s [self-esteem] quite high particularly when you are working with people who don’t want to see you. And they are going to make you feel quite worthless – ‘what do you know’ yeh, ‘I don’t need [you] to come in’.”

A sense of humour was seen as a further essential survival mechanism, although Becky was clear that humour needed to be used with caution, a view also confirmed by others.

Becky: FG1a 24

“There’s a time and a place. I think if you don’t have a sense of humour then you’re just going to be ill, with things that you see, and hear.”

The issue of maturity was an interesting one. Holly, Laura and Jo referred to their age on occasions, apparently seeing it as a resource and evidence that they were resistant to the impact of some of the negative influences they experienced. The data do not obviously support this contention, but irrespective of age some participants exhibited a more mature approach to the challenges they encountered than others. Laura spoke of the need to be assertive when negotiating learning experiences.
Laura: 1249

“So I have had times when I have thought actually I don’t need to be doing another ‘three month visit’ …….. What I need to do is this. And it is then having the confidence to sort of say ….. actually this is what I need..”

Laura was able to take a mature approach to negotiating her way around these difficulties, but Jess found the stress in the team a barrier to telling her PT of the challenges she was facing with the course.

Jess 1023

“..at the time the team was quite ….. ‘stressed’ maybe is the word. And I didn’t want to be an added pressure for somebody. You know, and I thought this is just going to create problems for everybody. Because I thought everyone else is managing OK, so why am I not? I suppose. You feel a bit of a failure in yourself.”

The negative experience of learning how to practice in environments of high stress and low staff numbers was set against the fact that extra funds were being invested in increasing the number of HVs, leading to hope for a better future and a feeling of being fortunate in comparison with their colleagues in the wider NHS.

Katie: FG2b 16

“Then on the other hand … you can look at the whole big [picture], […] you kind of feel that everyone else is fire-fighting and treading water and they have got nowhere to go, because their services aren’t increasing numbers and they continue to talk about cutbacks. Whereas you feel like you have got an opportunity to actually be part of something that is going to get better. I am quite hopeful.”
Hope and optimism figured clearly in the way that the participants were experiencing their own feelings about the challenges in the role and their future within it. However, this was not blind optimism. The experience of some supported their optimism but Georgie found it difficult to be hopeful even though she wanted to be.

Georgie: FG2 17

“I suppose there is an element somewhere of hope. But I think that it is just difficult. At the moment I suppose it is just difficult to see the forest for the trees.”

Clare observed that optimism needed to be tempered with realism in order to be prepared for the challenges faced.

Clare: 978

“I think there is being optimistic and being realistic: they are slightly different really. You don’t want to be optimistic where you can’t see the challenges.”

In spite of the very many challenges that lay ahead, the participants were realistic and positive about their role at the end of the course, and were looking forward to moving into their roles as qualified HVs. For some they had planned resilient moves to help them manage anticipated adversity in their new posts. In response to her observations of colleagues’ stress, Dawn was thinking about what she needed to do in her remaining time as a student to protect herself in the future.

Dawn: 1283

“So I am trying to use my ten weeks to really look at how I am practising, and what I really need to work hard at, to make sure that I don’t have a crisis point. But again, it is not always easy to avoid that.”

Clare, who was moving into the same team as Dawn on qualification, commented that collecting her daughter from school would serve as a resource for her resilience.
Clare: FG3 45

“Going into that team, my daughter is going to be my resilient factor, and it affects me because I am going to have to leave and pick her up. And I am not going to let that impact on that, so I have already set that as a resilience thing really.”

Others had organised their preceptorship groups in advance, and Laura had set up an informal support network amongst the qualified HVs she had met over the year.

6.5.3 The Health Visitor as a Chameleon

In the first focus groups one of the questions asked in relation to expectations of the HV role, was how the participants thought the HV worked. Brigid thought of the HV as “a chameleon”. The dictionary definition of ‘chameleon’ identifies both the lizard that changes colour and a person who is changeable. ‘Changeable’ can suggest a degree of inconsistency or unpredictability, but the sense in which Brigid was using the term was to suggest the characteristic of adapting to the situation.

Brigid: FG1b 5

“I think you adjust your knowledge .. how you are going to share that knowledge with the family , to their understandings, and .. not that you are lying or putting on a facade but you adjust your behaviour, and your actions within a home that's required really.”

It was interesting that this characteristic of adaptability emerged so early in the study given the task-oriented perspective that prevailed in other respects. Variation across client groups and responses to situations was also recognised by many participants, and the observation that individuals and communities are not all the same was a frequently voiced sentiment over the period of the study.

Further to this Dawn observed that health visiting differed from other areas in which she had practised, in that it was not black and white in terms of what had to be done and how.
Dawn: FG2b 6
“...how black-and-white that [nursing /midwifery] role is really, ... Whereas the health visiting role is... it is nearly all grey.”

This required adaptability in the approaches to working with clients, which was clearly described by Becky.

Becky: 1494
“. it is working out how to say things differently. And you sort of have to judge their characters before you say it. So you know how to ... what road to go down to what you are going to say.”

In addition to the anticipated differences in clients’ needs and responses, the unpredictable nature of HV activity was also widely identified with examples given of the changing agendas according to emerging needs.

Georgie: FG1b 11
“So you might go in there thinking this is a routine new born check, but actually this person has what may appear to be some form of depression, or is having ..very severe issues with feeding...”

Laura and Clare both recognised that they naturally liked to work in a planned way but that this could be disrupted at any time. This was not something that they had anticipated in the role.

Clare: 578
“I like to know how everything is going and how it is all working. And then I came into health visiting and nothing really goes to plan!”

Laura: 1181
“Until the client throws a curved ball at you and you don’t actually get to say any of those things!”

The importance of the ability to adapt to changing situations was therefore a resource for resilience in coping with uncertainty and disruption during the working day. Further discussion took place with the participants regarding
flexibility. There was a recognition of the need for flexibility within the team in addition to the way in which the HV worked with clients, with an overall explanation of flexibility offered by Alice as being able to “adapt… to situations” (FG1a 20). Jess and Clare both spoke of working with colleagues who were not flexible and who resisted any change in the organisation.

Jess: FG2a 38

“(Imitating a colleague) ‘Oh we tried that before in 1952 and it didn’t work. (general laughter) And I will never talk about it again!’ ”

Jess felt that such a lack of flexibility could reduce the resilience of the practitioner in their role, possibly resulting in them leaving. Clare felt that it would be possible to learn to be more flexible, suggesting that if it is accepted that change will take place then flexibility can follow.

Clare: FG1a 21

“…if you’re accepting that actually it’s not going to stay the same then you can learn, I think you can learn to be more flexible, because you’ve got to be really haven’t you.”

This seems a critical, if not unsurprising, requirement in the promotion of resilience for HVs in the context of significant organisational change. Dawn, however, questioned whether there was a possibility of being too flexible, taking on too much to the detriment of wellbeing. This correlates with learning to say ‘no’ as identified earlier. Jo added to the way in which being too flexible might happen through wanting to be seen as part of the team.

Jo: 1414

“I wanted to be flexible and I wanted to be I suppose to be part of the team. But then at the time I did feel a bit …’oh god I have got to get this [report] right because it is going to conference.’ ……So, I [did] feel a bit of pressure, but I was able to get some help. So it wasn’t so bad in the end.”
As they developed their knowledge and skills over the course some participants observed that their mental agility in the role increased, something that enabled flexibility in finding alternative ways around situations when ‘in the moment’.

Clare: 1444

“You know, that ‘thinking on your feet’ is a bit better for me. You are not quite the novice and you are maybe [not] an expert – not a beginner or whatever.”

If flexibility is viewed as an orientation rather than knowledge or a skill, then the participants had not learned flexibility in itself. However, it can be suggested that their ability to harness this orientation was aided through the increased reflexivity of praxis.

A different dimension to adaptation emerged through the ‘imagination and creativity’ element of the conceptual framework. When discussing using creativity and imagination in practice, Dawn suggested that recognising and using individual personal attributes could help in finding different ways to communicate with clients and practitioners. She saw creativity in communication as key to getting people on board with new ideas.

Dawn: 1558

“I think creativity is also an attitude to life … And yes I think it helps me see things in a different way, or in different ways. ….. it is being able to talk about a clear vision in a creative way, because we don’t all see things in the same way. … I think creative thinking helps you manage that or get people on your side in a way.”

Although Becky did not recognise herself as a naturally creative person, she described how she used her imagination to ‘rehearse’ situations in advance, thereby helping her develop strategies to manage challenging situations.

Becky: FG3 34
“In my head, if I know I am going in to follow up a domestic violence incident, I will say to myself – how am I going to say this that is not going to make them clam up and go ‘ooh!’ ”

It would seem, unsurprisingly, that learning from experience with clients is transferrable to colleagues and the organisation. Equally, learning experienced in teams can be transferred to working with clients. However, this universality in the application of learning and experience across both faces of ‘practice’ is not made widely explicit, either in the students’ experience of their course or in their description of their experience of practice. Dialogue between action and reflection has been evident in the way that theory and practice are combined in practising, both in relation to ‘organisational’ aspects of the role and in the client oriented aspects. Working with clients is seen as practice and that activity as practising. Working in the organisational sense is seen as being ‘in practice’. In relation to the development of resources for resilience, it would be helpful to bring the two together, seeing the entirety as practice and all of the activity included in that entirety as practising in the HV role.

6.6 Summary

In this chapter the findings have been presented under headings relating to the domains of the conceptual web of learning for practitioner resilience, which corresponds to the stages of analytical resolution and abduction described by Danermark et al. (2002). Analysis has been grouped within three cluster themes for each domain, these having emerged from the content analysis. The domains and associated cluster themes were as described below.

Exposure to the HV role in the real context of practice (representing the ‘real’), with the associated cluster themes: identification of expectation and reality, challenges emerging from the structures and mechanisms, and social contributions to building individual and collective resilience.

The organisation of learning (representing the ‘actual’), with the associated cluster themes: starting points, scaffolding learning for resilience, and endings’
The experience of becoming a HV (representing the ‘empirical), with the associated cluster themes: creating an identity, learning from negative experience and HV as a chameleon.

A number of tensions between expectation and reality emerged:

- ‘Nice’ versus difficult and complex
- Continuity with clients versus limited contact
- Support in role versus lack of resource
- Broad public health work versus predominance of safeguarding

These tensions, linked with how the participants experienced the structures and mechanisms in the real context of practice, lead to a variety of examples of adversity in the professional role which were consistent with those areas identified by Nordang et al. (2010) Adamson et al. (2012), and Hunter and Warren (2014). These included an increased workload due to the decreased number of HVs, the concentration on work at the child protection end of the safeguarding continuum, frequent uninvited changes in the workplace location in response to service needs, organisational change through wider changes occurring within the NHS and increasingly target driven commissioning of services, a poor organisational culture with examples of disconnected leadership, and overt and sometimes extreme manifestations of stress in their qualified colleagues. The HVIP, though ultimately aiming to address the workforce issues, contributed to adversity through additional demands on an already overstretched workforce to support student learning, and through inadequate workspaces. In relation to the demands of the course, adversity was experienced through the combination of the high demands of the academic and practice workload.

Although the participants identified some negative personal impacts of adversity on them and on their learning experiences during their course, they remained predominantly positive about becoming a HV, demonstrating increasing commitment to the role as the year progressed. Ways in which the development of resilience was facilitated or threatened during the course are summarised in Figure 6.3 (overleaf). This is expressed as a force-field analysis (Lewin, 1951),
where resilience represents the state of equilibrium that can be pushed forwards or back by the strength of the opposing forces. The relative strength of the forces is not represented in this diagram, as the data did not accurately support this. Such a depiction through force-field analysis reflects the repeated reference to ‘balance’ throughout the participants’ narratives, which was applied to the balance in their own lives, achieving balance in the scope of their workload, and in helping clients to achieve balance in their lives. The notion of resilience as a point of balance, or equilibrium, therefore seemed appropriate.

![Figure 6.3: Summary of factors facilitating and obstructing learning for practitioner resilience](image)

The factors facilitating learning for resilience built an atmosphere of trust that allowed ‘openness’ to challenge and shared critical reflection to flourish. There was clear evidence of transformation in participants’ frames of reference, as exposure to socio-economic inequality lead to the challenging of deeply held norms and beliefs. This acted to confirm motivation to ‘make a difference’ in the lives of their clients, and contributed to the development of a positive identity, a key learning experience in building resilience. Individual participants also recognised other significant change in their identity and behaviour.
Relationships between individual and collective resilience emerged as the influence of resilience of individual members of the team on overall resilience was identified. The notion of collective experience of adversity (Bottrell, 2009) appeared to be confirmed across many of the HV teams; although differing resources for resilience, principally leadership and team dynamics, influenced the variation in response. ‘Herd immunity’ was a metaphor used to describe the relationship between individual and team resilience, and the concept of ‘pulling through’ adversity was applied as a social process of resilience. Give and take, reinforcement of positive behaviours, and socialising together, were also behaviours that supported team resilience.

The following chapter discusses the data relating to expectation and reality in the HV role, including through the process of retroduction, the analysis of cross cutting concepts abstracted from the data that appear central to learning for resilience. The discussion is placed in the context of resilience and transformational learning literature, and facilitates the web of learning for resilience to be revised.
7. Discussion

7.1 Introduction

The previous chapter presented an analysis of the data collected from the focus groups, semi-structured interviews, and course documentation. Four tensions were identified between the participants’ expectations of the role and reality. Three of these were associated, in part at least, with the low numbers of qualified HVs in practice. The fourth tension related to complexity and ‘difficult’ work. Experience of adversity was identified from the data, including excessive workload and stress in HV teams, impact of these conditions on the participants’ learning experience in practice, and a predominance of high risk safeguarding work. Adversity was also experienced through the culture of teams and the wider organisations, and through the demands of the course. Participants demonstrated individual resilience in the face of this adversity and remained predominantly positive about their new roles. A number of facilitators and threats emerged from the data regarding the contributions of learning to building the participants’ resilience. These were summarised in Figure 6.3.

There was evidence of transformative change in the participants over the period of the course, this being most clearly demonstrated in their beliefs about socio-economic disadvantage and inequality. An increased ‘openness’ in the participants emerged associated with willingness to challenge and be challenged, resources that support adaptability and resilience in practice. Participants also recognised change in relation to their confidence, professional identity, and authenticity in their role.

This chapter builds on the previous analysis, through the stages of retrodution and critical analysis and synthesis, in relation to abstracted concepts from the data (Danermark et al., 2002). Initially, the research aims are re-stated and the research questions linked with the themes emerging from the data analysis. Findings associated with the research questions are then discussed in the context of previous research in order to identify consistency and inconsistency.
As previously identified the definition of resilience from which I worked through the study was that of Ungar (2011)

“In the context of significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural and physical resources that sustain their wellbeing, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways.” (Ungar 2011, p.10)

It is “a set of behaviours over time that reflect the interactions between individuals and their environments, in particular the opportunities for personal growth that are available and accessible.” (Ungar, 2012, p.14)

This was contextualised with the definition of McCann et al. (2013) of practitioner resilience as

“the ability to maintain personal and professional wellbeing in the face of on-going stress and adversity” (McCann et al., 2013, p.61).

Concepts of identity, openness, authenticity, confidence and flexibility were abstracted from the data as they linked with a number of learning experiences and structures and mechanisms encountered by the participants during the course. These concepts recurred throughout the data and appeared key to TL for resilience. The discussion is further developed through inclusion of wider theoretical literature and recent research relevant to practitioner resilience.

Messiness and complexity are recognised in the real world of education practice (Cohen et al., 2007), but the reality of managing this messiness through this discussion chapter has been challenging. Using a critical realist framework helped me to recognise the complexity of non-linear causation emerging through the interaction between the three domains of the conceptual framework. The challenge was how to present a coherent discussion of the concepts and theory involved when their application crossed domains. This felt like a game of 3D noughts and crosses with the additional dimensions of explaining what the noughts and crosses represented, and how they compared
with noughts and crosses in other games. My initial attempts to simplify this representation led to a new layer of classification that lost the links with the study data, and caused confusion. I decided to present the discussion in the same sequence as in Chapter 6, although this meant that concepts, for example professional identity, were applied in more than one domain. Explanation of concepts is included where they first occur, and is built upon as the discussion progresses. I have tried to promote cohesion through sign-posting overlaps. The discussion begins by defining learning and is then structured around the three domains of the conceptual framework before examining the way in which TL is identified through the data as an appropriate framework for the process of learning for resilience. Finally, a revised web of TL for resilience is presented.

7.2 Addressing the Research Aims and Questions

The overall aims and research questions of the study are re-stated below, and the extent to which they have been addressed is illustrated through the ensuing discussion.

Research aims:

1. To explore how learning in both university and practice settings contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the HV.

2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.

3. To explore the relevance of the application of TL principles to curriculum design in order to support the development of resilient practitioners who can respond to the adversity encountered in practice.
Research question:

How do student HVs’ experiences in higher education and practice settings contribute to the development of their capacity to respond to the tensions between expectation and reality in their practice role?

Sub-questions:

i. What personal resources do student HVs see as necessary to their ability to manage the tensions in expectations in practice?

ii. How do students’ experiences in the university and practice build their resilience to the change in role expectations?

iii. What experiences do student HVs identify from the university and the practice environment that have facilitated or obstructed the development of their capacity to respond to the reality of practice?

iv. What is the relevance of TL principles to students’ learning to build resilience?

Table 7.1 maps the research questions against the original categories of the conceptual web of learning and the cluster themes emerging from the analysis, demonstrating that the data collected through the study contributes to the study’s overall aims and research questions. The overlap of data across the research questions and domains of the framework confirms the interaction between the domains of the real, actual and empirical, and the notion of non-linear causation in the complex arena of professional education.
Table 7.1: Relationships between conceptual framework, emerging themes and research questions

<table>
<thead>
<tr>
<th>Domain</th>
<th>Element of conceptual framework</th>
<th>Cluster theme</th>
<th>Links with research questions</th>
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</thead>
<tbody>
<tr>
<td>Real: Structures and mechanisms in the context of practice</td>
<td>Adverse experience</td>
<td>Identification of expectation and reality</td>
<td>Research Question (RQ) Sub Question (SQ) ii. iv.</td>
</tr>
<tr>
<td>Wider socio-economic context</td>
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<tr>
<td>Team dynamics</td>
<td></td>
<td>Challenges emerging from the structures and mechanisms</td>
<td>RQ, SQ ii, iii</td>
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<td>Moral and ethical codes</td>
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<td>Peer support</td>
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<td>Social contributions to building individual and collective resilience</td>
<td>RQ, SQ i, ii, iii, iv</td>
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<tr>
<td>Team dynamics and coping mechanisms</td>
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<td>Supervision</td>
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<td>Work-life balance</td>
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<td>Actual: Facilitation of transformative learning</td>
<td>Self as a foundation for learning</td>
<td>Starting points</td>
<td>RQ, SQ i, ii</td>
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<td>Sensitise</td>
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<tr>
<td>Create knowledge</td>
<td></td>
<td>Scaffolding learning for resilience</td>
<td>RQ, SQ i, ii, iii, iv</td>
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<td>Take Action (including Active learning)</td>
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<td>Promote critical self-reflection</td>
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7.3 Definition of Learning

The research aims and questions refer to sources of learning, and it is therefore necessary to identify what I understand by learning. Learning can be understood as acquisition or as change; in TL terms the focus is on change. This is consistent with learning as a process for developing resilience. Jarvis (2009) has refined a definition of learning over several decades, which emphasises that the ‘whole person’ is involved in learning and that learning takes place ‘in a social situation’.

‘Human learning is the combination of processes throughout a lifetime whereby the whole person – body (genetic, physical and biological) and mind (knowledge, skills, attitudes, values, emotions, beliefs and senses) – experiences social situations, the perceived content of which is then transformed cognitively, emotionally or practically (or through any combination) and integrated into the individual person’s biography, resulting in a continually changing (or more experienced) person.’

(Jarvis, 2009, p.25)

Professional education contributes a ‘snapshot’ of learning in the span of a lifetime, and takes place in a whole system that includes the formal contexts of learning in addition to the wider organisational and social contexts of the individual learners. This conceptualisation of learning fits with an ecological perspective on resilience (Ungar, 2012) and the requirement for modern professional education to include opportunities to engage with change in practice (Lee and Dunston, 2011). Illeris (2014) offers a more concise definition of learning that is similarly inclusive:

‘Any process that in living organisms leads to permanent capacity change and which is not solely due to biological maturation of ageing.’

(Illeris, 2014, p.33)

Both definitions encompass the ‘wholeness’ of learning as a change process reflected in my research aims and questions, and in my conceptual framework. They take learning beyond the cognitive position widely viewed as favoured by
Mezirow, to include sociology, psychology, spirituality, and neuroscience, which are now recognised as influences within TL (Tisdell, 2012). They also suggest the ordering of causal powers and mechanisms involved in the process of learning through the strata of critical realism, although it was beyond the scope of the data collection for this study to drill down to the biological strata and beyond.

7.4 Exposure to the Health Visitor Role in the Real Context of Practice

7.4.1 Identification of Expectation and Reality

At the beginning of the study the participants had an expectation of what they would be doing in their role as a HV. This is summarised in Figure 7.1, which indicates the strength of expectations across the sample.

![Figure 7.1: Participants’ expectations of their role as a health visitor](image-url)
Although safeguarding was identified as a key part of the role, in common with Poulton (2009) health promotion was the highest rated factor in the motivation to become a HV. Routine family support was as widely anticipated in my study as work related to the safeguarding of children. These expectations are mirrored by Whittaker et al.’s (2013) study investigating the recruitment and retention elements of the HVIP.

In the study by Whittaker et al. (2013), as here, ‘making a difference’ was identified as a key motivation for the HV role and was seen as being

‘Connected with improving life chances, enhancing child and family health, preventing ill-health and other problems, protecting children and assisting vulnerable people.’

(Whittaker et al., 2013, p.54)

The expectations of the HV role of participants in my study were task focussed, and in the first focus groups there was little indication of understanding of the complexity of the relational aspects of the role or its challenging demands. Whittaker (2011) in a recent study of social work identified that Menzies-Lyth’s (1988) seminal work on anxiety and defences in nurses, still had currency. One of the social defences identified by Menzies-Lyth involved denying the importance of relationships, and a mechanism used within this defence was task allocation across the whole of a patient group so that nurses did not need to respond to the holistic needs of the patient. Although the context of her work was ward based and set in a different social era, Whittaker’s (2011) work demonstrated currency of this idea in relation to social work. The risk of distancing self from clients similarly threatens the veracity of the HV role. This highlights the importance of helping students manage the relational aspects of their role through developing capacity to respond to the stress and anxiety they experience.

**Reality in the Practice Environment**

Practice placements quickly exposed significant organisational pressures and stresses in the reality of the HV role. The demands of the HVIP added to the
pressure, and the organisational context was seen as impeding the wider public health role of the HV.

Mismatch between the expectation and reality of midwifery practice was similarly recognised as a source of stress by Hunter and Warren (2014), where situations of excessive workload, insufficient staff, and stressed colleagues, contributed to adversity experienced. Organisational issues were also implicated in the findings of Whittaker et al. (2013) regarding the influence of balance between autonomy and managerial support on motivation to stay in the role, and by Hunter and Warren (2014) regarding limitations on professional autonomy imposed by organisational control of practice activity. Consistent with the findings of Gu and Day (2007) the issue of a target driven service emerged from my data as a threat to resilience. Aranda and Hart (2014) further confirmed that lack of continuity in relationships and of ability to respond to individual need outside the parameters of the commissioned service, caused practitioners to feel overwhelmed and demotivated. Adamson et al. (2012) identified a similar combination of influences, including organisational support, on practitioner resilience across the organisational system. Ungar’s (2008) ecological model of resilience goes some way to addressing this, though this suggests a bounded rather than an open system.

**Previous experience of the Health Visitor Role**

The differences between the participants’ expectations and the reality of the role were often rooted in personal experience of HVs. This was demonstrated in my study, where on-going supportive contact with clients was not reflected in the reality of the role. In Whittaker et al.’s (2013) study, although student experience in this area was not explicitly examined, data from the qualified HVs also identified a lack of continuity with clients. In my study participants reported shock at the true nature of their involvement with families. For example it was a revelation to one of the participants that her HV would have known of her involvement (as a parent) with the child protection system as a result of her mental health problems. However, shock at the circumstances of some families was also reflected in the data from HV SNs who had worked for a prolonged period within a HV team. This was surprising and contrary to Whittaker et al.’s
suggestion that exposure to the HV role prior to application would give students a more realistic perspective.

**Practice Influence on Creating Identity**

Creating identity was a theme emerging from the conceptual framework, and confirmed a strategy for building resilience identified by Beddoe et al. (2013) and McAllister and McKinnon (2009). Section 7.6 later in this chapter discusses data relating to “The experience of becoming a HV”. The influence of the ‘context of practice’ being considered here also had a part to play in building identity, as initial exposure to differences in expectation and reality provided key experiences in its early development.

Jarvis’s (2009) definition of learning (detailed in Section 7.3) incorporates identity development as part of the changing biography of individuals. Illeris (2014) acknowledges the differences of opinion concerning the conceptualisation of identity; however, in his recent work he argues that it is identity that is being transformed through TL and describes it as follows:

‘..the identity comprises both how one experiences one’s self, one’s qualities and properties, and how one is experienced by others and therefore the concept of the identity includes both the self and the personality and something more that is due to the connection between the internal and external experience.’

(Illeris, 2014, p.38)

This recognises that identity is assimilated between self-identity and the identity of the self from others’ perspectives. Students’ learning can result in a change in how they see themselves, and also in recognition of how others see them.

The participants identified that qualified HVs had differing views of their role. Machin, Machin and Pearson (2012) observed that such role confusion is exacerbated through policy and regulatory change. At the time of this study clear parameters of HV proficiency as a basis for professional identity were defined within the professional standards (NMC, 2004) and further illustrated through the HVIP. The NMC (2004) standards define four domains of HV
practice that are mapped against ten key principles for public health practice, and prescribed activity against each of these principles provides the basis for proficiencies to be met for professional registration (Appendix 15). These proficiencies were not immediately evident in practice beyond the level of individual client contact.

The influence of shifting organisational and policy influences on professional identity is confirmed in Wiles (2012) study with social workers. She identified three streams of construction of professional identity. The first was through a series of traits. The second was ‘shared identity with other social workers’; reflected in this study as potentially problematic as my participants could not see what the shared identity of the HVs was. The third stream was ‘a process of individual development’ (Wiles, 2012, p.857). From the third stream she identified the need for social workers to ‘develop a personal sense of being a social worker’ (p.864). This was equally true for the HV students in this study, and is explored further later in this chapter (Section 7.6).

**Impact of the Physical Environment**

Adversity was evident in the data through the impact of larger staff numbers and the re-organisation of services resulting in change to physical work environments. From an organisational point of view, hot-desking was likely to have been seen as promoting flexibility in the work environment and maximising space resources. However, issues of a crowded workspace and hot-desking were identified by the participants in this study as being stressful and threatening the opportunities for social interaction within the team.

