The Process of Teaching Caring as a Multidimensional Phenomenon in Undergraduate Nursing Programs

by

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Abstract

Caring is the foundation of nursing knowledge and nursing practice. It is a moral ideal involving commitment, knowledge, and action. To study nursing is to study caring, which includes growing in understanding of 'self' and 'other' from the perspective of a caring person and becoming committed to the value of caring and to the health and wholeness of the persons being nursed. Although it is clear that the central core of nursing education should not be limited to one's ability to *care for* but should also be driven by one's ability to *care about*, what is not clear are the processes used by nurse educators to overcome the pressure to focus solely on teaching *caring for* in order to integrate *caring about* in their teaching.

The purpose of the study is to use a constructivist grounded theory approach to explore undergraduate nurse educators' perspectives on how they teach *caring about* while teaching *caring for* to nursing students, and the challenges and opportunities within their experiences. The tripartite integrated research question of this study is: How do nurse educators define the concepts of *caring about* and *caring for*, how do they teach *caring about* while teaching *caring for,* and what are the challenges and opportunities in teaching these concepts?

The researcher conducted 15 in-depth individual interviews. Constructivist grounded theory strategies were used to develop an inductive theory of the process of teaching caring concepts that are grounded in the nurse educators' perspectives. The framework, entitled "Teaching caring as a multidimensional phenomenon", was the social-cognitive process that emerged from the data of this study. This framework represents an integrated, multidimensional theoretical understanding of the overlapping impacts of personal perspectives, personal experiences, professional interaction, and the social context of teaching caring concepts in the nursing profession. This teaching process included four concepts: conceptualizing the meaning of caring concepts, recognizing the teachable moment, seizing and acting on the teachable moment, and facing and dealing with challenges. The findings demonstrate that the process of teaching caring as a multidimensional phenomenon involve *teaching engagement continuum*, which includes *connecting* or *engaging.* These continuous processes include formal and informal approaches of teaching that involve critical thinking and emotional intelligence skills. Key implications related to theory, research, and nursing education are identified, particularly related to expanding nurse educators' understanding of both concepts, and testing and using the explicit process of teaching caring as a multidimensional phenomenon.

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Chapter 1

Introduction

Background

Caring is the foundation of nursing knowledge and nursing practice (Touhy & Boykin, 2008). It is a moral ideal involving commitment, knowledge and action (Watson, 1995). To study nursing is to study caring, which includes growing in understanding of 'self' and 'other' from the perspective of a caring person, and becoming committed to the value of caring and to the health and wholeness of persons being nursed (Boykin & Schoenhofer, 2001).

Caring is critical to health care outcomes. These include nursing care outcomes, patient outcomes, and health care financial outcomes. The Canadian Nurses Association (2003) argues that when nurses are prevented from practicing in a truly caring way, they may experience ethical distress, which in turn affects their performance. Likewise, patient satisfaction is heavily influenced by the relationship and connectedness with nurses (Larrabee et al., 2004; Von Esseen & Sjoden, 2003). Furthermore, evidence shows that patient satisfaction is critical, as it influences future decisions to access health care and patient adherence to treatment, which in turn generally improves the health outcomes and reduces the cost of the health services (Palese et al., 2011).

Many agree that caring *per se* is a multidimensional phenomenon that can be described as a human trait, a moral imperative, an affect, an interpersonal relationship, and a nursing intervention (Morse, Soberg, Neander, Bottorff, & Johson, 1990; Paley, 2001). Gaut's literature review (1983) identifies caring as having at least one of the following dimensions: a) giving attention to someone or having concern for, b) being responsible for, and c) regard for, fondness or attachment. However, *caring for* is defined as "a work responsibility" that includes all of the skills and actions provided by a nurse to a patient, whereas *caring about* is defined as "a moral

obligation" that includes all of the values, emotions and feelings that represent the professional relationship between a nurse and a patient (Gaut, 1983: Cronqvist, Theorell, Burns & Lutzen, 2004).

Caring demands emotional intelligence. Emotional intelligence plays a key role both in the process of caring and the process of teaching caring, as it can affect a person's actions and decisions (Clore & Huntsinger, 2007; Beauvais et al., 2011). Goleman (1995) defines emotional intelligence as the process of "managing feelings so that they are expressed appropriately and effectively, enabling people to work together smoothly toward their common goals" (p. 5). Beauvais (2011) states that "nursing students' performance may be improved by preparing students to not only critically think but to integrate emotional intelligence into clinical practice" (p. 400). Moyer and Wittmann (2008) emphasize that *self-awareness* needs to be fostered and practiced until the new behaviours are mastered and used habitually.

In the model of caring, Kristen Swanson (1991) argues that caring is an *integrated* multidimensional phenomenon defined as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). Swanson's (1991; 1993) middle-range theory of caring is comprised of five integrated processes:

- *Knowing;* refers to understand an event from the perspective of the other individual
- *Being with;* refers to being emotionally available to the other, making oneself available on an on-going basis, and sharing feelings, whether happy or sad.
- *Doing for;* refers to help the individuals (patients) in doing what they would do for themselves, if they were capable of doing it

- *Enabling;* refers to assist others as they pass through the transitions of life and new events such as sickness or disability
- *Maintaining Belief;* refers to uphold of faith in the other's ability to persevere through a transition or an event with a resolve to face the future with meaning

In order to provide effective nursing care that reflects the holistic view of caring (one that includes physical, social and emotional aspects) the nursing profession recognizes that the process of how to care must be learned through teacher-learner interaction (Wilby, 2011). The Barnard model (1979) was developed to identify the *interaction responsibilities* involved in building *attachment*, which is the basic component of human nature (Bowlby, 1988) between caregiver and child. The Barnard model included instructional elements that built on David and Margaret Steward's model of teaching (1973). This model helps nurses / social workers to observe, instruct and evaluate the learning process of interacting and attaching between a parent and child (NCAST, 1990). According to Barnard (1979), the critical skills needed by the caregiver to promote attachment include; *sensitivity to cues, response to distress, fostering social-emotional growth, and cognitive growth*. In turn, the skills needed by the recipient include; *clarity of cues, and responsiveness to the caregiver*. Each partner adapts his/her behaviour to accommodate or modify, the other's behaviour. Caring is defined by Gaut (1983) as an attachment. It can be argued that the skills involved in building attachment might be similar to those involved in building caring. Furthermore, the teaching challenges of the non-verbal communication or the invisible attitude can be assessed and evaluated.

Research Problem

Although nursing faculties teach caring as the core concept of the nursing profession, they often concentrate their teaching on the psychomotor and cognitive domains rather than on

the affective domain of caring. Wilby (2011) argues that the nursing profession is challenging, as it demands the inclusion of intellectual and physical capacities as well as "emotional vitality" (p. 29). The concentration on psychomotor and cognitive domains occurs because the physical demands of health care and the health care system (technology, etc.) are not only numerous but concrete/visible and thus more easily measurable. Consequently, they often become the first priority for nurses, unlike psychosocial demands, which are more difficult to see or evaluate and therefore are often more difficult to attend to.

Herbst, Swingers and Kinney (2010) report that while nurses today are providing appropriate physical care for patients, this often comes by sacrificing time spent connecting with patients. In losing this connection, nurses forego the very reason that drew them to the profession in the first place – the desire to *care about* patients. *Caring about* behaviour is often skipped, forgotten or neglected by nurses due to staff shortages, a burden of physical care, and increased patient acuity resulting in a dependence on technology (Bulm et al., 2010).

Despite its importance, the concept of *caring about* in nursing practice and nursing education is threatened by a number of issues, such as:

- Nurses miss, forget or neglect the principle that nursing care is a multidimensional phenomenon. Instead, they focus more on the psychomotor skills (*caring for*) in their daily activity and less on the social, and emotional skills (*caring about*).
- Nurse educators are challenged when teaching the multi-dimensions of caring and focus more on the psychomotor and cognitive domains (*caring for*) than on the affective domain (*caring about*).
- Nursing students focus more on the psychomotor and cognitive domains (*caring for*) because that is what is emphasized in both classroom and clinical settings.

The Position Statement of the CASN (2011) on the Education of Registered Nurses in Canada claims that "changes in science, technology, client activism, the health system, demographics, and the nature of practice settings have transformed health care and nursing practice … [and have] … enormous implications for nursing education" (p. 1). In response to this transformation, nursing education needs to focus more on integrating the art and science of nursing in ways that are grounded in the art and science of caring. One core challenge for nursing education is that while caring is an essential concept of nursing, caring knowledge is elusive to many because of its complexity.

The goal of nursing education is to provide students with the knowledge, skills, and attitude to ensure the delivery of optimal or ideal patient care. In turn, Gold (2007) argues that "an ideal patient care experience is one in which all systems and processes are geared towards meeting the needs of the patient: a safety-oriented system that provides standardized, evidence-based care supported by technology, but one that also recognizes and responds to individual needs" (p. 293). Teaching processes require continuous evaluation (Sawatzky, Enns, Ashcroft, Davis & Harder, 2009), which means that the nurse educators must continually adapt to changes integrated into the health care system. Elliott and Wall (2008) argue that "nurse academics, whose role is to educate students, are faced with the challenge of ensuring that their teaching reflects the contemporary nursing environment" (p. 580). In other word, nurse educators have the full responsibility to be sure that what they teach in the classroom is the best evidence-based practice and to be aware of what the practice setting nurses model to the students.

Although the classroom environment is significantly different from the practice environment, both affect the students' learning process and both therefore must be in sync. Nelms, Jones and Gary (1993) contend that students not only learn how to care or not to care

from educator modelling in the classroom and clinical settings, but also from observations of caring and uncaring behaviours among other clinicians in the clinical setting. Kreber (2002) describes an excellent teacher as having sound knowledge of his or her discipline, knowing how to motivate students, being able to make the concepts relevant and understandable, and being willing and available to help students overcome difficulties. The teaching process also requires full awareness of the challenges encountered in the practice setting that may affect the students' learning.

The affective teaching in education requires numerous skills and abilities. The Schreyer Institute for Teaching Excellence (2012) defines teaching excellence as "an academic process by which students are motivated to learn in ways that make a sustained, substantial, and positive influence on how they think, act, and feel," and "a process that elevates students to a level where they learn deeply and remarkably because of teacher attributes" (Para. 1). Farmer and Fren (2009) argue that highly effective teachers design learning experiences that build on a strong understanding of, and concern for, their students. In nursing education, CASN (2004) defines the scholarship of teaching in the nursing profession as "the conveyance of the science and art of nursing from the expert to the novice, building bridges between the teacher's understanding and the student's learning" (p. 6). In addition, many scholars emphasize the importance of building a professional relationship between educators and students within a caring environment to help students, in turn, develop a caring stance with patients (Oosterbroek, 2009; Dragich, 2001; Waterman, 2007). Therefore, teaching requires an ability to give meaning and relevance to course content and then link it to practice.

There are many learning theories that provide appropriate instructional methods to teach caring as multidimensional. Examples of these are the social learning theory (Bandura 1971),

the ARCS (attention, relevance, confidence, and satisfaction) model of motivation design (Keller, 1987), and the three dimensions of learning theory (Illeris, 2003). These learning theories focus on all the three learning domains, cognitive, psychomotor, and affective. However, while these models and theories could serve to introduce and motivate the learner to understand the multidimensionality of the caring concept, they still do not define the elements of teaching *caring about* as an affective domain while teaching *caring for* as psychomotor and cognitive domains. Professional caring (*caring about* and *caring for)* is not innate; rather it is a learned skill (Leininger, 1984; Dragich, 2001). Thus, if nurse educators expect students to *care about* as well as *care for* their patients, then educators have a responsibility both to teach and to demonstrate in practice the multidimensional aspects of caring. Although it is clear that the central core of nursing should not be limited to one's ability to *care for* but should rather be driven by one's ability to *care about*, what is not clear are the processes that used by nurse educators to overcome the pressure to focus solely on teaching *caring for* in order to integrate *caring about* as in their teaching.

Purpose Statement

The purpose of the study is to use a constructivist grounded theory approach to explore undergraduate nurse educators' perspectives on how they teach *caring about* while teaching *caring for* to nursing students, and the challenges and opportunities within their experiences. The research question of this study is how would the nurse educators define *caring about* and *caring for* and how would they teach *caring about* while teaching *caring for,* and what are the challenges and opportunities? This qualitative research guided by constructivist grounded theory methodology and methods. Participants are nurse educators who have had a minimum of three years of teaching nursing care in undergraduate nursing programs within four schools of nursing

in Nova Scotia. The data collection conducted through individual interviews, field notes, and memos had been used to generate data. In the findings, there are four concepts emerged that represent the process of teaching caring as a multidimensional phenomenon.

Overview of Dissertation

Chapter Two discusses two theoretical bodies of literature related to the caring concept and teaching caring. These comprise a theoretical review of: 1. The caring concept, which includes caring in the nursing profession, a model of caring, caring outcomes, caring challenges in nursing practice, caring challenges in nursing education, caring and emotional intelligence, and caring and attachment; and 2. Teaching and Learning, which includes learning domains, teaching and learning caring, and theories and models of teaching caring. Chapter Three provides details of the grounded theory methodology and specifically the constructivist grounded theory approach used in this study, as well as the study design, setting, the study population and sampling strategy, data collection techniques, data analysis techniques, ethical consideration, rigour, and major limitations. Chapter Four reviews the findings and presents the four-concept framework of "teaching caring as a multidimensional phenomenon" that emerged from the data of the study. The framework includes conceptualizing caring concepts, recognizing the teachable moment, seizing and acting on the teachable moment, and facing challenges. The chapter also includes four stories that illustrate the amount of teaching engagement in the teaching process. Chapter Five discusses the findings and presents the implications of the study for theory, research, and nursing education.

Chapter 2

Literature Review

Literature Review in Grounded Theory

In order to understand the process of teaching caring as a multi-dimensional concept in nursing undergraduate programs, it is important to provide a synthesis of the related literature regarding the concept of caring, including caring challenges in nursing education and practice, and caring in teaching and learning. A literature review in grounded theory can, for our purposes, be divided into an initial literature review and a secondary literature review. The initial review is "an exploratory review of the literature … undertaken prior to the final decision on the general focus and specific method of the study" (McGhe et al., 2007, p. 339). The secondary review is defined as a review of an entirely new body of literature, which comes after the new theory emerges from the data (Hutchinson, 1993).

Glaser and Strauss (1967) stated that "cover[ing] all the literature before commencing research increases the probability of brutally destroying one's potentialities as a theorist" (p. 253). An extensive literature review should only be carried out after an emerging theory is developed, in order to prevent forcing data into preconceived concepts (Glaser, 1978). As result of the development and spread of grounded theory across many disciplines by different levels of researchers, a literature review becomes an essential aspect for building basic knowledge about the study area. May (1996) suggested that beginner researchers should review existing knowledge to increase their ability to recognize emerging patterns while remembering not to rely on these reviews in their study. Strauss and Corbin (1990) proposed that a literature review should take the form of identifying the phenomenon and what is known about it, and to be alert to theoretical sensitivity. Glaser (2001) called the initial literature review a "bundling", and

suggested that researchers should read to meet the requirements of the ethics committee and to guide the hypothesis of the study, but not so much as to restrict the freedom of discovering new areas (cited in McGhee et al., 2007, p. 337).

Constructivist grounded theory begins with a review of the literature, which is necessary in order to find out what has been done (or not done) in an area so that the study problem can be identified and articulated. Charmaz (2006) argued that it is important for the researcher to locate his or her study within the relevant literature at the beginning of the study. In addition, Charmaz (2006) emphasized that the literature review is not a chapter that holds a summary of others' work, but is rather a section that should include an argument that may form the foundation of the discussion in the writing stage of a study.

This literature review includes two sections. First, the caring concept which includes caring concept in the nursing profession, caring outcomes, caring challenges in nursing practice, caring challenges in nursing education, caring and emotional intelligence, and caring and attachments. Second, teaching and learning which includes learning domains, teaching and learning caring, and theories and models of teaching caring concepts

Caring Concept

Care, as a word, is used both as a *noun* and a *verb* in the nursing profession. Care can have several different meanings as a noun, including conscientiousness, diligence, cautiousness in avoiding harm or danger, protection, custody, guardianship, and safekeeping (Dictionary.com, n.d). The term "care" as a noun is also defined as "[t]he provision of what is necessary for the health, welfare, maintenance and protection of someone or something" **(**Oxford Dictionary, n.d). Similarly, care as a verb means attending, nurturing, and protecting (Dictionary.com, n.d); it can

also mean to regard highly, and to be concerned, have affection, and be willing (Oxford Dictionary, n.d).

Care is the root of the word *caring*, a term is widely used in nursing literature and considered the core of the nursing profession (Dalpezzo, 2009). Hence, the caring concept is linked to the nursing profession by nurse theorists as a paradigm unique to the nursing profession, even though there is no consensus regarding the definition of caring (Morse et al., 1999). The diversity of caring definitions arises from the different perspectives of nursing theories.

Caring in the Nursing Profession

The Canadian Nurses Association defines Registered Nurses (RNs) as follows:

> RNs are self-regulated health-care professionals who work autonomously and in collaboration with others to enable individuals, families, groups, communities and populations to achieve their optimal levels of health. At all stages of life, in situations of health, illness, injury and disability, RNs deliver direct health-care services, coordinate care and support clients in managing their own health. RNs contribute to the health-care system through their leadership across a wide range of settings in practice, education, administration, research and policy. (CAN, 2015, p. 5)

In this definition, it is clear that the role of the RN involves a comprehensive form of caring that includes physical, social, and emotional aspects.

The Code of Ethics for Registered Nurses (CNA, 2008) serves as a foundation for nurses' ethical practice. CNA believes that the following seven values are central to ethical nursing practice (2008, p. 4): providing safe, compassionate, competent and ethical care; promoting health and well-being; promoting and respecting informed decision-making; preserving dignity;

maintaining privacy and confidentiality; promoting justice; and being accountable. These values identify the ethical context of nursing practice that includes caring while providing physical interventions.

The American Nurses Association (ANA) defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (ANA, 2010a, p. 66). In this definition, all of the nursing concepts are integrated as a "human response", which is defined as "the phenomena of concern to nurses that include any observable need, concern, condition, event, or fact of interest actual or potential health problems" (ANA, 2010b, p. 40). This definition of "human response" captures the meaning of *caring*.

The foundation of nursing knowledge and nursing practice is caring (Touhy & Boykin, 2008; Leininger, 1981), which is both a moral obligation and a work responsibility (Cronqvist et al., 2004; Watson, 1988, 1995; Morse et al., 1990). It is the body of knowledge that informs the science and the art of nursing (Monti & Tingen, 1999). Within nursing theory, caring consists of "carative factors that result in the satisfaction of human needs" (Watson, 1988, p. 8). To study nursing is to study caring, to grow in an understanding of 'self' and 'other' as a caring person, and to be committed to the value of caring and to the health and wholeness of the persons nursed (Wilby, 2011; Duffy, 2009; Boykin & Schoenhofer, 2001; Nelms et al., 1993; Noddings, 1984). In other words, nursing is "informed caring for the well-being of others" (Swanson, 1993, p. 352), and the standard of nursing is caring that is gained through education and reflected in practice.

From the above definitions and elucidations, we can see that caring is the core and essence of the nursing profession. Furthermore, while few would disagree that caring strongly influences nursing philosophy, education and research (Morse et al., 1990), there are many different perspectives on the nature of caring (Paley, 2001). Morse, Solberg, Neander, Bottorff and Johnson (1990) identify five major perspectives of caring in the nursing literature by content analysis of 35 authors' definitions of caring concepts that provide either explicit or implicit definitions. The first perspective is *caring as a human trait*, meaning that caring is an innate element that can be moulded by personal experience and learning. Benner and Wrubel (1989) posited that caring behaviour is not only a part of being human, but is the "basis of being in the world" (p. 398). Caring behaviour could be affected by one's own experience of being cared for and by social and cultural aspects (Leininger, 1985).

Caring as a moral imperative is a second predominant perspective and suggests that caring is a commitment to uphold an individual's dignity and integrity. Caring is valuing the patients and all actions based on these values. Limiting caring as a moral ideal in the nursing profession means limiting the opportunity of care (Morse et al., 1990).

A third perspective is *caring as an affect*, which means caring is an emotional involvement with an empathic feeling for the patient's experience. These feelings are the basis for motivating the first step in a professional interaction between nurse and patient. Reluctance to expose these feelings because of challenges in the practice setting or rejection of these feelings by a patient may inhibit the level of caring (Morse et al., 1991).

A fourth perspective in the nursing literature is *caring as a nurse-patient interpersonal relationship*, which designates caring as the essence of nursing. Caring is feelings and behaviours occurring within the relationship between nurse and patient. The interaction between

the nurse and the patient articulates the patient's needs and defines the caring required (Morse et al., 1991).

A final predominant theme in the literature is *caring as a therapeutic intervention*, which delineates caring as an action. Caring, when viewed as an action, includes all of the procedures and interventions that build on adequate knowledge and skills. Patient perception of these actions is a critical element of this perspective of caring (Morse et al., 1991)

Gaut's literature review (1983) identified caring as having one or more of the following dimensions. Caring means giving attention to someone or openly showing concern for him or her. This concept frames caring as a psychological awareness and a helping relationship that requires actions from the care provider. Gaut (1983) also suggested that caring means being responsible for someone. This concept shows caring as an act that provides for others' basic needs that are necessary for human survival. In this regard, caring is a one-way relationship. As well, Gaut (1983) saw caring as regard for, fondness or attachment. This concept shows caring as an attitude or a disposition and makes a connection between the provider and those in need of care.

In comparing the perspectives of Morse and Gaut's analyses of the caring concept, two major categories of caring to emerge. One includes all nursing activities, interventions, and skills involved in *caring for*, and the other include the moral, emotional and values aspects involved in *caring about*. Gaut (1983) highlights the distinction among the meanings of *caring for* and *caring about*:

> *Caring for*, in the sense of providing for, or being responsible for, can be discussed apart from any sense of *caring about*; however *caring about* the other (in the sense of valued other) brings a quality to the relationship between the carer and the cared for. *Caring*

> *about* eliminates the apathy, indifference, obligation, withdrawal, isolation, manipulation and possession in one-way relationships of *caring for* in the limited sense of providing for. (p. 325)

Cronqvist, Theorell, Burns and Lutzen (2004) defined the concepts of *caring for* and *caring about* in much the same way as Gaut. They defined *caring about* as a moral obligation that focuses on genuineness, feeling, intuition, beliefs, insight and personal values. In contrast, *caring for* is a work responsibility that focuses on organization, routines, guidelines, responsibility for practice, and managing equipment and the environment. These two views of caring help articulate the multi-dimensionality of caring in nursing as both a work responsibility (*caring for*) and a moral obligation (*caring about*).

A Model of Caring

Kristen Swanson (1991) argued that caring is an integrated multi-dimensional phenomenon, defined as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). Swanson's research on caring used three different perinatal circumstances. Her first study investigated the experiences of women who miscarried; her second study involved research provided by parents and professionals in the neonatal intensive care unit; and her third study reviewed the recollections of socially at-risk mothers who were enrolled in a long-term, intensive public health nursing intervention. A phenomenological approach was used in all three studies (Swanson, 1991). Several epistemological questions formulated the theoretical underpinnings of Swanson adopted the theory, namely: Is caring a process observable only in the context of two or more persons relating? Is it an intent embedded in the behaviour of a caregiver? Or is it a perception

identifiable only through the eyes of a care recipient? Can caring be taught? Is it a moral ideal? Or is it a way of being in the world? (Baily, 2009).

Analysis of these three studies revealed five critical processes or categories of caring: *knowing, being with, doing for, enabling, and maintaining belief* (Swanson, 1991). These categories were compared by conceptual analysis and cross-validated with Benner's helping role of the nurse and Watson's carative factors (Swanson 1991).

Swanson considered *knowing* in the context of striving to understand an event from the perspective of the other individual. Knowing an event's meaning for others clarifies the impact of this event on their life, and the care provider thus avoids *priori* assumptions with regard to the meaning of the event (Swanson, 1991). As a result, the caregiver initially seeks to understand the personal reality of the individual client **(**Baily, 2009**)**. Furthermore, Swanson (1991) argued that "integral to knowing is the provider's philosophy of personhood and the willingness to recognize the other as a significant being. When knowledge occurs, the selves of both providers and recipients are engaged" (p. 163). The sub-dimension of knowing avoids the formulation of assumptions and focuses attention instead on the one being cared for, enabling the carer to make a thorough assessment, seek appropriate cues, and become authentically engaged in the caring process.

Being with is the second caring process categorized by Swanson. *Being with* means being emotionally available to the other, making oneself available on an on-going basis, and sharing feelings, whether happy or sad. Swanson (1991) argued that emotional presence is a way of sharing an event's meaning and appreciating the reality of others. In this process, emotional presence requires careful monitoring so that the care provider does not unconsciously overburden

the one being cared for. *Being with* is equated with "being there", which conveys an ability that includes sharing feelings and fostering a non-burdening environment (Swanson, 1991, p. 163).

The third of Swanson's caring processes is *doing for*. The premise of this category is that the carer helps the individuals (patients) in doing what they would do for themselves if they were capable of doing it. *Doing for* is considered to be anticipatory and comforting. Swanson (1991) argues that "when a person is in a state of being that requires another to do for them, it can be very embarrassing. Consequently, the caregiver must consciously act to preserve the dignity of the other" (p. 164).

Enabling is the fourth category of caring. Enabling is a process where the caregiver assists others as they pass through the transitions of life and new events such as sickness or disability (Swanson, 1991). Enabling involves caregivers using their expert knowledge to foster in their patients a sense of growth capacity. It also assists with the healing process, and facilitates patients' ability to carry out the task of self-care.

The final caring process is *maintaining belief*. Maintaining belief requires the upholding of faith in the other's ability to persevere through a transition or an event with a resolve to face the future with meaning (Swanson, 1991). The individual caring for the other maintains a feeling of hope and presents an optimism that is held within realistic boundaries as the carer assists the other through the situation. Swanson (1991) explained that "[i]n nursing, maintaining belief is a pervasive part of our profession; nurses approach human responses as meaningful aspects of their clients' realities" (p. 165).

Swanson's model presents all of the processes included in both *caring for* and *caring about.* Moreover, this model is compatible with the three elements of the learning domain (cognitive, psychomotor, and affective). Constructing an instructional method rooted in

Swanson's model and covering all of the three domains might produce a viable method of teaching the caring concept.

Caring Outcomes

Caring is critical to nursing performance, patient outcomes (e.g., patient satisfaction and adherence to treatment), and healthcare costs. The Canadian Nurses Association (CNA) states that when nurses are prevented from practicing in a truly caring way, they often experience ethical distress. This is defined as "situations in which nurses cannot fulfil their ethical obligation and commitments, or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectation of ethical practice [due to] … circumstances truly beyond their control" (CNA, 2003, p. 6). Such situations cause nurses to experience intense negative emotions such as anger, frustration, depression, embarrassment and sadness, which leads to performance ineffectiveness (e.g., burnout, sickness, sick leave) and reflects an inability to perform their moral obligation (Lutezn, Cronquist, Magnussen, & Andersson, 2003). In addition, Kalisch et al. (2009) stated that the lack of acknowledgment of the missed quality caring initiated by feelings of guilt, powerlessness and fear actually lowers nurses' self-esteem.

Patient outcomes are also affected by caring and by their relationship and connectedness with nurses (Larrabee et al., 2004; Von Esseen & Sjoden, 2003). Attree (2001) found that routine nursing care that is unrelated to patient needs and performed in an impersonal manner is considered by patients to be unsatisfying. In contrast, Bulm, Hickman, Parcells, and Locsin (2010) reported that even the basic humanistic behaviours (like being called by one's name rather than objectifying labels such as the craniotomy in bed X) lead to patient satisfaction. Furthermore, "[b]etter client outcomes also mean cost savings for the health system" (CASN, 2011, p. 2). Evidence shows that nurse-patient interaction is critical in many ways, as it

influences future decisions to access healthcare and patient adherence to treatment. Such actions further improve health outcomes and reduce the cost of services (Palese et al., 2011).

Caring Challenges in Nursing Practice

Wilby (2011) argued that the nursing profession is challenging, as it demands the inclusion of intellectual and physical capacities as well as "emotional vitality" (p. 29). The concentration on psychomotor and cognitive domains occurs because the physical demands of healthcare and the healthcare system (technology, etc.) are not only numerous but concrete and visible and therefore measurable. They easily become the first priority for nurses, unlike psychosocial demands that are more difficult to see or evaluate and thus more difficult to attend to.

Despite almost three decades of study of the essential caring behaviours required for expert nursing practice (Boykin & Schoenhofer, 2001; Leininger, 1988; Swanson, 1991; Watson, 1985), caring practices by professional nurses remain problematic. Herbst, Swingers and Kinney (2010) reported that while nurses today are providing appropriate physical *care for* patients, the care often comes by sacrificing time spent connecting with patients. In losing this connection, nurses sacrifice the very reason that drew them to the profession, which is the act of *caring about*. The *caring about* behaviour is often missed, forgotten, or neglected by nurses due to staff shortage, a burden of physical care, and increased patient acuity resulting in a dependence on technology (Bulm et al., 2010). Duffy (2009) explained the crisis in the quality of healthcare as follows: "Health care today is rushed, impersonal, and often stress-provoking. For example, it is still the norm to see a health care provider in a busy office/clinic for a few minutes at best and leave without questions answered, adequate knowledge, and lack of understanding in self-care, or prevention of future illness" (p. 5). Similarly, Hewa and Hetherington (1990) have long

argued that "[nurses'] work has lost meaning under the present circumstances, largely due to the devaluation of the kind of work they do in a highly technological context" (p. 183), and that "the price of scientific and technological progress is that the value of humanity is depreciated" (p. 182).

Kalisch (2006) found nine areas of regularly missed nursing care, namely: ambulation, turning, feeding, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance. Based on their study, Kalisch et al. (2009) defined the missed nursing care as "any aspect of required patient care that is omitted (either in part or in whole) or delayed" (p. 1510). There are many reasons that may lead to missed nursing care, such as team norms, the decision-making process, internal values and beliefs, and habits (Kalisch et al., 2009).

In the UK, according to Campbell (2013), a new regulation around nurses' training standards will be applied in response to many incidences of nursing care failure. These incidences accrue due to the fact "that many nurses have become too detached from the fundamentals of patient care and avoid too much routine contact with patients, such as help with feeding and moving around for those who need it" (para. 5). This regulation argues that more focus is needed on the psychomotor skills in nursing, which can be called *caring for*. Indeed, what is missing is the importance of *caring about* that includes being with patients and focusing on their needs as a moral obligation of the nursing profession. It is all about connectedness between the caregiver and the recipient; when this connection is missed, the *caring about* aspect is missed, which negatively impacts the quality of *caring for* as well. The argument is that the nursing profession today is built on well-developed education programs and technology, especially in developed countries, and considerable emphasis is placed on providing nursing care

in practice settings. Partly because of this focus and reliance on technology, decision-makers still think about psychomotor skills as the benchmark for quality nursing care.

Caring Challenges in Nursing Education

Although nurse educators teach caring as the core concept of the nursing profession, they often concentrate their teaching more on the psychomotor and cognitive domains than on the affective domain of caring.

The Position Statement of the CASN (2011) on the Education of Registered Nurses in Canada claims that "changes in science, technology, client activism, the health system, demographics, and the nature of practice settings have transformed health care and nursing practice … [in ways that have] … enormous implications for nursing education" (p. 1). In response to this transformation, nursing education needs to focus more on integrating the art and science of nursing in ways that are grounded in the art and science of caring. The challenge for nursing education is that, although caring is an essential concept of nursing, caring knowledge is elusive to many because of its complexity (Paley, 2001).

Clearly, despite its importance, a number of issues threaten to undermine the importance of *caring about* in nursing and nursing education. First, nurse educators are challenged when teaching the multi-dimensionality of caring because of the nature of the three learning domains (psychomotor, cognitive, and affective) that are involved in teaching caring. They tend to focus more on the psychomotor and cognitive domains than on the affective domain because the knowledge and skills aspect are visible, measurable, and take limited time. In contrast, the affective domain is less visible, often hard to evaluate, and generally time-consuming. In addition, the affective domain deals with emotions, feelings and values, and some people think that these behaviours are innate and natural and thus cannot be taught or learned.

A second issue undermining *caring about* in nursing education is that, in practice settings, nurses can miss, forget or neglect the principle that nursing care is a multi-dimensional phenomenon. This may be due either to work load, staff shortage, technology dependence, time limitation, or to the evaluation of nurses' performance mainly focusing on tasks and the *caring for* aspect. Hence, nurses focus more on the psychomotor skills (*caring for*) in their daily activities and less on the social-emotional skills (*caring about*). These two matters pose a challenge for nursing education. As a consequence, nursing students focus on the psychomotor and cognitive domains because that is what is emphasized in both classroom and clinical settings. In turn, students learn and conceptualize the habit of perceiving nursing care as a *caring for* (a skill based on knowledge) rather than a *caring about* while *caring for*, thus missing that caring is, in fact, a multi-dimensional concept (i.e., skills and human interaction based on knowledge).

Caring and Emotional Intelligence. Caring requires emotional intelligence, which can be defined from the two perspectives of *self-perspective* and *self-other perspective*. From a *self-perspective* point of view, emotional intelligence is a subgroup of social skills that includes the ability to perceive, use, understand, and manage emotions (Beauvais et al., 2011; Salovey & Mayer, 1990). These abilities help the nurse to be aware of self. In contrast, emotional intelligence from a *self-other perspective* involves, as Goleman (1998) suggested, "the capacity for recognizing our own feelings and those in others, for motivating ourselves, [and] for managing emotion well in our relationships" (p. 1). Managing feelings help nurses to express emotions effectively and enables them to work with others (patients) smoothly toward common goals. Goleman identified four categories of skills within emotional intelligence (1995): *self-awareness*, which includes accurate self-assessment and self-confidence; *social awareness*,

which includes empathy, organizational awareness and service; *self-management*, which includes self-control, transparency, adaptability, achievement, initiative and optimism; and *relations' management*, which includes inspiration, influence, developing other, change catalyst, conflict management, teamwork and collaboration.

Emotional intelligence is a crucial element in the process of caring as well as in the process of teaching caring, as it can affect the person's actions and decisions (Clore & Hutsinger, 2007). Beauvais et al. (2011) stated that "nursing students' performance may be improved by preparing students to not only critically think but to integrate emotional intelligence into clinical practice" (p. 400). Emotional intelligence skills may help nurses cope with the emotional demands of the healthcare environment, which can be stressful, exhausting, and lead to burnout (Beauvais et al., 2011; Moyer & Wittmann-Price, 2008). To provide a high quality of care, nurses must build on professional relationships with patients and have full awareness of their emotions (Evans & Allen, 2002). Nursing students can learn and improve their emotional intelligence through training and experience (Chang, 2009). This can involve modeling, mentorship, simulation, and reflection. Moyer and Wittmann (2008) emphasized that self-awareness needs to be fostered and practiced until new behaviours are mastered and used habitually.

Perhaps not surprisingly, the emotional intelligence of the teaching faculty may directly or indirectly influence how they foster emotional intelligence in nursing students (Allen, Ploeg, & Kaasalainen, 2012; Jenkins, 2006). Faculty must, therefore, be competent in understanding their own emotions and the impact of their behaviour on their students. Jenkins (2006) stated that faculty's ability to perceive, understand and facilitate emotions through their interaction with

students may positively influence the learning environment as well as the students' learning process.

Caring and Attachment. Gaut's (1983) analysis considers attachments as an element of caring. This element focuses on the connection between the caregiver and the other. Attachment is an emotional bond between two individuals based on the expectation that one or both members of the pair will provide care and protection in times of need (Kaya, 2010). Bowlby (1988) argued that "the propensity to make strong emotional bonds to particular individuals [is] a basic component of human nature" (p. 3). Bartholomew and Horowitz (1991) developed a four-category model of adult attachment that matches Bowlby's original working models of the self and others. These categories include secure, fearful, preoccupied, and dismissing. Individuals with a secure attachment style are assumed to have had early caregiving experiences that were consistent, attentive, and responsive, and they are liable to be most successful in forming supportive relationships. Secure individuals are comfortable in using others as a source of support when needed (Tan et al., 2005).