In the study by Whittaker et al. (2013), managers identified that the amalgamation of many teams in one location was problematic in relation to promoting a positive culture that accommodated social interaction. The availability of managers and their ability to promote an empowering workplace environment has also been identified as an issue when the span of the control of leaders is too large (Lucas, Laschinger and Wong, 2008). In some instances in the study by Whittaker et al. (2013), managers were artificially creating ‘team time’ for individual teams in order to address the issue. Restorative supervision
has recently been promoted as a specific model for fostering relationships between colleagues through social interaction (Wallbank and Woods, 2012). Recognising these issues is important learning for both students and qualified staff, and offers the opportunity for the promotion of resilience as an organisational outcome, rather than an individual responsibility. It would be unexpected for students to challenge the organisational structure whilst undertaking their course, but if the ultimate outcomes of TL are achieved then they should in future be able to engage in challenging organisational practice in the interests of the resilience of the workforce.

This examination of data relating to expectation and reality has confirmed that students experienced adversity across the whole system in which they were being prepared for their role. Establishing this context was important in responding to the research aims and questions, as the existence of adversity relating to expectation and reality could not be assumed.

### 7.4.2 Challenges emerging from the structures and mechanisms

**Socio-Economic Inequality: Implications for Learning and Professional Identity**

‘Making a difference’ was a widely stated motivation for coming into health visiting, confirming the findings of Whittaker et al. (2013). Skovholt (2012, p.49) observed that:

> ‘Being drawn to working with people often involves the day-dream of making a difference in the lives of others.’

As a part of building their professional identity it was important that the scope of ‘making a difference’ was realistic rather than idealistic (Skovholt, 2012). Being realistic in their optimism around the HV role was specifically identified by Clare and was evident through others’ references to starting a ‘ripple’ effect. Using reflection to recognise small gains was identified as a source of learning in this respect and an important outcome of learning for resilience. In addition Skovholt
(2012) suggests that realism acts to lower stress indicating its contribution to promoting resilience.

Participants had limited awareness of socio-economic inequality at the outset, so although they wanted to ‘make a difference’ they had a limited understanding of the reality of what they would make a difference to through their public health role as HVs. Exposure to socio-economic inequality in practice was a significant source of learning in this respect, and challenged participants’ norms and beliefs. This related not only to clients in poverty but also to those at the other end of the socio-economic spectrum who Jess had assumed would not have problems. This exposure made real what they needed to ‘make a difference’ to and contributed to their identity within the HV role.

It is interesting that the lived reality of inequality was such a shock to these students, as they would have had teaching in their pre-registration programmes about inequality, and observed variation in the circumstances of clients and patients in their previous practice. This may have been due to the defence of detachment observed by Menzies-Lyth (1988) as being taken to extremes in avoiding anxiety through patient contact. Personal-professional boundaries are recognised as supporting practitioner resilience (Adamson et al., 2012), but it is striking in Wendt, Tuckey and Prosser’s (2011) work that the balance between healthy engagement with clients’ adversity and unhealthy detachment is challenging. The suggestion of balance was frequently alluded to by participants, and is further confirmed by Kinman and Grant’s (2011) conception of empathetic concern and empathetic distress.

Hunter and Warren (2014) found that midwives also referred to ‘making a difference’ at both the individual and broader societal levels, although in their study this was associated with an undefined ‘public good’ rather than with socio-economic inequality. Dawn identified that as a midwife she was ‘in and out’ of a house and never really understood the depth of what was going on, suggesting that the focus of ‘making a difference’ can vary even between health professionals.
Hart, Hall and Henwood’s (2003, p.485) model of an ‘inequalities imagination’ supports the place of ‘cultural encounter’ in challenging norms and beliefs regarding disadvantage, and understanding the client’s perspective within this. The model, which reflects a TL approach, identifies six areas of learning in relation to inequality, ‘awareness, skill, action, encounter, knowledge and analysis’, that are placed within the overall context of ‘equalities desire’, with this last denoting an authentic motivation to address issues of inequality in practice. ‘Encounter’ encapsulates the experience of the participants through their initial and continuing exposure to inequality, and ‘awareness’ is the opportunity this affords them to re-examine their assumptions and beliefs. The ‘inequalities imagination’, they suggest, is central to recognising tacit knowledge in these areas and relating it to underlying structures and mechanisms. Imagination allows a student to see the situation from the client perspective. The application of the model also pushes students, through the dimension of ‘action’ to look at the part they play in challenging structures that promote inequality, the social action component of TL. In Hall and Hart’s (2004) work the model was implemented through a specific structured reflective activity in the classroom. Here exposure to the reality of socio-economic inequality in practice provoked significant reflection, both in relation to the clients’ experience and to understanding the participants’ professional responsibility and identity. The level of authenticity in participants ‘equalities desire’ at the outset of this study was difficult to gauge, but what was clear was that this was increased through encounters with the reality of disadvantage. Using the structured approach of Hall and Hart (2004) could make this learning more overt and enable students to self-assess the authenticity of their equalities desire.

Experience of Adversity in Practice
Unsurprisingly, in common with the literature regarding practitioner resilience across the disciplines (Jackson et al., 2007; Castro et al., 2010; Adamson et al., 2012; Hart et al., 2012; Gu and Day, 2013; Hunter and Warren, 2014) stress, as a consequence of excessive workload demands, constituted adversity for qualified HVs in practice. In the current study the stress on qualified members of
the HV team had both direct and indirect implications for the learning of the students. Witnessing the manifestation of stress constituted adversity as the participants observed first-hand the negative impact that the role was having on their colleagues and had to face the reality of the implications for themselves in the HV role.

The stress of the excessive workload of HVs also impacted on the students’ learning through practice experiences made available to them. This was evident through using the students as ‘an extra pair of hands’ and HVs displacing activity to the student to relieve their own workloads, regardless (the participants perceived) of how appropriate it was to the students’ learning. Additionally this reinforced the lack of continuity with clients as activity was allocated on a task-oriented basis. It was also evident through reluctance to provide learning opportunities, minimising their importance, and limiting the time allocated to students (see Laura in Section 6.3.3).

The marginalisation of students’ learning needs by other qualified members of the workforce might be interpreted as organisational aggression, which was identified by Jackson et al. (2011) in their study of student nurses. In that study the ‘aggression’ was overt, with clear antagonism being displayed towards students and an evident lack of respect for their views. However, more subtle ‘aggression’ was perhaps suggested in this study through diminishing the importance of practice experience that was key to the wider public health role of the HV, and through prioritising individual need for help with workload over learning for the students. This was compounded through qualified HVs questioning the preparedness of these HV students to take on the role in the future, whilst at the same time placing expectations of change in service delivery at their door. The participants experienced anxiety from this, questioning whether the wider system was adapting to support the process. This behaviour appeared to come in the main from HVs in the wider teams, rather than from PTs, although in some instances the PTs who were also team leaders or undertaking the PT course themselves were identified as having limited availability to the participant.
Becoming more Flexible and Adaptable

Flexibility has been associated with resilience (Hodges et al., 2005; Jackson et al., 2007) and identified as an outcome of transformational learning (Mezirow, 2009; Taylor, 2009). The organisational expectation of ability to adapt in the context of change encountered in the modern workplace has also been identified (Clegg, 2005; Illeris, 2014). Flexibility was referred to in a number of ways in the data, including ‘thinking on your feet’, adjusting to the needs and abilities of the client group, finding that what was planned at a client contact was not what needed to happen, fitting in with the needs of the HV team, and adapting approaches to change in order to get colleagues on board.

The difference between expectation and reality meant that the participants had to adapt from the outset. This need became evident through the complexity and unpredictability of practice, which exposed participants to reality whilst also providing learning experiences to support development of flexibility. Their task focussed approach when they started the course allowed little flexibility in how participants expected to manage client contacts. Recognition that this perspective meant that they were ‘just skimming along the top’, came through exposure to families and observing the way in which their PTs and mentors role modelled their response to the emerging needs of a family. The students learnt to adapt to the client agenda according to emerging need. This was a challenge to students who liked to know what was going to happen in order to prepare a response, but as they became more able to ‘hold’ knowledge and a repertoire of responses in their head, they became more able to adapt to the clients’ needs. This, perhaps unsurprisingly, suggests an increased vulnerability from inexperience in students that is at odds with Gillespie et al.’s (2007) finding that years of experience in practice was not correlated with resilience. Equally, flexibility related to the way in which participants were able to adapt to the work environment and the dynamics within their teams and organisations was also important. The influence of leadership and the context of change also demanded flexibility, and as Clare identified, was something that had to be achieved. Flexibility in the team and the organisational context was as much a part of their ‘practice’ as working with their clients.
Openness and Authenticity

Associated with flexibility were notions of openness and authenticity. From the data ‘openness’ appeared to relate to being open to change, to seeing and hearing what was going on with colleagues and later as a leader, to challenge self and others, and to building trusting relationships; all of which were felt to support practitioner resilience. The external need for honesty and trust between peers, colleagues and managers, as well as clients, was implicated in achieving this state of openness. Internal honesty with self was described by Dawn as authenticity in her role, a personal acknowledgement of an honest connection between her values and her identity. Feelings of authenticity were also reflected by others, including Brigid who identified that her knowing of ‘self’ was increased through her learning on the course. Placing this learning in the context of structures and mechanisms seems to have some resonance with Kreber’s (2010) observation that authenticity is not just inward looking, but has an outward dimension towards the social context in which the individual is situated. Cranton and Carusetta (2004) also defined authenticity as more than openness, seeing it as socially situated with a relational component that involves caring, relating to, and helping others.

Importantly for clients’ experience of health visitor contact, Whittaker et al. (2013) identified that high levels of adversity diminished HVs’ ability to be open to hearing what clients were trying to say. The structures and mechanisms associated with openness, identified from my data as peer support, team dynamics, supervision, moral and ethical codes, and the wider organisational context are all important in supporting practitioners’ resilience and maintaining their ability to sustain compassionate relationships. Gustafsson et al. (2009) however, identified an interesting need for balance between openness to change and realism. In their small pilot study with twenty healthcare workers, they identified that individuals can be too open to change, becoming engulfed in unrealistic ideas that can never be achieved. This in turn can lead to stress and anxiety, and feelings of failure, confirming the links observed by Skovholt (2012) between realism and stress, the observation made by Clare regarding the need for realism in maintaining resilience, and Dawn questioning whether individuals
can be too flexible.

7.4.3 Social contributions to building individual and collective resilience

Negative organisational culture and excessive work demands meant that the PTs and wider HV workforce were also vulnerable. In a sense, this is reflected in the narrative of Whittaker et al. (2013, p.73) regarding the emotional capacity to deal with the demands placed upon HVs referred to in the previous section.

“Please don’t tell me anything that I don’t .. because actually I haven’t got the capacity to deal with it”.

Although this was said in the context of an interaction with a client rather than a student, it may have relevance in both contexts. The behaviour of the qualified staff towards students in this study could also be indicative of resilient moves (Hart et al., 2007), the safeguarding of their own wellbeing in response to a shared experience of adversity (Bottrell, 2009). Interestingly Hunter and Warren (2014) comment that their data did not illuminate the nature of ‘protective self-management’ (p.7) in their participants, noting that this could have been perceived by colleagues as ‘emotional withdrawal or evading responsibility.’ In this way one person’s protection could perhaps undermine another’s resilience. ‘Deviant’ resilient behaviour, Bottrell (2009) suggests, can become embedded in organisational culture. In the same way it could be suggested that ‘positive’ resilient moves can be embedded in organisational culture, supporting her proposition of a social theory of resilience (Bottrell, 2009). The way in which students are responded to in practice has significant implications for persisting in the role, and Whittaker et al. (2013) clearly express the view that the period of the course constituted a prolonged interview during which students decided whether or not they would remain. Promoting resilience to facilitate their journey through the course therefore becomes a practical, as well as a moral imperative for educators in the university and in practice.

Concentration on high risk safeguarding work in practice constituted adversity through disrupting the balance in work activity and precluding health promotion
work with either individuals or communities. The potential adversity when working in child protection was confirmed by Kinman and Grant (2011) in their work with social work students, through recognising the difference between empathetic concern and empathetic distress. Although Kinman and Grant (2011) observed that social workers experience higher levels of workplace stress than others in the helping professions, participants in my study felt that the HV role currently being enacted was more akin to social work than to a proactive model of public health, though they clearly did not carry the same statutory responsibility as social workers.

In this study the domination of high-risk work presented challenges for the qualified staff in terms of supervision and the emotional and practical demands of child protection. For the students it additionally presented an environment where they were not naturally exposed to normal child development and the routine problems presented in everyday parenting that they needed to be able to work with in their future role. Seeing ‘the normal’ became a contrived learning activity, and contributed to the difficulties in being used as ‘an extra pair of hands’ as already identified. Students became actively involved in child protection work during their course, as this was the nature of practice, so were challenged to cope with the emotional and practical demands this placed upon them. At times, this was a negative experience due to a lack of support or inappropriate responses from practice colleagues. Taking this in combination with Kinman and Grant (2011) findings of empathetic and wider psychological distress in social work students and their observation that this correlated with lower levels of resilience, the context of safeguarding practice can be seen to constitute potential for adversity in practice and consequently present challenges to students’ resilience.

Participants also reported experience of adversity from the demands of undertaking the course. It is surprising that this source of stress did not figure more highly in the discussions with the participants, as past research has indicated high levels of stress in students studying for roles in the helping professions (Home, 1997) and past experience as a HV course leader confirms this. This omission may be more indicative of particularly high levels of stress
being present in the workplace that dominated the picture rather than lower levels of stress associated with the course. Collins, Coffey and Morris’s (2008) study examined stress experienced by student social workers and found very high levels to be present. These were largely attributed to the academic and practice demands of the course and the assessments, rather than to the influence of the organisational context. Whilst the former is not surprising, by contrast organisational context appeared to present significant additional adversity to the participants in this study. Given the changing landscape of practice identified, this would appear to be a continuing area of concern to educators for professional practice for the foreseeable future.

**Social Processes in Building Openness**

The domination of social processes in building openness was evident in the data (7.4.2.4). It was identified in Chapter 3 that Bhaskar (1989) viewed the relationship between the individual and society as dynamic, and one in which the human agency of individuals contributed to either reproducing or transforming society (Collier, 1994). Figure 7. (overleaf) presents an adaptation of Bhaskar’s original figure (Figure 3.1) applied to upward and downward causation in building openness. It represents the way in which the social mechanism of peer support socialised the participants as individuals, who in turn through individual agency, fed back into the social structures and mechanisms that supported their resilience. In this case participants contended that their openness ‘transformed’ social structures, building a climate in which it was safe to trust others, and to challenge and be challenged by them. In the example in Figure 7.2 informal support mechanisms are identified, but the structures and mechanisms of peer support, team dynamics, supervision, and learning contexts of PBL groups and action-learning sets, which contributed to building openness could equally well be applied.
Figure 7.2: Upward and downward causation in social processes building openness.

Adapted from Bhaskar (1989, p.36)

Trusting environments were necessary in both practice and in learning contexts in the university. In the university, PBL groups and action learning sets (ALS) created environments where self-disclosure was possible and existing frames of reference could be challenged. Informal social spaces during the day when participants could meet and talk were identified as critical to capacity to deal with the demands of the course, the difficulties they experienced in practice, and balancing the demands made upon them from multiple directions. In these spaces participants identified a shared experience of adversity (Bottrell, 2009), and it was evident that they felt they were there for each other no matter what. This echoed the findings of Bolzan and Gale (2011) whose work with disadvantaged young men found that shared experience and support bolstered their resilience.

Building trusting relationships with clients was a positive experience for students included in the study by Whittaker et al. (2013), and is reflected in the impact of positive relationships with pupils on teacher commitment and motivation (Gu and Day, 2007). It was also reflected here, as participants recognised the need to be open with clients in order to be trusted with information about their lives, and this affirmed their value in the HV role. However, they also found that the
more open they were, the more they were trusted with ‘difficult’ information that they then had to deal with, so the greater the test of their resilience. Being open was also valuable in engaging with clinical supervision, itself a resource for resilience.

**Emotional Intelligence and Leadership**

The emotional intelligence (EI) of individuals is summarised by Salovey et al. (2002, p.611) as:

> ‘The skill with which they can identify their feelings and the feelings of others, regulate these feelings and use the information provided by their feelings to motivate adaptive behaviour.’

EI therefore supports individuals in managing demanding and stressful situations. Kinman and Grant (2011) found that highly developed social and emotional competence, including dimensions of EI, contributed to resistance to stress in social work students. Jackson et al. (2007) also support EI as a resource for practitioner resilience. These findings are confirmed, at an individual level, in this study. Further, emotionally intelligent leaders were seen to nurture resilience in their staff.

Participants identified the influence of leadership on the resilience of the team and themselves, making connections between the responsiveness of leaders and their engagement with what was really going on, their willingness to include staff in decision-making about service delivery, and their style of communication with their teams. Some experiences of leadership were positive, and these were linked with positive orientations to the role and happier working environments. Others identified that poor leadership impacted on individual resilience and the resilience of the whole team, appearing to compound rather than relieve stress. For example, Dawn’s comment that the poor handling of a negative learning experience had the potential to “zap” resilience, consistent with Gu and Day’s (2007) observation of lack of affirmation by leaders as a source of adversity. Emotionally and socially competent leadership allowed participants and their colleagues to feel valued, and to contribute to decision-making. This unsurprising finding is supported by the work of Lucas et al. (2008), who...
examined the EI of nursing leaders against work empowerment theory. Their findings supported strong relationships between the EI of the leaders and the creation of empowering work environments. One of the identified outcomes of the model of empowerment used was a reduction of stress in the workplace, demonstrating links with practitioner resilience. Additional outcomes of the empowerment approach included commitment to the professional role and job satisfaction, both factors linking with motivation and thus resources for resilience.

7.5 The Organisation of Learning

7.5.1 Starting Points

Motivations for the role included the opportunities for further education and the chance to move into a new field of practice. Moving was attributed to a number of sources, stress within the old role, inability to work in a way that fitted with personal philosophies of care, or having been in a role for a long period of time. Also acknowledged was the perception that the HV role would be more family friendly, although this was said not to be the main motivation. For many, the impetus to change had come through receiving a national communication to all nurses with their payslip, regarding HV student sponsorships resulting from the HVIP. Some of the participants had never considered health visiting prior to this communication. Poulton (2009) found that career advancement was a motivation to become a HV, but change rather than advancement was evident in the data collected here. Whittaker et al. (2013) found that students were not optimistic about opportunities for career progression, and that is reflected to an extent here, as Laura felt quite strongly that the existing HVS would be moving into the ‘interesting’ jobs and that the current students would be left with everything else. Although not explicitly stated, the opportunity to study for a funded Masters course may have influenced the move into health visiting for some, and this could have benefits for career advancement.
At the outset participants found it difficult to articulate what their ‘purpose’ would be as a HV, a further resource for resilience identified in the literature review. Table 2.4). They also admitted that they did not fully understand the role, and the differences in expectation and reality that quickly emerged further clouded the picture.

**Motivation and Identity Development**
Initial motivation for the role and the past experiences of the participants provided the starting point for identity change as a component of learning to become a HV. Skovholt and Rønnestad’s (2011, p.40) perspective on the ‘pre-training’ phase of professional identity development, suggesting that individuals approach the role from a lay perspective drawing upon their own knowledge and experience rather than a professional approach, resonates with my findings. Skovholt and Rønnestad (2011) go on to suggest that individuals subsequently move through the training phase in which they follow rigid patterns and ‘jump through the hoops’ required to qualify. Post-training they move away from this rigidity and become more self-directed. This was also consistent with my findings and reminiscent of Benner’s (1984) novice to expert continuum. The ‘hoop jumping’ was reflected in issues of power implicit in my data. Participants were however questioning their experience and making active choices regarding what they took into their own individual style.

**Challenges to the Development of a Positive Professional Identity as a Health Visitor**
Challenges to establishing a positive identity as a HV were exposed through the data in relation to the clarification of what the HV role actually was, the definition by other professionals and the public of the role (including negative views), and a consensus on identity within the body of HVs. The development of positive identity has been established as contributing to practitioner resilience (McAllister and McKinnon, 2009), so the experiences of the participants that allowed them to respond to these challenges and supported their identity development are clearly important in learning for resilience.
Machin et al. (2012) presented a model depicting a Role Identity Equilibrium Process (RIEP) derived from a grounded theory doctoral study with 17 qualified HVs in the UK. In congruence with the current study, Machin et al.’s (2012) research noted HV identity confusion at both the individual and collective level amongst HVs and in the public dimension. The negative impact of this confusion contributed to adversity in practice. Reflecting the organisational component of the structure and mechanism domain of the conceptual web of learning, the RIEP discriminated between three levels of influence on the public identity of the HV: national organisational level, local organisational level, and interaction at the service delivery level. These levels of influence are also evident in this study, as the HVIP policy and NHS reforms were national imperatives, and the reality of their implementation and on-going service delivery was controlled in the context of the local organisation. In turn, the shape of service delivery affected the public’s relational experience of the role.

Identity and Transformative Learning
Both Jarvis’s (2009) definition of learning and Illeris’s (2014) work on TL, as discussed in Section 7.4.1 (p.199), make clear links between identity and the process of learning. Tisdell (2012, p.25) discusses the difference between Mezirow’s (2009) perspective on ‘epochal’ change in ‘core identity’ or ‘worldview’ through transformed being and transformed thinking, which, it is suggested, is more confined to cognitive processes. In drawing parallels with the biblical account of Moses’ transformation through his experience of the burning bush (Tisdell, 2012), the extent of change in the participants seems insignificant, but taking the definition of identity supplied by Illeris (2014), the transformation of identity and of thinking both seem to have a part to play here.

7.5.2 Scaffolding Learning for Resilience
Theoretical Learning as Contribution to Identity Building
Many of the participants identified theoretical learning as helping them to see the links between policy relating to inequality and the reality of inequality in their clients lives, where previously Jo had seen policy as dull and Dawn had not believed that such levels of deprivation persisted in modern Britain. Theoretical
learning was also implicated through the way that the public health module on
the course had challenged Dawn to look at the bigger picture, sparking her
interest and understanding of the relevance of politics to the political dimension
of the HV role and causing her to consider the political dimension of her HV
identity. Seeing the bigger picture in this way was identified as a resource for
resilience by Adamson et al. (2102).

Skilled facilitation of PBL, the strategy employed for learning in the public
health module, was identified as being particularly helpful in making the
connections between theory and practice. PBL trigger groups were small, and
students felt that they were able to build trust and be honest with each other, so
providing a safe environment in which to challenge each other’s norms and
assumptions. In terms of the internal and external perception of identity, the use
of the Johari window (Luft and Ingham, 1955) was specifically referred to in the
data as being helpful.

Role Modelling and Building Identity
Role modelling as a source of learning in nurse education is generally taken
from the position of modelling behaviour that it is desirable to copy, (Horsfall,
Cleary and Hunt, 2012). However, behaviour is also modelled in practice that is
not desirable, and students are exposed to ‘bad’ as well as ‘good’ behaviours
(Donaldson and Carter, 2005). This was evident in the data where participants
were clear that through role modelling they learnt both what they wanted to be,
and importantly, what they did not want to be. Building identity in this manner
involved the students utilising a ‘pick and mix’ approach to building their
personal professional identity, taking what fitted with their own beliefs and
philosophies, and rejecting what did not match. This process, combined with
bringing aspects of their own personalities and approaches to practice, allowed
them to construct a way of ‘being’ that fitted with their own philosophies of care
and professional practice. Jo felt that she was able to bring ‘herself’ to the role
in a way that had not been possible in other roles she had been in, and Dawn’s
verbalisation of ‘authenticity’ in the role reflected a match between her values
and the way she was able to practice. This individual construction of identity in
the HV role was also identified in the work of Whittaker et al. (2013), and confirms the earlier suggestion that although the participants were novices, during the training phase of their professional identity formation they were seeing beyond the constraints of this to their own individual identity as a HV (Skovholt and Rønnestad, 2011). Role modelling was also implicated in learning self-care, as participants saw the ways in which colleagues managed their own stress, reflecting the findings of Beddoe et al. (2013).

**Reflection, Liminal Spaces and Identity Transformation**

Reflection is identified in many ways through the data: as internal conversations and individual reflection, as informal reflection with colleagues and peers, as formal reflection with PTs, and reflection as an assessed component of summative work. Reflection was either verbal, including ‘talking to myself’, or written, using prescribed reflective models to a varying extent. The contribution of reflection to resilience is widely acknowledged across practitioner research literature (Fazey, 2010; Kinman and Grant, 2011; Adamson et al., 2012; Beddoe et al., 2013), and critical reflection as an essential component of TL (Mezirow, 2009b; Taylor, 2009; Kreber, 2012). Academic writing on reflection has evolved over several decades, from Benner’s (1984) work on stages of development from novice to expert in nursing (based in the work of Dreyfus), through Schön’s (1987) development of ideas relating to ‘reflection on action’ and ‘reflection in action’, to Argyris and Schön’s (1974) conception of single and double loop learning, and more recently ‘triple loop’ learning (Isaacs, 1993). Critical reflection as a component of TLT is associated with challenging deeply held norms and beliefs with implications for social action, and as such has a political dimension (Kreber, 2012).

Mezirow’s (1991) model of critical reflection includes three levels: content, process and premise reflection. Content reflection is concerned with describing the problem, process reflection with working through the decision-making in relation to the problem, and premise reflection with what it is that underpins the problem and how can it be remedied. Premise reflection is therefore more closely aligned with double and triple loop learning (Kreber, 2004). Mezirow’s
(1991) description of critical reflection, with its requirement for social action, is framed around the existence of a ‘problem’. However, where critical reflection is applied to positive events it can also be used to recognise the structures and mechanisms that have supported this outcome, and how these may be continued or transferred to other contexts. The social action in such a context would be how to sustain or trigger the causative mechanism(s) that enabled the positive outcome.

Berger (2004) identified, through her study of a group of students involved in a transformative approach to learning, that although there were high levels of reflection reported this did not lead to change. The reflection had not moved beyond content and process to premise reflection. Berger further suggested that for reflection to progress, and change to occur as an outcome of that reflection, students had to be taken beyond the limits of their experience. This is consistent with encounter with threshold concepts (Tisdell, 2012) as a component of TL. Berger (2004) conceptualised this as taking students to the ‘edge of knowing’, as she suggested

‘..it is in this liminal space that we can come to terms with the limitations of our knowing and thus begin to stretch those limits’ (Berger, 2004, p.338).

In Berger’s (2004) analysis she identified that being at the ‘edge’ in this manner can cause uncertainty and sometimes fear, and this was characterised in her data by hesitation or uncertainty in the participants’ narratives, or by comments indicating that it was something that they had not thought about before. The latter was evident in my data in relation to experience of public health trigger groups, and the way that participants referred to activity such as challenging parents or witnessing deprivation as ‘hard’ and ‘shocking’. Questions that I asked during the study also elicited the response that some areas had not previously been considered, for example Becky in relation to her values and beliefs; or that they found difficult to express, for example Clare who found it difficult to verbalise what element of her ‘self’ drew her to working in the community. This suggests that the experience of taking part in the study may
itself have impacted upon the development of resilience. Recognising this uncertainty in the students’ responses, Berger suggests, can be indicative of the deep level of premise reflection that can support change. Students need support at these times, and the importance of the mechanisms of social support for my participants has already been identified.