As the remaining three attachment styles (fearful, preoccupied, and dismissing) involve at least one negative insight of either the self or others, they are known collectively as insecure attachment styles. Those with insecure patterns of attachment tend to experience more concern about and to demonstrate more self-protective avoidance of potentially supportive relationships (Bartholomew & Horowitz, 1991; Kaya, 2010). Being aware of attachment styles and relational needs may help professional caregivers to be aware of their own contributions to their relationships with patients and to become more sensitive to these relationships (Tan et al., 2005).

Attachment styles can be affected by numerous personal and social factors, such as gender, age, and place of residence (Kaya, 2010). They can also be impacted by families and

romantic relationships (Holmes, 2000). According to Kaya (2010), nursing education effects and helps change the attachment style of nursing students. In her study, Kaya (2010) found that there is a decrease in the nursing students' insecure attachment style at the end of their nursing education. For the caregivers, having a secure attachment style is an important aspect for providing high-quality care to individuals (Tan et al., 2005; Kaya, 2010).

Attachment is a critical element of the relationship between a child and caregiver, and it involves making the child feel safe, secure and protected (Bowlby, 1982). According to Barnard (1979, 1989), the critical skills needed by the caregiver to promote attachment include sensitivity to cues, response to distress, fostering social-emotional growth, and cognitive growth. In turn, the skills needed by the learner include clarity of cues and responsiveness to the caregiver or instructor. Each partner adapts his/her behaviour to accommodate or modify the other's behaviour. Caring was defined by Gaut (1983) as an attachment; thus, it can be argued that the skills involved in building attachment are similar to those involved in building caring. In other words, teaching social-emotional caring involves affective and behavioural skills that could be taught by using this model of teaching attachment.

The Barnard model focuses on the interaction processes involving the instructor and learner, which arguably is valuable for teaching caring. The model of learning interaction (1979) involves instructional elements that build on David and Margaret Steward's model of teaching (1973). In the Steward model, four steps proceed in a series of teaching loops that include alerting, instruction, performance, and feedback. The teaching loop gives the learner the chance to be an active participant in the learning process (NCAST, 1990). Bernard's model also builds on Swanson's model of caring (1990). The Barnard model (1979, 1995) was developed to

identify the interaction responsibilities involved in building attachment between parent/caregiver and infant.

Teaching and Learning

Teaching is defined as instructing (someone) how to do something (Oxford Dictionary, 2015), while learning is defined as the acquisition of knowledge or skills through study, experience, or being taught (Oxford Dictionary, 2015). The Schreyer Institute for Teaching Excellence (2012) has defined teaching excellence as "an academic process by which students are motivated to learn in ways that make a sustained, substantial, and positive influence on how they think, act, and feel," and "a process that elevates students to a level where they learn deeply and remarkably because of teacher attributes" (Para. 1). Farmer and Fren (2009) argued that highly effective teachers design learning experiences that build on a strong understanding of, and concern for, their students. Kreber (2002) described an excellent teacher as having sound knowledge of his or her discipline, knowing how to motivate students, being able to make the concepts relevant and understandable, and being willing and available to help students overcome difficulties.

Positive teacher-student relationships that are characterized as warm, close and communicative (Pianta, Steinberg, & Rollins, 1995) have a significant influence on students' overall knowledge and behavioural adjustment (Baker et al., 1992). Cresswell and Fisher (1998) stated that interaction with students is a major part of the teaching experience and that the qualities that lead to effective teacher-student relationships are positive connections, warm attitude, tact in teaching, teacher immediacy, teacher power, teacher assertiveness, teacher responsiveness, and low differential treatment. A lack of any one or more of these traits may negatively influence teacher-student interaction.

Learning Domains

Bloom's taxonomy (1956) of learning features three domains: the cognitive domain (Knowledge), the psychomotor domain (Skills), and the affective domain (Attitude). The framework for teaching the cognitive domain in nursing involves the acquisition of knowledge and the development of intellectual skills such as problem-solving, decision-making and critical thinking (Reilly & Oermann, 1992). This domain includes many learning components such as data or information recall, comprehension, application, analysis, synthesis and evaluation (Bloom, 1956).

Psychomotor skills are an integral part of nursing practice and are found in the assessment and implementation steps of the nursing process. These skills form a significant portion of nursing intervention, and teaching them involves teaching physical movement, coordination and the use motor-skill areas (Harrow, 1972). This domain also includes numerous learning components, such as imitation, manipulation, precision, articulation, and naturalization (Dave, 1975).

Affective domain learning skills are predominantly related to the emotional process. This domain includes many learning components, such as *receiving*, which means being aware of the subject, *responding*, which means reacting to the subject, *valuing*, which means understanding and acting, *organizing* personal values, which means knowing and forming the values, and *internalizing values system*, which means adopting the behaviour (Krathwohl, Bloom, & Masia, 1964).

Teaching the affective domain is more complex than teaching cognitive and psychomotor domains (Neumann, 2008). Specifically, teaching the affective domain demands strong educational skills beyond introducing and explaining a piece of knowledge; it is more about

modifying and organizing values and beliefs to shift attitudes and behaviours toward a subject (Neumann, 2008; Masin, 2002). The main challenge in teaching the affective domain is its subjective nature, because there are limitations in identifying and assessing the behavioural skills (Masin, 2002).

Neuman and Friedman (2008) proposed an alternative model of the affective domain. It has five levels and is intended to help social work educators facilitate the development of values, ethics, aesthetics and feelings in social work students. Identification requires students to identify their values, beliefs and attitudes. Clarification requires students to clarify their feeling and values and indicate their sources and implications. Explanation invites students to explore the implications and limitations of their perspectives and compare them with others. Modification prompts students to alter their perspective or modify it in such a way that they are able to accept a shifting of their beliefs and values. Characterization is the fifth level, in which students develop an understanding of their attitudes, values and beliefs and organize them in a way that internalizes this change.

This model provides a highlight of the learning objectives that can be built to teach and assess the learning process for the affective domain. Neuman and Friedman (2008) stated that "gaining attention and assuring receptivity and motivation is a separate teaching concern that occurs in any and all learning situations" (p. 5). Moreover, in this model, the authors remove the motivation level, indicating that motivation is an essential element of all three learning domains and therefore is not limited to the affective domain (Neuman & Friedman, 2008).

Much of nursing education uses Bloom's taxonomy (1956) of learning. However, the processes of teaching caring and using the learning domains (the cognitive domain (Knowledge), the psychomotor domain (Skills), and the affective domain (Attitude) within these processes

depend on the context and the meaning of caring. So, if an educator considers the caring concept as skills and knowledge, the result will be teaching the *caring for* concept, whereas if the educator considers the caring concept as skills, knowledge, and attitude, then the result will be teaching both the *caring for* and *caring about* concepts.

Teaching cognitive and psychomotor domains are time- and labour-intensive, as mentioned previously, but these domains can easily be evaluated. In contrast, the affective domain is allotted less attention because it is, as described by Reilly and Oermann (1992), not so easily evaluated:

> The notion of teaching the affective domain in nursing programs is surrounded with mythology and confusion, reflective of a lack of understanding of the nature of the affective domain and its relationship to personhood and the profession. Some educators see the affective domain as primarily concerned with problems of attitude or [behaviour], especially in relation to students or staff. Others perceive affective [behaviour] to be based on values that are personal and not subject to questioning. Some equate the teaching of values with indoctrination, a practice antithetical to a free society. For many, the idea of teaching values conjures up the image of teacher "imposing" values on captive students. Interestingly, one never hears fears expressed as to the danger of the teacher imposing cognitive or psychomotor skills on the student. (p. 192)

In addition, Schoenly (1999) remarked that "a curriculum emphasizing values and morals practice requires teaching for affective outcomes. Yet, the affective domain continues to ignored by educators" (p. 209).

Teaching and Learning Caring

CASN (2004) defined the scholarship of teaching in the nursing profession as "the conveyance of the science and art of nursing from the expert to the novice, building bridges between the teacher's understanding and the student's learning" (p. 6). Many scholars have emphasized the importance of building a caring relationship between educators and students within a caring environment to help students, in turn, develop a caring stance with patients (Oosterbroek, 2009; Dragich, 2001; Waterman, 2007).

The goal of nursing education is to provide students with the knowledge and skills to ensure the delivery of optimal patient care. In turn, Gold (2007) argued that "an ideal patient care experience is one in which all systems and processes are geared to meet the needs of the patient: a safety-oriented system that provides standardized, evidence-based care supported by technology, but that recognizes and responds to individual needs" (p. 293). Clearly, teaching processes require continuous evaluation (Sawatzky, Enns, Ashcroft, Davis & Harder, 2009). This means that nurse educators must continually adapt to the changes integrated into the healthcare system.

In addition to remaining current, the teaching process also requires full awareness of the challenges encountered in the practice setting that may affect the students' learning. Elliott and Wall (2008) argued that "nurse academics, whose role is to educate students, are faced with the challenge of ensuring that their teaching reflects the contemporary nursing environment" (p. 580). Teaching requires the ability to give meaning and relevance to course content and then link it to practice. Furthermore, Nelms, Jones, and Gary (1993) contended that students not only learn how to care or not to care from educator modelling in the classroom and clinical settings, but also from observations of caring and uncaring behaviours among other clinicians in the clinical

setting. Although the classroom environment is significantly different from the practice environment, both affect the students' learning processes and both, therefore, must be in sync.

Professional caring (*caring for* and *caring about)* is not innate but is rather a learned skill (Leininger, 1984; Dragich, 2001). Thus, if educators expect students to *care for* and *care about* their patients, then educators have a responsibility to teach and demonstrate *caring for* and *caring about*. However, Fowler (2012) highlights that nurse educators "feel more comfortable and confident teaching facts and practical techniques than they do teaching attitude" (p. 1232). He identifies some factors that may play an important role in the development of a caring attitude. These include role modelling and providing appropriate feedback, enabling learners to know an authentic patient experience, taking time for caring, and valuing others. Patey (1987) identified a five-step process involved in teaching caring: identifying the opportunities for caring, choosing to care, helping students learn effective methods of caring, observing the result of caring, and reflecting on the action of caring. Furthermore, in order to provide effective nursing care that reflects the holistic view of caring (i.e., one that includes physical, social and emotional aspects), the nursing profession recognizes that the process of how to care must be learned through teacher-learner interaction (Wilby, 2011).

Theories and Methods of Teaching Caring

There are many learning theories that can be used to provide instructional methods to teach caring as a multidimensional concept. Learning is defined as "the acquisition of knowledge or skills through study, experience, or being taught" ("Oxford dictionary", n.d.). In a more comprehensive way that contains all of the cognitive, psychomotor and affective learning domains, Knud Illeris (2003) defined learning as "a very complex process involving both biologically founded psychological and societally founded social elements which follow

different sets of logic and work together in a complex interaction" (p. 398). A learning theory is generally defined as a conceptual framework that illustrates the acquisition, processing, and conservation of information through the learning process. It is used to describe the cognitive, emotional and environmental factors that influence learning process outcomes (Illeris, 2003; Ormorod, 2012). Learning theories fall into the four main categories of Behaviorism, Cognitivism, Humanism, and Social and Situationalism or Constructionism (Smith, 2003; Merriam & Caffarella, 1991; Surgenor, 2011). Based on this classification, each learning theory links to one or more of the learning domains (cognitive, psychomotor, and affective domains).

Applying a learning theory in practice requires an iterative process to assess and understand the impact of the theory on the learning process. The assessment should cover how the theory influences the learner, how the subject is learned, which learning domain(s) fit with the theory, which factors affect the processes of learning in the context of the theory, and how these factors should be dealt with (Hammond, Austin, Orcutt, & Rosso, 2001). The decision to use a learning theory and apply it to instructional practice must be based on a clear understanding of the theory's principles and how it works in different contexts.

Two learning theories in particular – the social learning theory and the ARCS (attention, relevance, confidence, and satisfaction) model of motivation design – provide learning models that are appropriate for teaching caring as a multi-dimensional concept. Constructing a conception of caring forms (i.e., *caring for* and *caring about*) is an essential element in teaching caring. This involves an awareness and understanding on the part of both the instructor and learner of the meaning of *caring for* and *caring about* and recognizing the differences between the two concepts. Role modeling, simulation, motivation and emotional intelligence are some approaches that can be applied based on these models as instructional methods.

Social learning theory. Albert Bandura's observational learning was first proposed in the mid-1960s and was later enhanced as a social learning theory in the 1970s. The theory is characterized by an emphasis being placed on the importance of observing and modeling the behaviors, attitudes, and emotional reactions of others (Bandura, 1971). Bandura (1977) stated that "most human behavior is learned observationally through modeling: from observing others, one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action" (p. 22). In addition, the motivational process to change a person's actions and behaviors depends on the observation of the consequences of these actions and behaviors (Bandura, 1971).

The social learning theory has three main concepts: observational learning, reciprocal determinism, and learner capability (i.e., forethought capability, self-regulatory capability, self-reflective capability, and self-efficacy) (Charneia, 2007).

Observational learning. Observational learning involves four processes: *Attention, Retention, Reproduction, and Motivation*. The *attention* process refers to the learner's attention level during the observation of a modeled event. People cannot learn from a model unless they pay attention to the modeled behavior. Bandura (1969) stated that a person could not reproduce modeling stimuli "if he did not attend to, recognize, and differentiate the distinctive features of the model's responses" (p. 222). The characteristics of the model, the learner, and the nature of the modeled behaviors are the three main components that affect the attention process (Charneia, 2007).

The second process is *retention*. This process focuses on a person's memorizing capacity of what the learner has observed and has two main elements: symbolic coding and rehearsal (Bandura, 1969). A person's memory will maintain an imaginable and verbal symbolic coding of

the observed behavior. This symbolic coding as imaginable and verbal will reappear to guide a person's performance that represents this modeled behavior. The highest level of observational learning can be enhanced through rehearsing the modeled behavior symbolically (Bandura, 1971). The coding operation is more effective than the rehearsal process in enabling long-term retention of a modeled situation because it is an internal representation of the modeled event (Bandura, 1971).

The third process in observational learning is the *reproduction* process. This process refers to the ability of the observer to represent a modeled pattern into proper actions. In this process, the cognitive analysis level is involved, which guides the selection and organization of the responses. In addition, in the reproduction process, modifying behaviors accrue based on self-feedback and comparisons between the symbolic representation and the performed action. Bandura (1969) stated that the "accurate behavioral enactment of modeling cues is also difficult to achieve under conditions where the model's performance is governed by subtle adjustments of internal responses that are unobservable and not easily communicable" (p. 224).

The fourth and final process in observational learning is *the motivational* process. This refers to ways a person can enhance what he or she has learned. For instance, a motivational factor such as a valued outcome plays a role in stimulating the learned behavior. This stimulation occurs as a result of a cognitive evaluation of the effectiveness and relevance of this outcome (Charneia, 2007). Bandura (1969) stated that "when favorable incentives are introduced, observational learning promptly emerges in action" (p. 225). Reinforcement also plays a role in motivation, but as a prior condition rather than a consequent one.

Reciprocal determinism. In 1977, Bandura introduced reciprocal determinism as an additional important element to observational learning and symbolizing capability. According to

Bandura (1977), social learning theory can be used to explain human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences. Reciprocal determinism adds to the theory the environmental aspect as a social element.

Learning capability: Forethought, self-regulation, self-reflection, and self-efficacy.

Bandura (1977) also presented the cognitive aspects of the social learning theory. These aspects represent the cognitive processing of interactions between a person and his or her environment that produce "certain crucial classes of cognitions that include presence-outcomes expectation, perceptions of self-efficacy, and standards for evaluative self-reactions" (Grusec, 1992, p. 781). They require four capabilities, the first, include the *forethought* capability, which refers to the self-motivation capacity of a person that guides his or her actions based on expected outcomes rather than actual outcomes (Grusec, 1992*). The self-regulatory* capability refers to a person's ability to moderate external situations and control thoughts and actions. It also involves a person being motivated to achieve his/her goals based on his/her belief of the ability to reach these goals and the ability to predict the time and effort it will take to achieve these goals (Charneia, 2007). *The self-reflective* capability refers to a person's ability to analyze experiences, thoughts, and actions. *Self-efficacy* refers to a person's perceptions of his/her abilities and how these perceptions guide his/her efforts and achievements. Bandura (1977) maintained that self-efficacy beliefs are developed as a result of information from four sources: enactive attainment, vicarious experience, verbal persuasion, and a person's physiological state.

In summary, Bandura's social learning theory emphasizes that competences, self-efficacy beliefs, and self-regulatory capacities are acquired through learning experiences which are dynamic reciprocal interaction of the learner's cognitive, the environment, and context(through observation). These concepts also play a role in determining a person's experience based on the way that they are sustained as learned skills and behaviour (Graces, 1992).

ARCS model of motivational design. The ARCS Model is a learning model developed by John Keller in the 1980s. Initially, this model was created to understand the major factors that influence learning motivation and to find a systematic way to identify and solve the problems around learning motivation (Keller, 1987). The ARCS model is the "only coherent and comprehensive instructional design model accommodating motivation" (Means, Joanne, & Dwyer, 1997, p. 5). The ARCS model combines behavioural, cognitive, and affective theories to illustrate that using proper instructional materials can influence the learning motivation (Keller, 2010).

Motivation refers to what prompts a person to want to do something, and the level of commitment a person has to do it (Keller, 2010). In the introduction to his book, *Motivational Design for Learning and Performance: The ARCS Model Approach*, Keller (2010) explained that most teachers are unable to motivate their students because they have limited control over the learning subject, limited time, insufficient materials, limited responsibility, and cannot manage the students' interests and enthusiasm. In response to this assertion, one teacher replied: "[M]y responsibility as an educator is to teach. It is up to the students to decide whether or not they want to learn. I can't control their motivation" (Keller, 2010, p. 20). However, motivation in learning is possible with a model that incorporates the main theories and concepts around human

motivation and a systematic approach that helps to design motivating instructional method (Keller, 1987).

The ARCS model was developed based on Tolman's and Lewin's expectancy-value theory, which suggests that people are motivated to learn and have the capacity to learn if this learning has value to them and if there is an optimistic expectation for success (Keller, 1987; 2010). The ARCS model was defined by its developer as "a method for improving the motivational appeal of instructional materials" (Keller, 1987, p. 2). The model has two features: First, it includes four conceptual categories, and second, it contains a set of strategies to address motivation (Keller, 1987). The four categories of this model are; Attention (A), Relevance (R), Confidence (C), Satisfaction (S), which together form the model's acronym, "ARCS". Each category includes subcategories and each subcategory has distinct strategies.

Attention. This category refers to the interest displayed by the learner in capturing the concepts or the subject being taught (Keller, 1987). It includes three subcategories: perceptual arousal, inquiry arousal, and variability. Within each of these subcategories, Keller (1987; 2010) provided further strategies to grab attention. Perceptual arousal involves the three main strategies of concreteness, incongruity and conflict, and humour. These strategies take place at the beginning of the learning session or activity and attract the learner's senses to focus on the subject. For inquiry arousal, there are two strategies: participation and inquiry. These strategies involve the interaction between the learner and the subject. In this stage, the learner reaches an acceptable level of attention that must be maintained. Maintaining the learner's attention can be managed through variability, which provides a variety of teaching methods to motivate the learner to follow the subject. According to Keller (2010), attention is a critical element that requires less distraction and more simplification, and by reaching this level of attention, the

learner will be ready for the next requirement, which is relevance. In the ARCS model, achieving attention piques the learner's interest to follow the subject and find out more about it.

Relevance. This category involves making the learning subject relevant to the learner's interest. Relevance is signified by using language and examples that are familiar to the learner (Keller, 1987). According to Keller (2010), "relevance refers to people's feelings or perceptions of attraction toward desired outcomes, ideas, or other people based upon their own goals, motives, and values" (p. 98). Relevance has three major subcategories: goal orientation, motive matching, and familiarity. Each of these sub-categories has strategies that help apply it. Goal orientation involves present worth and future usefulness. Here, the instructor explains the present and future advantages of the learning subject to the learner, which helps the learner to become aware of the learning subject's value to him/herself. Motive matching involves needs matching and choice. In these strategies, the instructor focuses on the learners' needs and on matching the learners and the learning subjects, based on these needs. The instructor also gives the learners a chance to choose the task or work in a specific area that is related to their interests. Familiarity modelling and experience is based on the notion that learners will not maintain attention on the learning subject if the subject is not relevant to their interests. Thus, it is the teacher's responsibility to get to know the learners' interests through communication and attention. These can be established through activities (Keller, 2010)

Confidence. This concept focuses on setting up positive expectations for achieving success among learners. A learner's confidence level depends on the level of motivation and the amount of effort needed to reach the learning objectives. Confidence has three subcategories: performance requirements, success opportunities, and control-confidence or personal responsibility. Students must be provided with a method for evaluating their probability of

success in any learning design, such as a syllabus and grading policy, rubrics, and a timeline to complete tasks.

Satisfaction. Learners must obtain some type of satisfaction or reward from a learning experience. This satisfaction can be from a sense of achievement or positive feedback and reinforcement. When learners appreciate the results, they will be motivated to learn. Satisfaction is based upon motivation, which can be intrinsic or extrinsic. According to Keller (2010), the person with intrinsic motivation commits to tasks for the enjoyment that comes simply from doing these tasks, whereas in the extrinsically motivated person commits to tasks not for pleasure but to gain the rewards from completing these tasks. Keller (1987) suggested three main subcategories represent the satisfaction element: intrinsic reinforcement, extrinsic rewards, and equity.

Keller (2010) stated that the four categories help to elucidate the principles of the ARCS model that provide guidelines to generate a method to motivate human learning. In addition, he developed ten steps that outline the ARCS motivational design process. These steps represent specific activities that create a teaching approach and include: obtaining course information; obtaining audience information; analyzing the audience; analyzing existing materials; listing objectives and assessments; listing potential tactics; selecting and designing tactics; integrating with instruction; selecting and developing materials; and evaluating and revising (Keller 2010).

However, even while recognizing that these instructional methods could be used to introduce and expose the caring concept, they still do not set forth a clear way for educators to teach *caring about* while teaching *caring for*. In other words, teaching the affective domain while teaching psychomotor and cognitive domains is a complicated task. The elements and

process of teaching these crucial aspects of caring and the level of the learner's engagement are not defined solely by applying the above instructional methods.

Summary

From this initial literature review, we can conclude that although caring is the foundation of nursing education and practice and is defined as a multi-dimensional concept at the theoretical level, it is still, at the education level, limited to the form of knowledge and skills and less as an attitude aspect. The literature alone, when viewed through the caring lens, makes it clear that the central core of nursing should not be limited to one's ability to *care for* but should rather be driven by one's ability to *care about*. What is not clear, however, are the processes that should be used by nurse educators to overcome the pressure to focus solely on teaching *caring for* and instead to integrate *caring about* as an element in their teaching.

The purpose of the study was to use a constructivist grounded theory approach to explore undergraduate nurse educators' perspectives on how they teach *caring about* while teaching *caring for* to nursing students, and the challenges and opportunities within their experiences. The research question of this study was thus: How would nurse educators define *caring about* and *caring for*, how would they teach *caring about* while teaching *caring for,* and what are the challenges and opportunities in teaching these concepts? The study's qualitative research is guided by constructivist grounded theory methodology and methods. Participants were nurse educators who have had a minimum of three years of teaching nursing care in undergraduate nursing programs in four schools of nursing in Nova Scotia.

Chapter 3

The Research Methodology and Method

This qualitative research was guided by constructivist grounded theory methodology and methods. It was designed to explore nurse educators' perspectives regarding the process of teaching caring as a multidimensional phenomenon in undergraduate nursing programs. Participants included nurse educators from FOUR schools of nursing at three universities - Dalhousie University (Halifax and Yarmouth Campuses), Cape Breton University in Sydney, and St. Francis Xavier University in Antigonish - in Nova Scotia, Canada who had a minimum of three years of teaching experience in undergraduate programs. Recruitment included eligible nurse educators who were willing to share their own teaching experiences through individual interviews. Theoretical sampling was also used, following analysis of several interviews, to ensure sufficient diversity in participant perspectives. During the interviews in this study participants were invited to view and respond to a visual question regarding a video involving a clinical instructor interacting with a student and patient. The verbal and the visual questions were used to generate and analyze the data based on the constructivist grounded theory approach. This chapter includes the purpose of the study, the research questions, the settings, participants' recruitment, data collection, and ethical considerations.

Purpose of the Study

The purpose of the study was to use a constructivist grounded theory approach to explore undergraduate nurse educators' perspectives on how they teach *caring about* while teaching *caring for* to nursing students, and the challenges and opportunities within their experience.

The motivation for choosing this topic for my Ph.D. thesis was that I found the topic to be too vague to be clearly taught and understood. Initially, my personal experience as a lecturer and clinical instructor in the College of Nursing, King Saud University, Saudi Arabia, drove me

to explore this area. I was challenged to teach students how to *perceive*, *attend*, and *sense* what is going on with a patient while also providing physical care. These challenges arose with teaching students how to interact with patients while also learning physical skills. I was aware of the challenges that students experienced, and I discussed these issues with other educators and experts at our college. During these discussions, I discovered that there was a general agreement about the importance of teaching students to focus on the emotional/social aspects of nursing, but there was a lack of understanding regarding *how to teach* caring as a multidimensional phenomenon.

Hence, this question moved from being an instructional challenge to becoming the main focus of my doctoral study. Through countless discussions with my thesis supervisor, Dr. Jean Hughes, around this matter, we agreed that to address this question, I first needed to explore in depth how nurse educators teach caring in an integrated way. More specifically, the main challenge to teaching caring as a multidimensional concept was how to teach *caring about* while teaching *caring for* in a way that gives both concepts equal attention and value through the learning process.

Research Questions

The five main questions in this study are:

- How do nurse educators define *caring about* and *caring for* concepts*?*
- How do nurse educators teach *caring about* while teaching *caring for*?
- How do nurse educators know if students understand and link the concepts of *caring for* and *caring about*?

- How do nurse educators help students to internalize the link between *caring about* and *caring for?*
- What do nurse educators see as the challenges and opportunities around teaching *caring about* while teaching *caring for*?
- What do nurse educators see as the outcomes (positive or negative) of teaching *caring about* while teaching *caring for* in terms of patients, students, the health care system and the nursing profession in general?

I decided to use a qualitative research method as it was viewed as the most effective approach for exploring and understanding the nurse educators' perspectives, beliefs, and values regarding teaching caring concepts. The qualitative research method I chose to conduct this study was grounded theory.

Grounded theory methodology was used in this study for three reasons. First, grounded theory is ideal for the exploration of phenomena for which limited theory exists. According to Strauss and Corbin (1998), in any situation, the deep understanding of human behaviour or actions captured through grounded theory comes from data from the natural field, and the meaning of these actions and behaviours comes from participants' perceptions of this situation (Chenitz & Swanson, 1986). Thus, a grounded theory approach that centres on teaching *caring about* while teaching *caring for* was chosen to explore nurse educators' perspectives related to teaching *caring about* while *caring for.*

The second reason I chose grounded theory was that, according to Glaser (1992), it generates "concepts and their relationship that *explain*, *account for* and *interpret* the variation in behaviour in the area under study" (p. 19). Therefore, grounded theory is used to interpret data regarding concepts and their relationships. In this study, an interpretation of the nurse educators'

perspectives, behaviours, and beliefs was used to generate the concepts and categories that explicated the process of teaching caring as a multidimensional phenomenon.

The third reason for using grounded theory was to develop an explanatory theory of human social behaviour based on data (Morse & Field, 1995). Therefore, grounded theory was used to build a theory that reflects the process of teaching caring as a multidimensional phenomenon based on the nurse educators' perspective.

An Overview of Grounded Theory

Grounded theory is one of the qualitative research methods developed by Barney G. Glaser and Anselm L. Strauss in the 1960s for the purpose of studying social phenomena (Strauss & Corbin, 1990; Charmaz, 2000; 2006; 2014). Although developed in the discipline of sociology, grounded theory was later applied in fields such as business, education, medicine, nursing, psychology, public health and social work (Hernandez, 2010). Grounded theory evolved from a collaboration of Glaser and Strauss while studying death and dying in hospitals. They were studying how dying occurred in deferent hospitals and how, and when, health professionals and their patients who were terminally ill knew they were dying and how it was addressed (Glaser & Strauss, 1967). They constructed a clear analysis of dying and developed systematic methodological strategies that could be used as a research method to develop theories from qualitative data (Charmaz, 2014). Grounded theory was defined as a systematic approach emphasizing the generation of middle-range theory from data at a substantive or formal level (Glaser, 1978). The middle range theories in sociology are defined as "theories that lie between the minor but necessary working hypotheses that evolve in abundance in day to day research and the all-inclusive systematic efforts to develop unified theory that will explain all the observed uniformities of social behaviour, organization and social change" (Merton, 1949, p.448).

Charmaz (2014) defined grounded theory as " a rigours method of conducting research in which researchers construct conceptual frameworks or theories through building inductive theoretical analysis from data and subsequently checking their theoretical interpretation" (p. 343).

The main difference between grounded theory and other qualitative methods is that grounded theory is used to *discover* and *explain* the social processes of the phenomenon under study and does not simply describe the phenomenon. Other differences are that (a) grounded theory includes the use of constant comparative analysis, of each piece of data with all other pieces, as a tool to identify emerging categories and concepts and their properties, dimensions and relationships, and that (b) data collection in grounded theory is a flexible process (Atwoa, 2005). Grounded theory method entails the following "1) analysis over description, 2) fresh categories over preconceived ideas extant theories, 3) systematically focused sequential data collection over large initial samples" (Charmaz, 2014, p343).

Grounded Theory Evolution

Grounded theory has undergone considerable development since it was first described some five decades ago. Generally, since its creation in 1967, grounded theory has evolved into three main approaches. These include the Glaser and Strauss approach, which is controversially called the classical or Glaserian approach (Hernandez, 2010; Heath & Cowley, 2004; Fernandez, 2004); the Strauss and Corbin approach, also called the Straussian approach (Rodon & Pastor, 2001); and the constructivist grounded theory approach developed by Kathy Charmaz (Charmaz, 2000; 2006; 2014). The noticeable changes of grounded theory method appear in the main publications of the generators and their students.

The Classical Approach. The classic approach was developed by Glaser and Strauss in 1967. Ten years later, they published the book, *The Discovery of Grounded Theory*, which

described the method in detail as an innovative qualitative research method (Charmaz, 2000; Glaser & Strauss, 1967). Then, in 1978, Glaser published a book, *Theoretical Sensitivity: advances in the methodology of grounded theory*, which provided further details about the grounded theory method. The two main objectives of this publication were to add a new methodological process, and to introduce the theoretical sensitivity in the analysis (Glaser, 1978). This was followed in 1987 by Strauss's book, *Qualitative Analysis for Social Scientists*, which included additional instructions, making grounded theory more accessible for researchers (Charmaz, 2000; Strauss, 1987). Glaserian Grounded Theory (GT) is marked by the assumption that there is an objective truth out there that can be discovered, and that the researcher maintains a purely objective stance in relation to participants and the data.

The Strauss and Corbin Approach. In 1990, Strauss and Corbin published their book, *Basics of Qualitative Research: Grounded Theory, Procedure, and Technique*, which delineated the differences between the classic approach and the Straussian approach. Confusion had arisen because Strauss and Corbin did not acknowledge that their method was different from the classical approach developed by Glaser and Strauss (1967). The clarification was not made until the final publication after Strauss's death in 1996 (Strauss & Corbin, 1998; Hernandez, 2010). The methodological split between the two originators centred on the aggression argument by Glaser in 1992 (Walker & Myrick, 2006) that involved forcing and merging the data (Charmaz, 2000; Goulding, 1999). There was also some conflict around the use of the grounded theory method to verify a theory (Charmaz, 2000).

Glaser views Strauss and Corbin's approach as a "full conceptual description" rather than a grounded theory approach (Charmaz, 2000, p. 513). The crucial conflicts between the Glaserian and Straussian approaches are located in two areas – namely, the role and the position

of the researcher, and the level of intervention in data analysis (Walker & Myrick, 2006). Charmaz (2008) states that the Glaserian and the Straussian approaches share some fundamentals but differ in conceptions and strategies. She adds that some of these differences that Strauss's and Corbin's are "demonstrate [d] through description and data collection in the social constructionist tradition" (p. 400). In other words, Straussian grounded theory is less objectivist and more constructivist in its method.

The Constructivist Approach. In 2000, Kathy Charmaz introduced a constructivist lens to grounded theory, thus moving it to a new paradigm. The constructivist grounded theory approach is a new ontological and epistemological position that differed from both the classical approach and the Straussian approach. In an article, Charmaz (2000) distinguishes between the constructivist and objectivist methods to justify her approach as another way to use grounded theory. However, constructivist grounded theory faced massive criticism from Glaser (2002), who argued that "constructivist grounded theory is a misnomer" (p. 1). In addition, Glaser (2002) argued that Charmaz's "discussion [in the article published in 2000] has none of the properties of conceptual theory generation of pure [grounded theory]. It is all accurate description (imagery), not abstraction", labeling Charmaz's approach as *Qualitative Data Analysis*, not grounded theory (p. 7).

In 2006, Charmaz published the book, *Constructing Grounded Theory: A practical guide through qualitative analysis,* that explicated the constructivist approach for new researchers who wanted to use grounded theory without being objectivist. Charmaz (2006) provided a clear statement about her approach, explaining:

> …in the classic grounded theory works, Glaser and Strauss talk about discovering theory as emerging from data separate from the scientific observer. Unlike their position, I

> assume that neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvement and interaction with people, perspectives, and research practices." (p. 10)

In addition, in 2014 Charmaz adds more details about the constructivist grounded theory approach in the second edition of the text *Constructing Grounded Theory*. In addition, she argued that the constrictive grounded theory illustrates the flexibility of the method and opposed its rigid application. However, throughout this evolution in grounded theory, numerous authors have analysed, critiqued, and investigated the differences among the three approaches regarding the philosophical underpinnings and paradigm differences (Annells, 1996; Charmaz, 2000; Charmaz & Bryan, 2007), as well as the methodological and verification processes (Hunter et al., 2011).

Philosophical Foundations of Grounded Theory

Understanding the philosophical underpinnings of grounded theory is an essential step to using it as a study methodology. Literature directed at postgraduate students and novice researchers emphasizes the importance of researchers establishing the philosophical foundations of their study from the start (Denzin & Lincoln, 2005). Despite the fact that Glaser and Strauss (1967), the originators of grounded theory, did not articulate the philosophical foundation of their approach, Corbin and Strauss (2008) and Charmaz (2006) state a number of philosophical and sociological assumptions that unambiguously underpin developed grounded theory.

The root of grounded theory comes from symbolic interactionism, which was developed from the pragmatist ideas of James Dewey, Charles Cooley and George Hearbert Mead (Goulding, 1999; Heath et al., 2004, Charmaz, 2014). The main focus of these scholars was

social interaction and the ability of individuals to adapt their behaviour based on the perspective of others, in any given situation (Heath et al., 2004).

The term *symbolic interactionism* was developed by Herbert Blumer (1969), one of Mead's students. He perceived it as an empirical social science perspective on the study of human group life and human conduct (Blumer, 1969). He extended and refined Mead's work and adds more explanations of the symbolic interactionism perspective (Purse, 1996; Stones, 2007). Blumer defined three basic premises of this perspective. First, the *meanings* of "things" determine *what actions* will be taken toward those things. Second, these meanings are developed from *social interactions*. Third, modifying these meanings in any situation is based on the interpretive processes used by a person (Blumer, 1969). Symbolic interactionism (SI) consists of three core principles: meaning, language and thought. Charmaz (2014) defines symbolic interactionism as "a theoretical perspective derived from pragmatism which assumes that people construct selves, society, and reality through interaction" (p.9). Grounded theory (GT) methodology is informed by symbolic interactionism as a philosophical underpinning. Researchers doing GT are informed by SI and thus are able to provide a deeper understanding of how peoples' behaviour is shaped through social interaction in specific conditions (Aldiabat & Le Navenec, 2011). To discover the basic psychosocial process in a study, the researcher should understand the behaviour and meaning of the experience for people in a natural setting (Glaser 1978). Aldiabat and Le Navenec (2011) argue that symbolic interactionism and grounded theory are compatible in their main goals and assumptions, and have linked assumptions of symbolic interactionism with those of grounded theory. Charmaz (2000) states that, from the constructivist view, "meaning and the emergence within symbolic interactionism complement grounded theory" (p. 513). And she emphasizes that grounded theory has flexible strategies, not rigid

prescriptions, and can be used with sensitizing concepts from different perspectives such as symbolic interactionism and/or pragmatism (Charmaz 2000).

Pragmatism is defined as "an approach that evaluates theories or beliefs in terms of the success of their practical application" (Oxford dictionary, para.1). It provides the conceptual underpinning of the work of Anselm Strauss, who was one of the founders of the grounded theory method (Bryant, 2009; Hall, Griffiths & McKenna, 2013; Hunter et al., 2011; Mills, Bonner & Francis, 2006). Strauss's background, as a pragmatist and symbolic interactionism, shaped the evolution of his approach in collaboration with Juliet Corbin (Hall et al., 2013). In fact, Strauss and Corbin described the relationship of grounded theory to reality and truth, and linked it to the relativist pragmatism (Mills et al., 2006).

Strauss and Corbin (1994) clearly state their position around pragmatism, arguing that they do not believe in the existence of a "pre-existing reality 'out there.' To think otherwise is to take a positivistic position that ... we reject. Our position is that truth is enacted" (p. 279). Their approach engaged the pragmatism perspective in identifying the research problem (Hunter et al., 2011). Although the pragmatism perspective is acknowledged to be relevant to grounded theory, it is still difficult to understand how to engage it in the methodology. This may be because Strauss pays little attention to his background in pragmatism in his writing through the development of grounded theory (Bryant, 2009). Charmaz (2000) argues that pragmatism is relevant to grounded theory because its applicability and usefulness are part of the grounded theory analytical evaluation criteria. In addition, 16 assumptions, explaining the influence of pragmatism and symbolic interactionism on Strauss and Corbin's grounded theory approach, were included in their text *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (Corbin & Strauss, 2008), the third addition.

Indeed, there are many indicators that show the pragmatic perspective in grounded theory, four of which include the following. First, pragmatists value both the experience and the role played by experience in the inquiry process (Harvey, 2012). As Charmaz (2008) asserts, in grounded theory, "research always reflects value positions. Thus the problem becomes identifying these positions and weighing their effect on research practice, not denying their existence" (p. 402). Experience and knowledge are therefore acknowledged, and the researcher must be conscious not to contaminate the data with his/her own ideas and, instead, use this knowledge as a tool to recognize the boundaries of the phenomenon under study and understand what is going on in the study participants' world.

A second indicator that reveals the presence of the pragmatic perspective in grounded theory is the researcher's preconception of the phenomenon being part of the experience, as researchers do not usually approach their subject without some preconceived notions (Strubring, 2007). Harvey (2012) asserts that pragmatism offers a clear notion of thoughts and action, in that ideas are framed as "instruments and plans of action rather than as images of reality" (Para. 8). The prior experience thus constructs descriptions of what will be done and why. Hence, the researcher has to be aware of what he/she holds as a preconception and what the data shows. Hernandez (2010) suggests that grounded theory allows the researcher to be open to what the data show and to allow the concepts to emerge from the data, not from the personal experience of the researcher.

A third indicator can be found in publications by both Strubing (2007) and Bryant (2009), in which they show how adopting pragmatism could solve many ontological and epistemological issues arising from the various approaches of the grounded theory method. At its core, pragmatism supports the relative assumption in viewing reality as multiple realities that are

linked and affected by the context. This is compatible with grounded theory as presented in both the Straussian approach and the constructivist grounded theory approach (Bryant, 2009).

A fourth indicator of the presence of pragmatism in grounded theory can be found in how grounded theorists maintain that, through the process of interaction, individuals assign meaning to actions, and that this meaning is continually revised through interaction with an object (e.g., person, thing, or situation). From the pragmatic perspective, an object has meaning for someone if it is useful (James, 1907). Strauss and Corbin (1998) emphasize that people act on the basis of perceived meanings developed from interactions with the object. This perspective is based on Blumer's work (1969). However, although obtaining meaning from the data is not a straightforward process, it is more feasible when gathered during an interaction. Collecting data in the field provides the researcher with a chance to understand the experience and the behavior of the participants. In addition, the researcher can recognize interactions between the participants with others in the field and/or the subject of the study, and how they interpret this interaction (Baker, Wuest, & Stern, 1992).

Both pragmatism and symbolic interactionism emphasize that the existence of an object depends on both the meaning of the object and interactions with that object (Sturbing, 2007). Mead (1936) states that "we cut the objects out of this world", indicating that meaning is controlled by what we cut out and how we cut it out (p. 155). Here, the researcher 'cuts out' meaning from the data, which represents the participants' "world". In other words, the researcher's understanding is cut out from the participants' view of their experience. Thus, using grounded theory involves looking for the meaning of phenomena through data in order to understand and explain the social process around the phenomena.

Paradigm Differences

Divisions between the founders of grounded theory led to differences in ontological, epistemological, and methodological perspectives (Annells, 1996; Charmaz, 2006; Hall et al., 2011). Ontology proposes the nature of reality and what can be known about reality (Guba & Lincoln, 1994). The ontological root of the classical grounded theory method is linked to the Mead-Blumer pragmatism perspective (which was considered a critical realism) and the Glaser and Strauss approach which was labelled a critical realist ontology (Annells, 1996). The critical realist ontology in the post-positivist paradigm assumes that reality cannot be perfectly understood, although it can be explored through inquiry (Cuba & Lincoln, 1994). In contrast, Strauss and Corbin saw relativism as a way of proposing reality as something that cannot be known but only interpreted (Annells, 1996; 1997). Strauss and Corbin (1990) state that "doing analysis is, in fact, making interpretations" (p. 59). Furthermore, constructivist grounded theory adopts the relativism of multiple social realities, which will be discussed in detail in the constructivist grounded theory section of this report (Charmaz, 2000).

Similarly, there are differences in the epistemology positions of the three approaches to grounded theory. Epistemology describes the relationship between the knower and what can be known (Guba & Lincoln, 1994). Glaser's epistemological position is positivist and objectivist, based on his position and assumptions of providing objective data, external reality and an independent natural observer (Charmaz, 2000). Strauss and Corbin are post-positivists because they give voice to their respondents; they are also subjective (based on their position), and their publications provide evidence of their constructivist paradigm of inquiry (Charmaz, 2000; Strauss and Corbin, 1997; 1990). The constructivist grounded theory "takes a middle ground between postmodernism and positivism", and knowledge created by the viewer and the viewed,

where the researcher aims to interpret the meaning from the data by interacting with the participants (Charmaz, 2000, p. 510).

Methodological Differences

Grounded theory methodology has some common strategies, although there are some differences among the classical approach, Strauss and Corbin approach, and the constructivist approach (Hall et al., 2001). At the methodological level, while the three approaches share much of the terminology such as coding, constant comparison, questioning, theoretical sampling and memos in the process of generating theory, each approach has a unique set of procedures (Walker & Myrick, 2006). Mills et al. (2006) argue that all differences in grounded theory approaches occur on a methodological spiral and reveal the epistemological underpinnings of each approach, stating that:

> Depending on the researcher's ontological and epistemological beliefs, there are several points of departure along a spiral of methodological development. Engaging in any form of grounded theory study, however, requires the researcher to address a set of common characteristics: theoretical sensitivity, theoretical sampling, treatment of the literature, constant comparative methods, coding, the meaning of verification, identifying the core category, memoing and diagramming, and the measure of rigor. (p. 3)

Consequently, in grounded theory the ontological and epistemological positions of the researchers identify how they will handle the methodology phase in their research.

Constructivist Grounded Theory Approach

Constructivism Paradigm

In this section, I will describe the constructivist perspective as a form of inquiry to understand grounded theory. Charmaz defines constructivism "as a social scientific perspective

focusing on how realities are made. This perspective supports subjectivity and assumes that people, including researchers, construct the realities in which they participate" (2014, p. 342). Schwandt (1994) states that constructivists "believe that to understand this world of meaning, one must interpret it. The inquirer must explain the process of meaning construction and clarify what and how meanings are embodied in the language and action of social actors" (p. 118). Constructivists view knowledge and truth as intellectual creations by human minds, unlike objectivists, who view knowledge and truth as an existing object that needs to be discovered (Schwandt, 1994). Guba and Lincoln (1994), argue that the constructivist ontology is considered *relativist*, which means there is no one *reality* or one *truth.* Realities are multiple and these realities are constructed in people's minds based on their experiences and the social context. Each person constructs the reality in unique and specific ways, but each construct has the capacity for changing the person's level of experience (Guba and Lincoln, 1994). Charmaz (2008) argues that a relativist stance assumes that theoretical analyses derived from the grounded theory process "are interpretive renderings of a reality, not objective reporting of it" (p. 206).

In addition, in the constructivist epistemological position, the researcher is *subjective*. Constructivists assume that the researcher must have an active role throughout the study by interacting with the study's subject and the findings created by this interaction (Guba and Lincoln, 1994). Constructivism perceives reality as multiple realities that are created by the viewer and the viewed, in order to form an interpretative understanding of the meaning of the subjects (Charmaz, 2000). Furthermore, constructivists view their interpretation of their research data as a construction (Charmaz, 2014)

Furthermore, in constructivism, the methodological position is *hermeneutical* which means focusing on interpretation, and *dialectical* which means relating to the logical discussion

of ideas and opinions (Guba & Lincoln, 1994). Constructivism recognizes that individuals construct the meanings of their experiences, or the situation, under the study and the researcher must interact with those individuals to expose these meanings. As a result of this interaction, researchers interpret multiple meanings. Then, they use an explanatory technique to compare and distinguish these meanings through questioning analysis. The aim is to find a "consensus construction" that is knowledgeable and well informed (Guba & Lincoln, 1994, p. 111). In constructivism, the viewer creates data and undertakes analysis by interacting with that which is viewed. Reality is not explored through data but is rather constructed through the interactive process within a context. Here, the viewer is part of what is viewed rather than separate from it, because the viewer shapes, defines and analyzes what he viewed.

Charmaz (2014) defined Constructivist grounded theory as,

> a contemporary version of grounded theory that adapts methodological strategies such as coding, memo-writing and theoretical sampling of the original statement of the method but shifts its epistemological foundations and takes into account methodological developments in qualitative inquiry occurring over the past fifty years… constructivist grounded theorists aim for abstract understanding of studied life and view their analysis as located in time, place, and the situation of inquiry. (Charmaz, 2014, p. 342)

Charmaz (2000) further argues that the constructivist grounded theory approach "reaffirms" the qualitative method for studying people in their natural setting and "redirects" away from the positivist paradigm. In addition, she points out that the constructivist grounded theory approach is not rigid or prescriptive but instead focuses on the meaning while interpreting the understanding, and is amenable to use in non- positivist approaches. Constructivist grounded theory adopts the inductive comparative, emergent and open-ended approach of the classical

approach, however, the constructivist grounded theory "highlights the flexibility of the method and resists mechanical applications of it" (Charmaz, 2014, p.13).

Additionally, constructivist grounded theory is a way to understand the participants' world by using flexible and exploratory strategies (Charmaz, 2000). Constructivist grounded theory looks to define and understand "conditional statements which do not hold a generalizable truth" but interpret how the participants view their realities in a specific context (Charmaz, 2000, p. 525). In contrast with the classic grounded theory, the constructivist grounded theorists assumes that "neither data nor theories are discovered either as given in the data or the analysis. Rather, we are part of the world we study, the data we collect, and the analyses we produce. We construct our grounded theories through our past, and present involvements and interactions with people, perspectives and research practices" (Charmaz, 2014, p. 17).

However, constructivist grounded theorists make four main assumptions: reality is multiple and constructed under specific conditions; the research process develops through interaction; the researcher and the participants both have their active positions in the research; and, through the research process, data are constructed by both the researcher and the researched (Charmaz, 2008; 2014).

Why Constructivist Grounded Theory?

The constructivist grounded theory method is used in this study for a number of reasons. First, the constructivist grounded theory approach is *flexible*. According to Charmaz (2000), the constructivist approach provides a more flexible perspective than the rigid perspective of the positivist approach, which is represented by classical grounded theory. Charmaz states that "they [the researchers] may still study the empirical worlds without presupposing narrow objectivist methods and without assuming the truth of their subsequent analysis" (2000, p. 511). Hence, in

the constructivist approach, the realities come from the participants' perspectives as well as from the researcher's interpretation. According to Charmaz (2006), "a constructivist approach places priority on the phenomena of study and sees data analysis as created from both shared experiences and relationships with participants and other sources of data" (p. 130). In the constructivist paradigm, knowledge is generated from the data. These data reflect the meaning of phenomenon, which is constructed by the study participants. The researcher's interpretation is considered the tool to understand this meaning. To achieve this goal, the researcher needs to enter the participants' world. Charmaz (2006) states that:

> As we try to look at their [the participants] world through eyes, we offer our participants respect and, to our best ability, understanding, although we may not agree with them. We try to understand but do not necessarily adopt or reproduce their views as our own; rather, we interpret them. (p. 19)

In contrast with the other two grounded theory approaches, constructivist grounded theory emphasizes the importance of the researcher's bond with the study participants to get more concrete data. Charmaz (2006) explains that "Dey (1999) points out [how] Glaser and Strauss's (1967) smash and grab data collection strategy dispenses with rapport, which for many projects is a prerequisite to gaining solid data" (p. 19).

The flexibility of the constructivist approach has given me an opportunity to interact with the participants and ask for clarification and examples in order to understand the diverse perspectives. Here, asking for clarification was carried out in a manner that does not reveal my opinion, or my preconceptions, of the inquiry point. Rather, using *why* and *how* questions helped me to gain further detail about the matter under study but did not force the answer in a particular direction.

A second reason for using the constructivist grounded theory approach is that it incorporates *reflexivity* (Charmaz, 2000, 2006). Charmaz (2014) emphasizes that the researchers are not passive; rather they are obligated to be reflexive to what they bring to their study matter - perceptions- and how they perceive it. This reflexivity includes the researchers' background, experiences, decisions, and interpretations are involved in the processes of their research. These, in turn, expose the influence of their interests, positions and assumptions to the readers. Reflexivity limits these issues by showing what the data offer the study and what the researcher provides to the analysis by recording thoughts and personal notations around the data. Charmaz (2006) states that "constructivist grounded theorists assume that both data and analyses are social constructions that reflect what their production entailed" (p. 131). In other words, the constructivist approach recognizes that both facts and values are linked, so any analysis of facts will be linked to the researcher's values. In this, researchers must be aware of their own assumptions about the phenomenon that they studying and avoid reproducing these assumptions so as not to upstage the participants. As a nurse educator, I am aware of my previous experience in teaching *caring about* while teaching *caring for*, and in order to enhance my reflexivity, I have continued to write these thoughts and assumptions as memos before and throughout the study process.

A third reason why I chose this approach is that it acknowledges the pragmatist prospective, especially at the final level of developing and evaluating a theory (Bryant, 2019; Charmaz, 2000). This means that the constructivist grounded theory approach is practical and provides a useful and meaningful product in the area of study. Charmaz (2000) states that "the grounded theories' hypotheses and concepts offer both explanation and understanding and [fulfil] the pragmatist criterion of usefulness" (p. 524). For Charmaz, science is determined in

part by what works and in part by power and entrenched views (Puddephatt, 2006). Thus, while there is evidence showing that teaching *caring about* while teaching *caring for* is a science, there is also evidence supporting the need for understanding the practicality of teaching this concept. Therefore, the pragmatic perspective adds a critical dimension to this method.

Thus, flexibility, reflexivity and the practical criteria of the constructivist grounded theory are my three main motives for choosing to use the approach as a method in this study. In addition, I got the chance to learn about the grounded theory approach with two experts in teaching and using the grounded theory method. First, I enrolled in a grounded theory course in 2013 with Dr. Rita Schereiber at University of Victoria School of Nursing. Second, I enrolled in a constructivist grounded theory in 2015 with Dr. Marilyn Macdonald in School of Nursing at Dalhousie University. Overall, I found that the constructivist grounded theory approach is more fitting to my position as a researcher.

From my teaching experience as a nurse educator, I approached this study with a belief that in teaching *caring* it should recognize that it has 2 *linked* components - *caring about* and *caring for* – which can be described and defined separately but must be taught as one multidimensional concept. The main focus of this study was how to teach both concepts together with a full awareness of their differences. However, I recognize that other nurse educators have other perspectives about this process. Through this study, I used a flexible method to interact with participants and with the data, a practical analysis with clear constructivist guidelines rather than rigid objective principles, and a conscious interpretation that acknowledges personal bias, all of which provided me with a deep understanding.

Study Setting

This study was conducted in Nova Scotia, one of ten provinces and three territories that make up Canada. Nova Scotia is located on the east coast of the country and is bordered by the three other Atlantic provinces of Newfoundland, New Brunswick, and Prince Edward Island.

Three university schools of nursing in Nova Scotia were included in this study: Dalhousie University (Halifax and Yarmouth Campuses), Cape Breton University in Sydney, and St. Francis Xavier University in Antigonish. These schools were selected to ensure that there was diversity in institutional size (student population) and diversity in location (urban and rural). These schools also provided an adequate number of educators who met the eligibility criteria for study participants. In addition, the School of Nursing at Dalhousie University (Halifax) is embedded within the Faculty of the Health Professions, which involves inter-professional teaching collaboration that might affect the concept of teaching caring.

Procedure

Sample

Initially, a purposeful sampling was used in this study. Eligible participants' included educators (professors, associate professors, assistant professors and clinical instructors, lecturers) who were registered nurses (RN) and worked either full- or part-time. In addition, eligible participants had to have experience teaching nursing (clinical teaching and/or classroom teaching) in an undergraduate nursing program for at least three years within any speciality. Three years was considered the minimum length of teaching experience needed to ensure sufficient engagement in teaching *caring about* while teaching *caring for*.

Participants Recruitment

Following ethical approval, initially from Dalhousie University REB and then expedited reviews from Cape Breton University and St. Francis Xavier University, I sent *un- addressed*

recruitment letters, both electronic and hard copy, to the main office of each school included in this study whose administration had agreed to distribute. Recruitment invitations then were distributed through the main office by email and the individual hard copies were placed in the nurse educators' mailboxes. These invitations included a brief description of the study topic, the purpose, the questions, the participant eligibility criteria, the nature of the interview, and the researcher's contact information. Participants contacted me via email and we set a time for the interview. I also sent the consent form to any participant who had not received the hard copy invitation.

There were many challenges to the participant recruitment process which extended the time for data collection from six months to one year. First, some schools delayed sending and circulating the invitation letters. These delays required me to do a second round of contacting and mailing the hard copies. Second, some participants were very slow to respond due to course workload constraints and/or bad time of year (e.g., between semesters, vacations). Third, some participants who contacted me immediately did not meet the eligibility criteria, although they were interested in participating.

The sample size that I had planned for the study included 25 to 30 nursing educators as recommended in grounded theory to provide adequate patterns, concepts, categories, properties and dimensions of the issue under study (Thomson, 2011). For this study, the recruitment process started following approval from the four schools included in this study and continued in conjunction with the data collection and analysis from Jan 2015 to Dec 2015. Recruitment ceased in December 2015 following receipt of 21 responses. However, only 15 nurse educators were interviewed, 6 were excluded, 4 of them did not fit the study criteria, and 2 changed their minds before the interview.

However, the 15 interviews provided sufficiently robust data for this study. This issue was discussed with the thesis committee on February 8, 2016. After having Committee members review 2 interviews and then my presenting the emerged categories/concepts and their properties from my data analysis, they agreed that the data included sufficient diversity to complete the study with 15 interviews.

Table.1

Participants' Ranks and Years of Experience

No. of Participants	Rank	Years of Experience
6	Professor, Associate Professor, and Assistant Professor.	>10 years
9	Lecturer/Clinical instructor	3-8 years

The final sample included diversity in terms of academic rank, the length of teaching experience, specialty, and work setting (Table .1). Specifically, 6 professors, associate professors, and assistant professors had teaching experience of more than 10 years, and nine clinical instructors/ lecturers with teaching experience of 3 to 8 years. The participants working in different specialty; 5 participants are teaching maternity/ pediatric nursing; 3 participants are teaching medical surgical nursing; 2 participants teaching critical care; 3 teaching community health; 2 teaching nursing administration.

In terms of sample size, given that the goal of grounded theory is to generate sufficient data in order for patterns, concepts and categories to emerge (Glaser & Strauss, 1967; Strauss & Corbin, 1998) it is not known at the outset what sample size will generate sufficient data (Thomson, 2011). Discerning the appropriate size in grounded theory is answered by the concept

of 'theoretical saturation' (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Charmaz, 2006). For the constructivist grounded theory it is more about the robustness of the categories /concepts which will be explained in the data analysis section (Charmaz, 2006).

Data Collection Strategies

Data collection included interviews with study participants from each school, making observations throughout the interview, and keeping memos and notes throughout the research process. Semi-structured interviews are regularly the sole data source for most qualitative research and, scheduled in advance at a convenient time and location outside of everyday events (Adams and et al., 2002*)*. The interviews include a small number of open-ended questions along with probes developed from the conversation between interviewer and interviewee. The individual in-depth interview allows the researcher to investigate deeply into social, professional and personal matters (DiCicco-Bloom and Crabtree, 2006). In constructivist grounded theory approach, interview guides are constructed in a way to gain a better grasp of situations. Interviews combine flexibility and control, opens interactional space, and investigates new ideas and issues that arise during this interaction (Charmaz, 2014). The major concerns of constructivist grounded theorists are conducting interviews in ways that are "learning the participant's words and meanings; and exploring the researcher's areas of emerging theoretical interest when a participant brings them up" (Chramaz, 2006, p.84). However, the interview includes a construction of the participants' stories, exposing the content of the interview, and constructing the researcher's and the participant's interaction (Charmaz, 2009).

In this study, the interview included questions that focused on the participant's perceptions related to teaching *caring about* while teaching *caring for* (Appendix. 2). The questions did not evaluate the participants' teaching performance but rather explored the process

and strategies of *teaching caring as a multidimensional phenomenon*. The interview included ten core questions, some of which had supplementary questions or probes. In keeping with the constructivist grounded theory approach, questions were changed or modified, based on the interviewer's needs for more explanation or detail (Charmaz, 2006).

The interview guide was developed over five months followed by two pilot interviews and subsequent revisions. The questions helped participants engage in comprehensive discussions providing extensive detail that occasionally answered more than the question asked and linked events and incidence to each other, which made the data very extensive.

During the first two interviews, I followed the interview guide questions. Then, after the initial coding of the two interviews, I recognized that with some questions, the participants linked answers together so when I asked the next question they repeated the answer to the previous question. I then wrote a memo about this issue and changed some questions to explore more details so as not to get repeated answers. For example, in the question "*how would you **define** caring for and caring about?"*, and the question "*how would you **teach** both concepts?"*, I found that respondents answered both questions in terms of what they thought about *caring for* and *caring about* concepts and how they perceived them as a nurse - not as a clinical instructor. Then when I changed the question to "how would you define teaching *caring for* and *caring about*?" participants provided more details about their approaches of teaching caring concepts.

One section of the interview included a short simulation video (4 minutes) showing a student-patient care scenario (Appendix.3). The video captured a common nursing care situation involving a student nurse taking a blood pressure on a patient with her clinical instructor observing the interaction. My theses supervisor Dr. Jean Hughes and I chose this particular video because it focused on a task-oriented situation and it focused on a common nursing procedure that

everyone would be familiar with. After watching the video, participants were asked to take the role of the nurse educator in the situation, and then discuss whether "*there are other things that come to mind that would help the researcher to better understand the approach that she/he described in Question 2. (How would you teach caring about while you teach caring for?)".*

Note about using the simulation video in this study

There were two reasons for using the simulation video in the interview. First, using the video provided the participant with a visual representation of a generic student-patient situation. It gave participants another opportunity to describe their instructional intervention in a particular learning situation. The video was not intended to guide the participants to a specific answer or to convince them to think in a certain way. The second reason for using this simulation video was to give participants the chance to add to, or change or confirm, their answers in Question 2. The answers were not compared in any way to evaluate both answers but, instead, were treated as additional information.

I argue that using this video was compatible with constructivist grounded theory informed by symbolic interactionism. Charmaz (2006) emphasizes that during the interview the researcher may need to request more clarification, and this video could be used as a tool to get more clarification. According to Blumer (1969), symbolic interactionism posits that each "object" has a meaning and that, based on this meaning, people interact with the object. These meanings are changed and modified based on how people interpret these meaning through their communication. Here, by introducing the main question of the study, in both verbal and visual ways, I hoped to clarify my study question to learn how teachers teach *caring about* while teaching *caring for*. In turn, it was hoped that this process would help participants to perceive, recognize and explain their experiences without confusing their understanding of the study

question. For pragmatism assumptions, using this video provided a practical tool for getting practical/specific answers. It was a tool to guide the main question and add more depth to the interview. If the scenario resounded with the participants' experiences, the participants' perceptions of the situation may have provided a fuller meaning to the phenomenon. Pragmatism posits that individuals do what works for them, therefore, using this video could provide a visual view/specific context of the main question in order to elicit participants' perceptions of what they do in similar situations.

I used the video at the end of the interview, and the responses to the video proved very useful in adding more details about the participants' approaches to teaching both caring concepts. And through the coding process links were noted between the verbal and visual views in most of the interviews, including differences in a few interviews. However, these codes were used as addition information to construct the categories. At no time was an evaluation made regarding participants opinions or described actions.

The video had many strengths. It provided a visual representation of the main inquiry of this study, and it included student–patient interaction while applying a common nursing procedure.

Accordingly, I got the chance to observe the participants' reflections on a visual example of the teaching moment. Some of the participants' perceived it as a common scenario and very similar to what they see in the clinical setting. Some participants added more explanation of their teaching approach based on their observation of that video.

Several limitations regarding the video were noted including that some participants did not provide an actual critique of the video, and only made positive comments. This may because they did not see any negative features or it may be that they were polite and hesitant to criticize a

video that I, a Ph.D. student, had chosen. Maybe if I had a separate research assistant conduct the video portion of the interview participants might have felt more comfortable to provide a full critique of the video. In addition, some participants provided only a few comments about the video. This might have been out of fear that they were being evaluated in some way, or they may simply have believed that they had already provided their perspective on the study question and had nothing more to add.

Data Analysis

Charmaz (2000) describes grounded theory as a specific analytic strategy rather than a data collection method. The purpose for doing data analysis in grounded theory is to explore the dominant social process, not to describe the findings. In addition, Charmaz (2000) summarizes grounded theory strategies in six areas, as follows: "a) simultaneous collection and analysis, (b) a two-step data coding process, (c) comparative methods, (d) memo writing aimed at the construction of conceptual analysis, (e) sampling to refine the researcher's emerging ideas, and (f) integration of the theoretical framework" (p. 560).

Coding

Data analysis in grounded theory involves a long chain of coding and developing categories and concepts to generate a theory. Kendall (1999) considers coding data to be an essential aspect of grounded theory to "transform raw data into theoretical contractions of social process" (p. 746). Charmaz (2006) defines coding as "categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data" (p. 43). Coding is an essential link between collecting data and generating a theory that explains these data in terms of the meaning of the phenomenon being studied (Charmaz, 2006). In other words, codes emerge when the researcher interacts with the data and asks questions of the data in order to gain

meaning. Charmaz (2014) describes coding as "the pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you define what is happening in the data and begin to grabble with what it means " (p. 113). According to Charmaz (2014), the coding in the constructivist grounded theory approach consists of two phases: *initial coding* and *focused coding*.

Initial coding involves line-by-line coding, incident-to-incident coding, and constant comparison. Initial coding guides the researchers to learn about the data, and they begin to make sense of the data (Charmaz 2014). Codes are constructed to reflect what the researchers see in the data and how they describe it and how they use it. Charmaz (2014) emphasizes that "no researcher is natural because language confers form and meaning on observed realities. Specific use of language reflects views and values. We share one language with colleagues and perhaps another with friends; we attribute meanings to the specific terms and hold perspectives. Our codes arise from the languages, meanings, and perspectives through which we learn about the empirical world, particularly those of our research participants as well as our own" (p.114). The codes took the form of gerunds, verb+ing, and the noun form, which helped to detect the process and stick to the data (Charmaz, 2006; 2014).

In initial and focused coding researchers *constructs the codes* (Charmaz, 2006; 2008; 2014). They actively name each code based on how they perceived it from the data, how they interact with participants and with data to understand and capture the empirical realities of the participants. However, researchers choose the words that symbolize actions and events in the data and then identify and decide what has significance in the data.

In the initial coding, there were two main critical steps that I had to focus on, first, in this early coding stage it was important to be very close to the data and code words, incidents,

actions, interacting, feelings and meanings. It was all about coding what the interview provided me. Second, I had to be open to any new ideas and ignore any preconceived notions. To handle that, while I was coding, I used memos to write down any thoughts that came to my mind about possible explanations of these codes or how they might link to each other. These two critical steps provided clear initial codes developed from the data that were not contaminated by my thoughts or considerations (Charmaz, 2006: Glaser, 1992).

I had huge numbers of initial codes in each interview. Initially, I used ATLAS ti.7 software to manage all these codes. Then, I compared between these codes after each interview coding and re-coded these initial codes to be sure that I had clear codes that represented each interview before moving on to the next step of coding. In this stage of analysis, I recognized that there were gaps that lead me to asked more questions of the data itself. Then I focused on these gaps throughout the following interviews. According to Charmaz (2014), researchers could use line-by-line or incident-to-incident coding based on the type of data they collect. In my study, which seeks a deeper understanding of the experience of teaching *caring about* while teaching *caring for*, I used both line-by-line and incident-by-incident coding to help me capture the dimensions and properties of each emerging code and category. The flexibility of the initial coding process helped me to break down the data into fragments, which in turn helped me to recognize implicit assumptions, actions and meanings within the data.

Furthermore, I used *in vivo coding* to help me explore some meanings in the data which provided me with useful codes in the later stage of analysis. In the initial coding stage, using participant language as *in vivo codes* helped to preserve the participants' meanings of their perceptions and actions (Charmaz, 2006). *In vivo codes* could be general well-known terms,

innovative terms based on a personal experience, or insider terms that reflect a group perspective.

Since English is my second language, I was very careful to ensure that I understood and captured the meanings of each piece of data. According to Charmaz " tensions arise between coding in one's first language and in English" (2014, p.331). Therefore, I used long initial codes to be sure that my codes were clear and represented the piece of data that I was working on. In addition, I reviewed all my coding with my thesis supervisor, Dr. Hughes.

Focused coding is the second major phase of coding in the constructivist grounded theory approach. Charmaz (2006) states that "focused coding means using the most significant and/or frequent earlier codes to sift through large amounts of data ... [and it] requires decisions about which initial codes make the most analytic sense to categorize your data incisively and completely" (p. 57). Focused coding is a conceptual selection of the initial codes based on their frequency and relevance to the study phenomena. In contrast to initial coding, this includes synthesizing large sections of the data and coding. It is not, however, a linear process; I went back and forth to compare and explain implicit statements in order to make them explicit by returning to the initial data. I got the chance to learn and practice coding in a grounded theory course that I enrolled in at the beginning of my data collection with Dr. Marilyn Macdonald. In focused coding, I started by grouping the initial codes from the interview transcripts based on their frequency, and their relevance to the teaching actions. I then compared theses focused codes with other groupings from other interviews. However this coding stage was complex, there were some initial codes that fit and linked to many categories which required me to re-read the interviews many times to link each to the most significant categories. Throughout this process there were on-going interactions with the data to identify links between the focused codes.

Interactions with the data throughout the analysis provide the strength for coding in grounded theory (Charmaz, 2006).

In addition, throughout the process of focused coding, I continually compared the actions, perceptions, meanings and experiences by reviewing the interviews and memos. After I developed the focused codes, I compared them to the original data to enrich the codes. Throughout the grounded theory approach the researcher often has an enormous number of focused codes and the analysis needs further clarification. Therefore, researchers often use *theoretical coding* to establish relationships among the focused codes. Glaser (1978) developed eighteen theoretical coding families to serve as analytical categories. However, in this study I did not use theoretical coding, because the constructivist grounded theorist avoids imposing a forced framework (Charmaz, 2006).

Another element is the *core category*, considered the central point in grounded theory because it integrates all of the emerging theory's different aspects (Mills et al., 2006). In the classic grounded theory approach, open coding continues until the core category has emerged, the core category being "the central category that accounts for most of the variation in a pattern of behaviour" in the area under study (Glaser, 1978, p. 93). Despite the importance of the *core category* in the classical approach, Hernandez and Andrews (2012) report that some theorists, such as Charmaz, do not consider a core category to be a necessary component. "[w]ithin constructivist grounded theory, there is no attempt to integrate the core category with other categories, since theoretical coding plays no part in the analysis" (Hernandez & Andrews, 2012, p. 7). Indeed, Charmaz (2004) argues that having a core category is not required for all studies, and that many major categories have the same degree of importance, meaning that none of these

categories can have a more central position than the others. Charmaz (2006) argues that to force a core category may lead to ignoring other important concepts in the process, she wrote:

> Raising categories to concepts includes subjecting them to further analytic refinement and involves showing their relationships to other concepts. For objectivists, these concepts serve as core variables and hold explanatory and predictive power. For constructivists, theoretical concepts serve as interpretive frames and offer an abstract understanding of relationships. (p.139)

Based on this perspective, it is very clear that constructivist grounded theorists perceive that using a core category may limit the analysis process and give less attention for exploring another important relationship among categories. In this study there was no core category; indeed, all categories were found to have the same level of importance.

In grounded theory, the constant comparative methods are used to "establish analytic distinction and thus make comparisons at each level of analytical work" (Charmaz, 2006, p. 54). The comparison could be, for instance, between two pieces of data to ascertain similarities and differences. In this study a constant comparison was made throughout *initial* and *focused coding* and between statements and incidents, actions, meanings at different points of each interview, and/or between different interviews. During such comparisons, I considered what was explicit and implicit within the data. All the differences and similarities between the initial codes at the beginning, and then focused codes and categories were defined with all the thoughts and observations and documented as part of the analysis stage.

Glaser (1992) defines theoretical sensitivity as the "ability to generate concepts from data and to relate them according to the normal models of theory" (p. 27). In other words, theoretical sensitivity is the ability of the researcher to be fully open to what the data are suggesting, allow

the categories/concepts to emerge from the data, and acknowledge personal theoretical bias that may trigger the emergence of categories and concepts. In constructivist grounded theory, theoretical sensitivity "relies on the researcher's intuitive and interpretive analysis of the data" *(*Hernandez & Andrews, 2012). Charmaz (2006) argues that to gain theoretical sensitivity through the theorizing process, we, as researchers, "look at studied life from multiple vantage points, make comparisons, follow leads, and build on ideas" (p. 135).

Memo writing is an essential intermediate stage between data collection and writing drafts of papers (Charmaz, 2006). Memos are the platform for coding, categorizing and theorizing phases. Memos used to record thoughts, new ideas and observations in order to separate the researcher's views from the data itself. According to Charmaz (2006),

> If your codes define another view of a process, action or belief than your respondent(s) hold, note that. Your observations and ideas do matter. Do not dismiss your own ideas if they do not mirror the data. Your idea may rest on covert meanings and actions that have not entirely surfaced yet. (p. 54)

Throughout conducting interviews, I wrote memos before and after each interview, and through the coding phases and the categorizing phase to reflect on my thoughts and observations. However, my main memos focused on defining each category/ concept that emerged from the study and their properties. These memos were very useful for keeping everything available for reviewing, comparing, revising, and sorting throughout the analytical process.