The existence of anxiety or fear is also reflected in Atherton’s (1999) suggestion that supplantive learning, where previous learning has to be let go in favour of a new position, can be experienced as loss and may be met with resistance. Taking students to the ‘edge’ in this way therefore highlights further the need for support and resilience when engaging in identity work. The notion of ‘shared experience’, and the comfort drawn from this, was identified by the participants as being supportive in learning how to manage new situations.

**Relational Aspects of Openness and Authenticity**

Kreber et al. (2007, p.33) quote Zimmerman’s interpretation of Heidegger, linking openness and authenticity with the ability to care, suggesting that the more we care the more authentic or open we become. Caring, here, refers to promoting the autonomy and confidence of others, rather than taking over aspects of their lives. This could support the contention that increasing openness, or authenticity, through the learning process can increase resilience. Taylor identifies ‘dialogue’, which he describes as ‘the essential medium through which transformation is promoted and developed’ (Taylor, 2009, p.9), as a progression from critical reflection. Dialogue, he suggests, is where the outcomes of critical reflection, changed perspectives on established ways of thinking, are put into action, and includes the relational aspects of communication, where trust supports self-disclosure.

**Critical Reflection and Authenticity**

Recognising authenticity as a goal of TL, Cranton and Carusetta’s (2004) study was concerned with how teachers became authentic in their practice, and as a consequence could promote authenticity in their students. Their longitudinal study looked at the development of authenticity in teachers in higher education over a period of three years. The model they produced (Figure 7.3) is of
relevance to teachers involved in professional education, but I suggest, given the definition of learning adopted at the beginning of this chapter it can also be applied to the practitioners themselves in the social activity of lifelong learning. So in order to be authentic (including openness, honesty, and caring) in their interaction in practice, they need to be critically reflective in relation to themselves, their colleagues and clients, and the relationships between them, and the context in which they are placed.

![Model of authenticity in teaching](image)

**Figure 7.3: Model of authenticity in teaching**

Source: Cranton and Carusetta (2004, p.280)

Kreber et al. (2007), in their later examination of the place of teacher authenticity in the facilitation of learning in higher education, concluded that authenticity as a teacher:

‘..involves features such as being genuine, becoming more self-aware, being defined by one’s self rather than by others expectations, bringing parts of one’s self into interactions with students and critically reflecting on self, others, relationships and context.’

(Kreber et al., 2007, p.40-41)

In being open themselves, teachers actively contribute to an atmosphere of trust, important in creating environments for self-disclosure.
In order to engage in critical reflection the participants had to be open to challenging deeply held norms and beliefs. Critical reflection has already been discussed in relation to building identity; however, a further dimension that emerged from the data was the concept of a safe internal space for reflection, as described by Dawn, prompted by a discussion about being more open. The suggestion was that as the space in which she could be critically reflective and honest with herself was within her, this capacity was not dependent on context and could be taken wherever she went. It could then be drawn upon to support being open and reflexive in the contexts in which she found herself.

**Praxis: Combining Theory and Practice**

Critical awareness of the relationships between theory and practice learning, and mental agility in assessing different approaches to the same problem, are inherent in flexibility in practice, and taking a TL approach the concept of praxis appears to have some relevance here. The term ‘praxis’ appears to be used at differing levels of action within the literature, and is dependent on the ontological orientation of the practitioner. Primarily, ‘praxis’ was associated with achieving social justice, and linked with the ‘conscientisation’ approach of Freire (1970), where political action and power struggles were integral components. Agrosino and Rosenberg (2011) suggest that there are three ways in which individual researchers can engage with social justice: by engaging with marginalised groups; engaging with the reality of their life; and becoming an advocate for the issues defined by the community. Although these observations are placed in the context of research, they appear equally applicable to the context of HV practice, and link with Dawn’s identification of the political nature of the HV role. At its simplest level praxis is expressed as combining theory and action (Agrosino and Rosenberg, 2011), an outcome of dialogue with the self and others that advances critical reflection to action (Taylor, 2009; Illeris, 2014). In this process students combine theoretical learning with their observations of the whole context in which that learning is applied. This equates to understanding and engaging with the ‘bigger picture’. Not all of the clients with whom the participants engaged were from marginalised groups, however engaging with the reality of their clients’ lives, and indeed the reality of the
organisational context, required a form of praxis as theoretical learning was contextualised in order to move the situation forward. There is therefore some consistency between the action of praxis and of challenging structural responsibility in the perpetuation of disadvantage, indicative of 5th wave resilience approaches (Hart and Gagnon, 2014).

The notion of social justice is perhaps most applicable to flexibility in adapting to the client agenda. This was a challenge for the neophyte HVs as they were challenged in their own assumptions about what the priorities were and had to review these in the light of the client’s perspective. Some of the participants were quite flexible in adopting a client led agenda, whilst others clearly struggled with this. Hart and Freeman (2005) suggest that issues of professional ego, including ‘professional self-preservation’ and the ‘grandiose professional self’ (p.505), have the potential to damage outcomes for clients. They argue, and this is supported through the application of praxis as a route to social justice, that HVs need to be much more critically reflective on these aspects of professional culture. ‘Agenda matching’ was also identified in the work of Whittaker et al. (2013), where the use of ‘scripts’ by students for planned visits undermined the principle of client led contacts, and made it difficult for them to ‘change tack’ according to the client’s agenda. Scripts were not identified as an issue for the participants in this study, but such an approach tends to reinforce the perspective of professional power as a controlling factor in practice. This undermines flexibility and could threaten the resilience of both the client and practitioner.

7.5.3 Endpoints

Taylor (2009) suggests that cognitive maturity affects the ability of students to move their reflection beyond content and process reflection, an explanation of why some are transformed by their learning and others are not. Such maturity seems to have been present in Dawn and several other participants, evidenced by their description of their experience; however this was not universally evident. Although very articulate, Jo was the participant who seemed to demonstrate the least change in her frames of reference and also appeared to
resist structured reflection.

Taylor (2009) suggests that written reflection supports the development of maturity in critical reflection through providing opportunities to return to thoughts when most appropriate. Journaling was identified by Jackson et al. (2007) as a proactive strategy for developing resilience. Within the course written reflection was required as part of the summative assignments. The use of personal journals was encouraged but how extensively this was adopted was not evident in the data. Reflection in summative work may not be as honest and self-challenging as personal accounts that are confidential to the writer, who can choose what is shared, with whom and when. Consequently, issues of power and personal privacy need to be attended to by teachers (Cranton, 2006). This was made explicit in the data through the experiences of Dawn and Becky whose interpretations of situations were diminished by their mentors.

Understanding and explaining the means by which reflection and reflexivity support resilience and TL may promote the use of journaling. This understanding could help to counter the attitudes of significant others that may be affecting their engagement, as seemed to be the case with Jo. Steinhardt and Dolbier (2008) in their intervention to promote individual resilience in college students identified the benefit of increasing ability to take responsibility in stressful situations through use of Ellis’s (2001) ABCDE thinking model to promote empowered interpretation. This model encourages recognition of stressors, of negative events that have led to their occurrence, of feelings and beliefs in response to the stressors, standing back from the situation, and energy to handle the event. This may be a specific framework that could help make explicit the process of critical reflection in relation to promoting resilience.

**Resilience as Capability**

In the literature review for this study, skills attributes and qualities associated with practitioner resilience were identified, and these have also been referred to throughout the data analysis and discussion. Consistent with a first wave approach to resilience that identified protective factors (Masten and Obradovic, 2006) limitation in viewing practitioner resilience simply as the existence of these components is evident. In recent years professional education has
become competence driven, with defined concepts of occupational competence as the starting point of educational curricula. Competence has been defined as ‘the ability to perform the tasks and role required to the expected standard’ (Eraut, 1998, p.135). It is thus limited to what an individual can do, whether or not they actually do this is practice. One of the drivers of competence-based approaches was the perception of flexibility in the workforce, and being able to transfer competence in a task from one role to another. However, this understanding of flexibility is limited to task allocation and does not support the transferability of wider cognitive and critical skills.

Following the imperatives of recent studies (Kinman and Grant, 2011; Beddoe et al., 2013; Hunter and Warren, 2014) that professional education builds practitioner resilience, curricula need to ensure that this outcome is met. The concept of capability (considered in earlier Ed D work) goes some way to addressing the limitations of viewing resilience as competence. In educational terms capability draws together all the individual skills and attributes associated with resilience, and processes of critical reflection and praxis, that support practitioner’s ability to adapt their knowledge and be flexible in their responses in professional contexts. In doing so it moves into the 4th wave of resilience theory, including interactions within the system of practice. If building resilience is a specified learning outcome of the professional education curriculum a means by which such capability can be assessed becomes necessary. Rating scales such as those used in the work of Kinman and Grant (2011) and Steinhardt and Dolbier (2008) allow change to be identified, but the limitation is that the scales are linked to components rather than the whole state of capability. Additionally they do not necessarily allow students and teachers to recognise their learning and its associated sources.

Moving further forward into a 5th wave of resilience theory (Hart and Gagnon, 2014), this capability would need to include the political acumen to engage in challenging policy and structures that perpetuate adversity. Given the relationship between practitioner wellbeing and ability to support their clients, disadvantage needs to be addressed both in the lives of clients and in the working lives of practitioners. Engaging with issues of social justice would
therefore also require challenging structural responsibility within organisations to support the resilience of the workforce. Laura, when describing the organisational response to stress as dealing with individual need rather than looking at wider processes alluded this to in a small way. Literature over the last two decades has recognised the need for organisations to consider the impact of their structures on adversity experienced by nurses in the NHS (Nolan and Smojkis, 2003). Kinman and Grant (2011) recognised the threat to practitioner resilience in ignoring organisational responsibility, however research in the area has largely overlooked the structural responsibility of organisations for the working environment context, instead tending to the neo-liberal approach that focuses on individual responsibility.

There is considerable overlap between “Endpoints” as the culmination of the learning process, and the participants’ experience of becoming a HV through their experience of the course. Wider discussion is therefore included in the following sections of this chapter.

7.6 The Experience of Becoming a Health Visitor

7.6.1 Creating an Identity

McAllister and McKinnon (2009) and Adamson et al. (2012) highlight the importance of positive identity and of identity building work in promoting resilience, and this is reinforced by the findings of Hunter and Warren (2014). Seeing identity in relation to the dimension of meaningfulness in terms of sense of coherence (Antonovsky, 1996) helps make explicit why identity is an important aspect of practitioner resilience. If students perceive their role as meaningful then it is worth striving to overcome adversity encountered in order to keep going. Aspects of identity building have been considered in relation to both to the context of the course, and the way in which learning was organised. Other facets of identity building were grounded in the individual participant’s experience.

Personal professional style
Skovholt and Rønnestad (2011) suggest that the development of a personal professional style, a constituent of professional identity, is important in ‘career vitality’ (p.40). In this study the influence of role modelling of professional colleagues, and the way in which participants could pick and choose what they wished to bring into their own role from their observations of others, linked these learning experiences with identity development. Skovholt and Rønnestad (2011) suggest that developing personal professional style takes time and experience, and in congruence with Mezirow’s view on TLT, requires the challenging of personal norms and beliefs, reassessing what fits with the new identity, what has to be let go, and what has to be developed in its place.

**Developing a voice**

Developing a voice was referred to by Becky, Clare and Laura, and seemed to be a significant part of building identity. Different sources of learning in developing a ‘voice’ were evident and reported in the last chapter, together with the links between ‘voice’ and identity. One illustration of this was presenting the ‘expert’ view of the HV, as a representative of the profession within a multi-agency safeguarding forum. Detailed knowledge and skills were involved in this representation, but confidence was critical to feeling competent to give that “valid voice”. Another example was also related to speaking up for the child, in this context to the parents when behaviours needed to be challenged. Both of these linked with the reality of the purpose of the HV as someone who put the child’s needs at the centre of their role.

Skovholt and Trotter-Mathison (2011) suggest that experience in practice allows students to move from the external expertise they accrue from theoretical learning to internal expertise gained from practising. This is also reflected in the work of Benner (1984) where the concept of intuition is applied to the increased intellectual dexterity in recognising and responding to what is encountered in practice. In making this transition practitioners become able to articulate their experience, and to use their voice.

Giroux (2005, p.454) describes ‘voice’ in professional learning as
“...the various measures by which teachers and students actively participate in dialogue. It is related to the discursive means whereby teachers and students attempt to make themselves ‘heard’ and to define themselves as active authors of their own worlds”.

Kidd (2012) described the use of student voice in helping trainee teachers to develop professional identity. The strategies for this included students sharing and hearing other students’ voices through reflective journaling, and through audio-recordings of students talking about their experience of coming into teaching programmes and encountering the reality of teaching practice. In this process, used in induction to their programme, the students learned about their identity through listening to and speaking with other learners. This reflects the value attributed by participants in my study to hearing the experiences of other students, and the stories of other practitioners in their practice setting. It also suggests a way in which this experience can be deliberately introduced to students at an early point in development of their professional identity. Such storytelling is also recognised by East, Jackson, O’Brien and Peters (2010) as a strategy supporting development of resilience.

Confidence and Identity
A slightly different perspective on developing a voice was the way Becky identified that her language had changed over the period of the course, and how she was able to adjust this according to the context she was in. This reflects a participant observation in Hammond’s (2004, p.564) study

“Because I’ve had the education I’ve got the language”.

Becky described the change in herself as “feeling like a professional”, and something linked with developing self-confidence, a further identified resource for resilience (Hammond, 2004; Jackson et al., 2007), in conjunction with extending knowledge and skills and seeing the reality of inequality in a very different way.

‘Feeling like a professional’ was identified through the concept analysis of Holland, Middleton, and Uys (2012, p.219) as the goal of professional confidence, a condition that they observe is inextricably linked with identity. The
process by which they identified that professional confidence is achieved is built around four components: reflective; higher cognitive functioning; affective and action (Holland et al., 2012, p.219) illustrated in Figure 7.4 below.

![Diagram showing the components of professional confidence](image)

**Figure 7.4: Attributes of professional confidence and how they interact**

Source: Holland, Middleton and Uys (2012, p.219)

The action component included taking the initiative, doing, and experiencing success. This has great resonance with identity and confidence building in the participants of my study, where their experience of success related to affirmation of their learning by their PT, mentor, clients and tutors, peers and colleagues feedback; passing assignments, and seeing change in children and families. The affective component of the model proposed by Holland et al. (2012) identifies feeling at ease and relaxed, and is congruent with the notion of authenticity in the role identified earlier. Connections between the cognitive and reflective dimensions of their model confirm the links between professional confidence and learning experiences that built the participants identity. This is further demonstrated through defining professional confidence as:

‘..a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope of practice, and significance of the profession, and is based on their capacity
to competently fulfil these expectations, fostered through a process of affirming experiences.'

(Holland et al., 2012, p.222)

All of the elements that have been identified in relation to building identity are ‘activated’ or ‘potentiated’ through the process of reflection, which may therefore be viewed as a causal mechanism. This is the process through which sense can be made of the multiple influences that can result in learning.

### 7.6.2 Learning From Negative Experience

This theme represents encounters with adversity across the range of experiences presented in the course, and the impact on learning through these encounters. The question arises in practitioner resilience literature as to why some do not cope with adversity, some survive adversity and others thrive as a result of encountering adversity (Steinhardt and Dolbier, 2008; McAllister and McKinnon, 2009; Wendt et al., 2011). In common with Hammond (2004), the response of others to participants encountering negative situations in my study was identified as being crucial to either sustaining or threatening their resilience.

Allen et al. (2013) identify that practitioners frequently faced with socio-economic inequality in their practice can feel overwhelmed and ineffective. This was evident in Whittaker et al.’s (2013) study, and was reflected in references in my data to the emotional impact of what was seen, though my participants predominantly retained optimism about their role through recognising small gains. Learning to be resourceful as a practitioner is conceptualised by Edwards (2005) through development of relational agency. Relational agency in education, she suggests, refers to joint action through collaboration with others to gain a wider perspective of the object being examined. This facilitates a view across and beyond the system within which the practitioner is situated. Ultimately learning comes back to the learning of the individual but the process is collaborative and combats the situation where practitioners who
“have developed their expertise in the following of procedures have weak forms of professional agency when working with unpredictable objects of practice” (Edwards, 2005, p.179)

In learning for practitioner resilience this extends the conceptualisation of resilience beyond the individual ecosystem of the practitioner to wider social systems, though the learning is still applicable to building resources for resilience at individual level. It is almost as if relational agency allows the practitioner to reach out through the wider social domain of collaborative action, and then pull that learning back into them as an individual.

Where positive PT and mentor support was available it can be suggested relational agency was strong, and positive learning to support coping with the adversity encountered ensued. The importance of PT / mentor support is confirmed in Wilson’s (2013) findings, where lack of PT support for student social workers threatened opportunity for critical reflection following stressful events in practice. Where PTs were helpful and supportive these students were supported to reflect on the challenges they faced in practice, and extract positive learning for the future. The social support networks identified by my participants also supports the notion of relational agency and its importance to practitioner resilience.

The work of McDonald et al. (2010) explored the concept of collaborative capital in the workplace, again making links with the social dimensions of resilience through identifying the importance of workplace conversations and colleagues’ support in a group of nurses and midwives. In unsupportive workplaces the participants noted that this was managed by denial of emotions and suppression of authenticity in practitioners’ roles, with the result that their resilience was undermined. This confirms the potentially damaging effect of inadequate support in encounter with workplace adversity for both practitioners and clients.
Another resource supporting managing adversity in practice related to links between learning and confidence drawn from life experience (Hammond, 2004). The ability to recognise from individual biography similarities between current and previous adversity and apply successful coping strategies was evident. Additionally the contribution of current learning, recognising positive growth and ability to respond to adversity, was also evident in the data and demonstrated the growth in learning biography that would support resilience in the future.

### 7.6.3 Health Visitor as a chameleon

**Use of Metaphor**

A number of metaphors and analogies were used throughout the data to describe the experience of the students through the process of the course, and to describe their ‘being’ as HVs. The term chameleon was used at the outset, reflecting the ability of the HV to adapt to changing contexts and requirements. At the end of the study the analogy of a ‘transformer’ toy was used, reflecting ability to draw on specific resources as stressful situations were encountered and then put them away until required again. (Conceptually this links with the ‘reaching out’ of relational agency described earlier.) The experience of the course was equated to a series of obstacles to be overcome through use of sporting metaphors, and requiring varying applications of balance. The opportunity offered by the role was optimistically described through analogies with growth and opportunity. Flexibility implied by the chameleon and transformer metaphors has already been discussed, but it is useful here to consider the contribution of metaphors to learning.

Metaphor is widely used in the work of Skovholt and Trotter Mathison (2011) to conceptualise the feelings of the practitioner in varying stages of their professional development. They also use metaphor as a structure in a reflective exercise on the resources for, and threats to, resilience asking practitioners to compare their encounters with practice to the factors supporting and threatening the growth of a healthy tree.
The methods used in my study allowed metaphors to emerge and to be explored in the data. Loads (2010) suggested the use of metaphor as a teaching strategy for assisting students to cope with the uncertainty and ambiguity faced in the complex context of the modern workplace. She used art workshops to enable teachers to depict metaphors and bring their meanings to a conscious level. This happened through the social interaction of explanation and discussion with peers, where meanings were valued, embodied through creation of the artwork and explored in a “restorative space” (Loads, 2010 p.413). In working with the uncertainty of teachers in their roles she hoped to enable them to support students in coping with their own uncertainty. Creativity is also recognised as a resource for resilience (Edward and Warelow, 2005; McAllister and McKinnon, 2009), and was reflected within my data. Loads (2010) use of art workshops combines the physical creativity using the medium of art and the intellectual creativity of metaphor, and through her data there is clearly powerful potential for assisting learning from critical reflection using this approach.

Confidence and Flexibility
Confidence was widely referred to by participants when speaking about their experience of learning to ‘be’ a HV, and has been discussed in relation to building identity. Confidence as a concept has received little direct attention in the literature, but is often used interchangeably with self-confidence and self-efficacy. This position is reflected in the resilience literature, where self-belief, persistence, and self-awareness, are identified (White, 2009) as attributes of self-confidence, all of these having also been implicated as resources for resilience.

The process depicted by Holland et al. (2012) has some resonance with the TL process, incorporating critical reflection through the processes of reflection and action, and combining these with higher cognitive and affective components. However, whether the development of self-confidence would be viewed as transformative, Cranton and Hoggan (2012) suggest, depends on the perspective from which transformational learning theory is understood. The development of confidence was implicated in developing flexibility, as it allowed
my participants to exercise judgement in their role, adapt to their context and
decide the best way forward. Growth in confidence was supported through
affirmation from colleagues, peers and clients, and through success in their
assessments. It also came through praxis, reflecting on theory, and responding
flexibly according to the context.

7.7 Transformative Learning: An Appropriate Framework for the
Process of Learning for Resilience?

Through the preceding discussion clear links have emerged from the data and
supporting literature between TLT and resilience. These dimensions build on
the initial conceptual web of learning for resilience, drawing on the data from the
study to further illuminate the contribution of TL to building resilience.

The definition of resilience from which I worked through the study was that of
Ungar (2011)

“In the context of significant adversity, resilience is both the capacity of
individuals to navigate their way to the psychological, social, cultural and
physical resources that sustain their wellbeing, and their capacity
individually and collectively to negotiate for these resources to be
provided in culturally meaningful ways.” (Ungar 2011, p.10)

It is “a set of behaviours over time that reflect the interactions between
individuals and their environments, in particular the opportunities for
personal growth that are available and accessible.” (Ungar, 2012, p.14)

This has been contextualised through the definition of McCann et al. (2013) of
practitioner resilience as

“the ability to maintain personal and professional wellbeing in the face of
on-going stress and adversity” (McCann et al., 2013, p.61).
The definition of practitioner resilience side-steps the position of Hart et al. (2007) in identifying popular resilience as ‘normal’, and of Trzesniak et al. (2012) in requiring the need to distinguish significant adversity in defining resilience. The existence of ‘normal’ and ‘significant’ adversity is not distinguished in the context of practitioner resilience, rather severity appears to be implied through the chronic nature of occupational and organisational stress. This is reflected in research indicating high levels of stress and burnout in health and social care professions (Vinje and Mittelmark, 2006; Nordang et al., 2010; Riahi, 2011).

Ungar’s (2011) ecological approach to resilience takes account of the professional context through inclusion of individual and collective action to negotiate for resources for resilience. The interface between individual and collective resilience is however problematic, as they do not necessarily co-exist. Murray and Zautra (2012) contend that by intervening at community level to improve well-being individual resilience can be built. Less clear is whether by intervening at an individual level, community (or organisational) resilience can be built, though Bhaskar’s model of upward and downward causation between individual and society (Fig 7.1) suggests that this may be feasible. My data also tend to support this, but the contention is not triangulated beyond the participants’ view.

Kantur and İşeri -Say (2012) proposed a framework for organisational resilience that identifies a number of common features with individual resilience, for example sense of reality, supportive environments, employee involvement and empowerment, creativity and flexibility. Kantur and İşeri -Say (2012) suggest that research related to organisational resilience is disjointed but their framework suggests relationships between individual and organisational resilience. This was reflected to a degree in the experiences of the participants in my study. Van Breda (2014) similarly identifies supportive networks as protective factors in organisational resilience, observing that these need to extend beyond the organisation into the wider community. Other protective factors he identifies for organisational resilience: work-life balance, collaborative
problem-solving, and sense of coherence (van Breda, 2014) are also reflective of resources identified for practitioner resilience (see Tables 2.1 and 2.4).

Social theory and concepts that have been implicated in building resources for resilience, for example relational agency (Edwards, 2005), are accommodated to a lesser degree in Ungar’s (2011) model with its emphasis on individual capacity. Bottrell’s (2009) notions of collective adversity, and Bolzan and Gale’s (2011) findings of positive impact of shared experience and support also point to the limitations of an individually focussed ecology. The social theory contribution within the confines of my study seemed to be limited to ‘reaching in’ to the social dimension to access collective learning that contributed to resource development in the individual. However, it can be argued that as the focus of the study was on a course of professional learning, and as neither transformative learning nor resilience can be predicted as a uniform outcome across a student group, the focus necessarily came back to the individual.

TL within the limits of this study has also focussed on individual learning of the participants. Learning has been a shared and often social experience but the outcomes have been identified at an individual level. The social action component of TL has been embryonic for some, and not obvious for others. Where it has been present this has been at an individual level. This is perhaps unsurprising given the power dynamics influencing the participants’ learning environments. The place of learning biographies and life-long learning has however been confirmed as important for resilience, so social action may yet be realised in the participants’ professional careers. Such an outcome is possibly more consistent with a 5th wave conception of resilience (Hart and Gagnon, 2014) than with an ecological interpretation.

The preceding discussion confirms the applicability of a TL framework for building resilience in health visitor education. In response to the findings of my study I developed my original conceptual framework beyond McAllister’s (2012) stages of the STAR framework: sensitise, take action, and promote reflection. The revised stages identified are: recognise starting points, sensitise to
adversity, instrumental learning, communicative learning, identity, engage in praxis, navigate learning, transformation. These are presented in a revised web of TL for resilience in Figure 7.5 overleaf. The acronym ReSILIENT has been used to flag the relationship between the contributors to the transformative learning components in the context of building resilience. The dimensions of student experience are drawn directly from the study data, and the contextual structures and mechanisms have also been refined with reference to the data. The web represents the wide system that individual students learning sits within.
Figure 7.5: Web of transformative learning for resilience

Original in Colour


7.8 Summary

In this chapter I have presented a discussion of the data through a process of retroduction and abstraction that demonstrates how I have met the research aims and responded to the research questions. Initially, I mapped the research aims and questions against the data categories in the conceptual framework. I then discussed the experience of the students, establishing their encounters with adversity in the reality of practice. I identified definitions of learning by Jarvis (2009) and Illeris (2014) as the basis for the process of learning for resilience. The discussion moved forward examining the abstracted concepts of identity, openness, authenticity, confidence and flexibility as overarching contributions to learning for resilience for the HV role. This discussion was integrated through the themes emerging from content analysis against the conceptual framework. The discussion drew on the literature relating to identity, critical reflection, authenticity, and social justice, specifically that from the domain of TLT. Consistency and inconsistency with previously identified literature in the field of practitioner resilience was also established.

The lack of movement from an individual model of resilience to a model based in social theory was identified, particularly in relation to learning through a course of professional education. Some relationships were identified between individual and group resilience, specifically in relation to emotional competence and leadership. The concept of capability was identified as having some relevance to professional learning in supporting practitioner resilience, recognising however that this does not include the dimensions of collective resilience identified by the participants.

I then drew on the discussion to review the conceptual framework, revising the expression of the stages of TL to accommodate specific application to learning for resilience. The following chapter will present the conclusions from the study, its limitations, and the implications for further work.
8. Conclusions

8.1 Introduction

In this study I set out to explore the way in which a course of professional preparation for registration as a HV could build resilience in students to respond to adversity encountered in practice. This was framed around differences between expectation and reality of the professional role. The findings of the study have addressed the research aims identified in Section 1.8, and responded to the specific questions listed in Section 1.9. In this concluding chapter I present a brief summary of the findings against the research questions. The contributions of the cross cutting concepts abstracted from the data are summarised before identifying the original contribution of the study. The limitations of the study are then discussed, and the implications for implementation and further research presented.

8.2 Overview of Findings against Research Questions

Research question:

How do student HVs' experiences in higher education and practice settings contribute to the development of their capacity to respond to the tensions between expectation and reality in their practice role?

The main differences between expectation and reality in participants' roles related to the unanticipated complexity and difficulty of the role, a lack of continuity of contact with clients, a lack of availability of support for staff in their role, and a predominance of child protection work to the exclusion of proactive public health work with groups and communities. The reasons for these differences were predominantly the shortage of qualified staff, which resulted in excessive workloads. Stress in practice created a context of adversity vicariously through seeing the distress of others, and directly through affecting access to learning experiences and the availability of support.
From the literature review I identified a wide range of skills, attributes and qualities identified as supporting individual practitioner resilience (Table 2.4). The elements included had a very high level of congruence with the participants’ perception of the personal resources required to manage in the reality of their role. Using the conceptual framework devised (Figure 5) and identifying inclusive definitions of learning (Section 7.4) a wide range of experiences related to the planned curriculum, the organisational context of practice, and to the social context of both HV teams and peer support, were identified as contributing, through building their resilience, to participants’ capacity to respond to these tensions. The specific contributions to capacity are identified through links to the sub-questions below.

Sub-question:

i. What personal resources do student HVs see as necessary to their ability to manage the tensions in expectations in practice?

From the initial focus group exercise reflection, motivation, a sense of humour, flexibility, perseverance, commitment, purpose, and positive self-esteem, were all seen as important resources for coping in the reality of their role. As the study progressed the importance of relational skills to manage the dynamics within the practice teams also became clear. Participants needed to be able to balance the competing demands of their clients, colleagues, their study and private lives, and access to relaxation through physical activity was seen as necessary. Reflection emerged as supporting flexibility in looking at different ways of responding to the demands made upon them. Learning to say ‘no’ was also identified as important.

Sub-question:

ii. How do students’ experiences in the university and practice build their resilience to the change in role expectations?

The social dimensions of learning were important, particularly peer support experienced in informal spaces within the day, in building trust and in sustaining each other through difficult experiences in the course. Additionally building trust in formal learning contexts such as the small groups for PBL trigger sessions
and ALS, allowed the participants to become more open and honest with each other, increasing their capacity for honest reflection, and ability to challenge each others’, and their own, prejudices and norms.

Exposure to socio-economic deprivation and inequality brought home the reality of the role. The lack of awareness they had in this regard was surprising considering their previous qualifications as nurses and midwives, and of significance given the orientation to social justice required by practitioners in order that they can support their clients. Although this exposure could have threatened resilience, it actually served to build their motivation to ‘make a difference’ to their clients so increasing their capacity to cope with the reality of practice.

Sub-question:

iii. What experiences do student HVs identify from the university and the practice environment that have facilitated or obstructed the development of their capacity to respond to the reality of practice?

Factors facilitating and threatening development of the participants’ resilience are represented in Figure 6.3 and identified here. Reflection, positive professional identity, social interaction, positive role modelling, increased openness and authenticity, increased confidence, facilitative teachers in university and in practice, and exposure to inequality in practice all facilitated learning that built resilience. Development of capacity was threatened by exposure to stress in their HV teams, poor management of negative experiences, lack of involvement in the wider public health role, becoming overwhelmed by demands made on them through the course, reluctance to disclose problems, lack of resilience in HV colleagues, and negative leadership in practice. Overall these are suggestive of the threat to practitioner resilience posed through poor organisational working conditions. There was some evidence of this in the data though relationships between organisational and individual resilience require more detailed study.
Sub-question:

iv. What is the relevance of TL principles to students learning to build resilience?

The application of a TL framework provides an appropriate structure for learning for resilience (Section 7.7). This process recognises students’ starting points, exposure to the reality of practice as sensitisation to underpinning norms and assumptions, the experience of instrumental and communicative learning in gaining knowledge and skills required to respond, and the processes of self-challenge in developing a professional identity.

The centrality of critical reflection was clear throughout, and engagement with dialogue and praxis facilitated the process through which theoretical learning could be critically applied in practice. Less clear was the extent to which individual participants had engaged with reflection through Mezirow’s (1991) levels of content, process and premise reflection. Some participants had clearly challenged their previous norms and prejudices, and were verbalising a quite different orientation to their clients and experience of social inequality. However, in others this was not as apparent. The continuing ability to critically reflect on self and context is important to challenging norms and expectations, and seeing and adopting different ways forward in practice; important dimensions in maintaining meaning in the role that supports resilience. For the future it was difficult to judge how this might affect participants’ on-going commitment to the role, and thus their resilience within it.

8.3 Cross-cutting Abstracted Concepts

A number of concepts: identity, openness, authenticity, confidence and flexibility were abstracted from the data, which appeared to contribute to development of practitioner resilience. All have been identified in previous studies as contributing to practitioner resilience. Analysis of these concepts against the three domains of the conceptual framework has confirmed the complexity and overlap of influence on learning across the domains.
8.3.1 Professional Identity

Within the domain of the real, the influence of organisational and policy change affected the way that participants saw themselves in their role and how they were seen by others, and was a challenge to identity development. Mismatch between professional body proficiencies and the reality of their day-to-day practice contributed to lack of cohesion between perspectives of self and others (Illeris, 2014). Some aspects of the role that participants knew theoretically they should be engaging with were not currently accessible to them in practice. These organisational influences reflect other work with HV identity (Machin et al., 2012).

Influences on building professional identity were evident across all three domains of the conceptual framework, associated with the real, the actual and the empirical in critical realist terms. Building professional identity as a HV was therefore a challenge to the participants on several levels; not least that most did not really understand what the role entailed at the outset. In terms of the TL component of the conceptual framework, the starting point for learning was past experience and initial motivation for the role.

The most influential experiences during the course appeared to be participants' exposure to socio-economic inequality in their clients, and role modelling of PTs, mentors and colleagues in practice. In terms of socio-economic deprivation this influenced the participants through its existence in both the structures of practice, and in the domain of TL where it contributed to motivation for the HV role. As a structure it was surprising that the participants seemed to have such low levels of awareness of the reality of socio-economic inequality in this country, and of insight into what this meant in the every day lives of their clients. However, exposure to socio-economic deprivation emerged as the most striking influence in clarifying the participants motivation to ‘make a difference’ through their role as a HV. This was an emotionally difficult experience for many but important in development of their identity.
Role modelling was a strong source of learning, both for how to ‘be’ a HV and also how they did not want to ‘be’ as a HV. The lack of a shared interpretation of the role by qualified HVs was a challenge at the outset, as the participants did not perceive a collective professional identity. However the scope to develop a personal professional style (Skovholt and Rønnestad, 2011) of ‘being’ a HV through bringing their individual personalities to the role was valued as a source of authenticity.

Critical reflection, theoretical teaching and recognition of achievement through academic achievement and affirmation in practice were all identified as processes supporting the development of identity. Progression from reflection to critical reflection, and its relationship with TL was difficult to assess within the data. Some participants seemed to have moved to the ‘learning edge’ and expressed the uncertainty thought to be indicative of this movement (Berger, 2004). The participants certainly experienced anxiety at times during the course, and the shared experience and support of peers was critical in being ‘pulled through’ these periods. It was not possible to discriminate how the discomfort of being taken to the ‘learning edge’ in terms of their identity may have influenced this anxiety.

8.3.2 Openness and authenticity

Openness related to being open to change, challenge, and to being aware of what was going on. Openness was important across participants’ relationships in practice, including clients, colleagues, managers, and within the university. Underpinning openness was the need for honesty and trust, so the social processes involved in learning included those that enabled the building of honesty and trust in the formal learning environment, and those that facilitated the way in which this could be translated in the context of practice. Formally, the organisation of learning through PBL and ALSs enabled processes that facilitated trust and honesty. The Johari window (Luft and Ingham, 1955) was identified as a specific source of theoretical learning that facilitated self-awareness, which also required a trusting environment for its application.

Building openness in practice was associated predominantly with social processes and learning from critical reflection, supported by structures such as...
supervision and peer support in the domain of the real. Reflection at the level of premise reflection was necessary to promote internal authenticity, and this was conceptualised in the data as a ‘safe internal space’. It appeared that achieving this allowed the participants to develop authentic practice through being open and honest with clients and colleagues. Links between authenticity and openness in the practitioner and promoting the confidence and autonomy of others (described as caring by Kreber et al., 2007) are important contributors to resilience beyond the individual practitioner.

The contribution of upward and downward causation in social processes building openness in the wider social group has been illustrated through Bhaskar’s (1989) model of interaction between the individual and society. This suggests the potential of individuals whose capacity for honest and open interaction has increased through social learning, to impact on the structural norms of the wider group (Figure 7.). Peer support through the informal spaces in the university day was identified as critical here, to the extent that this was sometimes seen to be more important than the taught content of the day. Sharing enabled the group to help each other with the challenges being experienced and this process built trust and encouraged honesty.

### 8.3.3 Flexibility

Complexity and unpredictability in practice were key experiences in learning how to be more flexible and adaptable. Participants believed that flexibility was essential to coping in their professional role. Working in the team and managing change in practice required them to adapt to change, but also afforded opportunities for them to think about how they could support others to change. Participants were able to use theoretical learning regarding change and leadership theory in this context, applied through the social processes of praxis. This involved critical reflection and dialogue with others, leading to adaptation and change in practice.

Emotional and social competence of leaders was recognised as being influential in the facilitation of empowering supportive environments that contributed to the resilience of individuals and teams. Negative experiences were recognised as positive opportunities for learning as long as they were responded to
appropriately. However, inappropriate or unsupportive responses by leaders were seen to undermine the resilience of individuals and teams.

8.3.4 Confidence

Confidence was identified as an influence across the concepts abstracted from the data. From the work of Holland et al. (2012) ‘feeling like a professional’, an outcome of learning that emerged from the data, is defined as the goal of professional confidence and demonstrated links with identity building. In addition the process of developing a ‘voice’ as a HV (described both as speaking out as an expert, and as developing and adapting professional language according to context) contributed to identity work.

Self-confidence was developed through managing complexity and unpredictability in practice, and seeing PTs as role models. Learning to ‘think on your feet’ described a change in ability during client interactions. Increasing confidence also contributed to ability to be flexible with clients and colleagues.

8.4 Contribution to the Field

Practitioner resilience is emerging as a distinct stream of resilience research. However the danger of either displacing responsibility to individuals to manage stress emerging from the organisational and political context of organisations, or of dismissing practitioner resilience as trendy and transient, is ever present. The reality is that practitioners in health and social care, in common with many others in the modern world, are experiencing considerable stress in their roles. The potential for professional education to contribute to building their resilience is a moral, public health and economic imperative. The TL approach should mean that students are prepared to challenge prejudices and norms regarding organisational responsibility.

When I first embarked on this study the literature in relation to practitioner resilience was limited. Hammond’s (2004) early study had examined biography of adults to investigate links between lifelong learning and health outcomes, including resilience, though studies applying resilience theory to the field of
practitioner resilience were largely concerned with individual skills and attributes. However, a small amount of research was emerging that took a more ecological approach to the conceptualisation of resilience (Ungar, 2011) and which had greater resonance with the complexity of practice. Studies in the fields of social work and teaching were beginning to focus on the diverse factors impacting resilience, recognising the influence of emotional and social competence in its promotion (Kinman and Grant, 2011), and the mediating influences in the professional and organisational context (Adamson, 2012; Gu and Day, 2007). These studies identified a role for education in promoting practitioner resilience, although only Kinman and Grant (2011) had directly considered resilience in students preparing for their professional role. As my studies have progressed the interest in practitioner resilience has increased, but work regarding how resilience can be built in students being prepared for professional roles remains limited, and where it does exist has been related to specific interventions within courses, rather than the total learning experience. Previous work in the field of practitioner resilience had identified that education has a role in promoting resilience, but the mechanisms had not been made explicit.

This study provides qualitative evidence that resilience can be learnt and contributes new knowledge on building practitioner resilience through the holistic learning experience of a professional education course. Combining TLT and resilience theory through development of a conceptual web of learning for practitioner resilience has provided a new lens for examining the learning processes in the system within which students are situated. Although the ordering of causation has not been possible in the design and scope of this study, the innovative application of a critical realist approach in the field of practitioner resilience has exposed the complexity of relationships between context, events and experiences within professional learning.

The research that has been completed to date takes the perspective of individual resilience as a practitioner. Emerging from this study are some preliminary indications of the relationship between individual and collective practitioner resilience. The importance of shared experience and peer support is

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consistent with the collective experience of adversity with marginalised youth (Bottrell, 2009; Bolzan and Gale, 2011), and supports a social theory of resilience. Not unsurprisingly, the influence of leadership on resilience is identified, but more specifically the impact of emotionally intelligent leadership on collective or organisational resilience is suggested.

8.5 Limitations and Scope for Future Work

Case study provides a suitable methodology for exploring complex contexts through multiple methods. The research questions were appropriate for investigation through a single case, although the findings could lay a foundation for a broader multi-case study investigating the efficacy of different approaches to curriculum design and organisation at some future point. As the study was based on one case study in a single institution, the scope for generalisation is necessarily limited. However, those working in similar contexts would be able to draw on the findings and discussion within the context of their own work. The study relied on the participants’ perception of resilience. The additional dimension of a pre- and post-test assessment of resilience could have been included within the scope of the case study methodology, and contrasted with qualitative self-report.

Recent progress in neurophysiology and neurological research has raised the possibility of further dimensions to resilience (Kent, 2012) and learning, as knowledge regarding the plasticity of neural pathways continues to develop. Critical realism allows for the ordering of causal mechanisms back through the strata to biological influences though it was beyond the scope of this study to facilitate this depth of causation, or indeed the breadth of causation beyond the individual to wider societal mechanisms. The questions I asked could perhaps have been more probing at times, but the study aims and design were focused through individual experiences of learning. The findings of the study are limited to the perspectives of the participating students and may have been seen differently by others. There is scope for further work, using a critical realist approach, which explores the possibility of ordering of causal mechanisms in
resilience. Longitudinal biographical approaches might be useful here, combined with quantitative measures of resilience. The possibility of inclusion of neurological study in combination would also be a new dimension.

The sampling method used was designed to minimise the possibility of coercion; however, the participants may not have been representative of the cohort. Twelve participants were initially involved with the study, and participation in the first two focus groups was consistent. In the third focus group six out of the twelve elected to take part, and six also engaged with the individual interviews. Four engaged with both focus group 3 and an interview. The participants’ reasons for taking part in the study were not clear, although those who continued to engage tended to indicate that they enjoyed the reflective process of examining their experiences. This may have suggested a predisposition to greater resilience. The lack of any male participants in the study meant that gender issues could not be explored.

Undertaking research as an insider in my own institution, and where interest in the findings is local to the participants and myself as a researcher, presents a challenge in what is said and what is not. Perspectives on insider research were considered in some depth in the introduction to the work and have been kept in mind throughout. I have taken care to use pseudonyms when identifying information to ensure that confidentiality is not breached; however, the number of participants was fairly small, and I was aware that some had told their colleagues that they were taking part in the study. Similarly, I was aware when disseminating my findings at one local forum that I needed to be sensitive that a qualified practitioner (not a participant) may be able to self-identify from my account, and to guard against this in the level of detail of participant context presented. There were benefits to being an insider, and these included understanding the language and jargon (Mannay, 2010) used in the HV world. I could relate to the context of the participants’ world (McNiff and Whitehead, 2010) and understood the organisational and policy context. The challenge was to avoid leading the participants down a particular road because that was where I was expecting them to go. The use of activities in the focus groups helped to put their thoughts “out there”, rather than questioning that focussed directly on
them. This seemed to help facilitate the participants leading the way. At times I could perhaps have asked more pointed questions but was anxious that this would have affected my neutrality (Mercer, 2007).

The process of engaging in reflection through the study was an experience that was likely to have contributed to the participants’ learning. Taking an overt co-production approach to the study could have avoided this as an unknown and made it an integral part of the study design. Co-production in research is a process through which the perspective of the subjects of the study can be more fully understood and included, as they are active participants in the research process, including design, data collection and analysis. As such it addresses the issue of the double hermeneutic, by taking account of both what the participants and the researcher think is being said (Brogden, 2010). This approach was not taken in this study, and although I confirmed that my understandings of the participants’ experience and views were valid at various points through the study, these still came from the perspective of my interpretation of what they had said, rather than from co-production. A co-production approach would however have required an increased commitment from the students, which in a course that is recognised to make extensive demands on students’ time presents an additional ethical challenge. Such an approach could be used in a follow up study with qualified practitioners.

The study explored practitioner resilience from the individual perspective of the learners. Although the organisational context of practice was included as a source of learning, relationships between individual and organisational resilience were not explored. The TL approach incorporates notions of action for social justice that are necessary to support practitioners working both with inequality and disadvantage in their clients, and within contexts of workplace adversity. Further work, perhaps through an action research process, might help to illuminate processes through which organisational resilience can be developed, that in turn foster practitioner and client resilience. Such collaborative research could challenge neo-liberal approaches to resilience and promote notions of structural responsibility.
8.9 Recommendations

8.9.1 Application to selection processes

The observations of participants regarding the lack of a clear sense of professional identity within the profession is unsurprising to me as motivations for becoming an HV are varied, and in my experience often not those declared at interview either for the course or subsequently for jobs. The stereotype of health visiting as a 9 to 5, five day a week job, with autonomy to decide how to organise and carry out the work, which mainly involves nice activity comprising chatting with clients over a cup of tea, has long been the fallacy that can attract burnt out nurses from acute areas of practice, or those looking for an ‘easy’ job to fit with wider personal commitments. Few would admit this at interview, though it was clear in my sample that this was, at least to a degree, the perception of many engaging with the HV course. Movement from this position through the development of a positive professional identity, identified as critical to practitioner resilience, is challenging. This identity requires values and beliefs supporting social justice, and an orientation to working with clients from their own starting points to reduce inequality in health, rather than imposing traditional models of professional power. The challenge is exacerbated if the student’s own starting point is one that, at least in part, is rooted in the undemanding and superficial stereotype presented above.

From my data it is clear that even those who had worked in HV teams had not really grasped the underpinning purpose of the public health role. On that basis, spending time in HV practice prior to starting the course as recommended by Whittaker et al. (2013) is unlikely to make much difference to this. It is interesting that despite this lack of insight, most of the participants clearly grew in their commitment to the role over the period of the study, however Clare’s comment regarding commitment to the role indicated that this was not the case across the cohort.
Values based selection processes
The data suggested poor awareness of social justice issues that is required in order that HVs can support their clients appropriately. A values based selection process is recommended that would assess the underpinning values of the participants in relation to their orientation to social justice, and to working from a shared agenda with the client. Multi-mini interviews (MMI) have been used in medical education for about a decade, and these have recently been adopted locally for first registration nurse education. These take the applicant through a series of 10 minute stations using scenarios and questions to assess elements such as critical thinking, ethical decision making, communication skills and suitability for the role (Eva, Rosenfeld, Reiter and Norman, 2004). Scenarios could be framed to assess the applicant’s orientation to social disadvantage and professional power relationships. In this way the predisposition of the applicant to develop a professional identity rooted in social justice could be assessed, rather than knowledge of the role (probably gained from personal experience and policy documents) that does not take account of underpinning values. In addition the baseline of two other key areas of learning for resilience identified from this study could be assessed through scenarios, those relating to flexibility and adaptation to change, and openness in communication.

Exposure to the student voice as a first step in building professional identity
The problem of realistic role expectations remains a challenge. Kidd’s (2012) work with student ‘voice’ perhaps indicates a way forward in helping students to embark on development of their professional identity. Audio recording of student experience of expectation and reality could be included as a station in the MMI and then discussed, or alternatively used as an exercise in induction week.

8.9.2 Application to curriculum design
A model for curriculum design
The web of learning could be used as a model for curriculum design, making explicit the overlap between outcomes that demonstrate achievement of academic benchmarks, such as critical thinking, reflexivity, problem solving,
creativity and flexibility, and development of resilient practitioners. These outcomes, including resilience, are indicative of sustainable education and preparedness for the modern day workplace.

Defining and assessing resilience as capability
Viewing resilience as a set of competencies centres on the individual skills that have been correlated with resilience. Taking a holistic approach to learning, utilising TLT has highlighted the need for resilience to be viewed as capability, or capacity rather than as a series of competencies (Eraut 1998). This perspective encompasses a more complete view of what students need to be able to think and do in order to be resilient to adversity in practice. The revised web of TL for practitioner resilience refines the original conceptual framework, making explicit the links between the process of TLT and the development of practitioner resilience.

Formative assessment of capability for resilience might be achieved through observation of the students managing adversity in practice, and critical reflection questioning the underpinning norms and assumptions that have led to the adversity occurring. Leadership content could overtly include addressing issues of structural responsibility within the organisation as a component of formative and/or summative assessment. In this process resilience of both client and practitioner could be addressed, making explicit links between practitioner resilience and outcomes for clients.

Supported exposure to socio-economic inequality
Coming on the course and being exposed to the reality of social inequality clearly has the potential to take the students to the learning edge in terms of challenging norms and beliefs, and in moving towards an identity including principles of social justice. The process of ‘taking them to the edge’ could be supported in the classroom through using the inequalities imagination approach (Hall and Hart, 2004) in both preparing students for encounter in the real world of practice, and following up on their experiences. Students need to be supported through the uncertainty and fear that can be experienced in this process (Berger 2004) and my study clearly identifies the role of peers in this
process. Peer support can only work if the students are given the tools they need. The organisation of the curriculum needs to include small group facilitation of learning to promote trust and honesty and provide safe environments to challenge deeply held norms and beliefs. Informal space for students in which they can support each other in developing coping and management strategies need to be preserved. This was present for these students, but experience of reduction in staff numbers and face-to-face contact time with students suggests that the need for this to be maintained be made explicit.

8.9.3 Application to students’ and teachers’ learning

Strategies for induction weeks in university and practice

University induction included a well-being afternoon during which a number of activities that could be used to avoid and relieve stress were introduced and experienced by the students. There was no mention of these activities during the study. The purpose of the intervention, and way in which the activity is drawn upon throughout the year needs to be reviewed and evaluated. The taught session about resilience and role transition that occurred in the second semester should be brought into induction week and linked with these strategies for stress relief.

The process of written reflection supports movement beyond content and process to premise reflection. Assessed written reflection is unlikely to present honest challenge of personal prejudice. The inclusion of reflective writing in the study skills component of induction week needs to demonstrate the positive outcomes of journaling, and the ways in which it can support learning. The dimensions of resilience related to meaningfulness identified in the literature review (Table 3) could be used as suggestions for focussing exploration of their ‘being’ in the situations on which they were reflecting. The use of specific thinking models such as Ellis (2001) ABCDE model, used by Steinhardt and Dolbier (2008) could be used to explicitly link a structure for reflection with managing stressful situations and practitioner resilience. This could make the
link between critical premise reflection and practitioner resilience more meaningful.

Students on this course undertook a two-week period of induction in practice. The strengths, weaknesses, opportunities and threats (SWOT) analysis completed as part of their personal development plan (PDP) should have provided a clear starting point for their learning consistent with a transformative approach. It can also provide an assessment of their existing resources for resilience. However this was not recognised, in the data, by the participants as a learning experience, and may not have formed a part of a joint activity. Exposure to the context of practice and critical reflection on this exposure would allow students to make explicit the elements of the reality of practice that challenged them and provide a point to move forward. PTs need to be helped to gain a better understanding of the purpose of recognising prior experience and initial impressions in setting the foundations for learning. The process of assessing starting points could then have more meaning and give a better foundation from which to assess forward movement in the development of resilience.

Making practitioner resilience explicit

The web of transformative learning can be used as a learning tool to promote understanding of the learning associated with resilience building. This could be used with students on the HV course and with students undertaking mentorship and PT courses. Its use with other students moving into new professional roles might also be appropriate. It should be used to prompt critical reflection on personal learning and development, not as didactic instrumental teaching. The web can also facilitate dialogue with teaching staff in both university and practice settings, and sessions should be facilitated with the course teams and during PT update days as part of continuing professional development. In this process ‘teacher authenticity’ can also be explored, challenging teachers and practitioners to critically reflect upon their purpose as teachers and their beliefs regarding what they believe the outcomes of learning should be. This has a part to play in the way that student-centred strategies that should promote transformational learning are enacted (Kreber et al., 2007).
8.9.3 Promoting political acumen through problem-based learning

The apolitical stance of the participants and their predominant lack of engagement with structural influences on social inequality suggested a lack of preparation to engage with resilience as a matter of social justice (Hart and Gagnon 2014). Political engagement is of relevance both to their resilience within the organisation through challenging structures affecting wellbeing of the workforce, and to their practice in promoting equity in health outcomes in their client population (Allen et al., 2013). The curriculum needs to re-engage student HVs with the political dimension of their role concerned with influencing policy. This could be achieved through a PBL trigger requiring participants to engage with a policy change exercise.

8.10 Concluding comments

This study represents the final component of study for the Ed D. Through the staged assignments I have brought together the two professional aspects of my role, those of health visitor and of teacher. The complexity of practice in the NHS and practice within higher education is significant. Combining the two areas of practice and drawing together their theoretical underpinnings into a coherent whole has been extremely challenging. Through my study two groups of theories, resilience and transformative learning, have been explored to discover the means by which they may be combined to the benefit of the professional lives of student HVs.

The study has provided an insight into the application of a TL framework for understanding learning for resilience. It has demonstrated the complexity and diversity of influences on learning through a professional education course. The influence of organisational change and demands on the experience of learning has been clear, and the need for practitioners to build resources for resilience has been confirmed.
The HVIP is drawing to a close, with the last students qualifying in the spring of 2015. Change within the NHS in general, and in health visiting in particular, seems likely to continue however as new patterns of working evolve. Findings from the study have been disseminated as it has progressed (Appendix 11). The challenge now is to work with colleagues in the university and practice to further consider the applicability of this approach in the curriculum.
References


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Appendices
Appendix 1: The salutogenic umbrella

M. Eriksson and B. Lindström 2012


On: 3.2.2014
Appendix 2: Reflective extracts
2.1 Focus group moderation

The greatest challenge that I faced as a moderator in the focus groups was completing the activity in the timeframe available. It was difficult to anticipate how readily participants would engage with an activity, and the extent of the discussion that would be generated. I had narrowed the scope of material included in the first focus group in light of experience in the pilot activity. This worked reasonably well. Working through all of the resources was not required, but the need to have sufficient material was supported in focus group 1 where participants moved quickly through some elements finding minimal need for discussion. At other times, particularly in the third focus group, the activity would have benefitted from more time, due to the level of engagement with discussion. On that occasion it was unrealistic to consider reconstruction of the tower, in addition to discussing the different statements. Piloting the activity with colleagues in the absence of student participants may have helped here.