Furthermore, throughout the processes of data collection and analysis, I used theoretical sampling once the initial categories emerged from the first five interviews. Theoretical sampling helped bring further clarification, and I asked more questions to identify and fill gaps that I found in the earlier interview analysis. I adjusted some of the interview questions to focus more on the

areas that needed clarification. Charmaz (2006) defines theoretical sampling as "a type of grounded theory sampling in which the researcher aims to develop the properties of his or her developing categories or theory" (p. 189). Theoretical sampling is a major component in grounded theory, which may control the sample size. According to Charmaz (2014), theoretical sampling could be used after the preliminary categories emerge to: check, qualify and elaborate on the categories' boundaries; show the relationship among categories; define and explain the categories and their properties; elaborate the meaning of the categories; discover variations within categories; define the gaps among categories; and, at a later stage, help to link between the categories.

Theoretical saturation occurs in data collection when "no new or relevant data seem to emerge regarding a category, and the category is well developed in terms of its properties and dimensions, demonstrating variation, and the relationships among categories are well established and validated" (Strauss & Corbin, 1998, p. 212). In constructivist grounded theory, saturation may limit the analysis or "foreclose analytic possibilities", which could lead to constructing a superficial analysis (Charmaz, 2006). In addition, Dey (1999) argues that the notion of saturation to the researcher has an effect on the data analytical process and the outcomes of a grounded theory study. Charmaz (2006) agrees with Dey's (1999) argument and suggests that "when you get stuck, go back and recode earlier data and see if you define new ideas" (p. 115). Furthermore, Charmaz (2014) emphasizes that theoretical saturation "refers to the point at which gathering more data about theatrical category reveals no new properties nor yields any further theoretical insights about the emerging grounded theory" (p. 345).

In constructivist grounded theory, robustness is an alternative term describing when deep analysis offers rich codes and categories/concepts and provides strong relationships among them

in such a way that it gives the researcher satisfaction in thinking and writing. Charmaz (2014) states, "by engaging in theoretical sampling, saturation and sorting, you create robust categories and penetrating analyses" (p. 224). In this study, it took a long time to identify each category/concept by coding, recoding, comparing, and using the theoretical sampling to clarify their properties and dimensions.

After memo analysis, theoretical sorting is the next step in constructivist grounded theory. Theoretical sorting provides the meaning to create and refine the theoretical links between the emerged concepts. According to Charmaz (2014), this theoretical sorting is achieved through theoretical integration of categories and by comparing these categories on an analytical level. In this study, grounded theory sorting provided me with a logic technique to organize my analysis and a way to create and identify theoretical links that enhance the comparisons between the four emerged categories. Sorting and diagraming provided this study with its initial analytical frame. Sorting steps included sorting memos, comparing categories in these memos, and used these categories with full attention to their order. However, at the beginning of data analysis, I followed the sequence of the interview questions to organize the early categories that emerged from the data coding. Then, after elevating these categories to concepts, I found that the order of these concepts was not a linear process, but rather a continuous process. This continuum appeared after analyzing the relationships between these four concepts.

Diagramming provides a visual representation of categories and their relationship (Charmaz, 2006). Initially, logic diagrams such as flowcharts should be used in the coding process, after which the conditional/consequential matrix and integrative diagramming at the higher level of the analysis should be used (Strauss, 1987; Strauss & Corbin, 1990). Diagramming is an essential step in Strauss and Corbin's grounded theory approach (Strauss &

Corbin, 1998; Charmaz, 2006). In contrast, constructivist grounded theorists diagram only if needed, which is indicated by the emerging analysis. Integrating memos involves organizing the memos to fit each other in such a way that it makes sense to the reader. Whether there is one major category or more, the integration must be in a logical order (Charmaz, 2006). In this study, I used diagraming in the early phase of coding to identify the main categories. Then I used diagraming to link the four concepts to each other and their order in the process (Appendix.6). Through sorting, diagramming and integration, I discovered hidden codes and relationships that were not clearin the coding phase. Using these three strategies helped me gain ideas to construct and develop the theoretical framework.

ATLAS. ti 7 was the qualitative data analysis software used to facilitate the management of data in this study. ATLAS. ti 7 is a powerful analytical tool. Its individual analysis options are centrally organized and designed for maximum efficiency, accuracy, and performance. This program was useful in creating a project box, multiple documents, and analysis tables for codes and categories. Also, it provided cloud views for codes and documents and was a highly visually-oriented tool. This software helped me to facilitate working back and forth between the interviews and between textual and conceptual levels of data.

Ethical Consideration

Prior to data collection, ethics approval was secured from the Dalhousie University Research Ethics Board on October 20, 2014 and renewal on August 28, 2015. Expedited reviews were accepted from both Cape Breton University (CBU), and St. Francis Xavier University (StFX), and ethics approvals were secured from both universities. CBU ethical approval was secured on October 27 2014 and renewal on October 28, 2015. StFX ethical approval secured on October 28, 2015 and renewal on October 15, 2015.

An explanation of the study was provided to all participants including details of the study design, the research process and data collection strategies. As well, the consent form ensured that each participant was well-informed. All aspects of the research process regarding privacy and confidentiality, potential risks and informed consent, were explained thoroughly. To ensure participants' rights to confidentiality and privacy, I used pseudonyms to identify participants and assured them that identifying information would not be used in published material and dissemination of data generated from this study.

All participants provided signed consent. There was minimal risk involved in participating in the study and participants were not exposed to harm. However, Patton (2002) cautions that in-depth interviews are highly personal and often expose a participant's inner self. Throughout the 15 interviews, I did not have any situation that could be considered sensitive or critical. However, if any issues had occurred during the course of the interviews, full confidentially would have been maintained, the participant's experience would have been acknowledged, and, if needed, I would have provided the participant with contact information for related resources (e.g., The Centre of Teaching and Learning at Dalhousie University).

By adopting the constructivist grounded theory approach and through collecting and analyzing data, there was a possibility to have two interviews with some participants. This possibility mentioned in the research ethics application and on the consent form, gave the participant the option to be interviewed a second time if needed. However, there was no need to do a second interview with any of the participants. Instead, I used some of the gaps and questions from the early interviews to guide the theoretical sampling interviews. In addition, at the stage of the first draft of the theory, I sent emails to all the 15 participants to participate in the member check to ensure that the emerged concepts fit their perceptions and notion about teaching caring.

Throughout the research, interview tapes, notes, and transcripts were stored in a locked cabinet and on the researcher's personal computer protected by a password. All documents, tapes, and notes will be stored on a password protected computer file for 2 years following publication. According to the Research Ethics page on Dalhousie University website, "Dalhousie University does not have a policy on the retention of data ... It is common to keep data for at least five years (this was the past Dalhousie University policy that is no longer in effect), but there is no requirement to do so" (Para 18).

The most important ethical issue that must be made clear is that the main concern of this study is to understand and explore nurse educators' perspectives regarding the process of teaching *caring about* while teaching *caring for*, and not to evaluate the educators' teaching competence. In other words, the concepts and the theory that emerged from this study were interpreted to understand the process of teaching caring as a multidimensional phenomenon, as gained from a variety of perspectives.

Rigour

The grounded theory evaluation criteria identified by Charmaz (2006; 2014) was used in the study. Charmaz (2006) argues that the evaluation of the final product of constructivist grounded theory is a critical issue and that the "lines become blurred between process and product" (p. 182). Four key criteria for evaluating grounded theory studies include credibility, originality, resonance, and usefulness.

Credibility

Credibility refers to whether the study has achieved intimate familiarity with the topic of the study, and whether or not the data are sufficient to achieve the expected quality. It also refers to whether or not there is strong relevance between the gathered data and the study argument,

and whether or not the study provided adequate and rich evidence that can be independently assessed by an audience (Charmaz, 2014).

I believe that this study and the emerged theory achieved the contestant with the participants' stories regarding teaching caring concepts. I spent more than four months preparing the interview guideline and conducting two pilot studies to make sure that the questions, including the video reflection, would provide a solid approach for obtaining adequate and rich data relevant to the matter under study. Despite the limited number of participants, the in-depth and lengthy interviews together with the methodological approach provide this study with rich and sufficient data that enhanced the data analysis. Throughout the analysis, the researcher gave full attention to achieving robustness in the data by following the constructivist grounded theory approach guidelines. This included conducting theoretical sampling to explore and identify the categories'/concepts' dimensions and priorities. This process also using memos to find and define the relationships between the categories and then sorting, and integrating these memos to upgrade the categories to concepts.

Generally, during the data analysis, all of the data were reviewed and discussed with the thesis supervisor, Dr. Jean Hughes. Moreover, two interviews were reviewed and discussed by the thesis committee members near the mid-point of the data analysis process, and there was an agreement that the data collected, how it was analyzed, and conceptualized were relevant to both the study area and methodology.

Originality

Originality refers to whether the study offered new categories and provided new insight; whether the analysis provided a new conceptual interpretation of the data; whether there is a social and/or theoretical significance to the study; and whether or not the new grounded theory has made a contribution to the current concepts and practice (Charmaz, 2014).

I believe that the framework identified in this study provides new insight into teaching caring in the nursing profession and in teaching the affective domain in any discipline. The findings show there is a 'hidden' or informal approach to teaching the *caring about* concept (the affective domain), whereas there was a concrete formal approach to teaching the *caring for* concept (the cognitive and psychomotor domains) which becomes the dominant socialization process. In this study, there is a social-emotional process of teaching and learning caring. In addition, the framework identified indicates that teaching caring is a complex non-linear process that includes knowledge, skills and attitudes. These aspects can be examined in nursing research, and applied to the nursing education system to shift the current focus and dominance of teaching the *caring for* concept to include the 'hidden' approach.

Resonance

Resonance refers to whether the categories are rich and describe the dimensions of the studied phenomenon; whether the researcher revealed all initial and inconsistent meanings; whether the researcher makes any generalization or linking; whether the study makes sense to

others who share the same experience; and whether the analysis offers them deep insight into their experience (Charmaz, 2014).

I believe that the framework's concepts identified in this study are rich and represent the subject of the study. Each concept was identified and explained through the data analysis, and the interviews underwent several reviews as well as a recoding, and comparing the data to achieve a clear identification and explanation of the properties of each concept. I also engaged in regular consultations with my thesis supervisor and another committee member to discuss the research process at important decision points. These meetings involved a discussion of my personal reflections and thoughts that may have affected how I interpreted the data.

Furthermore, a member check was conducted in this study to assess whether the emerged framework of teaching caring concepts resonated with the participants' perspectives, stories and ideas around the subject. The member check invitations, which included a summary of the primary findings (Appendix.4), were sent to all 15 participants who had previously agreed on their consent forms to participate in the member check. A total of 6 participants responded to this invitation either by phone call or written feedback. The main comments of the participants included three main points. First, the primary findings reflected their thoughts about teaching caring concepts. Second, although they stated that they did not use the same words and terms of the primary findings, they agreed that these words and terms captured the same meaning. Third, there were no disagreements or negative comments about the process and/or the concepts. The respondents thought the concepts were relevant and reflected their perspectives for teaching caring concepts as a multidimensional phenomenon.

Usefulness

Usefulness refers to whether the study findings offers a useful understanding; whether the analytic categories provide a generic process that can be examined; whether the study can stimulate further research; and whether the study has helped build the knowledge base (Charmaz, 2014).

I believe that the outcomes of the study could be applied in nursing theory, research, and education. The process of teaching caring as a multidimensional phenomenon provides a theoretical framework that can be tested and verified as a theory for teaching caring. More specifically provides complex teaching approaches that involve an identified formal approach for teaching *caring about* skills that uncovered the 'hidden' informal approach for teaching *caring about* qualities.

Limitations

This study was subject to several limitations. First, even though the study had a limited sample size (15 participants), it provided sufficiently robust data to create a theory that explains the process of teaching caring as a multidimensional phenomenon. However, further research is needed to confirm and expand the emerged theory with a larger sample.

Second, although participants work in different schools of nursing, the four schools of nursing in the three universities in Nova Scotia have been collaborating for a number of years around a similar curriculum (Registered Nurse Education Review in Nova Scotia, 2015). According to the researcher's observations, the nurse educators from all four schools use similar teaching approaches, so future research is needed to study the nurse educators' perspectives with different education approaches and/or different curriculum approaches (e.g., problem-based curriculum).

Another limitation is that this study is designed only to explore the teaching process, not

to focus on comparing teaching processes across different specialties. Based on the researcher's observations and the participants' discussions, two specialties (maternity/new born and critical care) require skills of constantly reading and responding to cues from the vulnerable patients. Future research is needed to expand the emerged theory and include a comparison of the nurse educators across specialties and their practice setting as factors that might affect teaching caring as a multidimensional phenomenon.

Summary

In this qualitative research I used a constructivist grounded theory method to explore nurse educators' perspectives of teaching caring as a multidimensional phenomenon in undergraduate nursing programs. The participants in this study were nurse educators who had a minimum of three years of teaching nursing in undergraduate nursing programs within four schools of nursing at three universities; Dalhousie University (Halifax and Yarmouth Campuses), Cape Breton University in Sydney, and St. Francis Xavier University in Antigonish. Fifteen educators participated in individual face-to-face interviews to answer the study question *how would you teach caring about while teaching caring for and what are the opportunities and the challenges through your teaching experience?* The study began by recruiting nurse educators who were willing to share their own teaching experiences and then proceeded to use theoretical sampling to explore and define some critical areas in depth that emerged from the earlier analysis. In addition to the interviews, the video reflections, and memos were used to generate and analyze the data. Data analysis followed the guidelines of the constructivist grounded theory approach that included two phases of coding, constant comparison, categorizing, sorting, integrating, and theoretical conceptualizing the process. A framework of the process of teaching

caring as a multidimensional phenomenon that includes four concepts emerged from the data analysis will be explained in this following chapter.

Chapter 4

Findings

As indicated in the methodology chapter the purpose of this study was to explore the process of teaching caring concepts but not to evaluate or compare the participants' responses. Therefore, this chapter presents the findings that emerged from the data analysis of the participants' interviews, including their reflections on the video of the generic student- patient learning situation (Appendix, 5a, 5b, 5c).

Framework: "Teaching the Caring Concept as a Multidimensional Phenomenon"

The framework, entitled "Teaching Caring as a Multidimensional Phenomenon", reflects the social-cognitive process that emerged from the data. The framework represents an integrated, multidimensional theoretical understanding that emerged from the participants' personal teaching experiences. This complex teaching process includes four instructional concepts: Concept 1- is "Conceptualizing the caring concept"; Concept 2- is "Recognizing the teachable moment"; Concept 3- is "Seizing and acting on the teachable moment"; and Concept-4 is "Facing and dealing with challenges". These four concepts reflect the nurse educators' experience of teaching caring as a multidimensional phenomenon.

This chapter will first describe the overall framework and then present findings related to each of the four concepts. Each concept will be defined, supported by quotes from the interviews, and linked to the process of teaching caring as a multidimensional phenomenon. Each quote will be tagged with the letter *E* (*educator)* followed by a number (from *1- 15)* to identify the individual participant who made the comment. For example, E1 means Educator 1.

Overview of the Framework

As illustrated in Figure 1, this process is multidimensional in that it integrates elements of cognition, skills, and socio-emotional capacities that reflect teaching caring as a multidimensional phenomenon. The process includes the interactive and intertwining four concepts of "Conceptualizing the caring concepts", "Recognizing the teachable moment", "Seizing and acting on the teachable moment", and "Facing and dealing with challenges". The concepts include a matrix of overlapping cognitive processes, teaching approaches, and human interaction. This teaching process involves all four concepts in interacting continuously in different ways depending on the context of the learning situation. The nurse educators in this study described the complexity of the process of teaching caring as a multidimensional phenomenon from their knowledge, experiences, and beliefs as teachers in undergraduate nursing programs within different health care specialties for different lengths time.

Concept 1: Conceptualizing the Caring Concepts

The participants defined the concepts of *caring about* and *caring for* based on their knowledge and experience and how they perceived the concepts as nurse educators and as practicing nurses. Some of the participants linked their approach to teaching *caring for* and *caring about* with their personal perceptions of the meanings of each concept.

Conceptualizing the meaning of caring concepts provides the contextual foundation for the process of teaching caring as a multidimensional phenomenon. It reflects the abstract stage – defining *caring about* and *caring for* – involved in the teaching process. What emerged from the data was the notion that conceptualization includes six properties: conceptualizing the meaning of *caring for*, conceptualizing the meaning of *caring about*, conceptualizing teaching of *caring for*, conceptualizing of teaching *caring about*, linking teaching *caring for* and *caring about*, and *creating a caring environment*.

Conceptualizing the Meaning of *Caring For* Concept

The *caring for* concept was defined by the participants in this study as doing physical things, providing direct care, being action-oriented, enabling, and having knowledge and skills. There is an agreement among all the participants on the general meaning of the *caring for* concept as an *act,* although participants used various terms to describe the meaning.

One participant defines *caring for* as doing something physical for the patient and/or the family. For example, E1 said: "So *caring for* to me actually means, like, caring for a patient or the patient's family. So, like, the physical doing of something" (Educator 1). E3 described it as: "when you *care for* someone, that's your job and you have to do it. You need to do all these things, and you need to do them really well. And that's really important" (Educator 3). E9 stated: "*Caring for* is the actual hands-on doing caring interventions kind of thing" (Educator 9).

Another perspective of the *caring for* concept described it as providing direct care and being action-oriented, which includes technical nursing skills. For example, E5 stated: "*Caring for* is providing the direct care components of what we do as nurses. So it's the technical stuff, it's the ensuring that the environment is safe and the person looks like somebody has provided care" (Educator 5). E11 "Well, caring for I guess would be more…to me, is more about providing the essential care that a patient needs that you, as a nurse, are qualified to give to that patient, whether it be a single person or a group of people or a community" (Educator 11). Furthermore, E8 said, "*caring for*…I see that more as being action-orientated and teaching the students how to care for a particular individual, family or community" (Educator 8).
Another perspective of the *caring for* concept involves enabling the patients based on their abilities and needs. This perspective suggested that all nursing interventions should help enable the patients to achieve their needs. For example, E6 said:

> *Caring for* is enabling her [the patient] to do for herself, her baby, her family, what she can do. So I have to sort of get a sense from her context what her, if you will, skill set is, what her skill ability is, what her attitude is, if you will, what her approach to the situation is, what her cognitive capacity is. Those kinds of things. So as I care for, to enable her to get to the good health, whatever the situation, to achieve that outcome, I have to suggest interventions, if you will…. But the interventions that I would have put in place to enable her to come along, to deal with her situation, to become stronger in her situation, if that was her choice, to enable her to get to where she wanted to be. (Educator 6)

Similarly, E12 commented: "*Caring for* is probably the easiest one to describe to me because it is the physical things that we do, the physical skills that we teach in order to improve the health or put a resident or a patient in a healthier spot. So we care for them, their activities of daily living. We teach how to be able to put that person in the best position to either promote health or maintain it" (Educator 12).

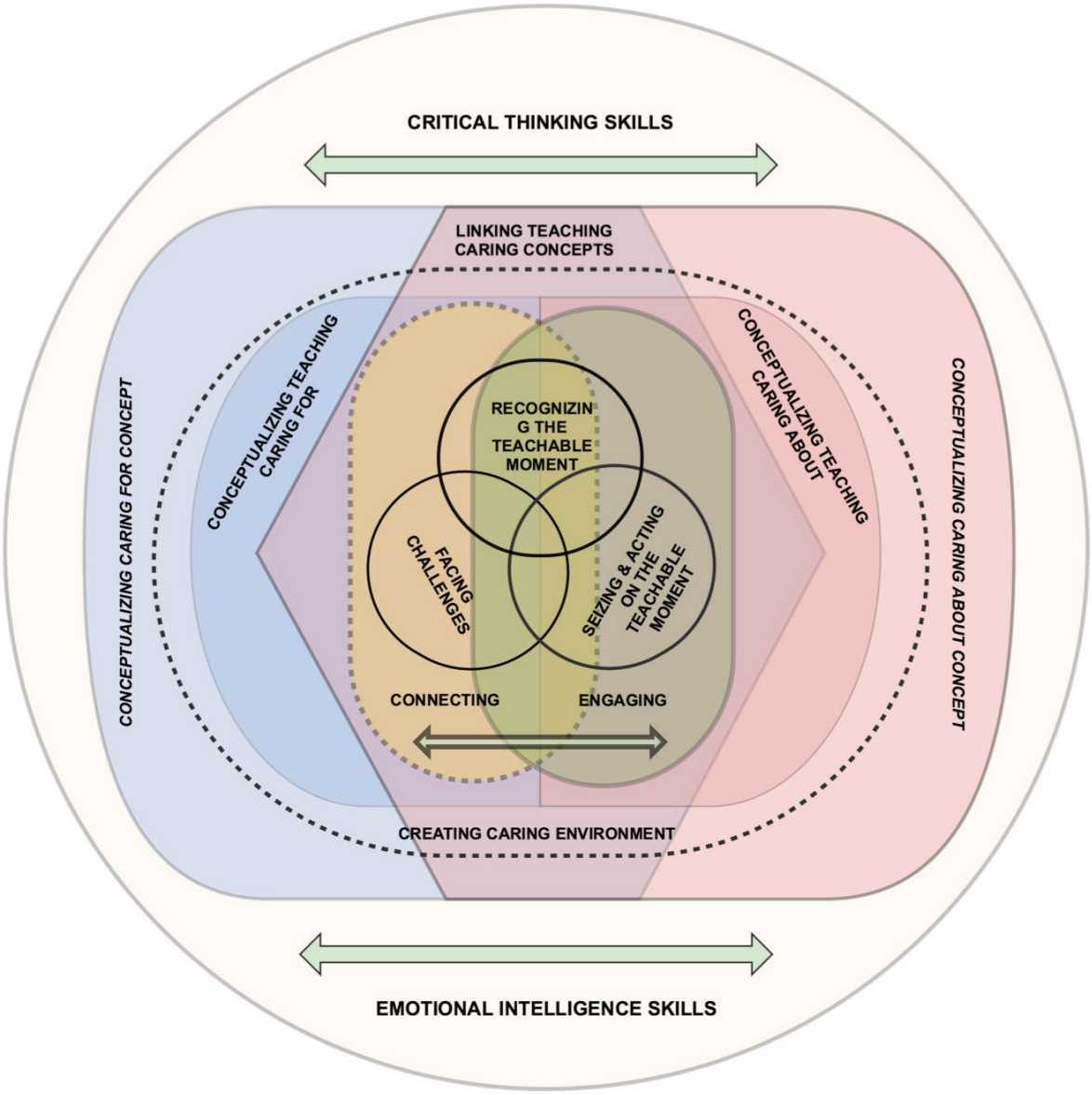

Figure 1: Framework of teaching caring as a multidimensional phenomenon. This figure illustrates the four concepts that comprise the process of teaching caring (Almater, 2016).

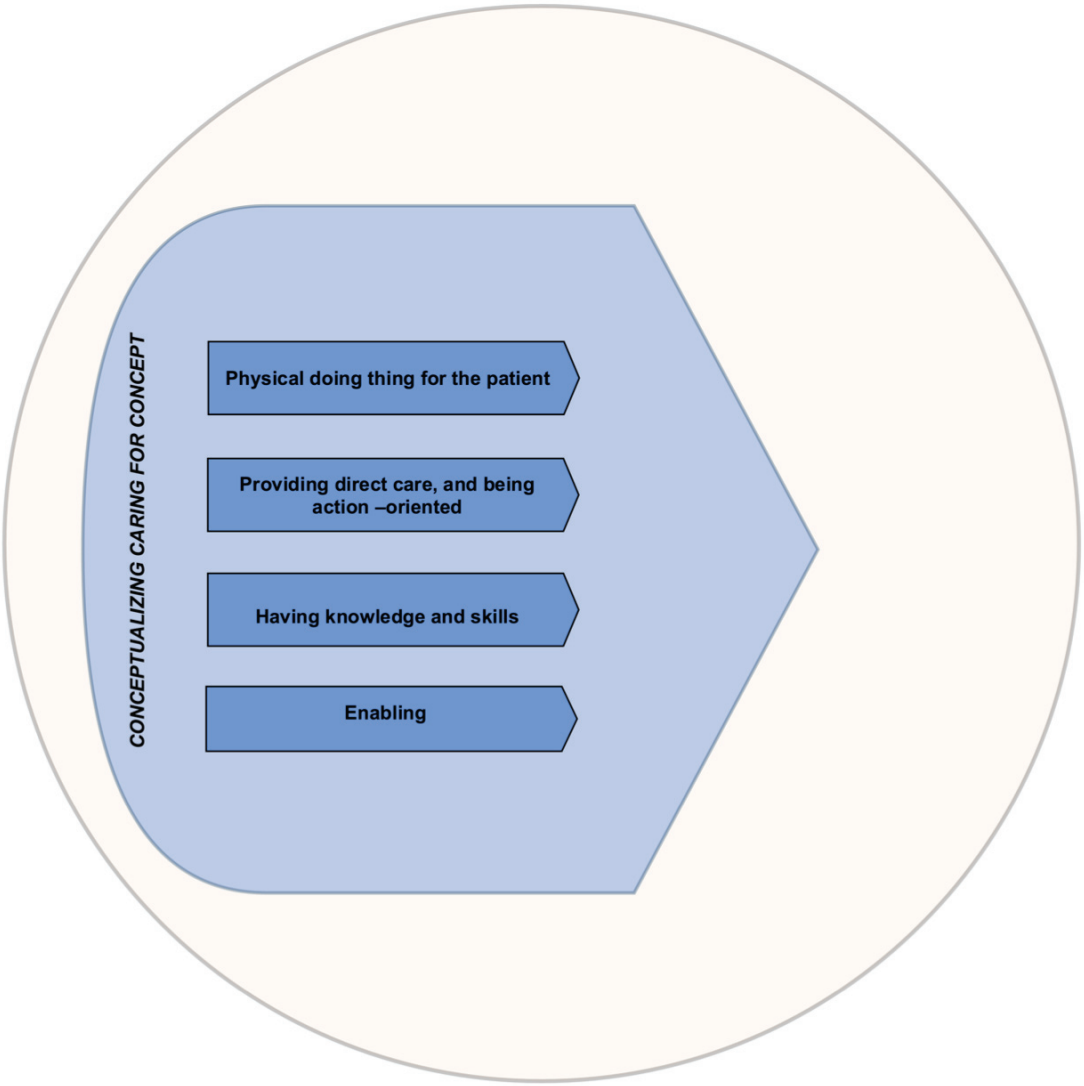

Figure 2: Conceptualizing the Meaning of *Caring For.* This figure illustrates how the nurse educators defined caring for concept (Almater, 2016).

Another perspective of the *caring for* concept is having knowledge and skills. For example, E7 explained that "*caring for*, I see having requisite knowledge and skills to care for people in different situations, either in healthy situations or unwell situations. So that's kind of more of the knowing what to do if somebody has an MI or knowing how to each a new mom how to do a bath, etc." (Educator 7). E4 described it thus: "So when I am going into a clinical area with students, I almost always find out what they know about that particular caring theory" (Educator 4).

Given these definitions of *caring for*, it is very obvious that the participants have a tangible understanding of the *caring for* concept as skilled interventions. Nursing care interventions include all the actions, rules, and techniques involved in daily nursing activities. These definitions were derived from their knowledge, experience and beliefs around the *caring for* concept.

Conceptualizing the Meaning of *Caring About* Concept

The concept of *caring about* was defined by the participants as engaging in a compassionate relationship and interaction based on inherent respect for the person, learning about the person, knowing and understanding the person's experience (empathy), and having contextual understanding of that person. In contrast with the definition of the *caring for*, there is no general meaning of *caring about* (Figure 3).

Some participants perceived *caring about* as a relationship and interaction with the patient and/or family. For example, E5 said: "When I think of *caring about* someone, it's more a feeling and it's more the interaction and the relationship that I have with that person" (Educator 5). E4 perceived *caring about* as an essential element to build a relationship upon, saying: "I

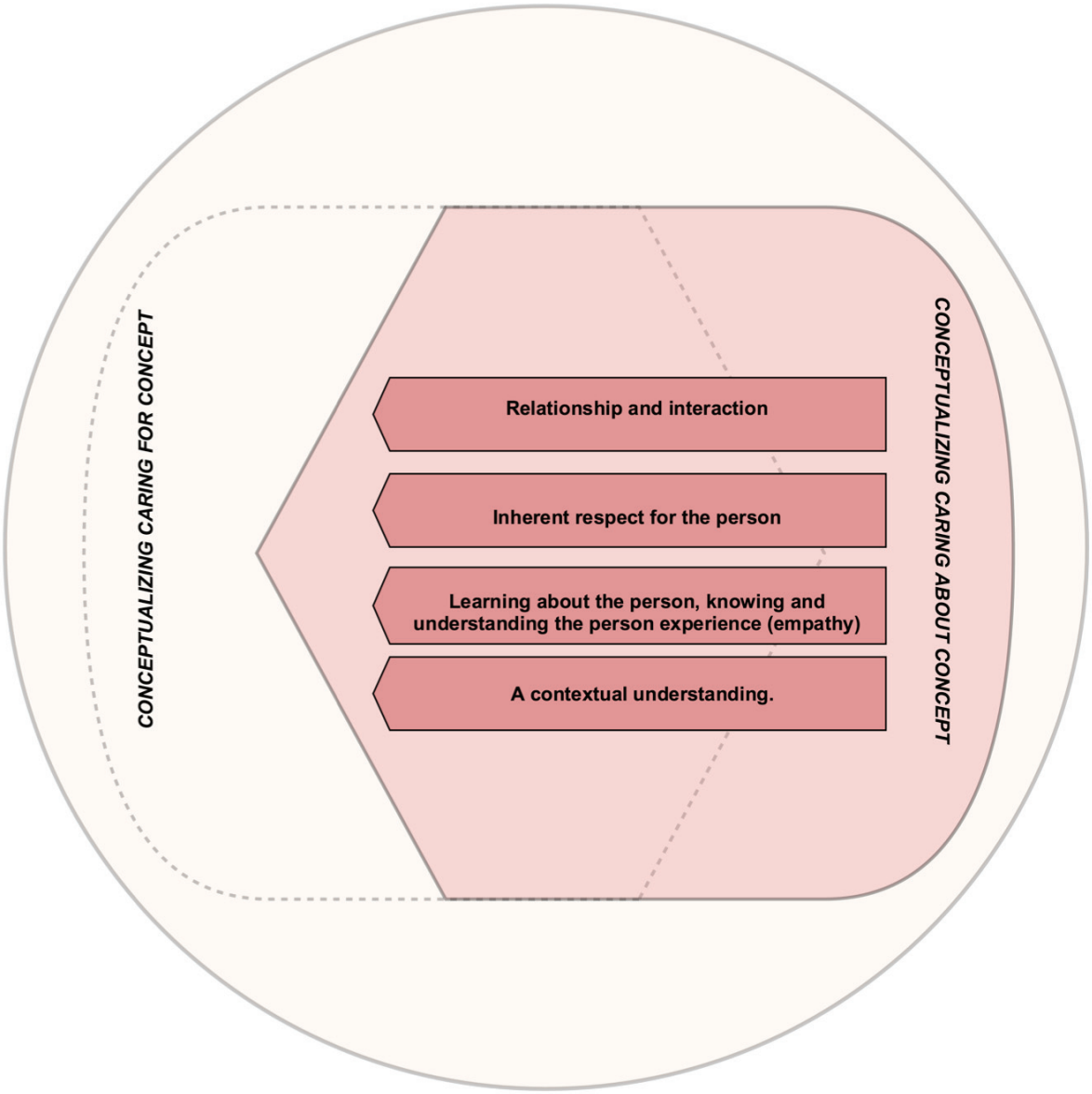

Figure 3: Conceptualizing the Meaning of *Caring About* Concept. This figure illustrates how the nurse educators defined *caring about* concepts (Almater, 2016).

think *caring about* is absolutely essential to the relationship that we have with clients and families. So, you know, it's a big concept to me" (Educator 4).

Another perspective of *caring about* is inherent respect for the patient as a human being. E3 perceived the *caring about* concept as respect, stating: "In *caring about* someone, I feel like [it] encompasses more of the inherent respect for them as a human being…like, looking at them as a person, not just someone that you need to do work for" (Educator 3). E12 shared the same perspective, saying: "To me, the caring about…comes from a place of respect, for me, a place where the student appreciates what that person is going through and they are respectful of their needs, their wishes, their words, their desires" (Educator 12).

Other participants perceived the *caring about* concept as knowing the patients and knowing how the patients perceive their experience (empathy). E7 described it as knowing the person as a member of a family. She explained: "So the *caring about* is teaching the students to get to know the person that they're working with, that they're part of a family, they're part of a community, they're part of a population" (Educator 7). Another participant perceived it as a contextual understanding, stating: "Caring about, I actually…for me, it means some type of contextual understanding. So it really implies empathy, it could imply relational practice…but some type of contextual understanding in performing caring, which to me is very action-orientated" (Educator 8). E6 described it as a contextual phenomenon:

> I guess the *caring about* is caring about what is happening to this person. Caring about the person as a person. So it's person-centered. So they're a patient, they're a client, but they're also, for example, a mother. We're talking maternal-child. So if it's about a mother, about what goes on in her life as a mother that might be influencing what I am seeing right here in this situation. So that's the context. And when I care about her, I care

about her in the context that she has experience that has brought her to the situation, whether it's just having her baby, whether it's breastfeeding, whatever. In other words that's just a piece – the breastfeeding or the having a baby. What is the whole picture? So I'm caring about her within her familial and experiential context. (Educator 6)

In contrast to the *caring for* concept, nurse educators' definitions of the *caring about* concept did not provide a tangible definition. Although, all the definitions reflect the *affective* aspect of nursing care, the *caring about* concept in these definitions includes socio-emotional interaction, communication, and empathy.

Conceptualizing the Teaching of *Caring For* Concept

The concept of teaching *caring for* is very concrete and was outlined for participants in this study. There were no challenges to describing and defining it (Figure 4).

Teaching *caring for* was defined by participants as *teaching* specific physical tasks and actions and assessing related healthcare knowledge and skills. For example, E1 described teaching *caring for* as an easy mission to achieve because it is a task-based matter. She said: "So I think you can fairly easily teach a student to care for somebody because again it's going in, you know, getting them to do their vitals, giving them a bed bath, giving them medications. You know, I feel like that's fairly easy to teach" (Educator 1).