At the outset the sessions had been identified as lasting from 60-75 minutes, so from the participant viewpoint it would have been inappropriate to keep them longer. A strategy to handle this dilemma would be for me to have more clearly delineated in my own mind distinct stages of the activity, identifying what must, and what might be, included. Additional phases could be kept in reserve, supplementing the basic unit, according to the engagement of the group and the extent to which external stimulus for discussion was needed. This experience highlighted to me the extent to which I just wanted to learn ‘that little bit more” from the participants, and the challenge in accepting that the data collection for the study is complete.

2.2 Experience of working with a second moderator

Having a second moderator was really helpful in having someone to take notes and with whom I could de-brief afterwards. I was reliant on the goodwill and availability of colleagues to act as second moderators. Three different people
took this role on for me with different groups. Although the stated expectations of how they would be involved with the group and subsequent debriefing were the same on each occasion the experience was different. One colleague (A) was involved with three groups, and was present with the same group for the first two sessions, and for the third and final group. Two others (B & C) were present for one group session each, so that group had a different second moderator on each occasion. As the second moderator was observing and taking notes, the dynamic of the group wasn’t obviously different during the conduct of the groups. The main difference was in the way in which I got feedback and was able to discuss the content and process of what had happened.

With A I was able to discuss both the process and content of the groups. She picked up on some phrases that she had found interesting, as I did, and we were able to explore these together. I was able to talk through with her the superficial level of engagement with the first group, and how I might get them to open up and say what they really thought. As the groups progressed this seemed to improve, though the interviews were an opportunity to offer the chance to look at material that they did not want to share in the focus group. The other two moderators did not offer the same level of critical friendship. B & C each focussed on the process of the focus group and gave feedback on this, but did not engage in discussion of what had gone on in the groups. Personality probably had something to do with this, but I had also co-researched with A in the past so we were probably used to working on a similar footing. C seemed to want to tell me what to do, and B did not say anything about how moderation could have been improved, or more drawn from the group.

In future I would try to use the same moderator throughout, to lay out expectations of the debrief process more clearly, and to schedule in more time for this discussion. All of these things are very difficult when relying on friendships and goodwill.
2.3 Interview

I was struck in my interview with Becky how open and honest she was. She had encountered significant adversity in her life, and that seemed to have contributed to her resilience in her role and on the course. Spontaneously she spoke about how much she had changed, and how she felt she had ‘become a professional’. She spoke about confidence, and about the language she uses. A lot of this seems to link with her developing identity.

The interview went incredibly quickly. It flowed reasonably well, with Becky raising topics that I wanted to cover spontaneously, which meant I did not have to ask so many questions. I tried not to ask leading questions, but the odd closed question did creep in.

It was interesting the feelings that the interview engendered in me. I felt admiration for the way in which she had approached the course, and how she had coped with the emotional work of the course which had obviously brought some very challenging past experiences to the surface. As an insider researcher, and from my personal experience I could understand the context, and how difficult some of the things she had encountered had been for her. You can never be sure what is going to arise during qualitative data collection, and how things might chime with your own experience and feelings. Using a private reflective journal helped me to express some of these feelings, understand them and move forward.

I had been working with the participants for nearly a year, so they had learned to trust me and had shared a lot of personal experiences in that time. Stepping back and taking a critical stance was difficult at times, and I had to remind myself that I was applying a critical view to the behaviour or attitudes exhibited, not the people.
2.4 Why has it all been so difficult?

When I started the EdD I knew that it wouldn’t be a picnic, but I hadn’t anticipated the way in which it would be difficult. I had studied for my masters whilst working full-time so I knew that wasn’t easy, but I was younger then (only 10 years but still younger), and didn’t have the responsibilities in my professional role I have now. My memory has been the problem. Previously I have had an excellent memory, but whether I have run out of pegs to hang things on, whether it is just that I am getting older, or whether it is as a result of a whole battery of difficult life circumstances, it is not what it used to be. This has really affected the way that I work. I’ve taken notes as I have read, but forgotten the content to such an extent that I have had to go back and read all over again. Reading a wide range of literature has exposed me to many different approaches. On many occasions I have thought ‘that is a really interesting perspective, I’ll be able to include that in my discussion’, only to find that the concept has escaped my memory when the time has come. If I write a note it means little by the time I get there. I don’t think this is anything sinister it is just the difficulty of holding and synthesising a huge range of material whilst keeping going with the day job.

Some material I have looked at I have found difficult to understand. Critical realism was new to me, but on the simplistic level it was described in research studies I read it seemed like a really good fit with how I see things. Then I started to read the original work of Baskar. Was it me or was it completely incomprehensible? Many acronyms, with no explanation, just expected to know every work he had ever published and the initials of their titles. I felt better when I found Andrew Collier’s text that interpreted Bhaskar for me. I flogged on, and I think I’ve got it now, but then I’ve thought that before.

Then I picked resilience theory and transformative learning theory. Both of these areas have many proponents with very different perspectives on definitions. All are equally convinced that they are right. So I know what I think but have I argued it sufficiently? Often on reading others works their justification
amounts to “I’ve read it, I know it’s criticised by some, but I think it’s OK anyway”. Have I done the same thing? Is what I’ve done acceptable?

Doctoral work is different to any other experience of learning I have ever had. In the past I have had a reasonably good idea of how I am doing. With this I repeatedly swing from optimism to pessimism and back. I’ve learnt a lot, some of it I have really enjoyed, but I won’t know till I’m done whether it is OK.
Appendix 3: Data Collection Audit trail
Appendix 4: Data analysis audit trail

Data analysis audit trail

Focus groups 1a & 1b recorded, moderator notes and debrief

Focus group 1a & 1b transcribed. Transcripts prepared for analysis

Summaries checked with participants in focus group 2a & 2b respectively. Focus groups 2a & 2b recorded, moderator notes and debrief

Focus group 2a & 2b transcribed. Transcripts prepared for analysis

Focus group 3 Recorded, moderator notes and debrief

Interviews and Focus group 3 transcribed. Transcripts prepared for analysis.

Interview transcripts to participants for member checking.

Interviews recorded. Reflective note taking following interview

Preliminary themes and conceptual framework shared with participants

Analysis with reference to conceptual web of learning. Repeated listening to audio files & scrutiny of transcripts \( \rightarrow \) emerging themes.

Completion of analysis and discussion consistent with stages of Danemark et al. (2002) explanatory framework

Conference poster: INCCR Edinburgh March 2013
### Appendix 5: Literature search strategy

<table>
<thead>
<tr>
<th>Search terms used/key words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student AND expectation AND practice</td>
</tr>
<tr>
<td>Health Visit* AND expectation AND reality</td>
</tr>
<tr>
<td>Nurs* AND expectation AND reality</td>
</tr>
<tr>
<td>Profession* AND expectation AND reality</td>
</tr>
<tr>
<td>Resilien* AND / OR education AND nurs* OR social work* OR teach*</td>
</tr>
<tr>
<td>Salutogen* AND education</td>
</tr>
<tr>
<td>Transformat* AND learning AND resilience AND education</td>
</tr>
<tr>
<td>Transformat* AND learning AND education</td>
</tr>
<tr>
<td>“transformational learning”</td>
</tr>
<tr>
<td>“Emotional intelligence” AND education</td>
</tr>
<tr>
<td>Wellbeing AND education</td>
</tr>
<tr>
<td>Hardiness OR sense of coherence OR flourishing AND nurs* OR social work* OR teach*</td>
</tr>
<tr>
<td>“Nurse education” and resilien* OR salutogen*</td>
</tr>
<tr>
<td>Author names of key contributors to field</td>
</tr>
</tbody>
</table>

| Range of literature searched-UK/international/dates /primary or secondary                  |
| UK, Europe, Australia, Nordic Countries, New Zealand, Canada, USA, Hong Kong.             |
| 2002-2013 plus Seminal work relating to concepts falling under salutogenic umbrella.      |
| Peer reviewed journals: Primary research; Literature reviews; Scholarly comment           |
| Linked to professional groups in health, social care and education                         |
| Seminal texts                                                                            |
| Educational theory texts                                                                  |

| Inclusion / exclusion criteria                                                             |
| Include: research relating to education and strengths based approaches                    |
| Research in higher education                                                               |
| Papers in English                                                                         |
| Comparable (higher) education systems for caring professions.                             |
| Exclude research with patient groups or specific diagnoses                                |

| Databases used                                                                             |
| 1. Education research abstracts on-line                                                    |
| 2. Psych Info                                                                             |
| 3. Web of Science                                                                         |
| 4. CINAHL                                                                                 |
| 5. Cross search facility                                                                  |

| Additional methods                                                                        |
| Hand searching specialist journal issues                                                   |
| Follow up on authors in field                                                             |
| Follow up from references in identified studies                                           |

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## Appendix 6: Focus group activity mapped against research aims and questions

<table>
<thead>
<tr>
<th>Focus group 1 October 2012</th>
<th>Activity</th>
<th>Links with research aims and questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 exercises</td>
<td>A1. To explore how learning, in both university and practice settings, contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the HV.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q. What personal resources do student health visitors see as necessary to their ability to manage the tensions in expectations in practice?</td>
</tr>
<tr>
<td>1. Moving into a new role: identifying expectations of the HV role. 30 minutes</td>
<td>1. Produce a mind-map / diagram of participants understanding of the HV role. On completion of the mind-map / diagram pull out areas of agreement and disagreement in understanding of the role.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Rating exercise with cards identifying qualities, attributes, strategies, drawn from literature review. How do participants see these as relevant? What might help them develop these qualities, attributes, strategies and skills?</td>
<td></td>
</tr>
<tr>
<td>2. What qualities, attributes and strategies do participants think will help in coping if expectations are not met on qualification? 30 -45 minutes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Focus group 2 February 2013 | Check understanding of what was said in first focus group through written summaries and discussion.  
2 exercises  
1. Use the diagram / map from focus group 1. Discuss ways in which reality of what participants are seeing in practice against this expectation. Produce a new drawing to depict how the participants now feel about the role they are preparing to take on.  
2. Produce photo of rating of qualities, attributes, and strategies from focus group 1. How do participants relate this to any of the learning experiences they have had so far, in the university or in practice? Do these qualities, attributes, strategies have the same or different relevance to the time they were first looked at? Can participants make links with salutogenesis and resilience as theoretical concepts? Would they re-arrange the hierarchy rating? | A1. To explore how learning, in both university and practice settings, contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the HV.  
A2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.  
Q. How do student health visitors’ experiences in higher education and practice settings contribute to development of their capacity to respond to the tensions between expectation and reality in their practice role? |
| Focus group 3 June 2013 | Re-visit product of focus group 2 linking development of qualities, attributes, strategies with learning experiences. 1. (Snowden: Anecdote circle) Participants to bring with them three experiences from the course that have been most influential on development of their capacity for professional practice. These could come in the form of short anecdotes including why they found the experiences most helpful. 2. Share preliminary analysis of focus group data with participants. Check out development of shared meanings from data independently, and then against researcher analysis | A1. To explore how learning, in both university and practice settings, contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the HV.  
A2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.  
A3. To explore the relevance of the application of salutogenic principles to curriculum design in order to support the development of resilient practitioners.  
Q. How do student health visitors' experiences in higher education and practice settings contribute to development of their capacity to respond to the tensions between expectation and reality in their practice role?  
Q. What experiences do student health visitors identify from the HEI and the practice environment that have facilitated or obstructed development of their capacity to respond to the reality of practice? |
Appendix 7: Devising the interview schedule

Briefing: Thanks for agreeing to do this individual interview. To re-cap, the purpose of the research study is to look at how learning experiences during the course of HV preparation can help to build capacity to respond to differences in expectation and reality in practice. So what the study is built around is the concept of resilience and its relevance to the health visitor course. The interview is being recorded in the same way that the focus groups were so that I can concentrate on our conversation and then look back on what is said in it’s entirety. In the writing up of the study you won’t be identifiable.

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Interview questions</th>
<th>Notes / prompts</th>
</tr>
</thead>
</table>
| Q. How do student health visitors’ experiences in higher education and practice settings contribute to development of their capacity to respond to the tensions between expectation and reality in their practice role? | 1. We have talked in the focus groups about expectations of the HV role and the reality. To start off with, can you tell me:  
   i. Why did you come in to the role? What was your motivation? (Was it through commitment to the role, or was it a more pragmatic career move?)  
   ii. Has anything in the role been unexpected or surprised you?  
   iii. How have you felt about your decision to take on the role, and any differences between expectation and reality that have occurred? | Warm up, sets context for interview. Familiar ground that the interviewee will be able to answer easily. |
| A3. To explore the relevance of the application of salutogenic principles to curriculum design in order to support the development of resilient practitioners. | 2. Can you tell me about any challenges / difficult times you have faced during the course?  
What has helped you through these times?  
What do you think are going to be the biggest challenges to you in your role as a qualified HV  
What do you think might help you to respond to difficult times in practice as a qualified HV?  
Have you developed resources that may have increased your resilience? | Focus group: sources of contradiction / challenge: Role confusion, lack of definition  
Directive v client lead  
Public health /proactive v safeguarding / reactive  
Uncertainty in new service: expectation of new practitioners  
Boundaries between personal and professional self |
| Q. What personal resources do student health visitors see as necessary to their ability to manage the tensions in expectations in practice? | 3. Over the course you have experienced a range of different learning experiences; practice learning, work-based learning; problem based learning; skills week, contact with peers and colleagues etc.  
Putting knowledge on one side, how do you think you have gained from each of these different experiences  
Have any experiences during the course helped develop your resilience? | Any mention of wellbeing activities in induction week?  
Yoga, mindfulness, creative writing, life writing, hand massage? |
<p>| A1. To explore how learning, in both university and practice settings, contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the HV. |  | |
| A2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners. |  | |</p>
<table>
<thead>
<tr>
<th>Q. What experiences do student health visitors identify from the HEI and the practice environment that have facilitated or obstructed development of their capacity to respond to the reality of practice?</th>
<th>We talk about “resilient moves”, things that can help in difficult times. Can you think of any resilient moves you have made, or seen others make?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. To explore how learning, in both university and practice settings, contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the HV.</td>
<td>4. Have you changed over the course? How would you describe the change? Are you more resilient? In what way? What has caused this to happen? Can you tell me about any experiences that particularly stick in your mind, which have influenced this change?</td>
</tr>
<tr>
<td>A2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.</td>
<td>Values and beliefs? Personal qualities /resources to help in coping with the challenges in the role?</td>
</tr>
<tr>
<td>Q. How do students’ experiences in the university and practice build their resilience to change in role expectations?</td>
<td>5. In the focus groups we have discussed some specific factors that literature shows are relevant to building practitioners’ resilience. How do you see “resilience” as relevant to you as a practitioner? i. How has your reflective practice</td>
</tr>
</tbody>
</table>
|   | developed over the course?  
|   | ii. Can you tell me about specific experiences that you have had and how they have influenced your reflective practice?  
|   | iii. Have you had any experiences on the course that have allowed you / encouraged you, to be imaginative or creative.  
|   | iv. Have you become a ‘critical thinker’  
| A2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.  
Q. What experiences do student health visitors identify from the HEI and the practice environment that have facilitated or obstructed development of their capacity to respond to the reality of practice?  
|   | 6. Have you had experiences that have been unhelpful to you during the course?  
|   | How have you dealt with these?  
|   | 7. Over the last year, is there one thing that sticks in your mind more than anything else as being a really critical learning point?  
|   | Opportunity to raise own perspective on learning  
| Closing: Thank you very much for all of your contributions. Is there anything else that you haven’t said that you would like to raise?  
| Debrief about interview after recorder turned off  

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Appendix 8: Ethical approval documentation
# 8.1 Research Ethics & Governance Application Form

**Faculty of Health and Social Science**

**Research Ethics & Governance**

**Application Form**

*Note: You should allow at least 3 weeks for FREGC to review your proposal and be aware that you may be required to revise your proposal and resubmit for further review.*

This form must be completed by the Principal Investigator/Supervisor as indicated below. No signature is required but the form must be submitted from the mailbox of the Principal Investigator/Supervisor. Submission from one’s mailbox constitutes the signature, and the application is considered with the understanding that all researchers agree to all the information provided and believe that it is accurate to the best of their knowledge. The FREGC does not accept application directly from students and it is expected that all students’ work will be reviewed by the supervisor before submission.

## Section A

### General Information

**Title of project:** Learning experiences: building capacity in health visitor students to respond to the reality of practice.

<table>
<thead>
<tr>
<th>Is the project</th>
<th>a PhD/ProfD/MPhil study</th>
<th>☑</th>
<th>BSc/MSc study</th>
<th>☐</th>
<th>Staff research</th>
<th>☐</th>
</tr>
</thead>
</table>

(Note as appropriate)

**Name of Principal Investigator:** Penny Lindley (Stage 2 Ed D student)

(This will the contact person for all correspondence with FREGC. Please indicate if you are the principal investigator or the supervisor of a student project by crossing out the inappropriate description.)

**School/Division:** Education

**Contact details:** Email: P.J.Lindley@brighton.ac.uk

Telephone: 01273 644067

**Name of Student(s) (for student project only):**

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Names of All Other Researchers: N/A

Does the project require IRAS/LA application?
Yes ☐ No ☑ Letter attached

Does the project require the sponsorship of the University of Brighton?
Yes ☑ No ☐

How will this project be funded? List all sources of funds (e.g. research grants, commercial sponsorship, school funds etc).
Funded by the researcher. Ed D supported by School of Nursing and Midwifery, University of Brighton

Has the project been subject to scientific or peer review (e.g. scientific review conducted by research councils or other funding agencies etc)?
Yes ☑ No ☐
If Yes, give details The study has been approved through the Research Panel Approval process. The panel consisted of Dr Carol Robinson and Dr Avril Loveless. My supervisors Professor Angie Hart and Dr Cathy Watts were also present. The outcome of the process is attached with this application.

Do any researchers have any financial interests in this research or its outcomes, or any relevant affiliations?
Yes ☐ No ☑
If Yes, give details

If you answer “Yes” to the above question, have you included an appropriate comment on the Participant Information and Consent Form? Yes ☐ No ☑

Proposed timescale of study
Start Date: April 2012 (data collection August 2012- August 2013)
Completion date: May 2014
Structured abstract (max 200 words see section 3.1.1 of guidelines)
The study aims to explore how student health visitors’ learning experiences contribute to development of their capacity to respond to the tensions between expectation and reality of their role. A case study methodology developed from a critical enquiry perspective will utilise focus groups, and semi-structured individual interviews. Participants will be recruited from a cohort of health visitor students. 8–10 participants will be recruited to a series of three focus groups. During the final months of the course semi-structured interviews will be carried out with 6 participants from the focus groups or from the wider cohort. Focus groups and interviews will be conducted on the University campus. A written invitation to participate will be distributed to all the students. All students will be invited to participate in the focus groups and interviews. If the required numbers are exceeded participants will be randomly selected. Data collection will take place between September 2012 and August 2013, and the study should complete in March 2014. The study will contribute to understanding of the relevance of salutogenic approaches to curriculum design and contribute to identification of a range of learning experiences facilitating development of resilience in students. If successful this may have relevance to other courses of professional study beyond health visiting.

Section B
Risk Assessment

Please tick the appropriate boxes.
Will the research study involve:

1. Causing participants physical damage, harm or more than minimal pain? Yes □ No □ X□

2. Manual handling of participants, vigorous physical exercise, or physical activity from which there is a likelihood of accidents occurring? Yes □ No □ X□

3. Intrusive physiological or psychological interventions or procedures? These might include: the administration of drugs or other substances; taking samples (eg blood, saliva or urine) from participants; use of probes or other equipment to measure or monitor bodily performance; techniques such as hypnotherapy. Yes □ No □ X□
4. Exposure of participants to hazardous or toxic materials, such as radioactive materials? Yes □ No □ X□

5. Inducing psychological stress, anxiety or humiliation? Yes □ No □ X□

6. Questioning of participants regarding sensitive topics, such as beliefs, painful reflections or traumas, experience of violence or abuse, illness, sexual behaviour, illegal or political behaviour, or their gender or ethnic status? Yes □ No □ X□

7. Vulnerable groups of people, for example children, people with learning disabilities or mental health problems? Yes □ No □ X□

8. Groups where permission of a gatekeeper is normally required for access to its members, for example ethnic groups? Yes X□ No □

9. Access to records of personal or confidential information? Yes □ No □ X□

10. Any other risk not identified above Yes □ No □ X□

Please describe:

Sufficient safeguards and monitoring procedures must be put in place in relation to any anticipated risks. If you answer “yes” to any of the above questions, you should describe the safeguards and monitoring procedures in place on a separate sheet of paper and attach it to this application form.
Section C

Governance Checklist

You are requested to answer the following questions to ensure that you will conduct the study within the Research Governance Framework of the University of Brighton and to fulfil your responsibility as the principal investigator or the supervisor.

1. I believe that the proposal is scientifically sound and ethical, and I am submitting the work to FREGC for independent expert scientific and ethical review. I agree that the study does not start without the approval of the FREGC and, if applicable, the NHS REC/LA.

2. I agree that the study will be conducted according to the proposal approved by FREGC, and that the study will comply with all the legal and ethical requirements. I shall ensure that the study will be carried out to the standards described in the Research Governance Framework of the University of Brighton, and if applicable, the Department of Health and any funding body.

3. I shall report any major changes in research methods or serious adverse events to the FREGC (and if applicable, NHS REC and any funding bodies) during the conduct of the study.

4. I have prepared and submitted the appropriate participant information sheet and consent form to FREGC. I shall ensure that the research team will give priority at all times to the dignity, rights, safety and well-being of participants.

5. I shall lead and manage the research work and submit annual progress and completion reports to the FREGC.

6. I shall ensure that the experience and expertise of all researchers are sufficient to discharge their role in the study. In the case of student project, I shall ensure that students have adequate supervision, support and training.

7. I confirm that procedures and arrangements are in place for the management of financial and all other resources required for the study, including the management of any intellectual property arising.
8. I shall ensure that, where relevant and appropriate, service users and consumers are involved in the research process.

   Yes ☐ No ☐

   N/A X ☐

9. I confirm that there are appropriate procedures for the collection, handling and storage of data. (The university guidelines on data protection are provided in Appendix 1 of this application pack.)

   Yes ☐ No ☐

11. I shall ensure that findings of the research will be open to critical review through the accepted scientific and professional channels and, where appropriate, they will be disseminated promptly and appropriately.

   Yes ☐ No ☐

12. As the principal investigator or the supervisor, I accept a key role in detecting and preventing scientific misconduct.

   Yes ☐ No ☐

13. For applications requiring NHS sponsorship, I confirm that agreement with the relevant Trust has been reached about the provision of compensation in the event of non-negligent harm. I have read the information about the university's indemnity cover (Appendix 3) which is normally sufficient for low-risk research projects. If this is not sufficient, I shall seek advice from the University's Insurance Officers and appropriate arrangement will be made.

   Yes ☐ No ☐

   N/A X ☐
8.2 NHS Research Ethics Committee Letter

03 October 2011

Penny Lindley
Assistant Head of School, Head of Continuing Professional Education Division.
Course Leader MSc Community Specialist Practice and MSc Specialist Community Public
Health Nursing, School of Nursing and Midwifery
Westcliff House
Village Way
Brighton BN1 9PH

Dear Ms Lindley

Full title of project: Learning experiences: building capacity in health visitor
students to respond to the reality of practice.

Thank you for seeking the Committee’s advice about the above project.

You provided the following documents for consideration:

Email dated 30/09 2011 & Ed D stage 2 University of Brighton September 2011

These documents have been considered by the Chair. The research based on
the information provided would not fall within the remit of an NRES committee according to the
current guidelines (GAIEC – Harmonised edition May 2011). Therefore it does not require
ethical review by a NHS Research Ethics Committee.

You should check with the NHS care organisation what other review arrangements or
sources of advice apply to projects of this type. Guidance may be available from the clinical
governance office.

You may wish to check whether the project should be reviewed by the ethics committee
within your own institution.

This letter should not be interpreted as giving a form of ethical approval or any endorsement
of the project, but it may be provided to a journal or other body as evidence that ethical
approval is not required under NHS research governance arrangements.

Yours sincerely

Nishanth Cherodian
Committee Co-ordinator

E-mail: ncherodian@nhs.net
8.3 Study proposal for ethics submission

Learning experiences: building capacity in health visitor students to respond to the reality of practice.

Penny Lindley Ed D stage 2

Abstract:
The study aims to explore how student health visitors’ learning experiences contribute to development of their capacity to respond to the tensions between expectation and reality of their role.

A case study methodology developed from a critical enquiry perspective will utilise a series of focus groups, and semi-structured individual interviews. Participants will be recruited from a cohort of health visitor students. 8-10 participants will be recruited to a series of three focus groups. During the final months of the course semi-structured interviews will be carried out with 6 participants from the focus groups or from the wider cohort. Focus groups and interviews will be conducted on the University campus.

A written invitation to participate will be distributed to all the students. All students will be invited to participate in the focus groups and interviews. If the required numbers are exceeded participants will be randomly selected.

Data collection will take place between September 2012 and August 2013, and the study should complete in March 2014.

The study will contribute to understanding of the relevance of salutogenic approaches to curriculum design and contribute to identification of a range of learning experiences facilitating development of resilience in students. If successful this may have relevance to other courses of professional study beyond health visiting.

Introduction

In 1995 a university in England set out to apply a whole systems health promoting approach to the university setting (Dooris and Doherty, 2009). Since then other universities have joined the health promoting university initiative and the latest strategy for public health in England includes the Healthy University
programme, identifying collaboration with businesses and voluntary bodies as a key feature (Cawood, 2010). A core purpose of the Healthy University initiative is to promote education for sustainable development. Sustainability is broadly understood to relate to environmental sustainability. Less well understood is the concept of sustainability in relation to the outcomes of education (UNESCO, 2005). This position reflects the growing body of opinion that the aims of education are broader than accruing knowledge and qualifications, extending to promotion of student wellbeing and development of the students’ capability in relation to the things that they may encounter in a life of work.

UNESCO (2005), at the beginning of its UN Decade for Educational Sustainable Development initiative posed, amongst others, the question

“What if education systems prepared learners to enter the workforce as well as handle a crisis, be resilient, become responsible citizens, adapt to change, recognize and solve local problems with global roots, meet other cultures with respect, and create a peaceful and sustainable society?”


These two initiatives support the increasing interest in education and health care practice regarding the ways in which practitioners can be supported in developing the capacity to withstand the demands and experience of practice. Health Visiting (the specialism of public health nursing focusing on families and children) has been under threat over the last decade, suffering considerable reduction in staff establishment and in the student numbers supported on courses (Lindley, Sayer and Thurtle, 2011). In the last two years, with a high profile child death (Care Quality Commission, 2009), and subsequently the recognition of the value of early interventions with young families, the need for this trend to be reversed has been acknowledged (Department of Health, 2011). The result is that recruitment targets for courses locally have more than tripled, and major service reconfiguration is required. All this is taking place in the context of the extreme financial constraint that exists across the public services.
This situation has contributed to discrepancies in practice between the broad, professional body public health standards, against which health visitor education is validated, and the reality of practice that is dominated by safeguarding (child protection) work (Lindley, Sayer and Thurtle, 2011). The theory practice gap has long been recognised as a phenomena in professional education. The current drive exacerbates this divide as student health visitors will continue to be prepared to fulfil a wider public health role in practice, whilst the reality of working in this way will be limited until the number of substantive health visitor posts is increased, and the service re-designed to meet the wider public health role.

The context of uncertainty and change in relation to both their new role and to the wider disruption caused by major change in the NHS can provide rich sources of learning, and the current situation can be seen to offer tremendous opportunities, however this may also pose significant threats. In their work as health visitors the students will be required to promote health and prevent ill-health through helping families to build on strengths, maximising their health outcomes as a result (DH, 2011). Given the organisational context identified it seems important that students are supported and enabled to recognise and build these qualities in themselves, in order that they have the capacity to be effective in their work environment.

Within the bounds of this study I aim to explore the means by which this may be facilitated through the learning experiences of the course.

A number of health promotion and public health theories and concepts, drawing on sociology and psychology, are recognised as having relevance to achieving these wider educational goals. These assets approaches, including resilience, have been described as contributing to a salutogenic framework (Lindstrom et al 2012). Salutogenic theory (Antonovsky, 1996) suggests a continuum from -ease to dis-ease, with -ease focussing on origins of positive health rather than responding to negative health at the dis-ease end of the continuum. Extrapolation of these theories and concepts to the context of learning is evident in the literature (McAllister and McKinnon, 2009; Jackson et al, 2007; Judkins et al, 2005; Hodges et al, 2005). Resilience, is widely seen as being the
ability to ‘bounce back’ when encountering adverse experiences. It is observed that some do this much more successfully than others (McAllister and McKinnon, 2008), and a number of conditions that increase this ability have been identified. Similarly hardiness (Judkins et al, 2009) has been defined as a personality trait strengthening resistance to stressful events. The value of paying heed to the attributes and qualities promoting resilience is identified to a varying extent in a range of literature (McGee, 2006; Vinje and Mittelmark, 2006; Gillespie, Chaboyer and Wallis, 2007; Vinje, 2007; Gallos, 2008). Lindstrom and Erikson’s (2011) recent work, although taking these ideas further, confirms that research is needed to explore this approach to education. Previous work for the Ed D supported the contention that learning that takes place through the ‘wholeness’ of the course including sources other than teaching specific components, a demonstration of the importance of ‘hidden curriculum’. Taking this broader approach; consideration needs to be given to the learning experiences of students across the whole range of academic and practice settings.

Learning theory has also contributed to the study’s aims and design. Illeris (2009) suggests that transformative learning (as identified by Mezirow (2009)), leads to fundamental changes in self, and only occurs in extreme circumstances where the person has to undergo profound change in order to progress. When Kegan (2009) refers to transformative or transformational learning however, he refers to learning that is not just about taking on more information, or content, but about the ‘changes in how we know’ (Kegan, 2009 p42) which is about building capacity. He contends that informative learning can take place, where the bank of knowledge is increased, but in absence of transformative learning this is not translated into increased capacity in relation to such things as creativity, abstract thinking, or problem solving. These characteristics, Flores et al (2010) contend, are central to critical thinking, and are identified as components of resilient or higher order thinking (Fazey, 2010). I would suggest that they are also relevant to the process of health visiting which is very demanding in the emotionally difficult work of risk assessment and decision
making regarding children and families (Department for Education, 2011).

What is already known:
There is a wide body of research regarding the promotion of resilience in a number of population groups who have experienced adversity, and relating to salutogenesis as a principle underpinning public health and health promotion practice. There is also literature identifying that education should take account of the need to develop associated attributes and qualities, which are necessary to deal with the adversity encountered in practice. There are a few studies drawing on promotion of resilience in social workers and teachers.

What this study will add:
There is a lack of work examining the whole experience of student learning and its contribution to development of resilient practitioners. Taking account of the breadth of contexts within which student learning takes place, this study will consider from the student perspective, learning across the range of their experience, and the ways in which this may have contributed to their capacity to respond to their experience of difference in expectation and reality of practice. No existing studies relating to specific application in health visitor education have been identified.

Research aims
1. To explore how learning, in both university and practice settings, contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the health visitor.
2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.
3. To explore the relevance of the application of salutogenic principles to curriculum design in order to support the development of resilient practitioners.
Research question:
How do student health visitors’ experiences in higher education and practice settings contribute to development of their capacity to respond to the tensions between expectation and reality in their practice role?

Sub questions:
- What personal resources do student health visitors see as necessary to their ability to manage the tensions in expectations in practice?
- How do students’ experiences in the university and practice build their resilience to change in role expectations?
- What experiences do student health visitors identify from the HEI and the practice environment that have facilitated or obstructed development of their capacity to respond to the reality of practice?
- What is the relevance of salutogenic principles to students learning experience?

Research approach and methods

Health care has been dominated by a medical model based in positivist ontology, valuing random control trials as the basis by which care should be developed and evaluated (Nairn, 2012; Porter and O’Halloran, 2012). Interpretative approaches are now commonly applied to researching the process of nursing and education (Pawson, 2012). As I have developed through my academic and practice careers I have moved away from seeing the world as simple cause and effect reflected in the illness and cure approach of medicine. I still see possibilities for causality albeit through complex interactions between interventions and the social and historical experiences of the people involved.

Nairn (2012) explores the importance in critical realism of relationships between ontology and epistemology. The post-positivist ontology of critical realism situates the researcher in a position in which reality may be taken to be ‘out there’; there is a real world but it is not unchangeable or unchanging. Social and physical structures change but they make up a single world. The epistemology of critical realism, the way in which sense is made of this world, is not fixed but grounded in social and historical contexts of the individuals experiencing the
world. Principles of critical realism are situated within three domains; the real, the actual and the empirical (Bhaskar, 1975). The ‘real’ are causal mechanisms that may lead to an effect within the system; the ‘actual’ specific interventions and their consequences, which may or may not be observable; and the ‘empirical’ the outcome of the interventions and the experience of those involved.

My position in undertaking this study is that there is a world including the environments of university, practice and personal learning that is ‘out there’ and has a high degree of commonality across the student cohort. There are social, historical and educational experiences that the students have in common and individually that affect the way in which they experience this world. The research aims and questions of the study relate to identification and explanation of causal relationships (Wilson and McCormack, 2006) in the complex environment in which the curriculum is situated. It is hoped that the combination of data collection methods will illuminate the real, actual and empirical domains that are central to this approach.

Critical realism is characterised through application at a number of levels. It makes distinctions between “things we experience and things that cause what we experience” (Longhofer and Floersch, 2012 p3) and between the three domains, (real, actual and empirical) referred to earlier. The three domains cover the range of what exists (real), what is experienced (empirical) and the elements that are introduced into the system and their consequences (actual) (Longhofer and Floersch, 2012). The implications of critical realism for understanding causal relationships dictate that what actually happens in an interaction cannot be explained without taking the context of that interaction into account. Within that context the concept of emergence is central in applying a critical realist perspective. Social or physical structures can emerge from interactions (Cruickshank, 2012; Longhofer and Floersch, 2012). It may be that different emergent properties cancel each other out thus preventing the outcome that may have been desired or anticipated (Wilson and McCormack, 2006). These emergent properties contribute to a strata of realities built up in a hierarchy. An example of such a hierarchy is identified as the mind emerging
from the brain, the self emerging from the mind and identity emerging from the self (Smith, 2010). This example illustrates the complexity of causality that critical realism seeks to address. This notion of open stratified systems is used to introduce the idea that there can be interactions at different levels within the organisation of the system that give rise to the causal mechanisms that promote or block outcomes (Cruickshank, 2012). In addition emergent properties can act back on earlier layers in the strata in a kind of feedback mechanism described as “downward causation” (Longhofer and Floersch, 2012).

A case study approach utilising mixed methods will be utilised in this study. Case study as a research approach (Simon, 2009), or overarching strategy (Yin, 2009) for gaining knowledge of the world as defined by the research aims (Denzin and Lincoln, 2011) facilitates exploration of complex real life problems (Anthony and Jack, 2009) and allows for non-linear approaches to causality. The approach allows the researcher to ask ‘how’ and ‘why’ in examining contemporary events (Yin, 2009). Simons (2009) supports the contention that it is suited to dealing with the complexity of education and practice, allowing for the uniqueness of the case under examination. For these reasons of complex causality and in seeking explanation, the use of case study is a good fit with a critical realist approach as the strategy recognises multiple influences within a whole system, and the emergence of alternative perspectives. The characteristics of case studies are categorised in a number of ways by different authors, but held in common are the notions of a “functioning specific” or “bounded system” (Stake, 2008, pp 119-120). The limits or boundaries of the system are defined, but the system is an open system in that the interactions within it, which are affected by external influences, are complex. A case study strategy from a critical realist perspective therefore provides an appropriate framework for the proposed study, in that multiple sources and experiences of learning are to be examined and interactions between them it is anticipated. These may be complex and possibly unique to the case and to participants within the case.
The ‘case’ proposed is a health visiting course within the University of Brighton, where the students have practice placements across the county. It is proposed that participants be drawn from students commencing the course in the academic year 2012-13. This is a single case, which is not seeking comparison between cases, or replication, but will explore the context of students undertaking one course. The boundaries of the case are the practice and university system within which the health visitor students’ preparation takes place. The decision to limit the study in this way is three-fold. Firstly health visitor courses, although meeting national standards, do not have a shared curriculum so are all unique. The research questions are appropriate to investigation of a single case, although findings might lay a foundation for a broader multi-case study investigating the efficacy of different approaches to curriculum design and organisation at some future point. Secondly, there are pragmatic issues to be considered. The study needs to be undertaken within the constraints of full-time work plus doctoral study, so the time taken to travel to alternative sites would be a further demand. Use of telephone interviewing and on-line focus groups has been considered, but experience of the former in previous Ed D work was that the interview data did not give the richness of the personal interviews. Finally as the students are NHS employees, access through multiple employing organisations would be complex.

Case study approaches utilise a range of methods for data collection. These contribute to the robustness of the research through triangulation. It is proposed to use a series of activity based focus groups and individual semi-structured interviews over the period of a year. Content analysis of course handbooks and documents will be included to provide background information on the expectation of curriculum delivery. Plans for focus group activity and a draft interview schedule are included. With case study design there is the capacity to amend or add alternative methods of data collection as the study unfolds, and should this be necessary I will discuss the need for further ethical clearance with my supervisors.

The focus groups will bring together students who are in the same cohort. As the focus groups will be spread over a period of nine months relationships
between the participants will develop over the period of data collection. It is not possible to predict the group dynamics, but hierarchies, negative and power relationships may exist (Barbour and Schostak, 2005). One of the advantages of focus group method is that the processes of achieving consensus or establishing the basis of disagreement, and the construction of meaning and understanding can be made visible (Willis et al, 2008). These processes need to be safe for the participants. Ground rules will be established at the outset of the first group, and re-visited on each subsequent occasion, requiring respect of individual views and opinions. Moderation of the focus group will ensure that the different voices within the focus group are heard.

In both interviews and focus groups there is always a possibility that material may be disclosed that indicates that an individual is either at risk in some way, or that behaviour that breaches required codes and standards has occurred. In the participant information, in the focus group ground rules and at the beginning of the interviews the limitations of confidentiality will be made clear.

It is not anticipated that the material covered in either the focus groups or interviews will be distressing, however this possibility cannot be ignored. In the event that participants become distressed the recording will be suspended, and the activity subsequently terminated if either the participant or researcher deems this appropriate. As students, counselling support can be accessed by participants through student services if necessary. As an experienced practitioner accustomed to working with clients with varying vulnerabilities and health needs, I can also direct to other sources of support and guidance relevant to the issues identified. I would not provide any counselling or professional advice in the course of this process.

Data collection will take place over the duration of the course allowing capture of a range of experience in a timely way (see attached Gantt chart). Access to course documentation will be negotiated through the head of school and course leader. Focus groups and interviews will take place within the university outside academic and practice teaching hours, at intervals over the period of the course. Timing will avoid points at which students are experiencing high
workload due to submission of assessed work. Focus groups and interviews will be audio recorded for later transcription. Summaries of the focus group transcriptions will be offered to all participants allowing opportunities for confirmation of material avoiding compromising confidentiality of group participants. Opportunity for more specific scrutiny will be offered if required. Transcripts of individual interviews will be made available to participants for confirmation of material.

I have a hard disk recorder to record focus groups and interviews, and a digital camera to take photos of products from the focus groups, and a video camera for record focus groups. Access to rooms will be negotiated within the school. I will bear the cost of transcription and of stationery and computer accessories required, and of any refreshments required within the focus groups and interviews. Some study time is available through scholarly activity hours allocated in my role, and a sabbatical is supported by my Head of School for the later stages of analysis and writing up the study.

Insider research

The Doctorate in Education requires that students will contribute to the body of professional knowledge and practice within a specific area of education, critically reflecting on the professional context in the process. It is recognised that much research undertaken within such professional doctorates can be defined as ‘insider research’ (Mercer, 2007). Indeed, within a professional doctorate it can be argued that all research is likely to be insider research as the researcher is investigating within the parameters of their own professional arena.

The merits of insider and outsider research can be argued positively or negatively depending on personal stance, and the degrees of insider-ness or outsider-ness are often complicated and unclear (Gair, 2011; Brannick and Coghlan, 2007). Mannay (2010) describes how she used an insider approach in
her research “gaining an understanding of mothers and daughters’ impressions and interpretations of their local environment”. She argues that her status as an insider researcher gave her insight into the context of the marginalised group that was the subject of the study, giving her credibility within the group. Conversely this insight can be argued to undermine neutrality in approaching the participants (Sword, 1999; Darra, 2008). Mannay (2010) recognises this danger and explores in some depth the strategies that she used in order to “make the familiar strange”. She used a number of visual techniques as a basis for interviews that participants went on to describe and explain, avoiding the possibility of questions that lead the participant in the direction that may have been expected by the interviewer. This strategy is reflected in the focus groups included in this study, in which it is planned to use a number of visually based activities that should allow the participants to raise issues for themselves, then to explore and build shared meanings and interpretations.

Mercer (2010) similarly recognises the danger of leading participants to express a particular view and describes the way in which she adapted her interviewing technique, reducing her level of intervention or affirmation, which may have had the effect of leading the participants to highlight the issues that she expected to emerge. Further Mercer (2010) identifies a dilemma in terms of how much the insider researcher tells colleagues about the research questions on the basis that this might direct the participants in a particular direction. Academic colleagues are not participants in this study, so these challenges are not so pressing on that level. However in gaining informed consent from the participants it is necessary to be honest about the purpose of the research. The research questions in this study are exploratory, and do not indicate an expectation of specific responses. It will be made clear at the outset of focus groups and interviews that as this is about the participants’ own experiences there are no right or wrong answers.

Insider knowledge can be seen as a positive contribution to understanding of the context of the study (McNiff and Whitehead, 2010), but conversely issues of bias need to be considered. Reflexivity is suggested as a requirement to reduce this bias. Reflexivity is identified as working on two levels. Epistemological
reflexivity relating to justification of choice of research strategies and methods; and personal reflexivity to self-awareness and reflection in action as the study progresses, with the object of recognising and reducing behaviour or interaction that might promote bias, and threaten the veracity of the research (Dowling, 2006). Reflection in and on action (Schön) is a necessary component of reflexivity. This can be supported through keeping a diary or field notes in close proximity to data collection, whatever method is used. Field notes and memoing are frequently referred to in grounded theory and ethnographic studies. Within this study the use of a reflective diary and specific reflection on data collection episodes, combined with reflection in action, will support reflexivity in the process of data collection. Following the focus groups debriefing with the second moderator will aid this process. With the interviews discussion with supervisors and peers (preserving confidentiality of participants) will also support reflexivity. This process will also allow me to be mindful of the different roles that I hold within the organisation, how these may be perceived by the participants, and any role confusion that may exist for me. Wearing more casual clothing, such as jeans and tee shirts may help to make a visual differentiation between the lecturer and research student role.

Risk of bias may be also reduced by rendering the situation strange by looking at the data through a different theoretical lens. In this case it will be through theory relating to salutogenic principles, rather than as a member of academic staff with responsibilities relating to the course.

The above issues are important, but one stands out as especially worthy of attention in terms of insider research in relation to my particular study, that of the complex power relationships within which this work is situated. Students who will be invited to take part in the study are students within the Division that I lead in a School at University of Brighton. In the past I have been course leader for the course, and as such have a clear insight into the approval of the course and its development. This can be seen as an advantage, however the predominating ethical issue with insider research involving students within the home institution is that of power. To mitigate these issues, I no longer have
responsibility for running the course or day-to-day contact with the students as pathway leader or personal tutor, so will not know the students well and will not be involved in management of their course. I may teach some sessions on the course, contributing to delivery of occasional sessions in up to three modules on the course, but will not be involved as a module leader or facilitator of series of action learning sets or problem based learning trigger groups. Neither will I be involved in marking the work of the cohort involved. It will be important for me to emphasise, when recruiting participants, that there is no compulsion to take part, that they can withdraw without penalty at any time, and that they will not be disadvantaged in anyway if they choose not to participate. Previous successful Doctoral research in the School involved a colleague in a similar position, researching students on a course related to her own professional discipline (Hall, 2001). I believe that the measures outlined above take account of the ethical issues arising from insider research in a similar way to Hall’s work.

In addition, as I am chair of an examination board where one module from the course is normally presented, I have negotiated that results for this module be presented at a different examination board. It would be inappropriate for me to deal with examination board processes for students involved in the study.

Participants

The students who will be invited to participate in the study are employed on training contracts in the NHS. The study is focussing on their learning experience as students. Confirmation has been received that ethical approval is not required through IRAS, and is included with this documentation. The pool from which participants can be recruited is self-limiting, defined by the boundaries of the case. A purposive sample will comprise 8-10 participants in focus groups, and approximately 6 participants will take part in the individual semi-structured interviews, drawn from the cohort of students undertaking the undergraduate Health Visiting course at University of Brighton. The course starts in September 2012 and runs over a full calendar year. The student cohort will be predominantly or totally female. Some of the students may have recently
achieved their first registration with the Nursing and Midwifery Council; others will have been qualified for some time.

Students undertaking the health visitor course have a very full programme of academic study and practice experience. It is therefore important to consider their workload in timing the different stages of the study. The focus groups have been scheduled at the beginning of the academic year, following university and practice induction, and then after the submission points at the end of Semester one and Semester two. The interviews will be carried out during the period of consolidation of practice that is at the end of the course. During this period the students are purely consolidating practice, not undertaking further assessed work.

Any study that uses peoples resources and goodwill needs to be justifiable. It is hoped that this study will be helpful in development of future curricula so is of benefit to the course design and organisation. If the means by which capacity can be built to be resilient in practice can be identified, this will also be of benefit to the participants themselves and their employing organisations. In addition, from previous work for the Ed D it became clear that the process of being involved with the study and the reflection that participation required, can in itself be beneficial to the students understanding of the outcomes of the educational process, and their personal development through this.

Identification and recruitment

Access to participants will be confirmed through the Head of School, and mechanisms agreed with the course leader. Students will not be coerced to participate and will be free to withdraw from the study at any time without adverse consequences. All students will be invited to take place through a letter prior to the start of the course. An announcement on the course VLE will highlight the study after students have commenced the course, and a final letter to gain further participants will distributed through university e-mail accounts if necessary.
Consent

Informed consent will be sought from participants at the beginning of the study and confirmed at appropriate points through the stages of the process. Written participant information will be given at the outset, and clarification supplied prior to each focus group and the interviews. Consent will be recorded through completion of a consent form prior to the start of the study. If students withdraw during the process of the study any data collected already will be used in the final analysis. This will be clearly stated on the consent form.

Confidentiality, privacy and data protection

The identity of participants will be protected throughout the research process. Focus group ground rules will require that information disclosed within the confines of the group is not discussed outside. This relies on the integrity of the participants, but as all are on a professional register with the Nursing and Midwifery Council (NMC) their code of conduct requires them to maintain confidentiality unless their duty of care dictates that it is the interest of safety to disclose information to an appropriate body (NMC, 2008). This expectation and interpretation of the bounds of confidentiality would extend to the context of the research and be clearly stated in the ground-rules set for the focus group activity and at the beginning of the interviews. Identification of the limits of confidentiality would allow action to be taken if a participant disclosed poor practice or safeguarding issues that require me to act in accordance with my own code of professional conduct as a nurse. Anonymity and confidentiality will be protected throughout transcription, storage, and analysis of data, and reporting of findings.

In any study that involves exploration of personal experience the researcher cannot be sure that difficult emotions will not emerge. In the normal course of events, if a student finds the emotional labour of the course difficult they can be
referred to student services for counselling support. Clearly there would be no intention to provoke difficult emotions through participation in the study, but if these did emerge then this support could be offered. My own professional experience would support appropriate referral to sources of support if difficult emotions are engendered by the process.

Participants will be offered the opportunity to check transcripts, or listen to recordings of interviews and summaries of focus groups, confirming that what is presented is an accurate record, and giving them the opportunity to clarify information and impressions given. Preliminary analysis of data from focus groups will be taken back to the participants for discussion and verification. The use of quotes from focus groups and interviews will be explained to the participants, so that they are aware of this when checking the content of transcripts. Data will be kept securely and processed on a private computer accessed only by me. The use of data will be explained to participants and the circumstances in which raw data is shared with supervisors will be identified. Principles of data protection required by University ethics processes will be adhered to.

**Data analysis**

The scope of the data collected through the mixed methods of the case study is wide, but the robustness of the study is evidenced through triangulation across the scope of the data relating it all back to the research questions (Yin, 2009). A theoretical framework drawing on salutogenic concepts and principles will be devised, to support this process. At this stage it is anticipated that this may take the form of an ecosystem, but this may develop in another form as the work progresses.

Although a number of sources will be used the main focus will be on qualitative data, and analysis will be undertaken across the sources using content analysis (Bell, 2005). All data analysis will be undertaken by me, with reference to the
focus group second moderator and participants as identified, and my supervisors. Content analysis of qualitative data allows for subjective interpretation through a systematic process of coding and categorising (Hsieh and Shannon, 2005). Matrices (Miles and Huberman, 1994) and concept mapping (Simons, 2009) will be used to help draw the themes emerging in different data sets together.

A predominantly inductive approach to data analysis will be taken, drawing themes from the data and exploring related theory as its relevance emerges. The process will be supported through reference to field notes and a reflective diary. This is more akin to Wolcott’s (1994) process of describing, analysing and interpreting the data, than Miles and Huberman’s (1994) deductive approach of defining start codes from theoretical frameworks and ascribing the data to these codes. This description, analysis and interpretation of the data will take place on a continuous basis, allowing adjustment to future data collection and ongoing exploration of theory to support the findings that emerge (Simons, 2009).

I hope to take an audio approach to analysis of interviews, rather than transcribing and exclusively using the written scripts. Becoming immersed in the spoken word, and the emphasis placed through participants’ language and intonation may take more account of instinctive interpretation (Simons, 2009) that may be lost through a mechanistic scrutiny of hard copy. Such an approach can be aligned with cognitive mapping of data as a means of identifying emerging themes (Northcott, 1996). Use of “listening” in the data analysis process may also help in the appropriate identification of participants quotes, essential to the ‘thick description’ that adds to the depth of the data through inclusion of individual experiences and contexts (Geertz, 1990).

Analysis of focus groups will be based on audio and video recordings of the activity and photographs of the products; and of documents through content analysis of the texts. Data will be coded and categorised for integration with findings from other sources. The process of the focus group will also be analysed to illuminate the ways on which the group works towards developing an understanding of the issues covered (Willis et al, 2008). Reflexivity, as
identified earlier, will be a critical contributor to data analysis ensuring the veracity of the study.

Through the process of thematic analysis the study will meet the aims in developing understanding of the relevance of salutogenic approaches to curriculum design. It will contribute to identification of a range of learning experiences facilitating development of resilience in students. The findings may have relevance to other courses of professional study beyond health visiting.

**Conclusion**

Through the process of the research participants will reflect on their learning experiences and will hopefully develop some understanding of the means by which they respond to the experience of difference in role expectation and reality. If congruent with salutogenic concepts such as resilience, this experience should help them understand their responses and how these may support them through their careers, in both the short and long term. The work is thought to be low risk, though with any qualitative research adverse impact on the participants cannot be completely discounted. Measures will be taken if such situations arise to ensure that participants receive appropriate support.

Through the process of thematic analysis the study will meet the aims of the study in developing understanding of the relevance of salutogenic approaches to curriculum design. It will contribute to identification of the ways in which a range of learning experiences may facilitate development of resilience (or related states) in students. The findings may have relevance to other courses of professional study beyond health visiting.

The study will contribute to understanding the relevance of salutogenic concepts such as resilience, to curriculum development and the organisation of learning experiences; and how learning promotes these attributes and qualities. The importance of this is recorded in the literature, but how it is achieved through education programmes is not evident.
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**Planned timescales**

- Ethical approval: April 2012
- Pilot focus group activities: June 2012
- Focus group 1: July 2012
- Focus group 2: August 2012
- Focus group 3: September 2012
- Transcribing: October 2012
- Pilot interview: November 2012
- Interviews: December 2012
- Literature review: January 2013
- Development of theoretical frameworks: February 2013
- Data analysis: Focus groups: March 2013
- Data analysis: Interviews: April 2013
- Completion of write up: May 2013
- Completion of thesis for submission: February 2014
8.4 Participant Information Sheet

Learning experiences: building capacity in health visitor students to respond to the reality of practice.

Who am I?

I am Penny Lindley, a student undertaking the Doctorate in Education (Ed D) in the School of Education at University of Brighton, and this research study is the basis of my final thesis. Although I am also an academic in the School in which you are studying, I am undertaking this study in my capacity as research student. I may teach occasional sessions in some of your modules but I will not be involved in assessing any of your work.

Purpose of the research study

We know that often what you expect a job to be and what it actually is can be two different things. I am carrying this research out to try and find out how we can develop courses and learning experiences that help you to develop the ability to deal with any differences between expectation and reality that may arise.

What will participation in the study involve?

The research will be carried out through a series of three focus groups where I hope there will be 8-10 people; and an interview that will be carried out with each person on their own. The focus groups will each last between and hour and an hour and a half. The interviews will last about 45 minutes with each person. The timing will avoid the times when you are meeting deadlines for submitting your assignments. The focus groups and interviews will take place on the Falmer campus.

Who is being invited to take part?