E3 described teaching *caring for* as outlined element: "I think we probably do a really good job of caring for people because that's very…it's outlined clearly. You know, even if you think about the tasks that people need to learn, the skills they need to learn, even the assessment skills, like, all those things are encompassed in that caring for someone – making sure those needs are met" (Educator 3). E7 considered teaching *caring for* as evaluating certain knowledge and skills to provide care for certain situations. She said: "So caring for is, in my view and with students,

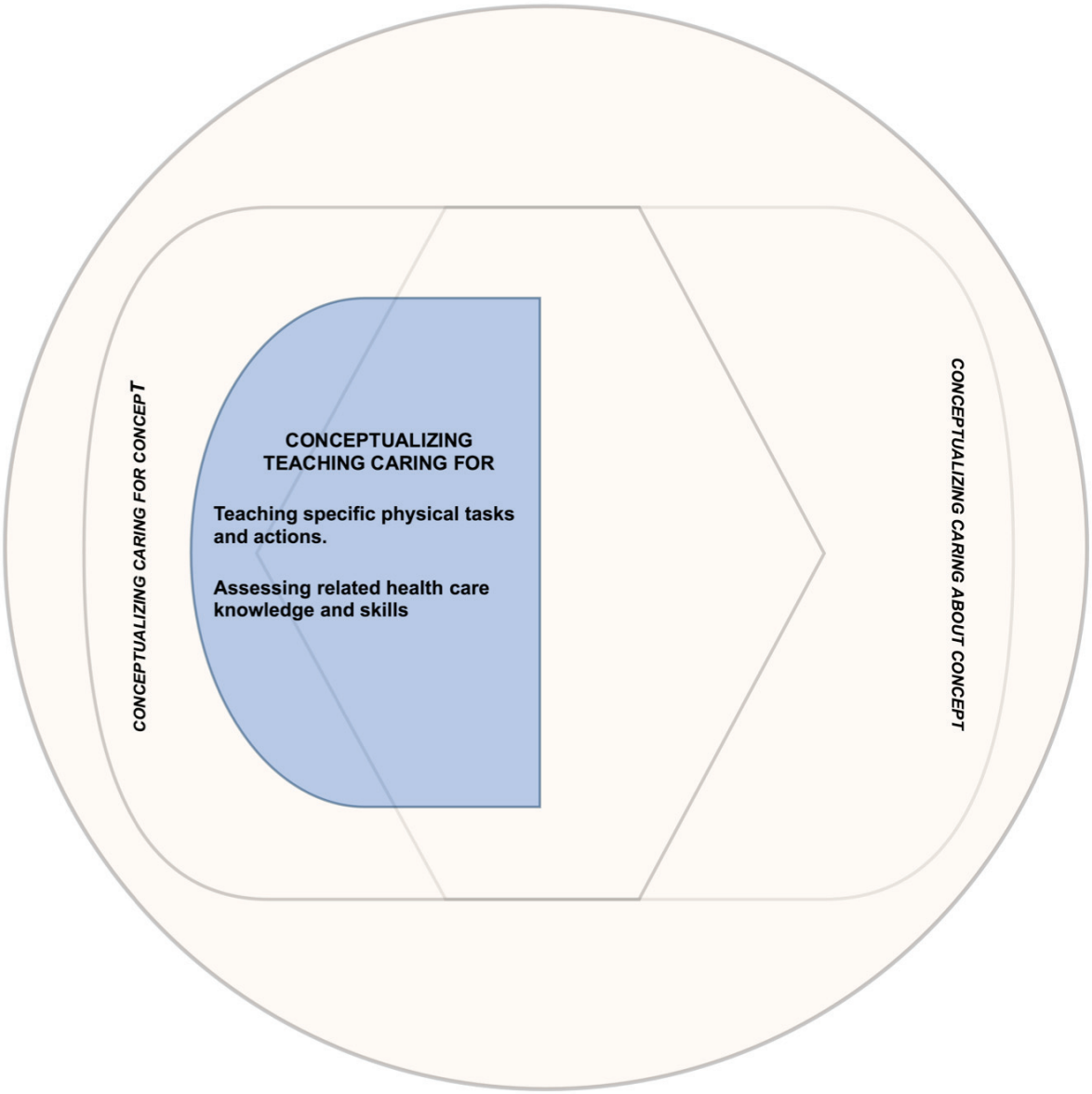

Figure 4: Conceptualizing teaching *caring for* concept. This figure illustrates how the nurse educators defined teaching *caring for* concept (Almater, 2016).

having the information and the skills to care for a person with a certain either disease or health promotion activity, etc." (Educator 7).

E8 perceived it as teaching student caring physical actions: "So *caring for*, I see that more as being action-orientated and teaching the students how to care for a particular individual, family or community" (Educator 8). E12 also perceived teaching *caring for* as teaching physical skills: "*Caring for* is probably the easiest one to describe to me because it is the physical things that we do, the physical skills that we teach in order to improve the health or put a resident or a patient in a healthier spot" (Educator 12).

It is clear that participants' perceptions of teaching the concept of *caring for* concentrate on teaching and evaluating tangible nursing knowledge and skills. Accordingly, the participants linked their perception of the concept of *teaching caring for* to how they perceived the concept of *caring for.*

Conceptualizing the Teaching of *Caring About* Concept

The participants defined teaching *caring about* as teaching the intangible and more complex aspects, including at least one of the following approaches (Figure 5).

Some participants described teaching *caring about* as encouraging interaction and establishing a professional or therapeutic relationship between student and patient. For example, E2 explained that her approach of teaching *caring about* includes encouraging students to involve the relationship aspect in their care plan list:

> They have their lists of what has to get done. And so they're compulsive about checking off what has to be done. But the other thing, because I would always put such emphasis on the relationship, I would ask them periodically – 'So let me see you have on your list for what you need to do for your patient.' And what I was looking for was this whole

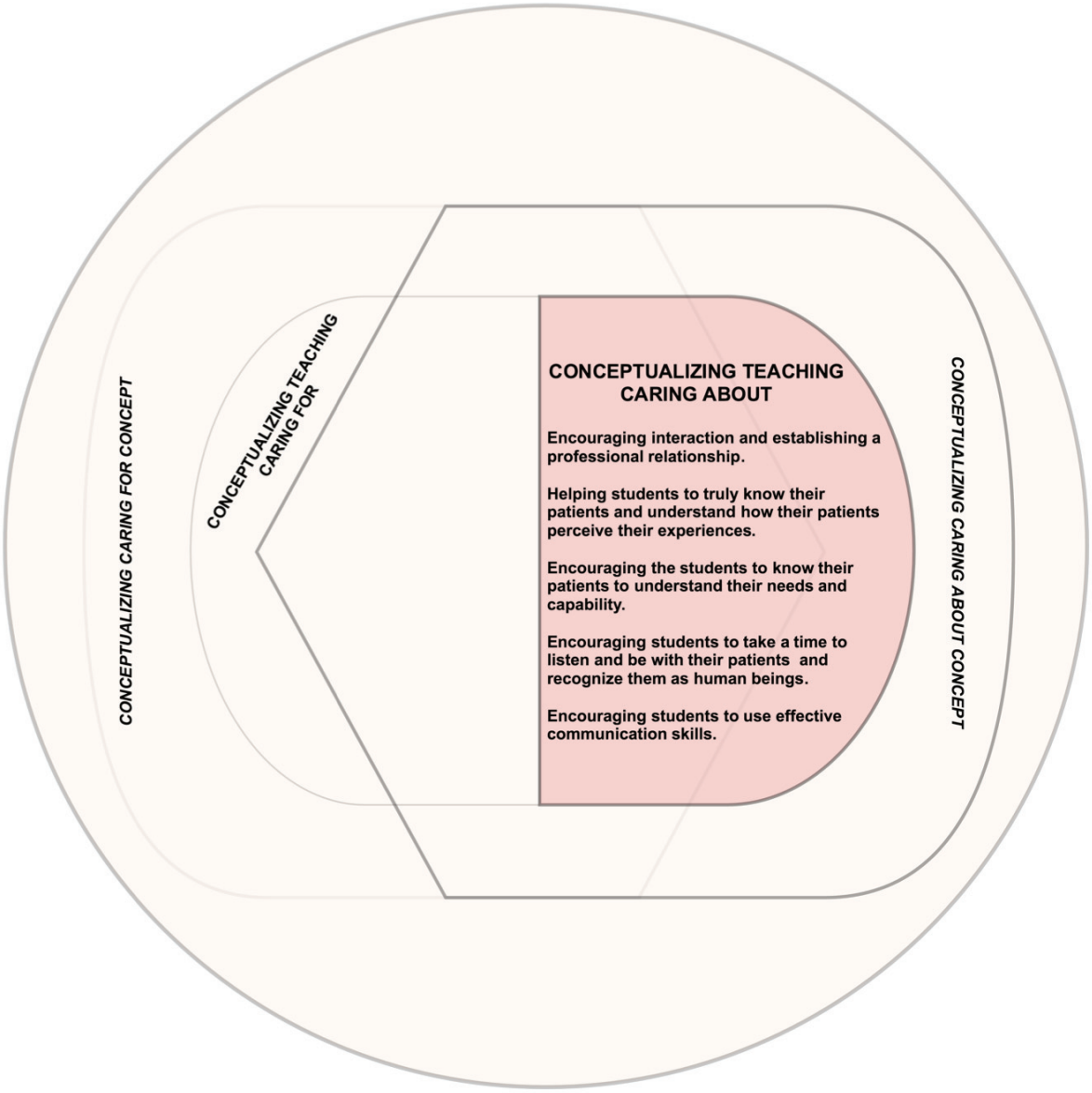

Figure 5: Conceptualizing Teaching *Caring About* Concept. This figure illustrates how the nurse educators defined teaching *caring about* concept (Almater, 2016).

> notion of the relationship building. Did they make any reference in what they had to do for a patient with respect to the relationship building and making connections with their patient? (Educator 2)

E5 perceived teaching *caring about* as helping the student to understand the meaning of the interaction with patients and giving reasonable attention to the patients' responses while providing care to them:

> So we teach the students…. So I have an obligation by my license to ensure that the needs are met, that the things are done to…that I still do all of the planning, the intervention, attempt to teach someone, whatever. I don't have control over their response to what I'm doing. And so it's their…it's probably their response to what I'm doing that speaks to caring about someone. Because caring about someone is an interactive thing. So if we are teaching our students that we need to be able to actually describe that, that yes, all these things were done.... So yes, all of these things were done. There was no interaction with the person. What was your communication like? How would you describe the relationship? How do you know that you developed a relationship with this client? I can think of one student…and the patient said to me, 'Yeah, he did everything right, but I really didn't feel connected to him'. (Educator 5)

Other participants described teaching *caring about* as helping students to truly *know* their patients and understand how their patients perceive their experiences. For example, E3 perceived teaching *caring about* as helping students to understand the patients' experiences, meaning how the patients perceive their experiences and their expectations:

> I guess that's often the starting point – trying to help people to understand…. But I think the *caring about* piece is that part of saying, you know, this is this person's experience and

> they've come from who knows where. Like, they come with a whole bunch of stuff. They know themselves, they know their reaction. Like, we don't fully understand where they're coming from. Like, that's a starting point, is actually recognizing that you don't fully understand who that person is or where they're coming from. So you need to be very respectful, that their reactions or their feelings about things that may not be what you expect. (Educator 3)

E6 described teaching *caring about* as encouraging the students to know their patients to understand their needs and capabilities:

> So, in other words, as you're getting to know your patient…. And I always wanted my students to make the patient's bed because, you know, a) it's a skill they need to have, and b) it enables you to be in the space with that patient. So that you could say, 'So when you knew you were pregnant, how was that?'…. So then the student should get a sense of…and I tell the students this, this is how you do it. How do you get… this is how they get a sense of the mom's preparation for the event.... So in other words, they have an opportunity to learn from that patient. And if they listen well, they'll be able to figure out what that patient is capable of doing for themselves. That's the enabling part. (Educator 6)

Some participants described teaching *caring about* as encouraging students to take time to *listen* and *be with* their patients – be emotionally present – and recognize them as human beings, not as 'patients'. For example, E2 perceived teaching *caring about* as helping the students to construct a concept that the patients want and need to be cared of as a human being as well as having ideal physical care. She said:

> I think as a society, we transmit to people that it is okay to be very technical, very cold, very clinical. I have this knowledge, I can do…I can start your IV first-try all the time. I definitely think…and patients are very grateful for that. And I believe they accept that to a certain extent. I believe they will tolerate a certain number of clinicians who maintain that cool, aloof distance. But I think – no, I don't think, I know in general – that they want to feel like human beings, that they're seen, that they're heard, someone knows I'm here, they know what's happened to me, and they're helping restore me to good health. (Educator 2)

E1 perceived teaching *caring about* as encouraging the student to value being with the patient and listening to them. She described it as, "I'm caring about what she's [the patient] saying. I'm sitting next to her bedside. I'm holding her hand.... I'm calling her family to see if they can come in and talk to her because I'm caring about what she's telling me" (Educator 1). E12 described teaching *caring about* as enhancing the ability of being present and seeing the patient as human:

> That is absolutely being present with that person. Understanding that, you know, they are important. I have to leave, but that no less diminishes who you are, and that our conversation is important, too. And just that element of being able to reach over and apologize for having to go – all this done on his…he did this completely by himself. And just took that moment to look the patient or the resident in the eye and hand on the shoulder, and "I'll be back." And he went back in the time that he said. So yes, it's not…to me it's just taking that extra little to recognize and being present. (Educator 12)

Some participants described teaching *caring about* as encouraging students to use affective communication skills that address patients' emotional needs. E7 explained teaching *caring about*

as helping the students to understand that knowing their patients will help them to perceive them as a whole person and consider the context. She said:

> In teaching, it's that teaching moment, that 'aha' moment. But in practice, it's that time that I might be doing this but the whole time I'm putting that IV in, we're talking about your family. You know, what are you doing today? How are you feeling today? How are things going? And doing that whole assessment that's beyond the physical. So it's really looking at teaching students to understand…. I think I said this at the very opening, that the person in front of them is a part of a family, a sub-system, a super-system, a major system. And they're not just there for that health concern, the promotion of health or whatever they're working with them. So we have to ground the student in knowing that. (Educator 12)

E9 described her approach to teaching *caring about* as helping students to learn how to be comfortable while communicating and interacting with their patients. She said:

> I think that, for me, it starts off early in Year 1 when you're talking to them about communication and you're talking to them about relating to patients. So I think they need to understand the kinds of things that are involved when you're *caring for* and *caring about* somebody, and understanding. And just teaching them how to dialogue, teaching them how to be comfortable. Not even thinking about skills at this point. (Educator 9)

E5 described part of her approach to teaching *caring about* as helping students understand communication and relationships. She said:

> Because caring about someone is an interactive thing. So if we are teaching our students that we need to be able to actually describe that, that yes, all these things were done…. So

> yes, all of these things were done. There was no interaction with the person. What was your communication like? How would you describe the relationship? How do you know that you developed a relationship with this client? (Educator 5)

Linking Teaching *Caring for* and *Caring about* Concepts

Although participants defined *caring about* and *caring for* as separate concepts, they all agreed that they are linked. However, participants varied in their teaching approaches; some taught concepts using a sequenced method, while others used an integrated approach. According to the data, there are three ways to link both concepts: teaching *caring for* and *caring about* as integrated concepts; teaching the concept of *caring about* first; or teaching *caring for* concept first (Figure 6).

Some participants considered teaching caring concepts in an integrated way. For example, E2 emphasized that teaching caring concepts must involve both *caring for* and *caring about*, otherwise it would not be teaching caring. She explained: "I really believe that *caring for* and *caring about* need to be one. And anything that happens in which *caring about* isn't present is the execution of a set of tasks" (Educator 2). E3 also believed that both caring concepts must be taught together:

> Like, those sorts of concepts, for me, I think I included them somewhat in the *caring for*, but I think that's actually where I got more into the *caring about* that person…. It's not really a distinct thing that I have to teach. I model it and I reinforce it. I do talk about it, but not in a 'this is something you have to learn' [kind of way]. (Educator 3)

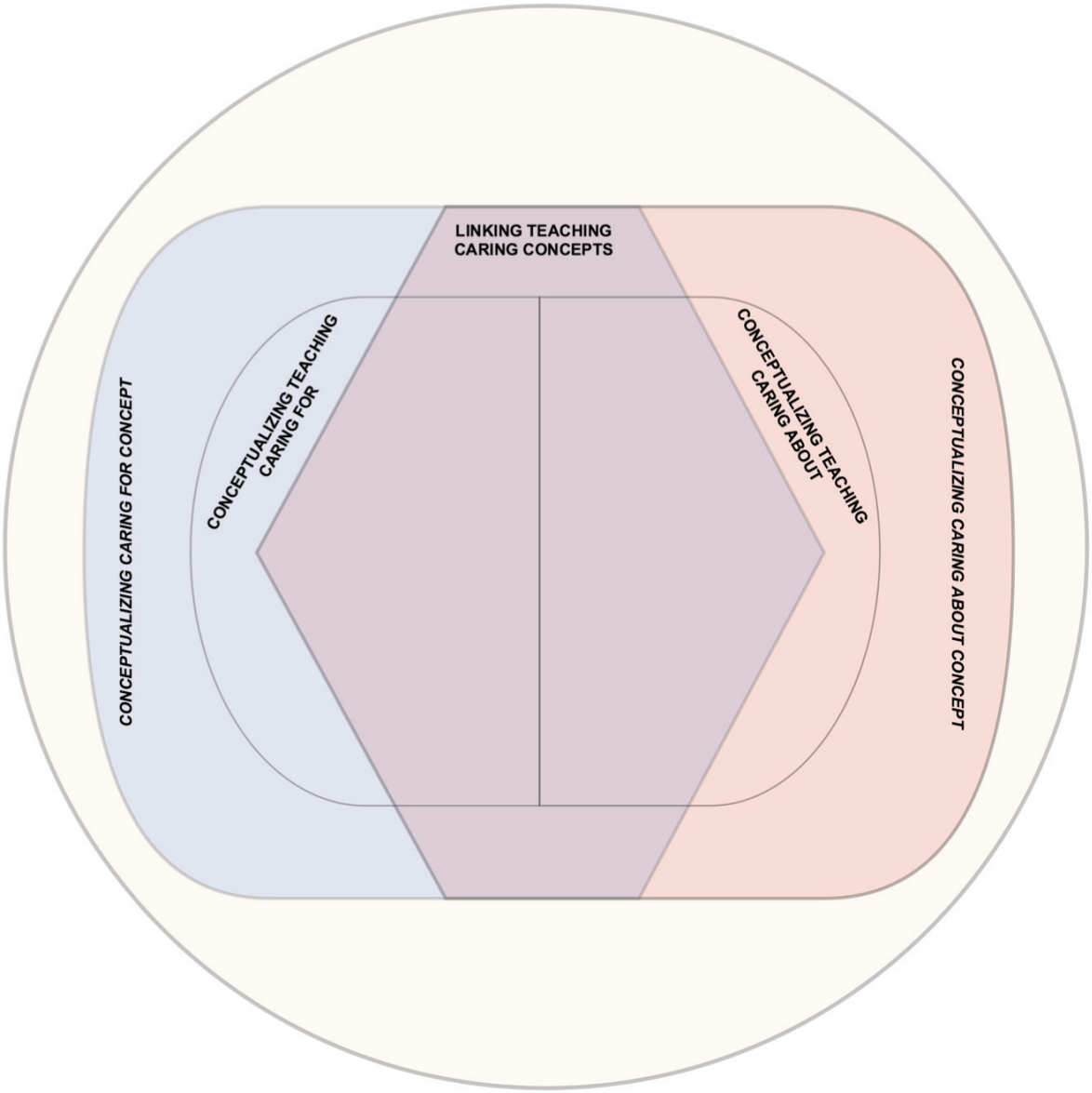

Figure 6: Linking Teaching Caring Concepts. This figure illustrates how nurse educators linked teaching caring concepts teaching *caring for* and teaching *caring about* (Almater, 2016).

E7 also believed teaching both caring concepts as integrated not separated elements. She remarked: “Well, I don't think you can take them one by one…. I think they have to be taught together” (Educator 7). E8 noted that both caring concepts could theoretically be taught in the conversation:

> They would be actually taught within the same conversation. When I teach *caring for*, I provide my students with examples of my past practice and how as a nurse we can *care for* our patients/clients, whatnot. *Caring about* actually takes that a little bit further. It implies something deeper. (Educator 8)

Some participants emphasized that both caring concepts must be taught, and that the *caring about* concept is essential when teaching *caring for* in order to build a professional relationship and gain the patient’s trust that enables the student to do the physical skills. E7 stated: “I begin with *caring about*. So I know the students are waiting for the *caring for* stuff, but that doesn’t come right away” (85). E2 states that she perceived both caring concepts as linked together, but that *caring about* must come first if a connection with the individual is to be established:

> I never thought of them as separate concepts. I always thought that in order to *care for* someone, *caring about* them was as important as *caring for* them…. But I never thought that I could just come into their space and start doing things without making a connection on some level with that individual. Which for me is the *caring about* piece, which to me always needs to be there. And I think that then the *caring for*, what we do with individuals, I think it is…I believe is different when the two are combined as one. (Educator 2)

Similarly, E6 shared the same perception about the importance of teaching *caring about* first, saying:

> For example, if I were going to care for say a new mother and baby, again I would need to get a sense of their story. That enables me to *care about* them because I know them. I know their context. I have a sense of their context. Which then enables me to do the caring for…. And that, as a nurse, that's what I would do so I get a sense of where they're at. That then enables me to…whatever my plan was for this…my plan was I can then adapt my plan to what they see as being their plan, even though they're not articulating their plan. I get a sense of what their expectations are, what their desired outcomes are. (Educator 6)

In contrast, some participants emphasized that students must learn and be competent at delivering physical skills *before* they interact and establish a relationship with their patients. For example, E9 emphasized that teaching skills come first to ensure that the students have the capacity to be comfortable to interact with the patient:

> And I think that comes though, too, with when we first start in the profession and the only thing you can think about is 'how do I do this skill?' Well, I can't interact and care about somebody if I can barely go in and open a dressing tray. I think it's foundational to get the… I think if they have the basic strong foundation, then you can build upon it. But if you don't have the basics then…your mind can only do so much at once. And if you're focused on 'I have to go in and I have to do a blood pressure first', and you're talking to yourself – 'First I'm going to put the cuff on, then I'm going to'…. So if you're doing this kind of self-talk to just get in and get the skill done, then how are you ever going to interact and *care about* somebody? I don't think there's room. I think once they get

comfortable with that piece, they can move to that. Now, they may be a very nurtured person who is very nurturing. But they're not going to show it to you at that point because all they can do is process how am I going to do this skill? (Educator 9)

E14 suggested:

> We can model them at the same time because we can do it. Because, for me, to do that dressing or put in that catheter or whatever, to start that IV, I'm not trying to figure out how to do this. I already know how to do this. So I have room in my head. I can do it and you can see me do it. But I don't see students able to do that early on until that stuff becomes second nature. (Educator 14)

In general, all participants emphasized that teaching professional caring must link both concepts. Some participants taught the caring concepts in an *integrated* way, meaning that both concepts were taught together at the same time. Other participants viewed the caring concepts as one concept *derived from* the other concept. However, this linking was taught in two different ways. Some participants taught *caring about* first to establish a therapeutic relationship with the patient as a way to build emotional connection and gain permission to enter the patient's physical caring space in order to introduce the *caring for* skills. In contrast, others taught *caring for* skills first to ensure a level of competency with physical skills and as a way to establish credibility with the patient and gain permission to enter the patient's emotional space.

Creating a Caring Environment

Additional important findings in the "conceptualizing of the caring concepts" is creating a caring environment (Figure 7). Some participants constructed a link between the personal experiences of being cared about and learning how to care about others. They perceived learning *caring about* as "a translatable". E3 commented:

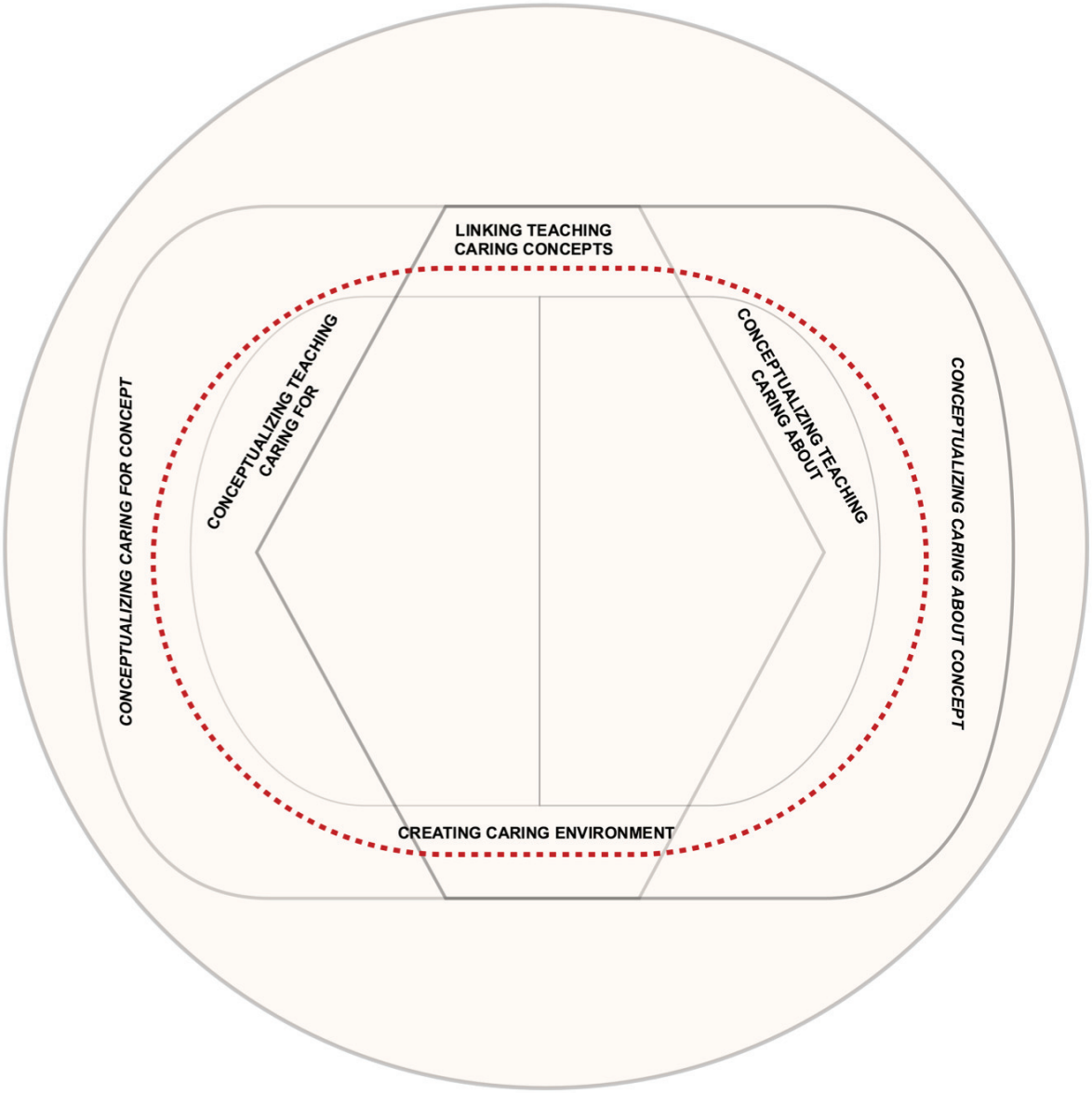

Figure 7: Creating Caring Environment. This figure illustrates how the nurse educators described creating caring environment as an element of conceptualizing teaching caring concepts (Almater, 2016).

> I think the *caring about*, interestingly, is translatable to environment, too. So I think you need to care about your co-workers and I think you need to care about your students. Like, all of that feeling of caring how a person is doing in the environment, I think that's all part of caring about. (Educator 3)

E7 added:

> Well, I've addressed a few things, I think, about this. One is the minute they enter our program, they need to see us *caring about* them. To start with, they need the role modeling, and they need to see us *caring about* each other. (Educator 7)

E11 said:

> The student is my client. So if I care about my student, then I expect that my student is going to learn to care about that patient or group of patients. So I guess I've never really thought about it as something I have to teach as much as I've just incorporated it as something to model. (Educator 11)

E8 argued that teaching and evaluating caring required having the sense of caring:

> You know, it's something that you also have to have the understanding for or the contextual understanding to be able to evaluate it. I myself could not evaluate my students about *caring for* or *caring about* if I myself didn't care. So I have to be very aware of that. (Educator 8)

E10 believed that the basic element of teaching caring concepts is helping the students to understand how to care about themselves:

> I think, having said that, that caring could also be taught on its own. Like *caring for* someone to me is a very daunting task to take on, you know, because you have about 30 patients to look for. You are drained by the end of the day. So I think how to care for something is not something which should become automatic. Nurses should be taught how to care for someone. They have to first of all develop certain skills, like to understand themselves, how it is affecting them, whether they are being stressed looking after certain patients and how they should deal with that stress so it doesn't affect the care that they give. (Educator 10)

In conclusion, emerging from the data was the belief that conceptualizing the meaning of caring concepts and the meaning of teaching both *caring for* and *caring about* is the first step in the process of teaching caring as a multidimensional phenomenon. Conceptualizing the meaning of caring concepts and the meaning of teaching both caring concepts provided the contextual foundation for the process of teaching caring. the contextual foundation includes six properties: defining the *caring for* concept, defining the *caring about* concept, describing teaching the *caring for* concept, describing the teaching *caring about* concept, describing the linking of teaching both concepts, and creating a caring environment.

2. Recognizing the Teachable Moment

Recognizing the teachable moment is the second concept of the process of teaching caring as a multidimensional phenomenon (Figure 8).

It is defined as the cognitive stage in which educators identified cues that indicated, in the moment, how well their students were able to engage in caring for the patient. This concept includes four sequenced properties*:* noticing the superficial cues and signs; accurately reading

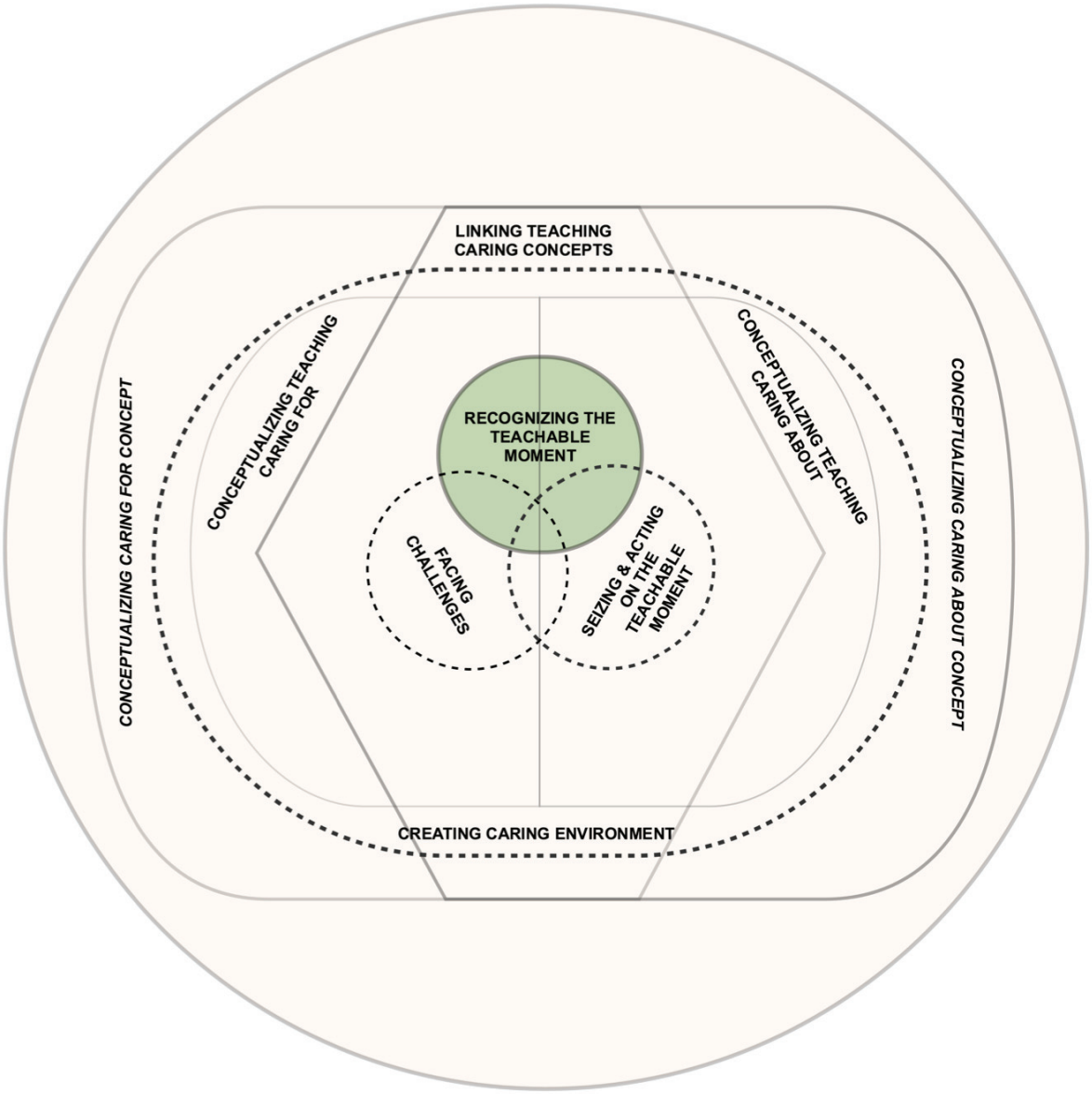

Figure 8a: Recognizing the Teachable Moment. This figure illustrates the second concept in teaching caring as a multidimensional phenomenon (Almater, 2016).

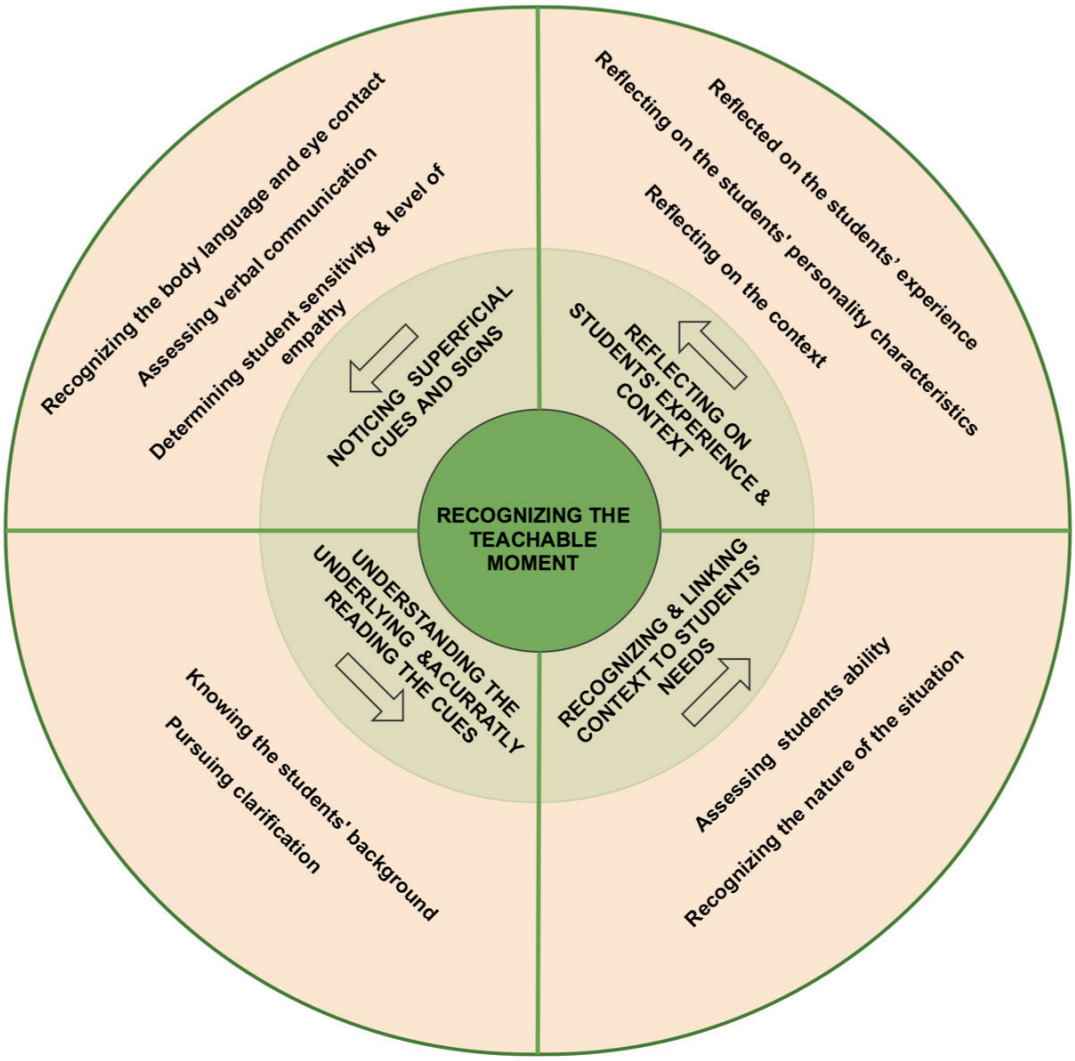

Figure 8b: Recognizing the Teachable Moment. This figure illustrates the properties of recognizing the teachable moment concept (Almater, 2016).

and understanding the underlying cues; accurately reading and understanding the underlying cues; and reflecting on the student's experience and personality and the context (Figure 9).

Noticing Superficial Cues and Signs

This element requires giving full attention to both the *caring about* and *caring for* learning pieces. Here, the educators noticed obvious and tangible cues, using various techniques such as observing students while enacting caring, following patient interactions, asking students about certain situations, listening to students' stories that involved both *caring for* and *caring about*, and determining student involvement. Some educators described obvious skill-related cues, while others described both skill-related and emotion-related cues. Four tools were identified by participants as helping them to notice the learning cues and signs; recognizing the body language and eye contact, focusing on verbal communication, determining the students' sensitivity, and detecting avoidance.

Recognizing the body language and eye contact of students is essential for noticing their level of comfort in dealing with and engaging in a learning situation. E1 said: "A lot of times, I think it's body language. You know, picking up on that, whether they're comfortable or not. As well as, like, the environment too….like, being aware of who's around you, who can hear our conversation" (Educator 1). E5 said: "It's two things. It's their physical presence in how they respond. So if they're kind of set back, formal, almost like resistant, and they just say, 'Okay, okay, okay,' that gives me one message" (Educator 5). E2 added: "The amount of eye contact they make with the individual, the nature of what they say to the individual in their care. Because if you…I think you can talk constantly. So you're so nervous that you're constantly talking" (Educator 2). E7 said:

> Maintaining eye contact with the patient certainly. A comfort…a posture comfort begins because they're getting to know the patient. So it's not an 'I'm the nurse, you're the patient' [scenario], but it's, I guess, getting more on an equal playing field. So it would be affect. It would be posture. (Educator 7)

According to some participants, assessing verbal communication**,** attending and listening to what students say and noting how they seek clarification and how they communicate are other indictors of the students' understanding and desire to interact with the patients. Some participants realized the cues through the verbal communication between the student and the patient. For example, E7 noted: "Certainly, it's verbal. I mean that's pretty obvious because she or he would then be asking the questions or making the statements or the open-ended statements that would gather information to get to know the patient" (Educator 7). E5 said:

> So, one of the things that is observable is how they ask questions of their patients. So, if they ask questions that have yes/no answers, they're less likely to engage with the patient. It's just like a checklist – yes, yes, yes, no, yes, no, yes, no. If you ask questions that look for information or beliefs or perceptions rather than a yes/no question, that tells me that the student is interested in engaging with their patient on a different level. The checklist tells me that they want to get their work done. So it's listening, really paying attention to the types of conversations that a student is having. (Educator 5)

E6 shared her experience with assessing the students' communication skills:

> But really, it is nurse-patient communication. And when I taught, I used to take it down to that. I'd say pretend, instead of saying mother-child, we're talking nurse-patient. So when we're looking at engagement and disengagement cues from a baby (which are basic cues of communication), it doesn't matter how old you are; it's just that babies show them in a

different way, that we're not used to looking at babies as intention beings but just as sort of, you know, a wet dishcloth or something that absorbs everything. But they have the same engaging and disengaging cues that students do. (Educator 6)

E9 said:

Oftentimes, by the way they talk to their patient, the kinds of questions they ask their patient, the stuff they can…when I ask them – 'So tell me about your patient.' And what they're telling me is all very factual – this was their vital signs, this was their assessment. But nothing about the emotional sense of the person, nothing about the socialization of the person, nothing about what else is going on in that person's life. So yeah, they can give me the hard facts and the objective data, but nothing other than that. (Educator 9)

Some participants recognized the cues from the students' ways of seeking clarification and asking question to their educators. For example, E1 said:

And sometimes, too, the questions. The students, they'll sometimes ask me questions. You know, 'what should I have done in this situation?' You know, 'what should I have done differently?' Or, 'did I handle this well?' And then, for me, that's definitely a cue to be like, okay, let's talk about this some more. (Educator 1)

E5 said:

But if they [the students] lean forward and they're asking questions and they're wanting to get information, then that gives me another indication. And I would take that as being that they're interested and they want to learn more or make improvements. (Educator 5)

E11 voiced similar thoughts:

When I know it's happening, though, is if the student is comfortable to come to me, if I've seen a change in how they're able to conduct themselves. If they develop more comfort

and confidence in the things that they are doing, I would say that then I feel like they're engaged. If they actually come to me when they have an issue, if they have a problem, if they're unsure, then I feel like they're engaged. (Educator 11)

Determining student sensitivity is another indicator for recognizing the students' level of engagement. According to some participants, there are two cues that indicate the level of students' compassion and empathy for the patients' experiences: the students' manner while talking about their patients and families, and the students' responses when hearing about patients' stories or scenarios. For example, E3 said:

> But I think that is how I would know, is by how they spoke about [the] families, the language they used when they described people's situation. Because I have had students use language sometimes that I perceive as clearly not being respectful of that mother's perspective. You know, kind of on the edge of judgement stuff or just very kind of…just a little disrespectful. And I don't even think intentionally but just sometimes not really being considerate of 'oh, you don't actually know this person's situation, just so you know'. You have no idea what their experience is. And I, so I think people forget that they make assumptions that they know how a person should feel or act. (Educator 3)

In addition, E9 said:

> I can assess the way they speak about the client in post-conference, the way they speak about the situation. And oftentimes you'll see people come in with judgments. And then once you bring them back to thinking like 'let's think about this – why is this happening?' You can see them go, "Oh, yeah, I never thought about that." Right? And you do see some changes. (Educator 9)

E11 shared the same perception: “Sometimes it’s when I see they’re making generalizations. They're generalizing about the patient based on things they heard or do or saw before” (Educator 11). E10 said,

> Sometimes, you don't know. And sometimes you can see, you know, they get upset when they hear something, when a patient wasn’t uncared for. Or you can see from their reaction that they kind of were moved by your story or not. Sometimes you cannot tell, right…facial expressions, showing a difference. You know, showing disinterest, not being moved. I usually try to pull the strings of their heart when I talk. You know, to elicit some reactions. But if I see indifference, I say, ‘oh, she does not like it, or he does not like it’. (Educator 11)

E13 said:

> We get them to present their patients in the morning often. So describing their patient, that helps me in terms of…I mean it is evaluating it, but it definitely helps me to understand where they’re coming at it from. Because I should see, you know, a very objective, holistic…. They describe them in a way that’s non-judgmental, that’s respectful, that’s considerate, that actually thinks about that other person’s perspective. (Educator 13)

According to some participants, avoiding interaction with patients or ignoring the presence of the patients or their families is another indicator of student disengagement. E6 explained: “With me, with a student, if a student turns away or isn’t paying attention, I know that. So I have to get her attention back” (Educator 6). E7 noted:

> When I see a student focus so hard on a skill that they miss something very big in that room…and it could be something simple like maybe the patient's wife is sitting there crying, and they're so focused to get that IV in, they don't notice that. (Educator 7)

E12 echoed the sentiment:

> You know, their conversations are not inclusive of the residents. You know, they're talking over the top of the resident if two students are doing care, and not including the resident in that conversation. They're rushing through feeding, you know, because they've got an agenda…. They go and do a skill. (Educator 12)

In addition, E11 specified avoidance as a clear indication of disengagement, saying:

> I think then they tend to avoid the situation. I find that they're not there. I'm having to look for them. I would just say, 'Have you gone and checked on your patient?' You know, seeming to always, to find them not in the patient's room, anywhere but in the patient's room, that's when I feel like they haven't engaged. And in teaching in the school of nursing, not with the patients, let me think if I'd know if they're not engaged. If they're bored. If they're telling me how this experience isn't good enough for them or they're not learning anything, then I think they're not engaged... Either that they're not actually physically making the effort to interact with their patients or in the learning environment, or they're not interested and/or they're bored or they're getting distracted, trying to multitask with something completely unrelated to what they're doing. (Educator 11)

Understanding the Underlying and Accurately Reading Cues

According to the participants, after noticing the superficial cues, they look for less obvious ones to build a deeper understanding of the students' behavior. Knowing the students'

background – level of experience, ability, and feelings – is one approach to understanding what is going on with students during a learning situation. For example, E2 said:

> So I really do believe that we can observe. Our observations of students in their interactions with patients, we can… and naturally, of course, depending on where they are in the program, how early on or how much experience they've had in the program will…I think the experiences that a student has in life before they enter nursing school, I believe forms…certainly will contribute to the comfort level they're going to have in a nurse-patient situation. (Educator 2)

E 13 focused on knowing the students and asking them about their feeling about being in the practice setting. She said:

> Like, one of the things I do right from the beginning is I always ask students where they're coming from, how are they feeling about being here? You know, do they feel excited to start, are they overwhelmed, are they scared, are they nervous? Is this where they want to be forever? Like, that sort of feeling. (Educator 13)

E14 described the process as follows:

> They have so many encounters every single day that they're in clinical experience to practice over and over again how they choose to be in an encounter. And naturally, if they're really nervous about what they're about to do, then what they say in terms of engaging with the patient won't be as…it probably won't put the patient at ease as much as they might like. (Educator 14)

The participants stated that they pursued clarification by creating a dialog to find explanations or asking direct questions to the students about the situation. Some participants

attempted to understand the students' cues by searching for related reasons for behaviour. E5 said:

> So, I've talked to the patient, and the patient said, 'Well, I didn't really feel like there was a connection. Yeah, he seemed okay with what he was doing but….' So I asked the student the same questions. And the response was, 'Well, yeah, it was going okay.' So what does that mean to go okay? Like did you have a connection with the patient? What did he say to you that made you think it went okay? And are you good with okay or would you like to get to a different level of relationship with your patients? And he just looked at me like, 'What do you mean?' 'Well, what do you think that means to have a different level of relationship with your patient? So what does that mean to you? So if you were the patient and I was your nurse or student nurse, what would you expect from that relationship? Because that's what our care is. (Educator 5)

E11 described using question to clarify the reasons behind students' disengagement:

> But then when they come and they sit down and they talk about it, I get a better sense of where they're coming from. Because sometimes it just doesn't come out in their discussion or it doesn't come out in a group discussion or it doesn't even show on paper. But when I ask them a specific question and they answer me, then I can feel like, 'oh, okay, so you were thinking about that'. But it sometimes takes that much before I see it. And some of them have other stuff going on in their life. So you might not see it but it might be for a reason that you didn't even imagine. It might be a perfectly good reason. (Educator 11)

E13 explained her way of using questions to understand the situation and to develop a connection with the student in the situation. She stated:

> But for me, I would take the cue from a question. Like 'how did you feel that went? And 'well, you know, I was uncomfortable.' It would depend on the response I have from the student, if they seemed uneasy to me or whatever. So to explore that idea or that feeling that they had, and to say, 'Well, if you're feeling like that, the patient may have been feeling that too.' So it's just…it's having the conversations in the moment. (Educator 13)

Recognizing and Linking Context to Students' Needs

Once they understood the superficial and underlying cues, the educators could recognize and link the context to the students' needs based on such elements as the students' knowledge, the nature of the situation, course objectives, etc. E3 described it as follows:

> So I think there is almost like an assessment skill involved in teaching. Like, you almost need to look at that student, look at the scenario. It's very similar to actually again caring about a person. You look at the whole picture and go: 'Okay, what do I need to do right now?' I think [it's] the same way with teaching. I think you have to look at how long they've been in clinical. Is this their first day or have they been here long enough that they should be doing more? Do I look at them and do they look nervous and panicked? And what can I do to sort of support them to start, right? Because there's part of looking at that student, too, and knowing what experiences they've had so far, how nervous are they generally; are they very shy and quiet? And then maybe they need me to start a little and encourage them. So I think it's about looking at the whole in terms of the situation and looking at that student and getting to know the student. (Educator 3)

E4 indicated the students' ability through the learning situation, saying:

> Well, I try and make the eye contact with the student to try and make sure that they're kind of paying attention. And if it's a very beginning student, I don't invite them so much into the

> conversation. You can see that it's hard for them to get into a conversation…. But I have to care about the student to know whether he or she is able at that point in time to engage. (Educator 4)

Similarly, E7 stated:

> So if I indeed assess that a student isn't caring about and is petrified, the student and I will talk first. And then I'll make sure that I spend extra time in the room with that student, and I'll role model what I want to see. (Educator 7)

Reflecting on Students' Experience and Context

The participants reflected on students' experience (present, past, anticipated future), personal characteristics (personality, background, where are they come from, thinking style, wellbeing, etc.), and the context of the learning situations to understand students' behaviour and factors affecting them. E3 described her reflection on a situation in a way that linked the student behavior to the context, saying:

> I recognized that this person [student] may not have known anything about managing pain with somebody who has addiction issues. So from his perspective, looking at the chart, he may have had really specific opinions about this person. He may have not understood why it is she needs that much pain medication. (Educator 3)

E8 linked the students' personality and their experiences in away to reflect on a learning situation, stating:

> Absolutely, it [student personality] can influence the situation. But bear in mind that the student could be anxious, and that it might not be the student not caring: It may be a lack of experience. The student might be anxious. But then again, there are people, not just students, but there are individuals who are nursing that sometimes don't care. And you

can see that in the interactions that they have in a particular type of situation. You know, some people are willing to go that sort of extra mile, but others aren't. (Educator 8)

E11 shared a similar perception, saying:

I think sometimes personality. Because the personality, if it's way different than mine, I think that might affect it, too, where I might not recognize what their caring is, you know. Or I might misinterpret it if their personality is quite different than mine. And then I guess there are students who are more introverted and students who are more extroverted. Again, I could misinterpret it because they're more forthcoming with information. So I try to be careful about not jumping to conclusions. And some of them are just really so much more reserved and it takes them a longer time, more practice situations before they feel confident enough in their knowledge to show that. So sometimes some students start there. They start with the 'I can get right in there, get involved', and then they learn the knowledge after. And some students learn the knowledge first and then they learn…. So it can be flipped around. But I always think they need more…you need to watch them over a long period of time, not make the conclusion too soon. (Educator 11)

E12 described it as follows:

Because it's different for most of the students. You know, some of them come back and they're almost like they're awestruck. You know, they don't want to talk about it. They are… and maybe they're just remembering times that maybe they didn't give the respect that they were due. You know, they hearken back to maybe their own personal experiences and are trying to absorb that. And many of them are frustrated because they are able-bodied, you know, young people with all their faculties. You know, they go on about not being able to, and what was the worst one? Well, seeing seems to be the one that

bothers people more than anything else – not being able to see where they're going. (Educator 12)

Having a Teachable Moment and Creating a Teachable Moment

There are two aspects involved in the teachable moment. The first is *having a teachable moment*, which is *taking advantage of an unplanned opportunity* that arises in the classroom or the clinic setting that is considered an ideal chance to assist students in gaining insight. The second aspect is *creating a teachable moment* (situation), in which educators *deliberately build situations* to engage students in learning situation. Having teachable moments was described by the study's participants as encountering an unplanned moment. E2 explained:

> I think it's something a faculty member has to live all the time. I don't think we can turn it on and off. I think in our… I think when a student asks us a question, the extent to which we engage with that student in that moment, I believe that's part of…. I believe right at that very moment that you're responding to them what they've asked for, that you give yourself…. They're in your space and they've asked you a question. And I think the way that we choose to respond is a small piece of what we want them to be and do in any interactions that they're having. So I think all of our interactions are teaching moments. (Educator 2)

E5 provided a slightly different description:

> I don't know, other than there may be teachable moments. And it's a fine line because the group has 8 students. If you have 7 students who get it and one student that doesn't, do you spend a lot of time with the one student? One, it singles them out and identifies that something…. You don't have to say anything, but the fact that you're spending a lot more time with that one student targets that student in the sense that there's something wrong.

> Not that you've ever said that. But from the other students' perspective, there may be that perspective if… And so you have to catch the moments. So we spend time with the patients and the students. We observe interactions." (Educator 5)

According to E7:

> I find [that I'm] doing it in the moment. Because it needs to be done in the moment because they still need to have that view of that room that the patient and family are in. And getting them to go through it differently. So it's really part of critical thinking. But it's caring about with a critical thinking perspective. Because critical thinking is all about reflecting upon…thinking about what you're doing and how you're thinking while you're doing it and why you're thinking it. So if we cross that over to teach students how to critically think to *care about* people, we can do it. (Educator 7)

E8 described having a teachable moment in a situation with one of her students. She explained:

> Last year, I had a student, first year in acute care experience. It was an inter-session practice. And what I found is that this student was going through the motions, but going through the motions very mechanically. What I didn't find is that she was actually understanding the particular situation or was she demonstrating caring. I didn't find her empathetic. I didn't find the student warm. I didn't find her engaging with the client. (Educator 8)

Creating the teachable moments described by participants often meant constructing a teachable moment to assess the students' learning needs. For example, E2 used case studies to create a teachable moment in the classroom, saying: "The cases, they were always disease-specific, if you will…. And so, of course, the case would always start with the nurse-patient relationship and the

establishment of that relationship. And it would always inevitably" (Educator 2). E4 explained creating teachable moments by creating an interaction situation in the clinical setting or even at the beginning of a clinical:

> So I would want to see if we could be three people having a conversation. But I have to care about the student to know whether he or she is able at that point in time to engage. So that really, really varies. So if the student then becomes part of it and we can carry on, like the student almost picks up from me and we meet whatever concern that that mother has in a way that she knows that it matters, we do that. And then we kind of debrief afterwards. So I think the debriefing afterwards is crucial to checking in with the student and seeing if there's learning. If the student has been very much involved, then I do ask about what that was like for the mother. (Educator 4)

E6 used a care plan to create a teachable moment by assessing the students' reports and linking them to the patients' contexts:

> And so…when the student gave the nursing care plan the next morning in her preparation for… And she would have met the mom the night before, the afternoon before. And I would have, I would have gone in to meet them before I assigned those. I needed to get to know the patient a little bit so that I could then understand what the student was bringing. And if there was some connection that the student…if the student in the nursing care plan had usual things like, I don't know, if it was the IV, the technical stuff listed but didn't have anything about…. So to me that was 'So what? What do all these things, what do they have to do with that mother in that situation in that context?' (Educator 6)

E9 used the post-conference to create a teachable moment:

> So when you're in post-conference and you have somebody, like, I say, that may have made lifestyle choices or been in lifestyle situations that it's very easy for students to be judgmental about. So when I can bring them back to 'let's think about this person's life and what kinds of things might have happened that their normal is very different than yours?' So they're making lifestyle choices that they can only see as good for them. (Educator 9)

In conclusion, the concept of "recognizing the teachable moment" represents the cognitive stage of teaching caring as a multidimensional concept. It includes recognizing and understanding cues around students' levels of engagement in a learning situation. It also involves linking the students' needs to the context, and reflecting on the students' experience within the context.

Concept 3: Seizing and Acting on the Teachable Moment

This concept, defined as the action stage, involves teaching activities (Figure.10). It involves four teaching approaches: role modeling, facilitating and enabling, engaging personal and professional knowledge bases, and evaluating.

Role Modeling

In demonstrating caring for students to observe and reflect on, role modeling is the main approach used by participants to model communication, interaction, and doing things. The following is a sample of the ways participants use role modeling in their approach to teaching the concepts of *caring for* and *caring about*. E2 said:

> I was a clinical teacher or instructor initially. And for me, I would always have students come with me to the patient's bedside. And essentially what I did with students was to

model to them how I expected them to be in their approach and in their care of an individual. (Educator 2)

E14 described it this way:

> I prefer to model it so they see the expectation. So they see what I expect. And then I'll talk to them outside the room. Doing a task is different because we're really, like, hands-on. And I think patients expect to see an instructor teaching someone to do a task. When you're getting into that *caring about* somebody, it's almost getting into their interpersonal skills. And I think it feels more personal. I think it's less clear to the patient. I don't mind the patient thinking that the student doesn't know how to do a task. I don't want a patient to think that the student doesn't care about them. I think that's different. And so my tendency would be to pretend as though everyone is caring about each other, model it exactly how I would like it to look, and talk to them outside the room about it, and then watch for it the next time. (Educator 14)

E13 said:

> So, you know, when I go into a room with a family, I often, if I'm going to ask them a bunch of questions, I sit down. Like I convey that I am there. I am not hovering by the door; I'm not standing, trying to get the information as quick as possible so I can go. Like, I go in and lean against the windowsill or I sit back and I chat with them. And I make sure they at least feel like I have lots of time, even if I don't have a lot of time. And I think that sets a tone in learning for students, too. (Educator 13)

E4 explained how to role model *caring for* and *caring about*, stating:

> And then when we would interact with the family, I would do my best to role model what I think would result in someone feeling cared about. All right?… And I walk into the room

with the student, and our task is to do a physical assessment and perhaps teach the person about health promotion kinds of teaching, about staying healthy now that you have a new baby. Well, when I walk in the room, I don't say, you know, just roll over, do this, let us look at. I take time to say what we're here for. And I'll make sure that the student can see how that's tailored to each person. But I do have a kind of method. So in that situation, you know, if it's the first time I'm meeting somebody, I give a little introduction. But to introduce what we're in the room to do, I often say after the preliminaries of, you know, did you sleep and all that kind of thing, I get into this sort of task with demonstrating to the student by saying to the mother: 'We're here to help you determine how you're adjusting physically and mentally to having just had a baby.' (Educator 4)

E5 described the role modeling in acute care:

> So the next step is to talk to the student. And it's how do I model for the student how you care about someone…. Because especially in the acute care side, that's part of it – we have to know how to get the things done as well as develop the relationship. But I think we role model. So we also have contact with the patients. And it's in the students listening to how we talk to the patient. We also provide a role model for how you model caring. (Educator 5)

E6 described how to role model caring about, and then included a reflection and discussion to link the student to the learning situation. She said:

> So that hopefully the student would pause and find out what that is. Sometimes that was hard for a student to do because they're so anxious about doing that skill to a body. So, if I was with them, I would serve as that intermediary and would role model some of that while the student was doing the actual doing, if you will. I would be doing that other piece

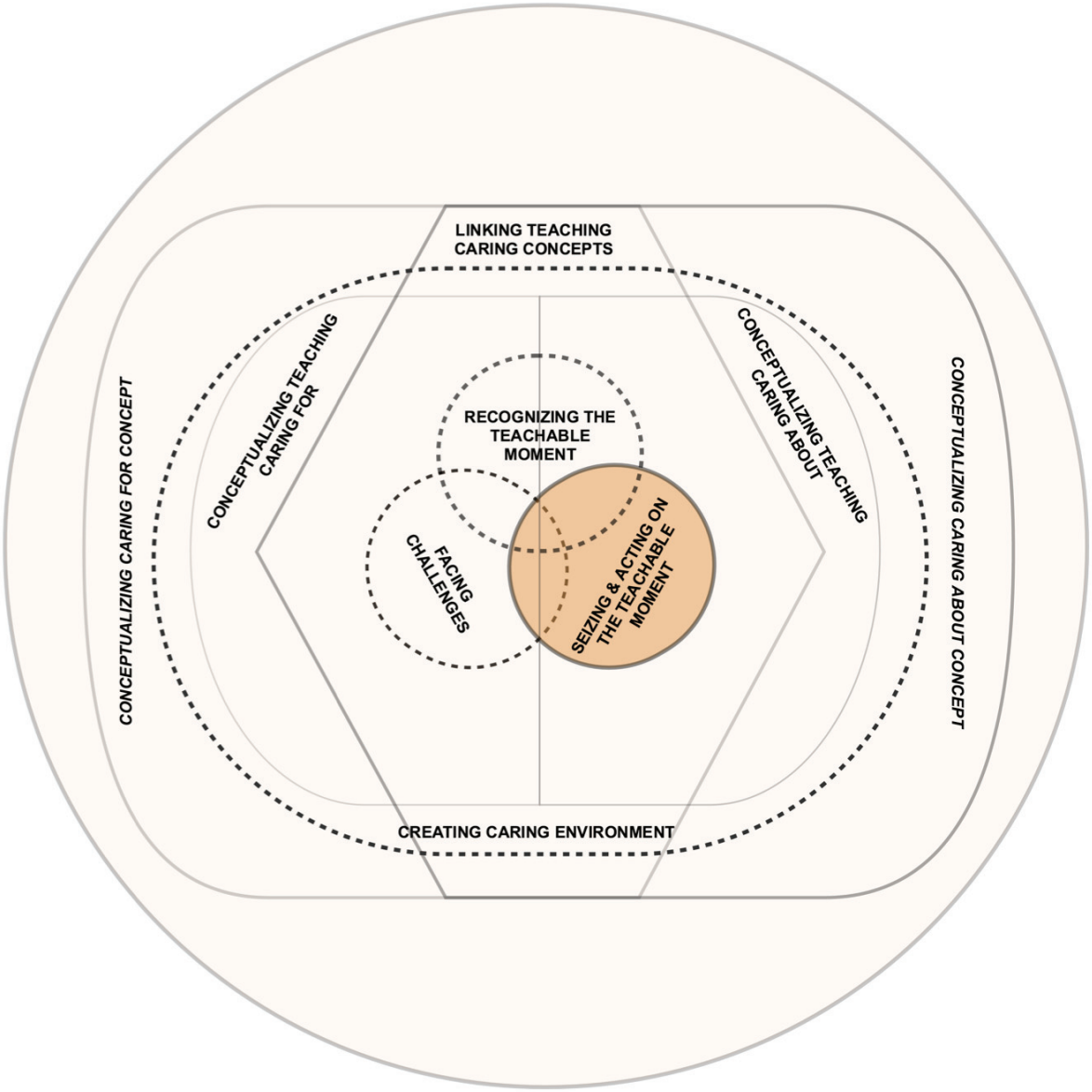

Figure 9a: Seizing and Acting on the Teaching Moment. This figure illustrates the third concept of the process of teaching caring as a multidimensional phenomenon (Almater, 2016).

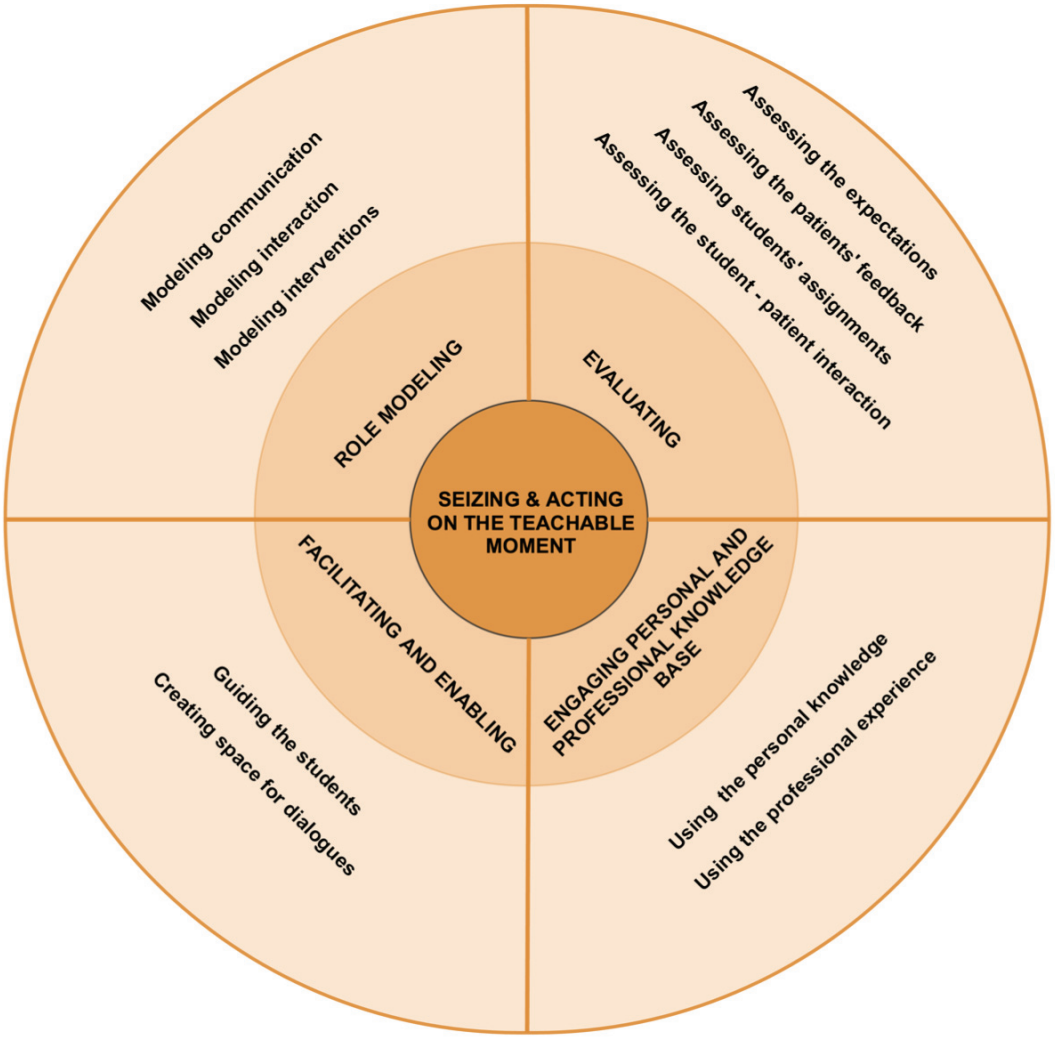

Figure 9b: Seizing and Acting on the Teachable Moment Properties. This figure illustrates the properties of the seizing and acting on the teachable moment concept (Almater, 2016).

– the *caring about*, if you will, while they were doing the *caring for*, the doing for. So that on reflection after it was happening, I would say: 'What did you see happening in there?' So that would enable the student to understand what I was doing. Some students would say I was interfering. But that's okay. You know, because then I would say… I wouldn't know that. I would see that cue. But then I would talk to them in a way that would help them to understand when we talked about such and such in class, this is what it looks like. (Educator 6)

E7 described her strategies of role modeling, saying:

So if I indeed assess that a student isn't caring about and is petrified, the student and I will talk first. And then I'll make sure that I spend extra time in the room with that student, and I'll role model what I want to see. Because I can say to you, you know, you need to ask her about her family, you need to ask her how her pregnancy is going.... And then we'll go back in the room and I will start doing what I want the student to do. And I'll tell them: 'I don't want you to do this verbatim. I don't want you to copy this. I just want you to see how you can care about as you're doing your care for this patient.' And the student knows at any point to jump in when they're comfortable. If they're never comfortable, that's okay, too. You know, we'll wait until they are, or whatever. And I find that works really good because first of all, the patient gets comfortable. And we're getting the work done that we have to get done, because we have to get the work done. (Educator 7)

Furthermore, E10 described role modeling as the best way to teach caring:

Personally, I think the best way to teach caring is through role modeling, demonstrating it yourself, not just [doing] the talk. Sharing experiences may help to a certain degree. So personally I feel from my experience that when I taught my [course], and I was with those

students that I was teaching in the clinical area, too, you know, they could see what I was talking about. I think role modeling is the most important way they can do it. And you have to catch them early before they go with the system. (Educator 10)

E9 and E11 illustrated how to role model communication and interaction with the patients. E9 said:

I think a lot of that is modeling, right. It's what they see you doing with the clients. Because they want to mimic you, right? They look at you as you know what's going on here, and you know how to nurse and you know how to relate to these patients, right? So they model what they see. So when they see me going in and really connecting with a patient, they're watching, they're listening, and then they're going to mimic that. They're going to do the same kinds of stuff. So I think that's how I teach it in the actual, at the bedside, is them seeing me walking in and not walking by the gentleman in bed #1 without acknowledging him. You know, they see that. No, that's not who we're going in to see, but certainly I'm going to see how he's doing and say hello to him. (Educator 9)

E11 explained it as follows:

I will communicate with the patient. You know, I will say things, because that's where the modeling part comes in. Like, I can tell that the student is not there. I can't very well say to the student right at that time that you need to tell Mrs. D this, this, and this. So I might just go ahead and say a little. And then I will talk to them afterwards about how I did…. You know, excuse me for being overly involved. Because you try to keep a back seat and let the student do it but sometimes you can see that their anxiety has got the best of them or they're just too task-focused. So that would be when I would choose to say, you know, I talked to them because I could see that they were getting kind of nervous and that they

were getting really tense. So I said, I just did … I used some small talk with them at the time, or I told them what you were doing to help them feel more relaxed with the situation. So yeah, I have just explained what it is, why I said what I said when I said it. (Educator 11)

Facilitating and Enabling

A second action approach identified by participants involves facilitating the learning experience in ways to assist the student to engage and learn. Guiding the student through the learning experience is another approach used by the participants to act on the teachable moment. This approach includes having conversation with students, asking questions, and having debriefings to enhance both caring concepts to the students. For example, E1 said:

> I am big on having conversations with the students. So whether it's, like, as a group or if it's, like, a specific scenario, like sitting down and having a private conversation with that student, and just kind of talking to them about how the situation made them feel, how they would do things differently. (Educator 1)

E12 said: "I think it comes out as you facilitate the sessions with the students by allowing all of them… time to be able to appreciate what actually or understand what really happened" (Educator 12). E6 said:

> So, if we're thinking within the confines of a clinical experience, you know, which may be 4 days in length, so to speak, assuming that I would get a sense of this early on…. Whatever care plans they gave me in the morning, they got back in the afternoon, with feedback on them. So, like, I didn't take them home. What they brought me in the morning, they had when they went back. I would take whatever and give them comments. And also verbally ask them questions. Because if there was something in their care plan, I

would give them the same patient 2 days in a row, if I could, so that they had an opportunity to work on that piece – that *caring about* piece that was often missing. And I could tell that by the data that they had on their care plan. Because I would say … so we did care plans. They always had to have expected outcomes. And if the expected outcomes were pretty, you know, standard, vague, whatever, I would say: 'What does that look like? How will that look like for Mrs. so and so? How will you know when that's happened? What are you seeing?' And talk it through that way. (Educator 6)

E9 stated:

So, if I was watching you and you did your dressing, and I could say to you afterwards – 'You know what? You did a great job with that dressing! How did you find Mr. Smith tolerated it? What was he saying? What did he think about it?' 'Oh, I don't know, because I didn't look at his face.' 'Well, you know…. So the next time you go in and you do your dressing, make sure while you're doing your dressing that you're making eye contact and that you're talking to him, and "Is this okay for you?" and making those connections.' (Educator 9)

E8 said:

A simple situation (and I would say this to the students) is talking about post-operative care, someone that has had surgery and who's at risk for developing complications. So I would say to the students: 'You can assess their vital signs, assess the patient, and that would be okay and that's an appropriate thing to do. But in order to facilitate that client's recovery, you want to engage him in deep breathing exercises and coughing and whatnot. And you want to do a good job. You want to do really good for your patient. You want to care about the fact that he doesn't develop any complications post-operatively.' So you

know, you could easily go on to something else, but maybe you spend a couple of extra minutes providing some patient teaching and going back and reinforcing that, and making sure that he's using the incentive spirometer. (Educator 8)

E10 used stories with specific situations to enhance the students' learning experience, saying:

> I sometimes recount stories from my experience when it was done in a caring profession or in a caring profession, the small little things which made a difference. So the students seem to like that. They seem to like that part when I link it to experience. And I mention these experiences where it went really well and when it did not go well. (Educator 10)

Engaging Personal and Professional Knowledge Bases

The third approach of the action concept in teaching caring as a multidimensional phenomenon involves engaging personal and professional knowledge bases. This approach is defined as using one's knowledge base as a foundation to enhance teaching both kinds of caring concepts in the moment. For example, E2 described her personal experience as a new nurse to explain the gradual development of doing nursing tasks and interacting with patients:

> Because, of course, in my initial years as a nurse, when I was learning to do the things I needed to do for patients, I'd forget that there was that person that I was actually working on. And I'd have to constantly talk to myself and remind myself, 'Okay, okay, there's a patient that you're looking after. Be sure to look at them. Be sure to engage.' So gradually over time, I realized that I could carry on a conversation while I was doing things with individuals. And so it was a skill set that I developed over time. (Educator 2)

Similarly, E7 described her personal experience:

> I was probably focused on caring for before I incorporated caring about. I know that might sound a little silly but from a standard and code of ethics perspective as a new grad, that

was my focus. So my focus was giving the best care I could physically, and not emotionally and spiritually. So I think once I became comfortable with the physical aspects, the tasks I had to do, and all of that stuff, and when that became second-nature, I then focused on the more rewarding aspect of nursing, and that's *caring about* and getting to know your people. (Educator 7)

E8 said:

Being a former student myself, you understand where the students are coming from. You know, you have that perspective. So yeah, absolutely. I think each one of our situations or experiences that has brought us to a certain particular point basically gives you a different perspective. So you know, I'm still actively involved with caring for palliative care patients in the community. So if I didn't care about that. And when I impart the information to my students, you know, I hopefully demonstrate the fact that I'm a caring individual myself. You couldn't teach caring if you're not a caring individual because it's so personal. It's very, very personal. So I couldn't teach *caring for* or *caring about* if I wasn't a caring individual and I didn't hold those same values myself. (Educator 8)

E10 said:

For instance, in my training a long time ago, we did a course which was counseling skills. It was in no way meant to make us counselors, but it taught us techniques – how we control the way we behave towards others. Exercises, for instance, on personal constructive. There is a particular patient we don't like caring for because … how to deal with it, how to deal with our emotions so that they don't project on the patient. You know, exercises like this. I found it very useful because … part of the exercise, the teacher told us (who was a counselor) there are certain personalities we have struggles with interacting…. And she

gave us a series of exercises so that we … she called them social constructs, how we do not like these ideas which, you know, we have been brought up with for some reason in our lives because of past experience, not affect the way we interact with others. (Educator 10)

E12 said:

I can remember thinking when I was in my 20s, I can't appreciate what seniors are like. I see my parents aging. You know, I don't know what it's like to have funny knees you know, and your eyesight not like it used to be. So that just … I began to use my own props to be able to stimulate what that would be like in the beginning days of my teaching here. And then it flowed into what has become [a program]. (Educator 12)

E5 explained her personal thoughts around providing caring about and caring for, she said:

Do we need to *care about* people to provide good care? I don't know. Because I think you could argue a case, you could argue either way. Are patients more satisfied when they receive care from people who they feel connected to, which is what to me *caring about* is. I would say yes because it builds … trust and respect, and that's the foundation of a good relationship with anybody. Whether it's a colleague, you need to trust them, you need to have some respect for them. Or whether it's our family members, we need to trust them. It's the same thing. (Educator 5)

Evaluating

Evaluating is the fourth approach in the action concept of teaching caring as a multidimensional phenomenon. This approach is defined as assessing the strength and limitations of the students throughout the learning experience. This approach includes assessing the achievement whether expectations are met, patient feedback, assessing written materials, and assessing the student-patient interaction.