I am inviting the students who will be in your cohort of health visitor students to participate. I will be facilitating the focus groups and carrying out the interviews. In the focus groups there will be another research student who will be helping me to get the best from the activity and making some notes on the process for me. The focus groups will be audio and video recorded, and the interviews will be audio recorded. This will mean that I have an accurate record of what is said and done. You will have the
opportunity to read a summary of the focus groups, and the transcript of the interview to make sure that they reflect what it was you meant to say. You will also have the chance to comment on the preliminary analysis of the focus group outcomes. In the event that more students volunteer to take part than it is practical to include in the study I will randomly select participants from those volunteering to take part.

What will happen in the focus groups and interviews?

The focus groups will include some group activity, and discussion of ideas that come out of the activity. The interview will follow up on things coming out of the focus groups and give you the chance talk about issues and experiences that you think are important. If anything unexpectedly crops up during the course of the focus group or interview that touches on things that upset you I will direct you to student services or other sources of support. Should you wish to make contact yourself student services can be contacted on: studentadvice@brighton.ac.uk 01273 642888

Do you have to take part?

Taking part in the study is entirely voluntary, and I will be delighted if you agree to take join in. If you want to withdraw at any stage, then you will be free to do so, without explaining your reasons, and there would be no problems for you as a result of taking that decision. If you did withdraw, I would use your contributions up to the time that you withdrew, in my study.

Is what you say confidential?

What you say will be confidential in the same way as it is viewed within your code of professional conduct. If something is said that means that confidentiality needs to be broken, for example because someone is in danger, then I will talk to you about it. I will make sure that your identity is not evident in the analysis and reporting of the study. I will use direct quotes in writing up the study, but will make sure that you are not identifiable in the process. All of the data I collect will be stored securely, and will only be seen by me and my supervisors. In this process your anonymity will be maintained. When I transcribe the data pseudonyms will be used, so even when the raw data is examined you will not be identified by your real name.

Why am I doing this study?

I hope the study will aid understanding of how we can best support students moving into new professional roles. This could be helpful for students in your position in the
future. Sometimes taking part in studies such as this can help students to recognise how the process of education has contributed to personal development.

**Will the outcomes be published?**

I hope the research will produce findings that can be shared through publication in journals and at conferences. If findings merit dissemination in this way they can contribute positively to future students’ experience. As a constituent of Doctoral research the thesis will be available through the university repository via the internet.

**Has the study protocol been vetted by an ethics committee?**

The proposal has been approved by the University of Brighton Faculty of Health and Social Science Faculty Ethics Committee. The NHS ethics process (GAfREC) have confirmed that approval is not required through their processes.

**If you are unhappy about the research process who should you complain to?**

Any concerns about the research process can be directed to:
My supervisor: Professor Angie Hart Mayfield House, University of Brighton, Falmer BN1 9PH
or
Chair of the Ethics Committee: Professor Julie Scholes, Mayfield House, University of Brighton, Falmer BN1 9PH
or
Head of School of Nursing and Midwifery: Dr Shirley Bach, Westlain House, University of Brighton, Falmer BN1 9PH

Many thanks for reading this, and I hope you will feel able to participate.

Penny Lindley

Doctorate in Education student
School of Education
University of Brighton
P.Lindley@brighton.ac.uk
8.5 Participant Consent Form

Learning experiences: building capacity in health visitor students to respond to the reality of practice.

♦ I agree to take part in this research; which is to explore whether my learning experiences will help me deal with differences between expectations and reality of the health visitor role.

♦ The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.

♦ The process has been explained to me and I have also read the information sheet. I understand the process fully.

♦ I am aware that I will be required to take part in a series of three focus groups and be interviewed about my experiences.

♦ I understand that any confidential information will be seen only by the researchers and will not be revealed to anyone else.

♦ I understand that I am free to withdraw from the investigation at any time. I understand that if I do withdraw, the data already collected will be included in the study.

Name (please print)
...............................................................................................................................

Signed
.................................................................................................................................Date
.................................................................................................................................
8.6 Participant Recruitment Letter

Dear student

I am writing to you as a student who will be commencing the health visiting course at University of Brighton in September 2012.

I am studying for a Doctorate in Education in the School of Education at the University of Brighton, and will be carrying out a research study with students on the health visiting course over the next academic year. The title of the study is “Learning experiences: building capacity in health visitor students to respond to the reality of practice.”

I am including with this letter the participant information sheet for this research study, and a consent form. Please read the information and consider whether you would like to take part. I very much hope that you will feel able to participate. If you would like to do so please complete the consent form, and return it in the stamped addressed envelope provided. I will contact you again when you start the course.

I look forward to hearing from you.

Kind regards

Penny Lindley
Doctorate in Education student
8.7 Initial University Ethics Decision Letter

Decision Letter (FREGC-12-018)

From: J.Scholes@brighton.ac.uk
To: p.j.lindley@brighton.ac.uk
CC:

Subject: Faculty of Health and Social Science Research Ethics and Governance Committee - Decision on Manuscript ID FREGC-12-018

Body: @date to be populated upon sending @

Dear Mrs. Lindley:

Application ID FREGC-12-018 entitled "Learning experiences: building capacity in health visitor students to respond to the reality of practice," which you submitted to the Faculty of Health and Social Science Research Ethics and Governance Committee, has been reviewed. The comments of the reviewer(s) are included at the bottom of this letter.

The reviewer(s) have recommended that subject to minor revisions to your application, the proposal be approved. Therefore, I invite you to respond to the reviewer(s)' comments and revise your application according to their recommendations. The amendments you make should be listed against each comment made by the reviewer.

To revise your application, log into http://mc.manuscriptcentral.com/fregc and enter your Author Centre, where you will find your application title listed under "Manuscripts with Decisions." Under "Actions," click on "Create a Revision." Your manuscript number has been appended to denote a revision.

You will be unable to make your revisions on the originally submitted version of the manuscript. Instead, revise your manuscript using a word processing program and save it on your computer. Please also highlight the changes to your manuscript within the document by using bold or coloured text.

Once the revised application is prepared, you can upload it and submit it through your Author Centre.

When submitting your revised application, you will be able to respond to the comments made by the reviewer(s) in the space provided. You can use this space to document any changes you make to the original manuscript. In order to expedite the processing of the revised manuscript, please be as specific as possible in your response to the reviewer(s).

IMPORTANT: Your original files are available to you when you upload your revised manuscript. Please delete any redundant files before completing the submission.

Because we are trying to facilitate timely approval of applications submitted to the Faculty of Health and Social Science Research Ethics and Governance Committee, your revised application should be uploaded as soon as possible. If it is not possible for you to submit your revision in a reasonable amount of time, we may have to consider your paper as a new submission.

Please note, you may not start your research, or forward your proposal to external agencies until the application has been finally approved by FREGC.

Sincerely,
Prof. Julie Scholes
Chair, Faculty of Health and Social Science Research Ethics and Governance Committee
J.Scholes@brighton.ac.uk

Reviewer(s)' Comments to Author:
Reviewer: 1
Comments to the Applicant
Good luck. An interesting proposal and well written.
Reviewer: 2
Comments to the Applicant
This is a very interesting research proposal and has the potential of making a significant contribution in the area of health professional education. The methodology is well explored but the overarching epistemological position is too brief; a greater theoretical exploration of the critical realist approach is necessary.

Date Sent: 09-Jul-2012
8.8 Final University Ethics Decision Letter

From: onbehalf+J.Scholes@brighton.ac.uk on behalf of Julie Scholes [J.Scholes@brighton.ac.uk]
Sent: 14 August 2012 13:59
To: Penny Lindley
Subject: Faculty of Health and Social Science Research Ethics and Governance Committee - Decision on Manuscript ID FRESC-12-818.R1

14-Aug-2012

Dear Mrs. Lindley:

It is a pleasure to approve your application entitled "Learning experiences: Building capacity in health visitor students to respond to the reality of practice," which has been approved by the Faculty of Health and Social Science Research Ethics and Governance Committee. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Please notify The Chair of FRESC immediately if you experience an adverse incident whilst undertaking the research or if you need to make amendments to the original application.

We shall shortly issue letters of sponsorship and insurance for appropriate external agencies as necessary.

We wish you well with your research. Please remember to send annual updates on the progress of your research or an end of study summary of your research.

Sincerely,

Prof. Julie Scholes
Chair, Faculty of Health and Social Science Research Ethics and Governance Committee J.Scholes@brighton.ac.uk

Reviewer(s)’ Comments to Author:
Reviewer: 2
Comments to the Applicant
The themes of critical realism have been explored and their relationship to the chosen methodology are apparent. Your study holds significant potential. Best wishes and every success.

This email has been scanned by MessageLabs’ Email Security System on behalf of the University of Brighton.
For more information see http://www.brighton.ac.uk/is/spam/
8.9 Confirmation NHS Permission Not Required.

RE: FREGC-12-018.R1 - Learning experiences: building capacity in health visitor students to respond to the reality of practice.
Doctoral research.
Vaughan Helen [Helen.Vaughan@wsht.nhs.uk]

Sent: 20 August 2012 16:08
To: Penny Lindley
Cc:

Dear Penny,
Thank you for calling me back. You confirmed that the Students will identified and recruited through University staff and that all the research activity will take place on University premises and that no NHS time will be taken by the participants to participate.
I can, therefore, confirm that the students are not considered NHS staff participants and NHS permission is not required.
Best wishes,
Helen

Helen Vaughan
Senior Research Governance Officer
Sussex NHS Research Consortium

Research and Innovation Department
Dear Penny

Thank you for contacting me. I am happy to give my consent to you contacting students for your study. I do hope it goes well.

Kind regards

Shirley

---

Dr Shirley Bach, School of Nursing & Midwifery,
University of Brighton, Westlайн House, Village Way, Falmer, Brighton, BN1 9PH

Direct Line: +44 (0) 1273 643483  Mobile: +44 (0) 7909 520102  Fax: +44 (0) 1273 644010

Email: s.a.bach@brighton.ac.uk

http://www.brighton.ac.uk/snm/

---

Dear Dr Bach

I have now received ethical clearance from FREGC to proceed with my study “Learning experiences: building capacity in health visitor students to respond to the reality of practice”. I write to formally request access to Health Visitor students in the School of Nursing and Midwifery.

I have discussed access to students on the courses running during academic year 2012-2013 with the Course Leaders. I plan to carry out a series of three focus groups, and individual semi-structured interviews over the period of the academic year. The timing of this data collection has been planned to coincide with periods when students work-load for the course is at its lowest. Every effort will be made to ensure that participation is not detrimental to the participants.

I hope this will be positive experience for the participants, enabling them to critically examine their learning experiences over the period of the course, and to learn further from this examination for their future professional lives.

I hope that you are able to agree access to this student group, so that I can recruit participants prior to starting the course in September. This will be done through a letter and participant information approved by FREGC.

Yours sincerely

Penny Lindley  Student: Doctorate in Education
### Appendix 9: Focus Group pilot

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<th>Strategies and skills</th>
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<td><strong>Co-operation</strong></td>
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<td><strong>Creativity</strong></td>
<td><strong>Prioritisation</strong></td>
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<td>Energy</td>
<td><strong>Abstract thinking</strong></td>
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<td><strong>Self-esteem (feelings of own value)</strong></td>
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<td><strong>Self-efficacy (belief in ability to control events in life which have significance to individual.</strong></td>
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<td>Trusting</td>
<td><strong>Listening</strong></td>
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<td><strong>Responding</strong></td>
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<td><strong>Open-minded</strong></td>
<td><strong>Belonging to a social group</strong></td>
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<td>Self understanding</td>
<td><strong>Taking control (internal locus of control)</strong></td>
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<td><strong>Challenge</strong></td>
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<td>Level headed</td>
<td><strong>Perseverance</strong></td>
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<td>Self-discipline</td>
<td><strong>Find support when needed</strong></td>
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<td><strong>Sense of humour</strong></td>
<td><strong>Courage (capacity to move into situations when feel fear or hesitation)</strong></td>
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<td><strong>Being (taking time for self by allowing self just ‘to be’)</strong></td>
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<td><strong>Independent thinking</strong></td>
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Appendix 10. Focus group plans

Focus group 1

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<td>Clare</td>
<td>Georgie</td>
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<td>Nicola</td>
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Materials

Ground rules on flip chart.
Research questions with focus for this group highlighted.
Large sheet of paper and pens for mind map.

A3 copy of Lindstrom and Erikson diagram of hiker
Backpack
Cards of skills /strategies, qualities /attributes
10 point Likert rating strip

Audio recorder
iPhone recorder
iPad
Camera

Management of focus group
Welcome participants and ask them to put name they wish to be addressed by during the group on a name ‘tent’.
Invite them to help themselves to some lunch, and to take a place at the table.
Introduce the second moderator.

Guide

Introduction:
We are aware that expectations of professional roles don’t always match up with reality and this is sometimes difficult for newly qualified professionals. This has been highlighted in teaching and social work as well as in health professional roles. Literature relating to strengths based approaches suggests it would be helpful to understand how learning experiences on the course can build capacity to deal with this, and this is what I am exploring through this study.
The research is not focusing on how good or bad the course is. It is focusing on your learning during the course, and any of the things that have happened that have been learning experiences for you, however small. These may or may not be obviously related to ‘teaching’ in Uni or practice. I am interested in your understanding of your learning experience. This may be individual or shared.
I’m not expecting you all to agree about everything, and in fact the value of a focus group format is it allows you to discuss your ideas and experiences with each other. My role as moderator is to facilitate the group and to try and keep the discussion focused. I will ask questions as we progress through the two activities that I have prepared for today. My colleague’s role as second moderator is to take field notes to help me understand the process of the group and to track who is contributing to the discussion as sometimes that is difficult to ascertain from the audio recordings. She will also be able to help me identify issues that should be followed up in subsequent groups.

Just a few **ground rules** to guide us, which I’m sure will be the same as those you are used to in other contexts:
• Allow one person to speak at a time, and give everyone the chance to make a contribution. If you have not had the opportunity to say anything I may ask you directly what you think to give you this opportunity.

• There are no rights and wrongs and everyone is entitled to their opinion, listen to each other and respect these opinions. You can obviously disagree but do this in a respectful way.

• Discussion in this room is confidential within the usual limits of professional confidentiality. In the unlikely event that something is disclosed that indicates that you or others may be in danger or compromising your professional accountability I will raise this with you so that appropriate action can be taken.

• As you know I am going to record the activity. When the discussion is transcribed I will ensure your anonymity.

So there are two activities that I would like you to undertake. The first will take about 20 minutes and the second up to 40 minutes. We will complete them both within an hour.

**Activity 1**

Moving into a new role: identifying expectations of the HV role.

20 minutes

You may already have looked at your expectations of the course? What I want you to do now is to look at your expectations of the **health visitor role** and develop a mind-map to reflect your thoughts. You can use drawing and words to map your thoughts out on this piece of paper.

• **What** does the health visitor do?

• What words would you use to describe **how** the health visitor works?

• **What** do you think should be the **defining characteristics** of the health visitor? What would you like **look** like as a health visitor? **What** qualities will you have developed?
• How will you **feel** in your role?

On completion of the mind-map pull out areas of agreement and disagreement in understanding of the role.

**Activity 2.**

30 - 40 minutes

Lindstrom and Erikson, in their “Hitchhikers guide to salutogenesis” (2010) use the analogy of a walker, hiking through life with a back-pack on their back, to describe the process of the Ottowa Charter and the life long learning process of health. In the back-pack are a number of resources that can be drawn on along the way. Drawing on that analogy, here you are moving into the health visitor role. *(Diagram from Lindstrom and Erikson).* In the backpack *(use back pack to hold the cards for the exercise)* are a number of qualities, attributes, skills and strategies that may have some relevance to building your capacity to cope with the reality of your new roles. What I want you to do is to take a card in turn from the backpack and discuss how relevant you think it is as a resource to help you on your journey in to health visiting, and then rate its relevance on a scale of 1-10. Then place them on the table at the appropriate place along that scale so we can build up a picture of what your thoughts are at the moment.

Do you have any ideas of what you think might help you to develop these areas during the coming year?

Thank you very much for all your contributions today. The next focus group will take place at the end of February / beginning of March in the new year, when we will follow up on this activity and start to look at your learning experiences.
and ways in which your expectations and experience have been confirmed or modified.

<table>
<thead>
<tr>
<th>Motivation</th>
<th>Reflection / reflexivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimism</td>
<td>Critical thinking</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Co-operation</td>
</tr>
<tr>
<td>Creativity</td>
<td>Prioritisation</td>
</tr>
<tr>
<td>Energy</td>
<td>Abstract thinking</td>
</tr>
<tr>
<td>Self-esteem (feelings of own value)</td>
<td>Problem solving</td>
</tr>
<tr>
<td>Self-efficacy (belief in ability to control events in life which have significance to individual.)</td>
<td>Building positive relationships</td>
</tr>
<tr>
<td>Curious</td>
<td>Self direction</td>
</tr>
<tr>
<td>Trusting</td>
<td>Listening</td>
</tr>
<tr>
<td>Respectful</td>
<td>Responding</td>
</tr>
<tr>
<td>Open-minded</td>
<td>Belonging to a social group</td>
</tr>
<tr>
<td>Self understanding</td>
<td>Taking control (internal locus of control)</td>
</tr>
<tr>
<td>Commitment (to self and work)</td>
<td>Challenge</td>
</tr>
<tr>
<td>Purpose</td>
<td>Maintain life balance</td>
</tr>
<tr>
<td></td>
<td>Healthy lifestyle activity</td>
</tr>
<tr>
<td>Sense of humour</td>
<td>Perseverance</td>
</tr>
<tr>
<td></td>
<td>Find support when needed</td>
</tr>
<tr>
<td></td>
<td>Courage (capacity to move into situations when feel fear or hesitation)</td>
</tr>
<tr>
<td></td>
<td>Being (taking time for self by allowing self just ‘to be’)</td>
</tr>
<tr>
<td></td>
<td>Independent thinking</td>
</tr>
</tbody>
</table>
Focus group 2

Refreshments and welcome

<table>
<thead>
<tr>
<th>March 2013</th>
<th>March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jo</td>
<td>Laura</td>
</tr>
<tr>
<td>Alice</td>
<td>Dawn</td>
</tr>
<tr>
<td>Becky</td>
<td>Katie</td>
</tr>
<tr>
<td>Jess</td>
<td>Brigid</td>
</tr>
<tr>
<td>Clare</td>
<td>Georgie</td>
</tr>
<tr>
<td></td>
<td>Nicola</td>
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</tbody>
</table>

Ground rules on flip chart.
Research questions with focus for this group highlighted.

Audio recorder
iPhone recorder
Camera

Thanks for coming
Re-cap on Focus group 1
Summarise and agree outcomes

Hierarchy exercise with cards identifying qualities, attributes, strategies, drawn from literature review. How do participants see these as relevant? What might help them develop these qualities, attributes, strategies?

1. Use the picture from focus group 1.
Discuss ways in which reality of what participants are seeing in practice against this expectation.
Produce a new drawing to depict the differences and how these make participants feel about the role they are preparing to take on.
2. Produce photo of rating of qualities, attributes, strategies from focus group

1. How do participants relate this to any of the learning experiences they have had so far, in the university or in practice? Do these qualities, attributes, strategies have the same or different relevance to the time they were first looked at?

Can participants make links with salutogenesis and resilience as theoretical concepts?
Would they re-arrange the hierarchy?

Thanks for coming
Arrangements for next focus group

Focus group 3

Refreshments and welcome

<table>
<thead>
<tr>
<th>August 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jo</td>
</tr>
<tr>
<td>Laura</td>
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<tr>
<td>Becky</td>
</tr>
<tr>
<td>Dawn</td>
</tr>
<tr>
<td>Brigid</td>
</tr>
<tr>
<td>Clare</td>
</tr>
</tbody>
</table>

Materials

Ground rules on flip chart.
Research questions with focus for this group highlighted.

Audio recorder
iPhone recorder
Camera

Thanks for coming

- Poster of work in progress taken to INCHR in Edinburgh in March after the second focus groups.

- Discuss how analysis of findings can be shared further with participants. Suggest sending outline of preliminary findings at beginning of September to e-mail addresses that I have.

- Explain shift of focus to resilience theory and identify links with transformational learning in theoretical framework.

**Wooden tower building activity** to try to home in on sources of learning in relation to capacity building.

Statements on blocks are not statements of fact. They are there to focus the discussion and identification of individual experiences. I expect varying levels of agreement and disagreement with the statements, and that is absolutely fine. What I am trying to get to are the specific learning experiences that may or may not have been helpful in developing capacity/resilience. At the end of the study I would like to be able to identify whether it is possible to scaffold learning to build practitioner resilience.

Tower built with statements related to learning on outside of tower. The idea of using a “jenga” type game to explore resilience has been used in work with troubled adolescents involved with the criminal justice system in London. Here the idea equates to building learning. One of the joys of case study research is that it is an iterative process, so it is not possible to pilot revised activity as it evolves, so we will see how this works out!
Talk about the statements on the blocks identifying specific experiences that link with learning related to the experiences. If there is any order established in which the learning experiences should occur then blocks can be moved around with the earliest experiences at the bottom of the tower. If experiences should not occur or are unhelpful they should be removed from the tower.

Thank for participation
Appendix 11: Dissemination and external discussion
Becoming a chameleon?
Learning experiences: building capacity in health visitor students to respond to the reality of practice.
Doctoral research in progress

INTRODUCTION

Literature argues that:

- Concepts such as salutogenesis and resilience are relevant to education for professional roles.
- Tensions can exist between expectation and reality in professional roles. Specific personal resources are helpful in responding to these tensions.
- There is a lack of work examining the whole experience of student learning and means by which development of personal resources can be achieved.
- A few studies draw on promotion of resilience in the caring professions none specifically in HV education.

But:

- SO WHAT SO FAR?
  - Expectations of assuming the role
    - "Blossoming"
    - Stepping through a door of opportunity
    - Frustration
  - Tensions in expression of HV role
    - Health Visitor v Health Visitor
    - Care v controlling
    - Autonomy v External locus of control
    - Straightforward v complex
  - Building student capacity to cope with tensions
    - Recognise resources in role models who have positive impact on HV teams.
    - Flexibility seen as key. HV as a chameleon, able to change according to context.
    - Theoretical learning on salutogenesis and resilience is only being applied to work with clients.

Next steps
- Exploration of learning experiences supporting development of personal resources.
- Achieving transformational learning:

FOCUS GROUP ACTIVITY

Focus group 1

- Expectation of HV role
- Exploration of resources that might support HVs in the practice context

Focus group 2

- Reality of HV role: Pictorial representation of feelings associated with the role and discussion of these feelings.
- Linking personal resources with managing feelings in context of practice.
11.2 Royal College of Nursing Conference: April 2014

Practitioner Resilience: Building Capacity In Health Visitor Students To Respond To Adversity In Practice

1. RESEARCH AIMS
1. To explore how learning, in both university and practice settings, contributes to the development of the students’ capacity to respond to the tensions between the expectation and reality of the practice role of the health visitor.
2. To identify sources of learning across the scope of the students’ experience in theory and practice which facilitate or obstruct their development as resilient practitioners.
3. To explore the relevance of the application of salutogenic principles to curriculum design in order to support the development of resilient practitioners who can respond to the adversity encountered in practice.

2. METHODOLOGY
• Theoretical Framework of Critical realism allowing for complexity of combining understanding of context (real), organisation of learning through curriculum (actual) and students’ experience of the course (empirical) (Bhaskar, 1998) as contributors to learning for development of resilience.
• Case study methodology (Stake, 1998)

Combining Concepts from Transformative Learning and Resilience Theory

3. DATA COLLECTION
i. Series of 3 activity based focus groups
ii. Course documentation
iii. Individual semi-structured interviews

4. FINDINGS
i. Tensions between expectation and reality
Nice difficult and complex
Continuity with clients limited contact
Support in role lack of resource
Increase in public health work resistance and negativity

FINDINGS continued
ii. Themes from content analysis

<table>
<thead>
<tr>
<th>Domain</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure and mechanisms in context (Real)</td>
<td>Identification of expectation and reality</td>
</tr>
<tr>
<td></td>
<td>Challenges emerging from the structure and mechanisms</td>
</tr>
<tr>
<td></td>
<td>Social contributions to building individual and collective resilience</td>
</tr>
<tr>
<td>Transformational learning contributions (Actual)</td>
<td>Starting points</td>
</tr>
<tr>
<td></td>
<td>Scaffolding learning for resilience</td>
</tr>
<tr>
<td></td>
<td>Endings</td>
</tr>
<tr>
<td>Student experience (Empirical)</td>
<td>Creating an identity</td>
</tr>
<tr>
<td></td>
<td>Learning from negative experience</td>
</tr>
<tr>
<td></td>
<td>Health Visitor as a chameleon</td>
</tr>
</tbody>
</table>

iii. A few quotes from the transcripts

“...and so my visualisation is... the lesson is...you need to have the confidence to be able to communicate, to articulate, to be able to ask questions...”

“The impact through daily interaction with the family, their relationships with the team and the service user...”

“She was very enthusiastic about her day, the general plan for the day was through the tour of the centre and then having a tutorial session, this is a positive approach to the day...”

5. CONCLUSIONS
Facilitators and threats to learning for practitioner resilience

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical reflection</td>
<td>Exposure to stress in HV teams</td>
</tr>
<tr>
<td>Positive identity: making a difference</td>
<td>Poor support in relation to negative practice experiences</td>
</tr>
<tr>
<td>Social interaction and shared experiences</td>
<td>Expectation of involvement in wider Public health role not met</td>
</tr>
<tr>
<td>Student-centered learning strategies</td>
<td>Becoming overwhelmed by demands</td>
</tr>
<tr>
<td>Positive role modeling of resilience</td>
<td>Reluctance to disclose problems</td>
</tr>
<tr>
<td>Challenge to frames of reference: openness to see the bigger picture</td>
<td>Lack of resilience in HV colleagues</td>
</tr>
<tr>
<td>Building confidence and self-efficacy</td>
<td>Exposure to inequality through practice</td>
</tr>
<tr>
<td>Facilitative teachers in HEI and practice</td>
<td>Organisational aggression*</td>
</tr>
</tbody>
</table>

* Jackson et al, 2011

University of Brighton

References
11.3 Second World Congress on Resilience: Romania
May 2014
Analysis

Three main areas of learning supporting practitioner resilience

Building professional identity

Building "openness"

Becoming more flexible and adaptable

In conclusion: Professional learning as a support to resilience

Sources of learning

- Exposure to socio-economic inequality: a challenge and a resource for resilience
- Social interaction and shared experience
- Practice: A dialogue between critical reflection and action
- Learning from negative experience
- Role modeling
- Observation

References

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Appendix 12: Focus Group Activity and Data Collection
12.1 Focus group 1

Resilience attribute rating exercise group 1a

Resilience attribute rating exercise group 1b
Activity mapping

Group 1a

Group 1b
12.2 Focus Group 2

Gov. investing in HVI;
Nice giving young gun Reson.
Good like we are building
Capacity - professional & personal
Give and Take

Hopeful
HIVI gives Hope
No regrets doing so.
Feel like I have a chance to
make a dif.
Developing - fast-paced;
communicative - adaptive,
Experiences. Knowledge
of culture

Appreciate good back
Referring skills;
Developing skills in
relationship building.
We are beginning to question.