Some participants used the degree to which students' achieved expectations as away to evaluate the students' level of engagement. For example, E1 said:

> So I always follow up on things that I recommend to students. It depends… the level of follow up will depend on how big the issue is or whether the issue continues. So you know, I'll keep an eye on that student and I'll just kind of, you know, do little check-ins to see how things are going. (Educator 1)

Similarly, E3 used expectations to evaluate students' level of engagement:

> Well, using the expectations is what I use. I use the evaluation tool a lot. And I use the evaluation tool for anything that I'm trying to help a student work on. So I think even things like caring about somebody, you can find a way to encompass that because our clinical evaluation tools tend to be specific about some things but actually quite broad about other things. So you know, there are things in there about seeing the person as a whole person. (Educator 3)

E6 said:

> I guess what I expected for them to do was take the time to understand a relational…. It didn't have to be complete, it didn't have to be full, but they had to have a way of seeing that patient as a person, as an individual. And so then if they could do that then as they were doing the procedure – a dressing change – they would be sensitive to those disengaging cues that people emit when they're not comfortable, when there's something bothering them, when there's angst. So that hopefully the student would pause and find out what that is. (Educator 6)

E13 said:

> Because I find students also sometimes won't hear feedback in the same way if there's not an implied consequence to it.... They know they're being evaluated when they perform an assessment. But they don't always know that I'm evaluating their attitude, I'm evaluating their work ethic, that I'm evaluating their ability to work with others. But if I use the clinical evaluation tool to say these are the other aspects that we look at, then they say, 'Oh,' and then they start to see things that they didn't realize was part of how they needed to perform in clinical. (Educator 13)

Some participants used patient feedback to evaluate the students' level of engagement. For example, E2 commented:

> Well, first of all, when I start with a group of students in clinical, I always explain to them that, at the end of the day, if I have time, I go and see the patients who have been in their care. And I don't ask them directly about what you did but I ask them a general question – How did things go today with you and the student? To give them the opportunity. And so students know that upfront that I will be … that I do that. (Educator 2)

E4 said:

> I check in with mothers after students leave, as much as I can. You know, I'm not going to say that I do it all the time. But, at the end of the day, often I will go in and say … because they know why I'm there. I've been introduced many times to them. And say … you know, I thank them for sharing, you know, all this really exciting family time with the students. And I ask them if they have any feedback for me or for the student, or what it was like. And if we've talked about something that has been really intense for them or done something in their care that's been, you know, sort of traumatic. Like some people get very

upset about having their staples removed or something, and having a student do it. And so, you know, did they feel honoured and respected in that? And sometimes you don't know in the moment. So I try and check back if I can. (Educator 4)

E5 said:

> How they [patients] perceived their care, how they found the student in terms of talking with them, you know, interviewing them. Not that the students do a lot of interviewing. So that … I mean I don't obviously, depending on what the days are like on the clinical unit, we don't always have a chance to speak to every single patient. But I may take one day that I talk to all of the patients, and see what their perception is of the care they've received and whether they felt that the student was … if they connected with the students. Most of the time the feedback is, 'Oh, that student is just awesome, and they were sweet, and they checked on me and made sure that I had everything I needed, and spent time with me. (Educator 5)

Some participants assessed the students' care plans to evaluate level of engagement. For example, E4 said:

> Well, a really good clue is what they put in a care plan. If I see a care plan that's based totally on doing dressings, giving medication … then that's a clue to me that that connection hasn't been made. How do I know that it has been made? Again, looking at the care plan. And in fairness to students, it should be someone that they've met already, not someone that just comes off the paper. That you can see that they're thinking … the care plan looks like it matches the person they're caring for in some very specific ways. Like the number of family they have helping them, or things they have said and done in their life. That it looks … that you couldn't put this plan for somebody else. Like it's very

individualized. So that's one way. Internalized the link? It's the way they report, I guess, their care as well, either to me verbally or to a nurse verbally or in their chart. I have to be careful with that because occasionally students just copy the style of charting that they've seen, and it doesn't really reflect their own way of thinking. (Educator 4)

E7 mentioned:

> We are evaluating student clinical. We only know what we know when we see it. A lot of their evaluation is based upon their reflective writing and then we go from that. We can't be with 8 students at the same time. (Educator 7)

E14 said:

> Sometimes people use written reflections for that. And again, I think if you've got a solid base in the concepts related to caring, then you can use the reflection very well to really, the jargon word is 'drill down' on the thinking. Just really think about what has happened, what parts of it you want to repeat, what parts you want to learn something different. So I do use written reflections for that sometimes. (Educator 14)

In addition, E12 said:

> So I think how they seem to get it, I guess, is when they're able to articulate what behaviour change they will make in their own practice to accommodate the learning that had just happened. And from the evaluation pieces that we've done, because they do fill out papers at the end of it, from all that, it is such a small minority of students who don't fill out that part that says what they're going to do differently. So, to me, it means that if they've walked their way through the experience and then are able to come out on the other end and talk about what they'll do differently, they've gotten the connection between the two. And I wouldn't know the numbers but very few aren't able to articulate at least

something or write it down, that they would have learned and to take away and put in their practice. (Educator 12)

Some participants used student-patient interaction to evaluate the level of student engagement level. So, for example, E1said:

> You can just tell that they genuinely care about their patients. They're not just there, you know, because they have to be there. They want to spend time with their patients. They want to get to know them. They want to talk to them…. I think it's with time that you realize. Because if they've gotten it, it will always be part of their practice. (Educator 1)

E2 said:

> I believe, as a clinical instructor, that I can assess the ease and comfort that there appears to be between a student and a patient…. But I definitely do believe that we can evaluate the connections they're making and the extent to which they're establishing relationships with the people in their care. (Educator 2)

Additionally, E3 said:

> I think also we seeing *caring about* people in how you prioritize their needs. And if they say they need x but you don't think it's really important, then you wait. Versus if you recognize them as a whole person who needs something, which I think is the *caring about* that person, if they call out for that thing, you bring it to them then. Right? So I do think there are actions that you can actually recognize to say this person really does care about that other person's experience, they care about how they feel. (Educator 3)

E5 described a student-patient interaction situation that she had experienced:

> I had another student in the same group, interestingly enough, that actually just went and spent time with her patient. They played cards. But while she was playing cards, because I

walked in while she was there with him, she was asking him questions about how he was coping with his disease and all of those kinds of things. So it was like a different perspective, a different situation. (Educator 5)

E8 said:

Well, you can see that relationship forming with the student and the client. Or you can see that they somewhat go beyond that extra step than from what is needed at the particular moment in time. For example, if the student is required to do a bed bath, and they do the bed bath somewhat very mechanically but don't actually engage the client or talk to the client or inform the client what they're doing. Or afterwards, you know, just sit there and hold the client's hand. You can see that because you can see if a student is engaging with a client or is engaging with myself in class because they're responsive, they're providing you with some feedback. But you seem to sense or I seem to sense that, you know, there's something changing here or something that's going on. If a student is not engaging in caring, that to me is a red flag that I have to address. (Educator 8)

Some participants used debriefing to evaluate the level of students' engagement. For example, E4 mentioned: "So, I think the debriefing afterwards is crucial to checking in with the student and seeing if there's learning. If the student has been very much involved, then I do ask about what that was like for the mother" (Educator 4). E7 said:

I ask them to engage in reflective practice. Many times, I've asked them to stop, let's reflect back on what has occurred, and tell me what meaning have you gotten out of this situation, how would you have done it differently, or would you have done it differently. So I think it's very important for students actually to engage in reflective practice. (Educator 7)

E12 said:

> You have a sense by into about the third week of the comfort level with the students. And it happens in the post-conference when we get to talk about other things other than their fear of nursing skill. You know, for the first little while, they seem to reach up into 'Okay, what can we maybe as a group do that might make a difference?'.... And so that to me is one of the indicators – the depth in which they are moving their level of thinking into a bigger picture to me is one of the indicators, I guess, that they are getting it. (Educator 12)

In conclusion, the action stage includes seizing and acting on the teachable moment using specific teaching approaches to interact with students. These approaches comprise role modeling, facilitating and evaluating, all of which build on engaging personal and professional experiences. In some cases instances, *seizing and acting on the teachable moment* followed *recognizing the teachable moment (in real time)*, and in other cases participants described *proactively creating a teachable moment in anticipation of* a student learning need. In other words, this action stage is at times *created* by educators to impose teaching *caring about* while teaching *caring for*.

Concept 4: Facing and Dealing with Challenges

The fourth concept of the teaching caring as a multidimensional phenomenon is facing and dealing with challenges that appeared throughout the teaching process or at the evaluation phase. This concept includes cognitive and actions strategies involving *recognizing* challenges within a particular situation and finding ways to *adjust* the teaching approach to the situation (Figure.12).

the facing and dealing with challenges concept includes five properties: recognizing learning resistance and struggles; facing limitations; reflecting on the challenge situation; handling challenges; and reinforce and motivate (Figure.13).

Recognizing Learning Resistance & Struggles.

Identifying and understanding students' struggles and oppositional responses and barriers to learning the two caring concepts is one aspect of the facing challenges concept. *Learning resistance* is an obvious challenge for some participants, and there are many reasons for this resistance from the participants' perspectives. One reason is that students focus more on learning the *physical visible skills* than the *nurse-patient relationship and interaction*. In other words, students are more mindful of learning what they consider to be 'nursing work'. For example, E2 said:

> In the classroom, interestingly enough, I found that students were so anxious for what they considered to be 'real nursing'. And that was, you know, 'Tell me how to read this EKG, and I want to know how to give this injection, and I want to know how to prepare this intravenous, and I want to know….' All of these technical types of things were what was so exciting for them. And when I would try to talk with them about the nurse-patient relationship, it was kind of for them it's, like, well, 'Oh, you know, we know all about that. We get that. Like, don't worry about that. (Educator 2)

E11 said:

> So, to me, that would be one of the challenges, is that it's complex. Nursing – it's complex. There's a lot that's new to them [students]. They get quite excited about all the physical tasks they have to learn how to do, and they get so nervous about it. They're so caught up in their own nervousness that they might forget about the fact that the patient is also nervous. So that would be one of the challenges. But I think that a lot of times it's when

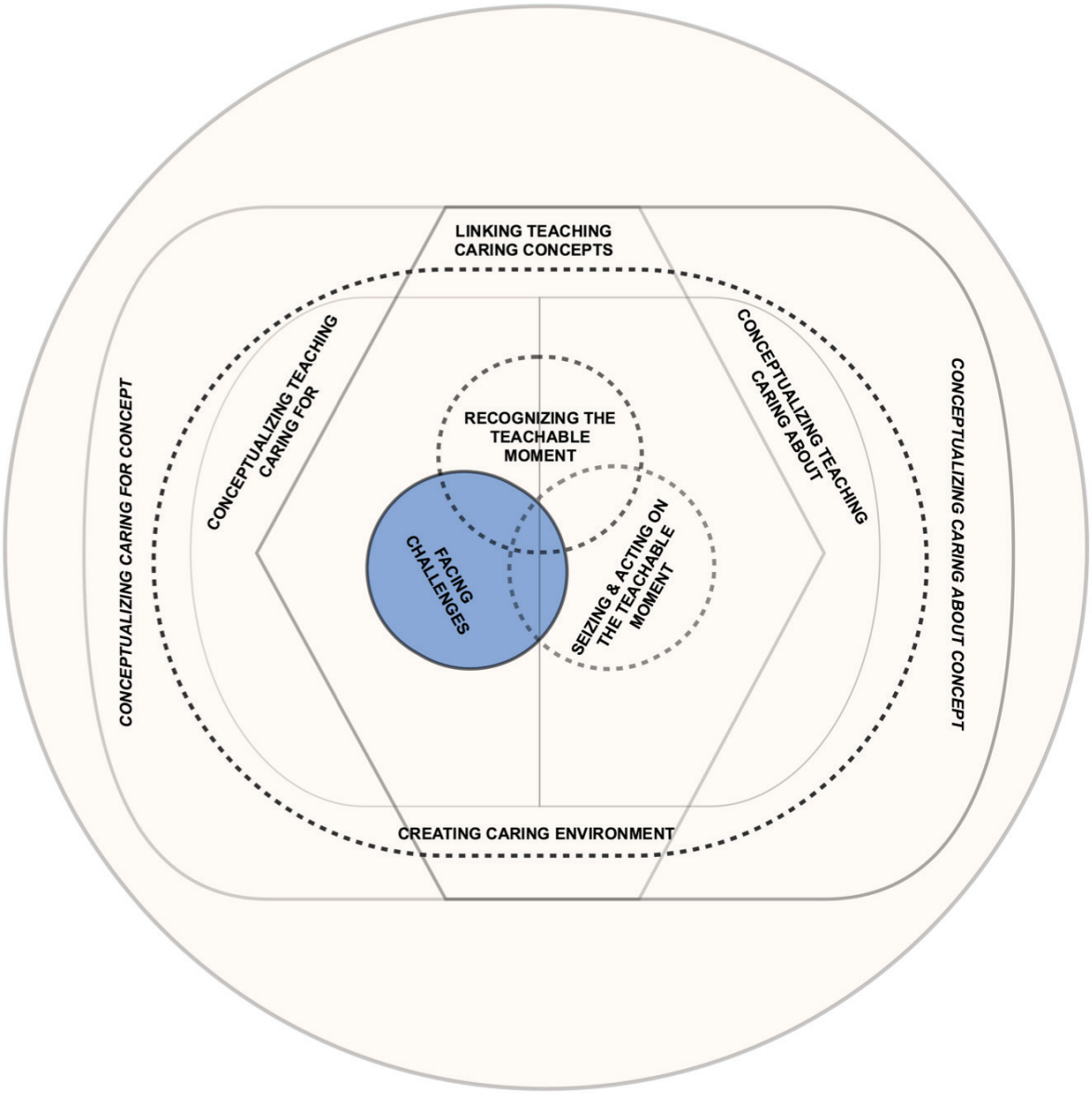

Figure 10a: Facing and Dealing with the Challenges. This figure illustrates the facing and dealing with challenges concept the fourth concept of the process of teaching caring as a multidimensional phenomenon (Almater, 2016).

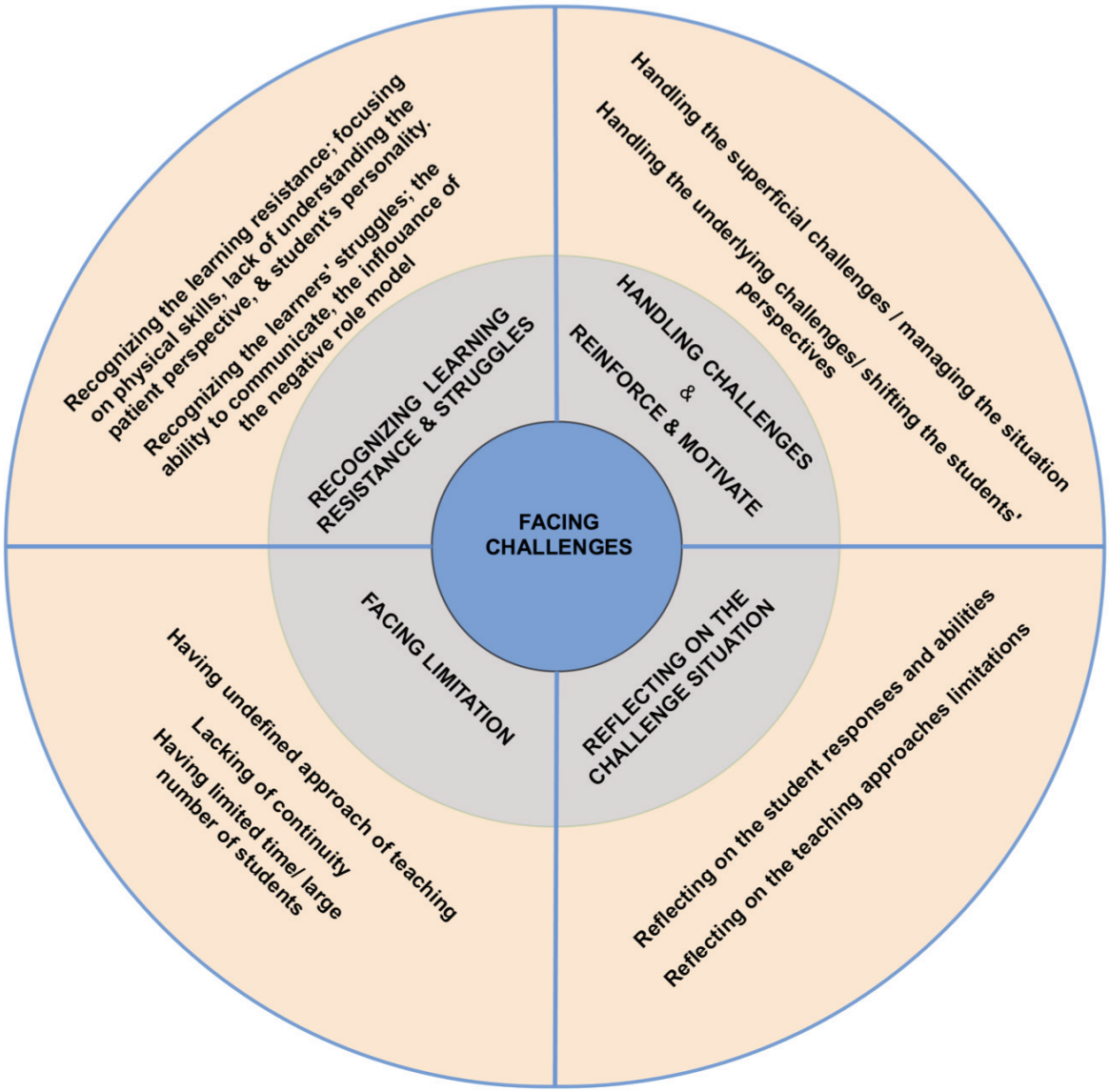

Figure 10b: Facing and Dealing with the Challenges Properties. This figure illustrates the properties of the facing and dealing with challenge concept (Almater, 2016).

> the student is quite new to an area, if they're not communicating with the patient at the time that the procedure is happening because they're so nervous themselves about what they're doing. (Educator 11)

Another reason for learning resistance as perceived by participants is *the students' lack of understanding* the patient perspective. For example, E4 said: "So I had a lot of difficulty controlling my reaction to this, that this is a really unthinking, uncaring thing to do. Matching that against the student's lack of understanding about what had happened in the interaction" (Educator 4). E9 said

> But I think if they're not open to it and they think that…. And I don't even know if they consciously think that they're not *caring about* somebody. I don't think it's a conscious thought in their mind. I think it's just so ingrained of who they are as a person that it's just not a way that they think. (Educator 9)

E3 said:

> So I remember one student I had that would make kind of off-the-cuff comments about patients, not overly disrespectful. And I was probably sensitive because it was a patient who had some mental health issues. And so some of the comments, I just felt they were like on the edge of implying certain things about her ability to be a mother, for example. And it wasn't obvious enough but it was enough that I noticed it. But that person actually had a really hard time getting other people's perspective. And I knew that about him because I had been working with him in general. (Educator 3)

Some participants believed that the *student's personality* is a reason for learning resistance. For example, E7 said: "And surely if I am in a room, the student is going to care about the patient…. But are they really caring about the patient?" (Educator 7). E10 said:

> I had a student, my very first experience as a clinical instructor in acute care. She was totally resistant to any suggestions that I had. She knew it all. And I chose not to deal with it because there was nothing that was a safety issue. (Educator 10)

E12 said:

> There's the other… that don't really seem to care. You know, they don't…. And care, I mean they're not interested in it. It's just a walking through the motions. There's no heart in what it is that they're doing. And the language is often a bit stilted with the resident. I guess the kind of exchange seems to be a bit packaged as opposed to genuine. (Educator 12)

Additionally, E9 said,

> Because I think some people innately care about people, and some other people care about getting their job done. So I think some of it is innate and who the person is, how they've been nurtured their whole life. And do we change that in 4 years of an undergrad program? I don't know that we do. I think that we can try and we can certainly show those that want and are geared to be like that. We can show them how to be like that, and they'll take that and they'll run with it. And then there's other people that, you know, yes, I'm going to do it right now because you're going to grade me on this. (Educator 9)

E4 said:

> But you know, it's partly personality. And I'm not an expert in personality types by any means. I also think it's instructor personality. Some students and some instructors are so

different that the communication is very difficult. If we don't have time to have the same meaningful words, it's a missed opportunity in my mind. And it happens. So I'm sure that there are cues that students could give me that I've missed because of just the nature of our relationship. And whether it's one that's again based on caring about or whether it's more of a functional, sort of let's get this job done. (Educator 4)

Students' struggles are another challenge recognized by the participants. Nurse educators addressed some struggles that may affect the students' learning experiences and limit their level of engagement with patients. There are two main reasons for the struggles, as defined by the participants in this study: students' ability to interact, and students' adoption of a negative role model.

One reason for these struggles is *the ability of students* to communicate, ask the appropriate questions, and share their thoughts. For example, E7 said: "So, nervousness really isn't a key indicator, it's not knowing what to ask. So, it's when I see a student struggling with asking questions or struggling with rephrasing what she's heard or he's heard, those are indicators" (Educator 7). E9 said: "Some students who come in first year, and I see them in the first year, and they barely speak above a whisper, they don't make eye contact. It's not that they're not genuine caring people, it's that they're shy and introverted" (Educator 9). E13 stated: "I don't think they always have the skills around the communication piece because I think that takes a while to learn, actually. And they're nervous. It's always hard to do your best communicating when you're nervous" (Educator 13). E3 mentioned:

Even inside the room, if the scenario all of a sudden goes in a different direction, and I can see that that student is not comfortable or not sure what to do, then I will jump in. And the reason I actually do that in part is to take care of the student. So the student isn't feeling

like, ‘Oh, no, I’m really sinking here.’ But it’s also for the patients. Because patients find it hard to have students. And so if I bring in a student, and they’re so uncomfortable that they’re not saying anything at all. I’ll do lots of chit-chat and small talk, and I’ll just try and put the patient at ease.” (Educator 3)

The second reason for the students’ struggles is *the influence of the negative role model* in the practice setting on the students’ current perspectives and their future attitudes toward caring concepts. For example, E3 explained:

> One of the challenges can be, I think, on units where the nurses don’t model that behaviour. And that’s the same of any nursing role or task. If you bring students to an area where the nurses aren’t inherently caring about the patients and, you know, they’re disrespectful, or they’re not attending to their needs very quickly, or they complain about patients, I think that can be hard. (Educator 3)

According to E4:

> I don’t normally think of this, but something a student said the other day made me think of it. It’s patient satisfaction. And the student said that nurses were… they were in a hospital where they suddenly introduced a very comprehensive kind of satisfaction survey. And the nurses reacted by saying: ‘Oh, well, if they comment on us, you know, it’s going to make our work so difficult because now we need to be nice to them.’ And the student was trying to make sense of this because as a student, they’re very highly idealist. And they said, ‘Well, aren’t you always nice to patients?’ They were really confused. (Educator 4)

E4 added:

> But if the experience that happens when the student is with the staff member shows a disconnect perhaps between the two kinds of caring that we’re talking about, the student

> may believe that now they're seeing what a real nurse does because this is someone who's paid to be a nurse as opposed to someone who's paid to be an instructor. They see it differently. They really try and compartmentalize us. And so they may think: 'Oh, this is the role model I should follow, and I should move away from what my instructor said because, really, real nurses don't have time to get to know people.' (Educator 4)

E10 explained it further:

> And sometimes they approach me. They tell me …'You keep telling us this, but this is what I've seen. And I was so upset. What do I do?' I tell them: 'If you believe something, hold onto it.' And I don't know…. When they come with those situations, I sometimes give them examples of students, how they dealt with it in the past. Like, I always explain it and give them an example of students I taught who were not communicating with the patient well, and they were making jokes, and the patient was not finding it amusing at all. And I told them, 'So what did you do?' He told me, 'I just didn't contribute to the laughter. I stayed straight-faced.' And he told me the patient appreciated that. So I tell them sometimes you don't have to do anything…. There's so much to it. There's pressure too, right? Because if the students try to differ from the nurses, they can be bullied, they can be picked upon. So it requires a strong personality. I think the personality also plays a role. (Educator 10)

Facing limitations

Acknowledging the limitations affecting the educators' ability to teach (e.g., having an undefined approach, lack of continuity over time with students, limited time during the day, large number of students) is one way to overcome the barriers to teaching both *caring for* and *caring about*.

Having an *undefined approach* of teaching is a main limitation for combining the teaching of the caring concepts. For example, E1said:

> So this is something I often struggle with sometimes because I feel like you go into the profession of nursing because you care about people, right? And for me, I don't really feel you can teach somebody how to care. I think you can facilitate it, but I think there has to be some… it has to be somewhat there, if that makes sense…. But the actual *caring about* a patient – I don't know really know how you teach that. I feel like that's like an innate thing where someone is a caring person or they're not a caring person… So it's, like, how do you teach someone to *care about* somebody when maybe they don't care? So it's, like, trying to teach me how to fix my car engine when I don't really care to learn. So maybe they just don't really want to *care about* their patients … whether it's because they don't want an emotional attachment or maybe they just don't want to be there. I don't know how you teach that to somebody. I don't know how you teach somebody to care [about] somebody. (Educator 1)

E3 stated:

> The other challenge – and this is the bigger challenge that I don't think I have a clear approach to – but you do have some students… I find most students honestly go with it. And maybe that's just because I'm with them. And if somebody else is with them, they would take the approach of that person. Because students are very smart and they pay attention to the expectation of their clinical instructor. (Educator 3)

E5 said:

> But we have to make it real for the students. It's, how do we make the theories that we're teaching, how do we make them real? That they're not just theory, [and] that we have to

> learn the theory? So we bring it in when we're talking about a family or a person who's experiencing this. Okay, so think about…. 'So what are the concepts of this theory that would apply here? What does it mean in this situation to be enabling, for example? Like, what does that mean? What does it mean? So show me. Tell me what you would say to this person.' And there's silence, but you can see that they're thinking about it. And then a brave soul will put their hand up and say, 'Well, when this is happening, is that this?' Yes, that's exactly what that is. So that kind of thing. But that's hard to do in a class of 180 students. (Educator 5)

E9 said:

> It's too much. So I think that we need to do it one way or the other. Either teach the very, very basics of nursing and teach the *caring about* at that same time, or not expect that of them if we're expecting them to do a whole bunch of skills…. So I think you can do it in the classroom and I think you can do it in the clinical setting. But I think we can't do it all at once. I think it needs to be layered and you need to decide in your program what way you're going to do that. You know, are you going to do it by teaching it early when they don't need to focus on other stuff? Are you going to understand that here I am in inter-session with a new group that I can't expect to see that at this point? You know? But yeah, in third year, I do want to start seeing it. And I really hope I see it in fourth year. So it needs to be there, it needs to be written and open, and taught. Because if it's not, then you're hoping that it gets taught somewhere, but you don't really know if it is or if it isn't. (Educator 9)

Lack of continuity is another limitation in combining teaching the caring concepts. For example, E4 said:

So, at the end of that very short clinical time, as you say, with an evaluation, share with the student that this really needs to be developed. And in this system that we have, I can tell the student to say that to their next instructor, but I can't say it to the next instructor that I had this student…. So that can be a barrier because I'm not sure that the student has the insight that it's really an issue or the student believes that I'm just a little bit excessive in my desire for students to really connect with patients. (Educator 4)

E2 said:

I think it would have to be modeled by most faculty in order for the student… I think there would automatically be students who wouldn't need for me to even bring it up. I think there's another group who, once they saw it modeled, would take it on. But I think there's another group that would need reinforcement continuously to actually take up those behaviours. And the only way that could happen (and still there wouldn't be 100% guarantee) would be, it would have to be very much integrated across. All faculty members would have to… wouldn't necessarily do it in the same way, but the students would recognize that this faculty as a group really embraces the importance of the nurse-patient relationship and the importance of the connection of a nurse with the patient and/or family. Because if [only] one faculty member does it, it's not sufficient. (Educator 2)

E5 said:

So there are some barriers to that. Because I may be a clinical instructor in the third-year group or I may have… I'm the course professor for the first-year group. I don't necessarily see those students in second year, third year, or fourth year. So for me to be able to see, I may have identified something in the first year. I don't know if they've made those changes because I don't have the continuity with the student. And I'm not sure how you could have

that, unless you standardize clinical groups and put instructors with them all the way through. (Educator 5)

E9 said:

> I think if it's not part of the hidden curriculum, but it's part of the open curriculum, it's a concept that you're not going to somehow…. Some students might get it, some students might not get it, depending on who they're with. I think if it's a concept within your curriculum, you see it, it's there, then you're going to teach about it. As opposed to they may get it depending on what instructor they had. I think not only do you teach it and model it in clinical, but you teach it and model it in the classroom. (Educator 9)

Having limited time and/or a large number of students is anther limitation in combining teaching caring concepts. For example, E6 explained: "Our time is so short in clinical… or, not so short…. We have to use it efficiently. But if I felt the students had that preparation, then I could work with them into the *caring for*, *caring about*" (Educator 6). E10 stated: "Well, I guess the number of hours in the course. You have to do so much stuff in a limited time. So you do have to focus sometimes on the *caring for* and give it the priority" (Educator 10). Furthermore, E11 stated:

> That one is a little harder to manage in some ways, I think. And I wouldn't say I've always done it successfully. Sometimes because you don't have time maybe to work with the student again or you've only seen them for a few…a set number of weeks. (Educator 11)

Also, E12 said:

> And it's a bit difficult for me because I'm on two floors. And so I'm running between two distinct floors so I can't always be in the places where I need to be. So I really use that post-conference to talk about those challenges. (Educator 12)

E4 said,

> So, there are other things…Time. To be fair to students, it's a very complex thing to learn, to integrate doing what's loosely called psychomotor skills that are part of the whole litany of nurses' duty to *care for* a condition, and add on the *caring for* and [*caring*] *about* a person. So I believe, I strongly believe in the value of faculty and staff nurses being with students to role model and to encourage making that connection. (Educator 4)

E5 said:

> But the sizes of the classes are barriers. You know, in the clinical area, trying to be everywhere at once with 8 students, you can't do that. Realistically that's… you know, there are days that you don't get… there are some students you don't see at all. And you hope that the nurse they're paired with is going to tell you. You know, you go and you seek them out, 'Did everything go well today?' (Educator 5)

Reflecting on the challenging situation

Reflecting on challenges is another property of the fourth concept in teaching caring as a multidimensional phenomenon. The participants described some reflections on the students' responses, which shows the level to which these educators understand the situation and have identified a way to deal with it.