Challenging culture:
Anxiety / Frightening
Stressed Teams;
Experiencing Stuff
Overload;
Too much change;
Hopelessness;
Too much to do;
Lack of
Conflict -
No choice
Little Support
Big/Complex
Issues - not just
staff numbers.
12.3 Focus Group 3

Jenga™ activity.
Appendix 13: Extracts from transcripts
### 13.1 Extract from Focus group 3.

<table>
<thead>
<tr>
<th>BRIGID</th>
<th>I had to laugh! ‘I am exactly the same as I was at the beginning of the course’.</th>
</tr>
</thead>
</table>
| **Several voices**  
*general laughter* |  |
| BRIGID | No. No. |
| PL | So how have you changed? |
| BRIGID | I think I know myself a lot better. |
| PL | Yes. |
| BRIGID | And I think as a nurse, you think that you are caring, but I think this role as a student health visitor has really kind of enhanced my own ‘knowing’ and how I can … and my resilience is .. And I have found more resilient qualities within myself when things haven’t gone well. And to build upon them, and I have had to really dig deep within myself. |
| PL | So there are two things there then aren’t there? |
| BRIGID | Yes. |
| PL | And we will come on to the resilience bit, let’s not forget that bit. But can you expand on how you think you know what you have learnt about yourself? |
| BRIGID | Gosh – motivation I think, to keep going. And to recognise my limitations I think. |
| PL | Yes – and particular examples of that or … or when you …? |
| BRIGID | I think it is juggling the study side with the working role side. I think it is a delicate, delicate balance. And of course your personal life as well. Yes I think it has just heightened a development really and I don’t think I will ever go back to the way I was before.  
I think I have really addressed how I can balance things much better. And it has given me an insight into families. Addressing their … the issues with them, and helping them to balance issues within their family lives. It has been quite an emotional time. |
| PL | Yes – and can you think what has … and obviously the thing about workload, and that would have been a trigger. But can you think of what have been the trigger-points for those … for that change in you? And/or what has happened that has helped you? Have you had any resources – external help with resources to help to deal with it? |
| BRIGID | I put my peers on the course – I think we have supported each other. And actually I think we have formed a more of an honest relationship with each other. I think honesty is the main thing within myself and being more open and … |
| PL | So being honest with yourself? |
| BRIGID | Yes |
| PL | But also … |
| BRIGID | With … |
| PL | Because there is another one there, isn’t there, about how you can create … |
| DAWN | ‘You can create some emotional space in practice’ |
| PL | Yes, ‘emotional spaces in practice’ but there is also something about ‘trust in the university’ somewhere – so where has that one gone? |
| JO | Three up – ‘places for critical self-reflection in the university’ – is that what you mean? |
| PL | Yes, does that … that is critical self-reflection, but we are talking about ‘group’ are you? |
| BRIGID | I think if we didn’t have … I think, within the group, we kind of have like little satellite groups didn’t we? |
| DAWN | It is good to know that other people are experiencing the same or similar things. |
| BRIGID | That was comforting |
| DAWN | And that was … take a lot of comfort from that. And because you talk about it, you build a certain degree of resilience in that shared experience. |
| LAURA | And I suppose in some ways you are kind of thinking of break times just thinking about eating, but they are not. They are more important than the actual learning sometimes. |
| DAWN | In fact eating is secondary. |
| LAURA | Yes. |
| **Several voices** *(general laughter)* |
| LAURA | Or you are meeting somebody, before you actually start, and you are kind of offloading stuff that has happened to you, or how you are feeling or things like that. And then there are times throughout the day, and the break times are vitally important, it is kind of just networking and for people to pick up how other people are feeling. You know sometimes I think those are more valuable than the
learning, within that day, so a *(unclear)* day.

**PL**  
So they are kind of informal learning spaces.

**BRIGID**  
And support.

**PL**  
And support yes.

**DAWN**  
And people, you know, they will pick you up, when there have been times when it has been difficult.

**Several voices**  
Yes.

**PL**  
And so there has been support there. Has there also been learning from each other, in terms of how you respond?

**JO**  
I think there has, whether it is learning or whether it is just sort of receiving strength. And there are people, and at times you think oh god this is awful and I can’t manage. And then somebody says come on, look what you have done, this is great so let’s pull you through.

And you learn or you pick up other peoples’ strength. I am not sure if that is a learning thing or just support.

But you sort of learn from other peoples’ management of their crisis or problem. And you pick it up, and you think that is a good idea, and OK I will try this or … so you sort of pick up from each other.

**PL**  
Yes

**BRIGID**  
I think we are more open – there is more openness.

**DAWN**  
Definitely

**BRIGID**  
To kind of encompass more.

**PL**  
Have you all found that? That openness: are you able to take that away from your peer group here, out into practice?

**Several voices**  
Yes. Definitely.

**PL**  
So, is that because you have created a safe place out there, or is it just because you have …is it because of something else? Is it because you have changed in relation to being more open?

**DAWN**  
It depends what you mean. The concept of a ‘safe place’ – I was thinking about that and the emotional and creating … but actually it is in a sense you create that space inside yourself.

**PL**  
Right.

**DAWN**  
It is not an external space it is an internal space – for me it is definitely an internal space.

I find that – that everybody has that.

**PL**  
So actually, for you then, going out and being able to be open,
would be because you had developed that in yourself.

<table>
<thead>
<tr>
<th>DAWN</th>
<th>Yes, inside, yes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PL</td>
<td>That is interesting</td>
</tr>
<tr>
<td>DAWN</td>
<td>And that is developed I think from the shared experience, from support and from peers. And support from the teams you are working with, and your mentor and PT as well. If it has been a good experience. But then also, I was looking at the negative and can I say another one?</td>
</tr>
<tr>
<td>PL</td>
<td>Yes do</td>
</tr>
<tr>
<td>DAWN</td>
<td>The ‘Negative experiences are good for learning’ it has always been something that it is really hard to deal with. But actually have to say those are the experiences that possibly linger more with you. Whether they are negative for you or whether you have felt it has been for you – you have had a negative impact on an individual or family. And it is the support that surrounds you and the feedback that you get from your PT and the reflection that you get, that you can come out of that with a good learning experience. It is one of those things that you carry with you.</td>
</tr>
<tr>
<td>PL</td>
<td>Yes, because in the literature there is something about learning from negative experiences. But negative experiences can be ‘negative’ can’t they, so it is more about …</td>
</tr>
<tr>
<td>DAWN</td>
<td>it is what happens with that negative experience. If you have a negative experience that doesn’t … that you are not supported in, you know I think that can be really detrimental. It can reduce your resilience and it can zap it away rather than build on it, so it is definitely the support that you get from that and the reaction and the reflection that you do. You know, there is a lot about reflecting and we do tend to always reflect on negative experiences don’t we? And rather than … and there is a lot again there is a lot again in the literature about using reflection positively. But because we are all nurses, I think to a certain extent, we always look at those experiences that haven’t been great.</td>
</tr>
</tbody>
</table>

360
So, that could be the nature of caring in a way, that we are constantly trying to look to make things better. I think we have a bit of a tendency to do that I think.

<table>
<thead>
<tr>
<th>PL</th>
<th>And are others of you feeling the same way?</th>
</tr>
</thead>
</table>
| BECKY    | I have always been one of those people who hate people looking at my work when I am sat there. I was like it through school, college and nurses training. And I think now that I have come into this role I have found it really difficult saying to people, when I have actually done something - not wrong – but when I haven’t dealt with things in the right way.

Now I feel more comfortable in saying to someone – ‘I didn’t do this’. And I think it is having that support of other people who understand. They are not going to judge you and I think it is having that confidence to actually be able to express, that actually things didn’t go quite how they should have gone, but then you talk it over.

And as long as you have got someone to talk it over with. And they can say well next time maybe you could do this or what would you do next time? It is the whole reflecting thing constantly. I think you constantly do it.

And as you say, it is always the negative things that you sort of reflect on – and don’t sit there and say – ‘cor that was a good visit’!

| DAWN    | But you know you when you have had a good day, though, don’t you? You know when you are in the car and you are driving and you think (happy voice) ‘Aah that was …’ But then that it is, and it is gone and you are moving on to the next thing. |
13.2 Extract from Becky’s interview

BECKY
Yes – yes – I got overall for all my modules, I got Bs, which really, really shocked me. And I find that I speak differently as well, to people.

I find that my language that I use is different. Although, when I am out at work, if I am talking to someone who is very educated I will speak very ‘professionally’.

But then I will go into another house, where it is a young mum, and she is ‘here alright’ … and I don’t talk pointedly, but I play it down a bit, and actually I talk normally. I don’t know …

PL
So you are adjusting your language to your client?

BECKY
Yeah – to try to get them to engage a bit more.

PL
Yes.

BECKY
But now I feel … well I have changed completely I think.

PL
And I was going to ask you that – so can you pinpoint what has changed?

BECKY
Umm … I think my confidence, because I know that I can actually do it. I know I can write an essay. And I got As for my practical side and my report writing.

I know that I can do it – but I need to have the confidence in myself. I need to keep reminding myself that I can do it.

But yes, my PT and my personal tutor have both said that I am a completely different person to who I was at the beginning and my mum and dad have seen it. And yes it is really good.
What do you think is different? Obviously in actually doing your academic work, but what is different? Confidence?

Yes. I feel like a professional. I feel that I have ‘bettered myself’ from doing the course. I don’t know what it is? It is really bizarre.

Do you think differently?

Yes – and I look at things a lot differently.

Can you describe any of that – and how?

Well, I look through photos of my boys, and I think – oh my god I did that! I propped their bottles up with pillows! And I sort of think now … I even play with my children differently.

Really?

Than I did do – and I probably look after my niece differently, because she is two.

So how - how is it different?

An example would probably be, a little baby, and before I would walk up and say (talking to baby voice) ‘hello, are you alright?’ and that would be it.

But now I sort of wait, because I know that they have to process, and I just keep smiling and a little while later on I will get a smile from them. And it is just knowing children more, and knowing what they need and what they want.

Yes.
BECKY
Rather than just guess - as a mum you sort of guess what children want, but it is sort of knowing a lot more now.

PL
Yes.

BECKY
So it is my knowledge I suppose.

PL
Yes and I guess there is experience in there as well, isn’t there?

BECKY
Yes.

PL
Do you expect more of yourself now?

BECKY
Yeah I do.

And even at work, like today, I said to my colleagues, I said – ‘I have done that care plan, but it is probably all wrong’. I want it to be right! And now after looking at somebody else’s it is not quite there.

But yes, I want … I have always been like this: I want people to be proud of me, and I people to be pleased with what I have done. And I want to make my mum and dad proud. And they say ‘you have made us proud already you don’t need to say that’

But I do, I want to … I want people to be proud of what I have done and who I have become.

PL
Do you think other people have got higher expectations of you?

BECKY
I don’t think they have, no, because I feel like I should be doing more at work.

Whereas I have been told, actually at the beginning of the consolidation, you obviously need to consolidate but you wouldn’t actually need to, because you
are at the standard that we would expect you to be at, at the end of the consolidation.

And I expect more of myself, and I don’t … I think people just take me for me. I think they expect more but I don’t think they do – does that make sense?

PL
(silent response)

BECKY
No! (chuckles)

PL
So you think they should expect more of you? Or do you think they are just kind of assuming that actually you are doing enough?

BECKY
Yes – I think, yes, they don’t expect as much of me as I expect of me.

PL
Right, ok so you push yourself harder than they push you?

BECKY
Yep.

PL
Would you like them to push you harder?

BECKY
(hesitates) Maybe, because that is more of a challenge again!

PL
Yes.

BECKY
Yeah – but I am doing things that … well I was doing things at the beginning of consolidation, that my PT said to me, you know – ‘we would expect you to be doing it down the line, you know you are doing …’

They are really encouraging and it is really good to hear.

But I think I want to make them go ‘wow!’ even more – so very bizarre.
PL
So you want to impress other people?

BECKY
Yeah.

PL
Do you want to do it for yourself too, or is it more that you want to do it for other people at the moment?

BECKY
More for other people – yeah.

PL
Yeah – and I mean I think that is not an uncommon thing really, and sometimes doing it for you actually comes a bit later?

BECKY
Yes – because even the studying part: we went out for a meal with work last night to celebrate me and another student passing. And I sat there, and I found myself saying – ‘I have really enjoyed the studying!’ and I went ‘Argh! What have I said?’

PL
(laughing) Wash your mouth out!

BECKY
Yes!

Because at the time it was hideous – it was really hideous.

I wasn’t a mum because I would send the boys up to bed and I would say – ‘I have got to do my school work so off you go’. And they would go up to bed and doing the completely wrong thing for the bedtime routine. But they have got me back now.

But I can see myself, and I have already said to my PT, that I want to do another module, the Building the Community Capacity, but I need a break first.

But my mum has already said to me – ‘I know you are going to do more studying’. And I was like (excited) - ‘I know’.

It also keeps me busy at home, because me and the boys dad separated two years ago this month, and in the evenings if they are at their dad’s it is just me
at home. And it is a bit lonely and then that is when my brain starts going on overload. So doing the course has just kept me busy. I have been doing it every night, and every weekend if the boys were with their dad – just constant studying.

PL
And the stress of doing the course, hasn’t been a negative then?

BECKY
No.

PL
That is interesting isn’t it?

BECKY
Yes.

PL
Yes

BECKY
It has been constructive stress. Because others would go – ‘just have a night off’ – and I would sit and I would be like this (sound of fingers tapping nervously).

And I would end up getting up, and getting the computer out, and doing a bit of research.
Appendix 14: Practice teacher support processes

1. Student : Practice teacher dyad.

Direct supervision of student by PT on day-to-day basis.
PT undertakes summative assessment of student

2. Student: Practice Teacher: Mentor triad

Direct supervision of student by mentor on day-to-day basis.
PT oversees mentor and student
PT undertakes summative assessment of student
Appendix 15: Summarised personal development plan

Personal / Professional Development Plan

Introduction

Welcome to the University xxxx. We are delighted that you have decided to undertake the B.Sc.(Hons.) Course which prepares you for entry to the NMC register for Specialist Community Public Health Nurses (SCPHN). Students on this course are preparing for roles in either the health visiting (HV) or school nursing (SN) fields of practice. You will undertake the same mandatory modules, applying the theory taught predominantly to your own field of practice, but also learning about some other practice contexts of public health nursing that you may have some involvement with in the future.

There are a variety of people to help you through this course and it is for you as an individual to seek out the help that you require from the relevant people. All the documentation and extra help can be found on Blackboard in the Studentprofile site. Both HV and SN fields of practice have a pathway leader who will be responsible for supporting you in relation to your chosen specialty and all issues that may arise within your practice placement. You will be allocated a Practice Teacher (PT) and in some cases a mentor, by your seconding/sponsoring Trust/Authority, who will be responsible for providing the clinical component of the course; the PT will make the final clinical assessment of competency to practice. If your PT is from a different field of practice from you, then you will have also been allocated a mentor in your own field of practice, to support your learning on a day to day basis.

You will also be allocated a personal tutor who will help guide you through the course and in particular will give help with academic issues as required; generally this person is your pathway leader. All modules have a designated
leader who is responsible for the teaching programme and assessment of the module and will deal with any issues that may arise for you within this module.

This Personal Development Plan (PDP) will be of benefit in achieving coherence through the period of the course, particularly if an extended part-time route is chosen. In such a situation the needs identified at the beginning of the course may well change over the total period. This mechanism will ensure that need is assessed on an ongoing basis and adjustments made accordingly. Insights gained from the process of developing the PDP will be drawn into the Work Based Learning Project module, enabling students to recognise and capitalise on the value of the work undertaken. This will also enable you to demonstrate the achievement of KSF standards to meet PCT/Trust requirements.

The main purpose of the PDP is to help you learn more effectively and understand yourself better. The PDP will also provide the means of monitoring your growth and development through the course, and provide the basis for your continuing professional development on qualification as a SCPHN.
Initial Review

The following pages will help you to identify your existing strengths and your aims for the course.

1. Curriculum Vitae
Include your current CV at the beginning of this section. This will enable you to complete your self assessment.

2. Self - Assessment
This is the student’s responsibility. Self-assessment gives the student the opportunity to reflect on her/his strengths and weaknesses in order to provide the baseline for the development of the personal development plan.

3. Learning Contract
The fulfilment of the contract is a joint responsibility between the practice teacher, mentor (where applicable) and the student. This should take the form of identified time working together, intended dates for formal or informal review of progress, an agreement on the part of the PT to observe or demonstrate skills, and an agreement on the parts played by PT, mentor and student in the assessment of practice.

8.5.1.1 4. Action Plans
Action plans will be used to plan the way in which the learning outcomes of each module will be met in practice. These action plans are based on the student’s self-assessment, discussions during initial interview, and the PT’s knowledge of the experiences available in the practice area, which can facilitate the necessary learning. The action plan will include preparation for, and implementation of, assessment in practice.

Students will have come from differing clinical backgrounds and will have had a variety of experiences due not only to the nature of their work but also to their
previous roles and professional education. It is, therefore, important to ensure students gain maximum benefit from the modules, developing new skills appropriate to their personal needs, thus achieving professional competence. The process of personal development planning will be ongoing throughout the course and will allow for:

- consolidation and development of existing skills
- individual learning outcomes for each module
- specific development areas identified by students and their PTs, mentors and personal tutors

**Self Assessment**

(To be completed by the end of practice induction) Self-assessment forms part of your Personal/Professional Development Plan. At the beginning of the course you should answer the following questions. This self-assessment will then be used as a basis for discussion with your Practice Teacher and Personal Tutor. It must be revisited and reviewed during each semester and at the end of the course.

<table>
<thead>
<tr>
<th>What would you personally like to achieve by undertaking this course?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal and professional goals.</td>
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<table>
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<tr>
<th>Fears and anxieties</th>
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<tr>
<th>Previous clinical experience and areas for development (skills etc.)</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Personal strengths and limitations</th>
</tr>
</thead>
</table>

Signature of student ………………………………………. Date completed……………………

Now identify your own personal preferred learning styles by completing the Honey and Mumford questionnaire. You may also like to access the online psychometric testing by logging onto:

www.profilingforsuccess.com/main/enter2.htm
Learning Contract: Semester 1
(To be completed by the end of practice induction) To include frequency of meetings, time set aside for reflection on practice, facilitation of learning opportunities, educational support, supervision of practice skills etc. A learning contract must be completed each semester, and for the period of consolidation of practice.

Role of student:

Role of Practice Teacher / Mentor:

Name of student ………… Signature of student……………………

Name of practice teacher…………….. Signature of practice teacher…………..

Signature of mentor (where appropriate) ………………………………………

Date…………………..

Learning Contract: Semester 2
(To be completed within two weeks of the beginning of Semester 2)

Learning Contract: Consolidation of Practice
(To be completed within 2 weeks of the beginning of consolidation) To include frequency of meetings, time set aside for reflection on practice, facilitation of learning opportunities, educational support, supervision of practice skills etc. A learning contract must be completed each semester, and for the period of consolidation of practice.
Action Plans:

Module title: Practising Public Health

Learning outcomes:

1. Critically analyse public health perspectives and their relevance to practice.
2. Examine and evaluate the processes of assessing health need and risk in individuals, families, communities and populations. This will include utilising health informatics and epidemiological data.
3. Examine inequalities in health in the light of social policy, legal and ethical, and professional frameworks and sociological theory.
4. Critically analyse models of health promotion and their use in collaborative public health practice.
5. Demonstrate the skills and knowledge required to work competently, with others, including service users, to promote health and well-being across the public health continuum.
6. Plan and participate in the development, implementation and evaluation of strategies to address inequality at individual, family, community and population level.

Practice Assessment:

Through the process of an initial health needs assessment through the profiling of the health needs of the geographic location of your practice area; identify an collaborative intervention in response to an identified health need relevant to the identified field of practice.

Plan, and present to the practice team the strategy to address this need in collaboration with client/s and other professionals or voluntary workers involved in public health work.

The practice components will be assessed by the Practice Teacher.

Action plan:

Signature of student:……………………………         Date:……………….
Signature of practice teacher.........................................  Date...........................
Action Plans for further modules:

Module title: Developing practice: The challenge of change

Learning outcomes:
1. Critically analyse leadership strategies related to practice in order to enable individuals, groups, communities and agencies to work effectively in partnership
2. Examine and evaluate existing interpersonal skills within a theoretical framework in order to establish, negotiate, maintain and improve communication with individuals and groups.
3. Utilise key concepts and theoretical frameworks in engagement with others to promote decision making and creative problem solving in complex and uncertain situations pertinent to the professional role.
4. Develop strategies for service planning and improvement with consideration of financial, human, information, time and material resources.
5. Encourage, consider and evaluate service user and carer views together with other stakeholder perspectives in the delivery and evaluation of health and social care services ensuring the promotion of equality and diversity.
6. Lead and manage teams through the process of continuous change ensuring quality and integrity of service delivery.

Practice Assessment:

Plan a practice development.
Present a conference style poster to the PT/mentor and practice team relating to this development. Write a reflection on the process and discuss with the PT /mentor.

Module title: Project Development through Work Based Learning: Specialist Practice

Learning outcomes:
1. Critically define an issue related to practice / professional role development
2. Select, critically appraise and evaluate a broad range of relevant research and literature
3. Demonstrate knowledge of research methodology, both qualitative and quantitative (including epidemiology), and the ability to critically evaluate research with regard to validity, reliability and the significance of findings for practice
4. Critically evaluate the effectiveness of the tools used and approaches taken to undertake a project
5. Critically examine the issues arising from practice/role development, including interprofessional learning, resourcing, national and local criteria, socio economic and political issues and ethical dimensions
6. Create new perspectives on professional practice/role development
7. Reflect critically on self-progression in skills, knowledge and cognitive ability, collaborative and experiential learning.

Learning outcomes 5-7 may be adapted to the particular project choice. This module will also enable the completion of any NMC Standards of Proficiency not met within the other modules taken.

**Practice Assessment:**

Three clinical skills (one of which must include communication) must be identified for assessment and marking by the PT:

**Module Title: Capacity building for early interventions**

**Learning outcomes:**

1. Critically analyse principles and concepts, including resilience, that underpin capacity building and apply this knowledge to multi-agency working with children and adolescents and their families.
2. Evaluate the social and health policy requiring early interventions in childhood and adolescence.
3. Critically analyse current evidence underpinning child development, including developments in neurophysiology.
4. Plan and participate in the development, implementation and evaluation of strategies to promote capacity building in diverse contexts.
5. Demonstrate an ethical awareness of the dilemmas and challenges of working to promote early interventions for families and communities.
6. Develop critical insight in applying principles learned to their own professional practice

**Practice assessment**
Taped assessment of a capacity building approach with a client, assessed by the practice teacher

**Professional Development**

1. **Tri-partite Progress Reviews**
Time must be planned to discuss your progress with your PT and with your personal tutor each semester.

2. **End of semester progress reviews with PT**

3. **Practice Log**
It is essential that you maintain a record of time spent in practice in order to be eligible for registration. It is recommended that you also maintain a reflective journal in order to demonstrate your professional development; this could be placed in this PDP folder.

**Evidence of Fitness to Practice**

1. **Standards of Proficiency**
All the Standards of Proficiency must be met during the course. The learning outcomes for the optional modules will need to be mapped against the proficiencies by you.

2. **Declaration of Fitness to Practice**
This must be signed by your PT at the end of consolidated practice
## Standards of Proficiency for Specialist Community Public Health Nurses

<table>
<thead>
<tr>
<th>Principle</th>
<th>Domain</th>
<th>Practising public health 20 credits</th>
<th>Developing practice; the challenge of change 20 credits</th>
<th>WBL 40 credits</th>
<th>Option choice module 20 credits</th>
<th>Capacity building for early Intervention 20 credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surveillance and assessment of the population’s health and wellbeing</td>
<td>Collect and structure data and information on the health and wellbeing and related needs of a defined population. Analyse, interpret and communicate data and information on the health and wellbeing and related needs of a population. Develop and sustain relationships with groups and individuals with the aim of improving health and social wellbeing. Identify individuals, families and groups who are at risk and in need of further support. Undertake screening of individuals and populations and respond appropriately to findings.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>2. Collaborative working for health and wellbeing</td>
<td>Raise awareness about health and social wellbeing and related factors, services and resources. Develop, sustain and evaluate collaborative work.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>3. Working with, and for, communities to improve health and wellbeing</td>
<td>Communicate with individuals, groups and communities about promoting their health and wellbeing. Raise awareness about the actions that groups and individuals can take to improve their health and wellbeing. Develop capacity and confidence of individuals and groups, including families and communities, to influence and use available services, information and skills, acting as advocate where appropriate.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Domain</td>
<td>Practising Public Health 20 credits</td>
<td>Developing practice; the challenge of change 20 credits</td>
<td>WBL project 40 Credits</td>
<td>Option choice module 20 credits</td>
<td>Capacity building for early Intervention 20 credits</td>
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<tr>
<td>Work with others to plan, implement and evaluate programmes and projects to improve health and wellbeing. Identify and evaluate service provision and support networks for individuals, families and groups in the local area or setting.</td>
<td>✔</td>
<td></td>
<td>✓</td>
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<td>Appraise policies and recommend changes to improve health and wellbeing. Interpret and apply health and safety legislation and approved codes of practice with regard for the environment, wellbeing and protection of those who work with the wider community. Contribute to policy development. Influence policies affecting health</td>
<td>✔</td>
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<tr>
<td>Develop, implement, evaluate and improve practice on the basis of research, evidence and evaluation.</td>
<td>✔</td>
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<td>✓</td>
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<tr>
<td>7. Promoting and protecting the population's health and wellbeing</td>
<td>Work in partnership with others to prevent the occurrence of needs and risks related to health and wellbeing. Work in partnership with others to protect the public's health and wellbeing from specific risks</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>8. Developing quality and risk management within an evaluative culture</td>
<td>Prevent, identify and minimize risk of interpersonal abuse or violence, safeguarding children and other vulnerable people, initiating the management of cases involving actual or potential abuse or violence where needed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>9. Strategic leadership for health and wellbeing</td>
<td>Apply leadership skills and manage projects to improve health and wellbeing. Plan, deliver and evaluate programmes to improve the health and wellbeing of individuals and groups.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>10. Ethically managing self, people and resources to improve health and wellbeing</td>
<td>Manage teams, individuals and resources ethically and effectively</td>
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</table>
Fitness to practice

The Practice Teacher must complete this declaration at the end of the period of consolidation of practice, in order that the student may be registered on the NMC register as a Specialist Community Public Heath Nurse.

……………………………. has successfully completed 10 weeks consolidation of practice in the Health Visiting / School Nursing field of practice*.

I confirm that it is my professional judgement that ………………………………. has achieved the proficiencies for Specialist Community Public Health Nursing, and that he /she is fit for practice, purpose and professional standing. This is subject to confirmation of a pass in any outstanding module results by the Examination Board.

Practice Teacher Name:…………………………………………

Signature:………………………………………………………………

Date:…………………………

* delete as appropriate