E1 explained:

> And sometimes people just don't link, they don't connect. And so, you know, maybe they… you know, one week they didn't have a great connection with their patient, but then the following five weeks, their conversations flowed really well with their patients. I mean, I don't expect every nurse and patient to have a great relationship all the time, if you know what I mean… I don't know, sometimes you wonder, like, what do they have going on in

their personal lives? Maybe they have something going on that…. Yes, the student has going on. And it's, you know, following them into clinical. Or maybe the student just doesn't like what they're doing and they don't want to be there. And they're just, you know, going through that tick box and checking off, yeah, vitals are done, meds are done, you know. And they're just kind of going through the motions but don't really care and don't really want to be there, potentially. Those students are hard. (Educator 1)

E2 said:

I do think that there are students who come to nursing because they have a vision about 'I want to be' (for example) 'an emergency department nurse'. And their perception or their vision of that is that we don't get into relationships with these people. They arrive in some sort of emergency situation, and we dive in there and we patch them up and we make them better, and we move on to the next one. So I think there's people who seek that type of 'I'm not here for relationship building, I'm here to do these skills that I like to do', and that makes a difference for people. (Educator 2)

E3 said:

That is very tricky because I think this person actually did care a lot about doing the right things for people. So, you know, [he] worked really hard on assessments, worked hard on tasks, and could get that, but just for some reason had difficulty seeing the perspective of another person from a whole. Like, he didn't even see my perspective very often. You know, things like, for example, when he was late, he couldn't understand that I had a perspective about that. It was just his perspective. Like he just saw things in a particular way. So I think there's people who just sometimes have difficulty seeing outside their own perspective. And I also find sometimes that's paired with somebody who doesn't…. So if

you don't see another person's perspective, you often have difficulty taking feedback. (Educator 3)

E4 said:

> I think sometimes when we see people's emotional reactions, we internalize them a lot. So students in this area would… if someone seems impatient or upset, the student would automatically think: 'Oh, it's because I'm new and they don't trust me very much.' And it might be, but it's unlikely really, I find from my experience. It's more likely that the person is anxious about something, and the student is imagining that it's their fault because they are so centered on themselves, the students learning. And that's natural. So I think students have that as a bit of a barrier for themselves. They're so concerned about their own performance. And obviously, with the instructor there, that heightens the concern (Educator 4)

E9 said:

> I think when people are open to change, you can change. So perhaps if they see in themselves…. And I think with the introverted person that I was telling you about earlier, when they're aware of that (and they usually are), they can be open to that kind of a change. And just because you're introverted doesn't mean you're not caring about somebody. You can do that non-verbally. It doesn't have to be verbal. You can go in and bathe somebody and not say a word, but by the way you're caring for them, they can see that you care about them. And a quiet person might do that. (Educator 9)

The participants shared some reflections on their approaches to combine teaching both caring concepts. For example, E2 said:

We can set everything to a learning module. For example, if it's learning to read a cardiac monitor, we can package that and the person can go away. And they may not be an expert but they can develop a certain skill level with the reading and interpretation of that strip. And so if we can find a way to package establishing relationships and making connections with the people in our care, I believe that we're smart enough to do that. (Educator 2)

E4 said:

Yes. So you know, I had to kind of get over my embarrassment that this student had been so unprofessional, really, I guess, or just inadequate in helping the mom. Obviously, I went and talked to the mom, but that's another story for another day. So, I had to get past that and not be frustrated with the student. That doesn't get me anywhere, and try and see what we could do to correct gently some of the student's ability to show empathy. And so I don't think that that necessarily happened for me with this student…. What the question, then, I have to ask is: 'Are there some students who have a very low capacity for empathy, and will they become nurses who carry that through? And is it possible to graduate in nursing with a low capacity for empathy?' (Educator 4)

E7 said:

My main goal, my main, I guess, tool, is assessing the best way they learn. So the onus is on the faculty member, because if I have 80 students sitting there, they don't all learn the same. And I can't expect them to all learn the same. So I need to first of all understand how they learn and match what they need to learn with how they learn. (Educator 7)

E3 said:

You know, how do you communicate with somebody around…? I see this a lot because of where I work in maternity. Like, I think, many… people aren't always…. And it's funny,

because you'd think nursing students would be comfortable with emotion. But women who have babies cry a lot. So there's lots of crying. And so I find students have a lot of opportunities to be, like, 'Oh, I don't know how to ask you about how you're feeling because you're crying. And I don't really know what to do.' (Educator 3)

E11said:

So I try to be careful about not jumping to conclusions. And some of them are just really so much more reserved and it takes them a longer time, more practice situations before they feel confident enough in their knowledge to show that. So sometimes some students start there. They start with the 'I can get right in there, get involved', and then they learn the knowledge after. And some students learn the knowledge first, and then they learn…. So, it can be flipped around. But I always think they need more… you need to watch them over a long period of time, not make the conclusion too soon. And sometimes I find that I don't really get a sense of it until I sit down with them for their evaluation. And then we talk about their learning experience. And then sometimes I finally feel… Like I might have thought they weren't interested or weren't caring or weren't wanting to even do this type of work. But then when they come and they sit down and they talk about it, I get a better sense of where they're coming from. Because sometimes it just doesn't come out in their discussion or it doesn't come out in a group discussion or it doesn't even show on paper. But when I ask them a specific question and they answer me, then I can feel like, 'Oh, okay, so you were thinking about that'. But it sometimes takes that much before I see it. And some of them have other stuff going on in their life. So you might not see it but it might be for a reason that you didn't even imagine. It might be a perfectly good reason. (Educator 11)

E10 said:

> I think it's very important at this point in time because we seem to be… I don't know… we seem to be more engaged now in technology and trying to become mini doctors sometimes. Which is fine, you know. But we are forgetting the basic things which are important, just as important, just the caring aspect. And we have to be careful that, you know, the technology and the advances don't kind of create a power position and make us feel important at the cost of denigrating the patient's input. (Educator 10)

Handling challenges, reinforce and motivate,

Handling challenging situations is another property of the facing challenges concept, and involves two levels. The first is handling challenges at the superficial level by managing the situation to and solve the problem, and/or issuing instructions to make it easy for the student. The second is handling the challenges at a deeper level by facilitating a discussion with students to address the factors triggering their fears, and shifting the perspective to help the students accept the challenges instead of giving up, thereby making it a safe experience. Regarding the level of managing the situation, E1 explained:

> If things continued to kind of follow that same pattern, then there would have to be some sort of a follow-up plan, which I've done before with students. You know, where we sit down together and we come up with a clear plan as to what we can do for the student for them to be successful in clinical. (Educator 1)

E5 said:

> I haven't had a lot of those kinds of situations. But that's what I did with this student. I just said, 'You know, like, the next time, try another approach, try doing this.' And then give a

couple of examples of alternate ways to ask a question, to have a conversation, and then see what they do with that. (Educator 5)

E3 said:

Hopefully the student[s] will gain their feet and they'll start to do some things. So I try to make everybody kind of feel comfortable. And then if that didn't go well, then outside the room, I talk to that student and be, like, 'Okay, so here's what I saw'. Like, what went well or what didn't go well, and what I'd expect the next time. Like, I wouldn't do that in a room with a patient. So, I think it is just really about reading the situation. (Educator 3)

E14 said:

Sometimes I'll pull a student aside. So, student Y, I'll pull her aside, her or him, and say: 'You know, these are the things I've noticed. How do you feel about this?' etc., etc. And it's, like, they're mad at me for pointing this out. But I'm your instructor and I am here to help you. And so, sometimes I just… I find that students can get… can just get… well, mostly just very defensive, [saying] 'Well, that's not true,' or, 'I haven't had time,' or, 'My patient was going to x-ray.' You know, there's always… I find, like, they just get very defensive. (Educator 14)

E10 said:

So really, my comment when I finished the course [is], I tell the students: 'I've told you the best that I can how to care for persons, but really the ball is in your hands. Whether you do it or not is beyond me. I can just tell you what it should be. But basically it lies within your own moral convictions.' (Educator 10)

Handling the underlying challenges in such a way that it helps students to shift their perspective of providing care to include *both* caring concepts is the goal of multidimensional caring. For example, E1 noted:

> And sometimes I find with students, if you just put a different spin on things, then they're, like, 'Oh, I never thought of it like that before.' And they'll change their practice from then on out. I've had good results with kind of flipping the situation to a more personal situation for them. (Educator 1)

E7 said,

> I guess we don't really know. But past behaviour informs future behaviour. So if they have been willing to… if I see them taking that risk, I may or may not have an opportunity to see that, or feedback from the patient. And I guess I don't expect it to be an immediate change in behaviour. But it would be things like, you know: 'I tried that and it really felt much better to have a conversation with a patient that way.' So that kind of feedback from the student who's tried to internalize or integrate some of the things that we talked about, how we have those conversations. (Educator 7)

E4 said:

> So there's a different kind of feedback when I use those tools, if I see a minimal engagement or lack of engagement. So then it comes to the next step of the feedback. So, it's… And I don't necessarily mean, like, say on a reflection, you know, good job, bad job, sort of thing. It's actually, 'Have you thought about?' It's to keep the student thinking about where else they could go with this aspect of nursing. (Educator 4)

E5 said:

> I like to use the words: 'I wonder if'. [So] 'I wonder if you tried this, if there would be a different outcome. And I don't expect you to go back to your patient right now and have that conversation again. But I really would like you to think about when you have to talk to your patient tomorrow about approaching the conversation like this. And then let me know how it works out. Let me know if you have a different feeling about the interaction, if things were better for you.' Because it's as much about the patient feeling trust and that someone is concerned about them as it is about the student learning that it's okay to not do everything perfectly and to be able to say to someone, 'That must feel awful' or 'I can't imagine'. You know, those kinds of comments which help to establish that relationship. (Educator 5)

E11 said,

> I have thought, you know, you try to get them to sometimes read something appropriate that will help them to look at things in another way. So you try to get them… I try to look for different resources that they can read. I can't say that I get to follow up necessarily and see if they've done it or if it's helped them to think about it in a different way. It's always easier when they get it by just exposure than when you have to try multiple ways of helping them along. (Educator 11)

Reinforce and motivate involves continuing to strengthen students' understanding of the meaning of *caring* as a multidimensional concept and its link to the professional relationship. As E9 explained:

> They become the nurse that people want to have. They want that nurse that's going to come in and be genuine, that's going to care about you, that wants to know that you're

doing well, that maybe is going to push you a little bit more so that you can get better, that you are going to help yourself. (Educator 9)

E4 stated:

> So they kind of defend themselves by saying, you know, 'I want to stay in nursing, so if I show that if I care too much then how am I going to cope with that? I hear about nurses burning out all the time. So, you know, you're setting me up to be burned out.' Which is a challenge that I kind of like to take on because I think the research is showing more and more, it's not that we care too much that helps us burn out, it's that we want to care and we stop ourselves or we stop by something. So it's that frustration inside, that tension that contributes more to the burn-out than the actual fact that we connected and cared for people. That being said, obviously nurses need breaks and they need the time to debrief and they need support, and so on. But that's an interesting conversation with students. They're really surprised by that idea. Because they haven't been in practice and they can't imagine kind of what that tension is when you know how to care very fully for someone and you don't get to do it for whatever reason. (Educator 4)

E2 said:

> I think we certainly help students not to be too hard on themselves and that we make sure that they know that they are trying to combine all of this learning in the brief time that you have with your patient. And that we don't expect them to demonstrate everything they need to be in a short period of time, that they will need time to grow and reach a certain comfort level with how they are with their patients. (Educator 2)

E3 said:

Like, going in and getting to know somebody a little bit better, that's the part that should make you feel good because patients love it. They love having somebody, you know, wanting to spend some time with them. And you already have that skill. So I think it actually could help students to feel more confident. I think it helps them to feel more useful, because if they recognize that as something of value… they can bring that to the environment. Whether it's helping the nurses, whether it's helping the patients, whether it's making themselves look good to a clinical instructor, if it feels like it's a contribution, I think it actually can make students feel good about themselves and what they bring to the clinical setting. Because, you know, most students again, you feel like you're not contributing half the time because, you know, you're slower, you're not sure where things are. Like, it is work having students around. So I think if you emphasize that that's really important, that that's a really important part of nursing. (Educator 3)

E6 said:

To link it, to make those linkages between it, you can't just talk about it in class and expect it to happen. You have to role model it. And to me, for a clinical instructor, that's the whole… that's the reason we have clinical instructors, is my way of thinking, is that that patient that that student has is your patient, my patient. It's my patient, all… I have 8 students. I have 8 patients, or however many patients. So that I have to care about all of those 8 patients and know about them so that when we're with the student in a situation, I can help them make those linkages. (Educator 6)

E10 said:

I always tell my students, you know, *caring about* is not something… it's not a soft feminist skill, it's as essential as *caring for*. And it's caring because the person, no matter

if you give them the same skill, *caring about* makes a big difference to the hospital experience. And I tell them that nursing can be a very hard job, a very draining job. And if you want to survive it and if you want to feel energized, you do have to *care about* because in a selfish way, *caring about* others will give you a lot of personal satisfaction. (Educator 10)

E11 said:

> I've had students where they did such a good job of interacting with their clients, and they were very compassionate and appropriately involved. So reinforcing that when it does happen, and just saying how you can see that benefit, because they might not even notice it themselves because it's a new thing for them. Sometimes they're better than me, quite often. So then, you just sort of say, 'Wow, I'm really....' Just openly admire what they've done when they've done something admirable. I think that helps. Sometimes you say to them: 'Don't ever lose that!' (Educator 11)

E12 said:

> There's a sense of pride in being engaged with someone who you've got this… you're developing this relationship with, I guess, this therapeutic relationship, you know. And it's not talking over the top of them or going in and just doing. It's involving that person. And so I think they've come out with just, I think, a sense of pride in knowing that it was done in a caring way. (Educator12)

E14 said:

> I wouldn't give up with a student like this. I wanted to see a chance. And we hear a lot about… I like your comment about students coming in thinking about skills. We do hear a lot about that in nursing. But over the years, I have to say there are many, many students

who get it when it comes to needing to really communicate with people in an empathetic way and a way that shows understanding of the person. There are a number of students who want to be that kind of nurse. That's why they came into nursing. And there are others who certainly need to be taught that. (Educator 14)

Facing and dealing with challenges that develop throughout the teaching process or at the evaluation phase is the fourth concept of the teaching caring as a multidimensional phenomenon. This concept includes cognitive activity that involves *recognizing* challenges within a particular situation, and also finding ways to *adjust* the teaching approach to this situation. This concept includes five properties: recognizing resistance and struggles; facing limitations; reflecting on the students' responses and the teaching approaches; dealing with the challenges; and reinforcement and motivation.

Teaching Caring: Illustrations

From the participants' narratives, there is a clear process of teaching caring as a multidimensional phenomenon. Teaching *caring about* attitudes while teaching *caring for* skills involve four concepts which emerged from the data in this study. However, the participants' stories showed that the used different amounts of the teaching caring concepts and their properties (Figure 14). From the participants' stories there were different amounts of attention given to each concept based on the learning situation.

The following four illustrations were selected to reflect the different teaching amount of the teaching component, which will be discussed in the next chapter. These stories are told by 4 different educators regarding different situations, and different contexts.

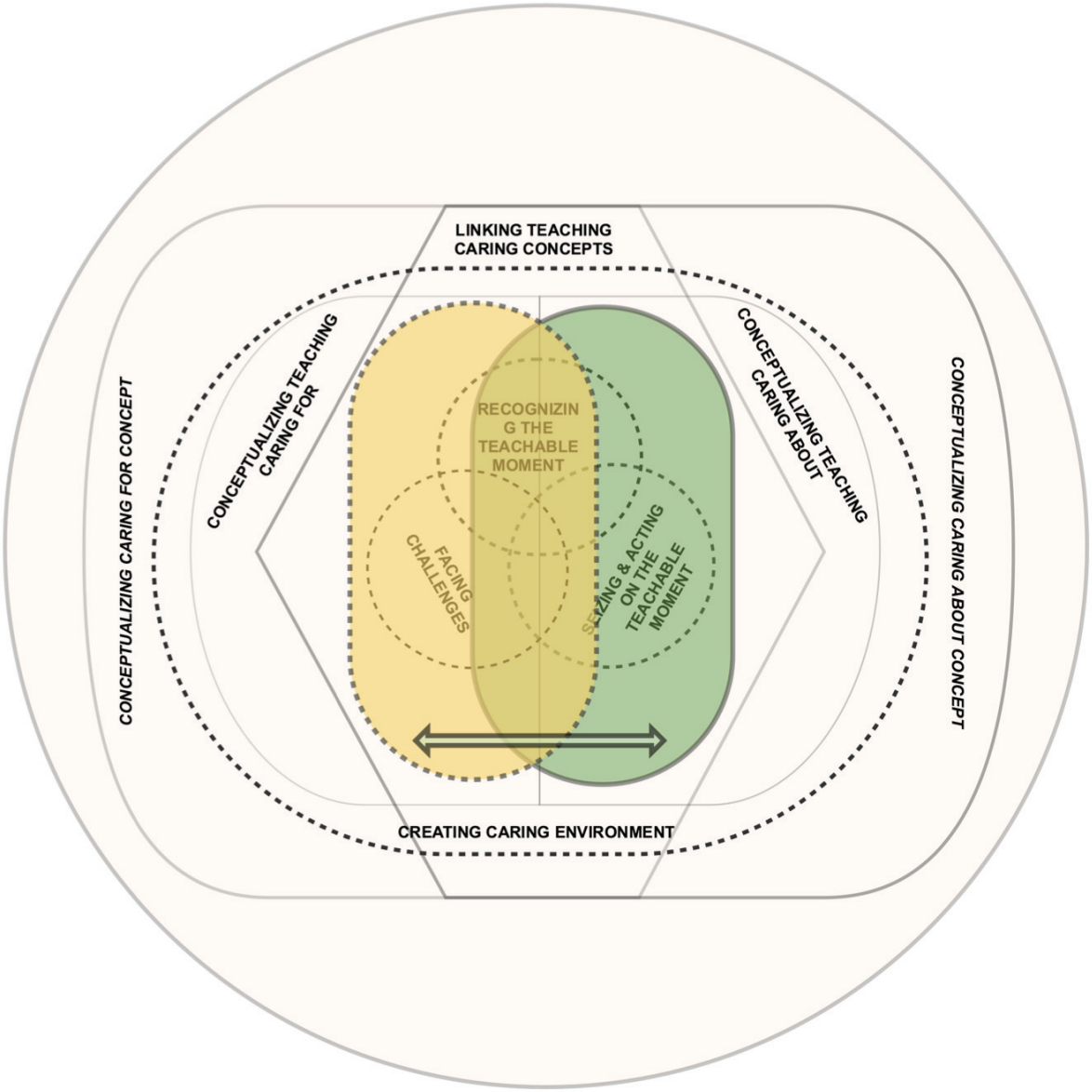

Figure 11: Teaching Engagement *Continuum*. This figure illustrates the different amounts of each concept employed by educators in the teaching process within different learning situations (Almater, 2016).

Illustration .1: Facilitating a shift in the student's perception/ Student struggles

"You just need to show her that you care"

I have a story of a student who she came up to me, she was looking after a person who…now, he had been struggling and having difficulty breathing. And now it's the end and we know he's going to die. And she's doing all she can to care about him and care for him. But at the point, the daughter comes in. And she comes out and she says, "I don't know what to do. I don't know what to do for this daughter." And I said, "You know, you just need to show her that you care." And she went in to her and she said… I said, "You know what, just go tell her I'm here for you. How are you?" And she did. And she came out and she said, "That lady bawled when I said to her - How are you?" And she said, "We connected. I made her tea. I kept going in and checking on her – Is there anything I can get for you? I sat with her." That gentleman died that night. And I came in the next day, and the student was there. She was standing there and I could tell. Like you know, she was looking upset. And I said, "How are you doing?" And she said… No, I said, "What's going on?" She said, "He died." And I said, "Ah." And I looked at her really sincerely because I knew that she really cared, and I said, "How are you doing?" And she bawled. And then I took her in the room. Yeah, she got it. And she said, "You know what, as soon as you said to me how are you doing, I knew exactly how that daughter felt.

Recognizing the teachable moment:

-Recognizing and linking student's need to the context

Seizing and acting on the teachable moment:

- Facilitating

Facing and dealing with challenges:

- Shifting the perspective

- Reinforcing

Illustration .2: Managing the situation/ Internal contextual challenges

Presentation of Self

I had a student a couple of years back, a young man, who was a lovely student nurse. And I had him in [Course]. And in class, he asked really intelligent questions. And I was lucky enough to have him come to my clinical the following spring. And he had on his neck a huge tattoo right here. And it was an open-faced… It was a screaming face with the tongue hanging out. And it was to me kind of shocking. And it was his… You know, he loved it. So he was coming to clinical with me. And I said to him, "I know you like it. It's not my favorite. But more so than that, it's… I can see that it would be off-putting, maybe even offensive to some of the residents, the seniors that we're caring for because they don't know you." And so he was a little…not particularly pleased that somehow or other, this had to be hidden, and we had to negotiate how that was going to work. And finally I said to him, "You know, at some point you have to realize it's not about you. You know, this caring is not… You can be the most caring person but that person who you are looking after, they come from a different space. So we have to go to them first. And what is your presence with this going to mean to them down the way if you are caring for them for a while and they get to know who you are, and you can explain this? But when you walk in straight away, you recognize it comes from their place, not from your place. There was a little bit of resistance. And it's too bad. There were different messages given to him. But my message was I'm the one that's taking you to clinical so I get to decide what is appropriate and what is not. So they were… You know, we did negotiate what was going to happen to have this covered up. And so we did figure that out together. And he came back and was "very compliant with it during his time with me during clinical.

Recognizing The Teachable Moment:

-Recognizing superficial cues.

- Reflecting on the student's experience and the context.

Seizing and Acting on the Teachable Moment

- Engaging personal and professional experience.

Facing Challenges:

-Facing resistance (lack of understanding the patient perspective).

-Managing the situation.

Illustration. 3: Managing the situation /External contextual challenges

"What are you teaching your students?"

So there is this student who has… In one way, I know from practice with the student a little bit, the student has both high anxiety and a little bit of arrogance about knowledge. So it's an odd combination to begin with. Kind of an unusual student. And the student is assigned to a 40-something year old woman who's been trying to have a baby for many years. She's a professional. She's highly educated. She has a highly educated partner. She's finally pregnant. She gets a doula, she gets a midwife. She sets up for herself all the most caring people she can find around her. And she has a birth plan which doesn't work out. She has an emergency caesarean section. She has a baby who goes to the neonatal unit. And the baby is okay but still in the neonatal unit. So enter my student to do a morning assessment for this mother...So the conversation before I even enter the room is something like, "I'd like to debrief your birth with you." No gentleness in sort of getting into it. But she really wants to talk to this because this is quite traumatic. So she tells the student in the presence of her husband a lot of information about how upset she was and so on, and the baby is the NICU. And there's crying and so on. The student I think did listen. But says to the mother, "Well, it's time for you to be pleased that you have a baby who's getting healthy… No, the student reported this to me. Because the student then went on… And the mother was so shocked by it that she said to the student, "Thank you for your opinion," kind of. That's what I understand happened. I wasn't there. So the student comes out all joyful, reporting to me what a wonderful therapeutic intervention had happened. And I said, "You said what?" So I was not demonstrating caring about the student. I was certainly caring about the mother, and feeling quite responsible that I had allowed this very inexperienced person in the room with her when she clearly needed a different kind of listening. But the story goes on, that the student had…You know, because you've got 8 students on the unit, you don't see them immediately. By the time I encountered the student, the student had already charted this interaction on the notes. Again in glowing terms, praising self that the mother had been able to debrief and move on from this experience less than 24 hours later, right. I don't think you have… I think any gender could understand the inappropriateness of that. But anyway. So then one of the nurses comes to me and says, "What are you teaching your students?" This is clearly not caring about and caring for. It just wasn't. There wasn't any caring in that. Although in the student's mind, there was. I had a lot of difficulty controlling my reaction to this, that this is a really unthinking, uncaring thing to do. Matching that against the student's lack of understanding about what had happened in the interaction. And so we did talk about it. But the student could not get past the fact that I had criticized the student by saying, "You did what?" So very sensitive to criticism.

Recognizing the teachable moment

- Knowing the student' background & knowing the context.

Seizing and acting on the teachable moment:

-Evaluating/ getting feed back, assessing the student's written report.

Facing challenges:

-Facing limitation/ indefinite teaching approach.

Illustration .4: Managing the situation/ Student struggles

" Nothing I can do about that: Grain and bear it"

I did a clinical on ENT. And there was a student there and she was like, "I do not like it here. This is not for me." And it was obvious. It was very obvious that she didn't like it… She had a patient, and it was a very complex patient. And she was a fairly young patient. And it was really quite a sad story. And I kind of thought that the student would be a little more engaging with the patient, where she was younger and, you know, the student could kind of relate to her a little bit because of the age. And just like her care was poorly done. Many things were missed. Her care plans were really poorly done. And she really wasn't spending much time with her patient, which I kind of thought she would. And so I pulled her aside and I just said, you know, what's going on here? Like things don't seem to be going really well for you today. And that's when she totally opened up to me and said like, "I don't like ENT. I don't like this floor. This patient is too difficult. I don't understand." And yeah, she really just kind of… She actually came… She started crying actually. She was so upset about the whole thing…So her and I sat down and we had a discussion about it. And she said that… She said, "Well, first of all, I don't like this type of nursing." And I said, "Unfortunately there's nothing I can do about that. We have 6 weeks of clinical. So unfortunately you kind of have to grin and bear it. But at least you know for future that this isn't the type of nursing you want to do." I said in terms of the patient, you know, I said, "How come you're not being a little more interactive with the patient and spending more time with her?" And she… The patient was very… She was definitely depressed and going through some sad times. And so the student had just said, you know, she just didn't know what she could do to help the patient to make her feel better. So she just felt that by spending the least amount of time with the patient possible was better. That was her response. And then she said she did find the patient challenging. And you know, I just kind of assured her that I

Recognizing the Teachable Moment:

-Noticing superficial cues.

-Seeking clarification

Seizing and Acting on the Moment:

-Engaging professional and personal base knowledge.

Facing Challenges:

-Handling the superficial level challenges (managing situation).

Summary

It is clear that the process of teaching *caring* as a multidimensional phenomenon is a complex process. It includes a layered matrix of social-emotional interaction, cognitive activities, and actions linked to each other in different ways. This complex teaching process includes four main instructional concepts which can be delineated as follows: concept 1, conceptualizing the caring concept; concept 2, recognizing the teaching moment; concept 3, seizing and acting on the teachable moment; and concept 4, facing and dealing with challenges. These four concepts represent the nurse educators' experiences with teaching caring as a multidimensional phenomenon. How these concepts are employed in teaching caring differs from educator to educator, based on a number of factors. The next chapter will discuss the four elements of the overall framework of teaching caring as a multidimensional phenomenon and will also identify the key implications of the findings.

Chapter 5

Discussion and Implications

This study presents the nurse educators' perspectives of the process of teaching *caring about* while also teaching *caring for* to undergraduate nursing students. In this chapter, I will discuss the framework for teaching caring as a multidimensional phenomenon that emerged from the data. In this chapter, and identify key implications for theory, research, and nursing education.

Discussion

The framework, entitled "Teaching Caring as a Multidimensional Phenomenon", represents an integrated, multidimensional theoretical understanding of the overlapping impacts the participants' personal teaching experiences. This section will provide a brief overview of the framework and discuss the key findings of each concept embedded within.

Based on the findings of this study, nurse educators described their approach of teaching caring as a multidimensional phenomenon that includes a matrix of four overlapping concepts. These four concepts are linked to each other in a non-linear process that includes a continuous and integrated field of teaching activities involving two ended continuum – *Engaging* and *Connecting.* The four concepts included in the process of teaching caring as a multidimensional phenomenon involve: "conceptualizing the meaning of caring concepts", "recognizing the teachable moment", "seizing and acting on the teachable moment", and "facing and dealing with challenges".

Concept 1: Conceptualizing the Caring Concepts

Defining the meaning of caring concepts and the processes involved with teaching each caring concept are key findings in this study. Interestingly, participant; knowledge, experiences,

beliefs and specialities influenced their perspectives. Conceptualizing the meaning of caring concepts provided the contextual foundation for the process of teaching caring as a multidimensional concept and included six properties; "conceptualizing the meaning of *caring for"*, "conceptualizing the meaning of *caring about"*, "conceptualizing the teaching of *caring for"*, "conceptualizing of teaching *caring about"*, "linking teaching *caring for* and *caring about"*, *and "creating a caring environment"*.

Defining the concepts of *caring for* and *caring about* provided the foundation for describing how nurse educators teach the concepts as separate domains. Some nurse educators used the concept definitions provided on the consent form:

> C*aring for* includes the work responsibilities that focus on organization, routines, and guidelines regarding practice, as well as those involved in managing equipment and the environment. In contrast, *caring about* patients includes the moral obligation that focuses on genuineness, feelings, intuition, beliefs, insight and personal values. (Appendix.1)

However, they then added further information regarding the meaning of teaching both concepts, which provided a more comprehensive definition of both caring concepts.

The nurse educators' narratives around "conceptualizing the meaning of *caring for*" included solid descriptions of the nature of the concept involving psychomotor and cognitive activities. The *caring for* concept was defined by the participants in this study as physically doing things, providing direct care, enabling, and having knowledge and skills. Given these definitions of *caring for*, it is obvious that the nurse educators have a tangible understanding of the meaning of the *caring for* concept as physical skills built on a knowledge base. These skills are well-defined actions that are taught, observed, and evaluated. The various meanings of the *caring for* concept are derived from the participants' knowledge, experiences, and beliefs. Such

findings are not new, given that nursing interventions (skills) have long been well-defined and considered the core of nursing education and practice (Morse et al., 1990; Wilby, 2011; Duffy, 2009; Boykin & Schoenhofer, 2001).

Nursing care interventions include all actions, protocols, and techniques involved in daily nursing activities that are concrete visible and can be measured and evaluated (Duffy, 2009). Indeed, based on how participants linked the nursing interventions to "what we do as nurses" (Educator5, p. 95, line 24) and what "nurses are qualified" to provide (Educators 11, p.96 line 3) to provide, these perspectives limit the nursing profession simply to knowledge and psychomotor activities. There are many reasons why this perspective is dominant, given that the nature of the *caring for* concept is a visible approach that can be clearly taught and concretely evaluated, and therefore, is the concept on which schools of nursing place major concentration. In addition, the nurses working in most clinical settings are likewise evaluated based on their performance of physical skills.

Participants' perceptions of the meaning of *caring for* in large part also reflected how they teach the concept. Teaching *caring for* was defined by participants as teaching specific physical tasks and actions and assessing related health care knowledge. Specifically, it involves the transmission of knowledge and the development of intellectual skills such as problem-solving, decision-making and critical thinking (Reilly & Oermann, 1992). It also involves physical skills; that is, teaching physical movement, coordination, and the use of motor-skill areas (Harrow, 19720) including imitation, manipulation, precision, articulation, and neutralization (Dave, 1975).

In contrast to their clearly defined descriptions of *caring for*, the nurse educators' narratives of "conceptualizing the meaning of *caring about*" included general descriptions of the

affective components aspect of nursing. The *caring about* concept was defined by participants as engaging in a compassionate relationship involving interactions that conveyed inherent respect for the person, learning about the person, knowing and understanding the person's experience and situation. In contrast with the *caring for* concept, the participants' descriptions of *caring about* did not identify a specific skill set, although all the definitions did reflect *affective* elements of nursing.

The nurse educators defined "conceptualizing teaching *caring about"* as teaching the intangible and more complex aspects of nursing, including at least one of the following elements: encouraging interaction and establishing a professional relationship between student and patient; encouraging students to use affective communication skills that address patients' emotional needs; helping students to truly *know* their patients and understand how they perceive their experiences; and encouraging students to take time to *listen to* and *be with* their patients – be emotionally present – and recognize them as human beings, not just as 'patients'. Clearly, teaching *caring about* involves two main elements: the affective social-emotional interaction (emotional intelligence), and valuing the person's experience. Based on the nurse educators' perspectives of teaching *caring about*, social-emotional interaction requires an ability to communicate effectively with the person and understand the person's feelings, perceptions, and needs. Valuing the person's experience requires listening to his or her concerns, taking actions based on those concerns, and then following up on them.

As described by the nurse educators, the student-patient professional relationship is built on expectations and responsibilities. According to the College of Registered Nurses in Nova Scotia: "The nurses form the professional relationships with their patients to understanding the patients' care needs [and] create an environment of caring that provides safe, competent,

compassionate and ethical care" (CRNNS, 2012). Furthermore, the various meanings of caring concepts in the nursing profession all point to *holistic caring* as being the significant key in the professional relationship.

Teaching *caring about* involves building skills in the *affective* domain, which focuses on attitudes and personal values. As described in Chapter 2, the affective domain is a complex learning field and requires a definite understanding of its nature. Skills involved in the affective domain learning skills are predominantly related to the social-emotional processes (emotional intelligence). This domain includes numerous learning components, such as *receiving*, which means being aware of the subject; *responding*, which means reacting to the subject; *valuing*, which means understanding and acting; *organizing* personal values, which means knowing and forming values; and *internalizing values system*, which means adopting related behaviour (Krathwohl, Bloom, & Masia, 1964). However, while some nurse educators commented on the challenges of teaching the affective domain (for example, knowing whether or not the student was actually engaged), their narratives show that their teaching approaches did indeed include several *caring about* qualities (Illustrations 1, 2, 3, and 4). The nurse educators' narratives about regarding reading and understanding the cues of the students' level of engagement in a learning situation link to the element of *receiving* and *responding.* In a learning situation, students engage in *receiving* the patients' attitudes, emotions and reactions, and they *respond* to them by with verbal or non-verbal communication. Teachers assist students to understand the situation, *value* the patient's experience, *organize their personal values*, and *internalize the new values*, which in turn assists in changing attitude.

In so doing, the nurse educators are using the same affective domain elements to teach students as they expect students to use in interaction with patients. in a teaching situation. Nurse

educators are receiving the students' verbal and non-verbal communication by recognizing and *responding* to these cues and signs, and by "observing and seeking clarification". The nurse educators *understand* and *reflect* based on these cues in away that reflected valuing the students' experiences.

Although participants defined *caring about* and *caring for* as separate concepts, they all emphasized that teaching professional caring – which includes the physical, cognitive, and affective domains of nursing care – must link both concepts. Participants linked the caring concepts in two ways: (a) integrating both caring concepts while teaching, or (b) teaching caring concepts as one *derived from* the other. Participants who believed that teaching *caring about* was as essential as teaching *caring for*, also believed that teaching both concepts together helped to establish a therapeutic relationship with the patient. In particular, they believed that *caring about* served as the foundation for building emotional connections and gaining permission to enter the patient's physical caring space in order to introduce the *caring for* skills. Participants who believed in teaching *caring for* before teaching *caring about* argued it was essential in order to ensure a level of competency with physical skills and as a way to establish credibility with the patient and gain permission to enter the patient's emotional space.

Given the data from this study, it is difficult to know which concept to teach first, *caring for* or *caring about* concept, because the main objective was to explore the teaching caring process while the nurse educators link them. However, participants did agree that teaching professional caring in nursing includes a full range of teaching *caring for* activities as well as teaching *caring about* qualities. Dalpezzp (2009) argues that there are three attributes of nursing care: the tasks and producers of nursing care, the nature of nursing care, and the functions of nursing care. Fawcett (20015) adds that the attributes are associated with nursing and include

process, relationships, caring, tending, responsive interpersonal, interactive, skilled, quality, ethical, healing, intervention, protections, prevention, and help.

The participants' narratives of the caring concepts included the importance of "creating a caring environment". As described in Chapter 2, several studies on nursing education in the literature emphasize the importance of building a caring relationship between educators and students *within a caring environment* to help students, in turn, develop a caring stance with patients (Oosterbroek, 2009; Dragich, 2001; Waterman, 2007). As a nurse educator explained: "So, if I care about my student, then I expect that my student is going to learn to care about that patient or group of patients" (Educator 11, p. 116, line 9). The nurse educators in this study believed that *caring about* was a translatable skill. Specifically, they believed that *caring about* students is a factor that inspires and motivates students to *care about* their patients. Participants assumed that students would understand the meaning of *caring about* if they experienced *caring about* through their own learning journey, as shown in the story in Illustration.1.

From the findings of this study, it is clear that three concepts involved in the framework of the process of teaching caring – "recognizing the teachable moment", "seizing and acting on the teachable moment", and "facing and dealing with challenges" – are built on the contextual understanding of *both* caring concepts. In addition, the teaching approach is based on how the nurse educators perceive and define the caring concepts.

To conclude this section, conceptualizing the meaning of caring concepts and the meaning of teaching both caring concepts provided the contextual foundation for the process of teaching caring. This concept has six main properties: defining the *caring for* concept, defining the *caring about* concept, describing the teaching *caring for* concept, describing the teaching *caring about* concept, describing the linking of teaching both concepts, and creating a caring

environment. Participants argued that it is essential for nurse educators to recognize and comprehend all of these properties in order to achieve the fundamental concept of the process of teaching caring as a multidimensional phenomenon.

Concept 2: Recognizing the Teachable Moment

The findings indicate that the second concept of the process of teaching caring as a multidimensional phenomenon is "recognizing the teachable moment". There are two general types of teachable moments. The first is "having a teachable moment" that is an unplanned opportunity that arises in the classroom or the clinic setting and is considered an ideal chance to offer insight to the students' abilities and learning needs. The second type is "creating a teachable moment*"* or situation by proactively designing it to engage the students in a learning situation as away of facilitate/ address learning needs. The nurse educators create these learning situations to be sure to introduce both *caring for* and *caring about* concepts to the students.

"Recognizing the teachable moment" is defined as the cognitive stage of the process of teaching caring as a multidimensional phenomenon. This concept includes various cognitive activities, such as recognizing, understanding, and reflecting on the students' level of engaging in a learning situation. In the data, it was clear that nurse educators identified and understood the cues regarding how well students were able to engage with a patient in specific caring situations. They deliberately set expectations for specific skill levels – *caring for* – and interaction levels – *caring about* – which they assessed and evaluated. This cognitive stage required different levels of attachment between nurse educators and the students on one level, and between student and t patient on another level.

In addition, this stage required the nurse educator to gain a contextual understanding of the teaching situation in order to facilitate the learning process. As described in Chapter 2,

attachment represents a level of emotional connection between two individuals based on the expectation that one or both members of the pair will provide care and protection in time of need (Kara, 2010). Within this concept of "recognizing the teachable moment", the attachment between a student and a patient at the beginning of their professional relationship would not be "secure" for either of them, but having a nurse educator who can recognize and understand the cues of being uncomfortable, fearful, and nervous will help to ease and improve the learning situation. Therefore, the level of attachment between the educator and student helps to reduce the uncomfortable thoughts about being judged and evaluated and builds *trust* for new learning situations. This could be linked to "creating a caring environment", which was introduced in the first concept of "conceptualizing the caring concept", thus establishing a level of attachment as an emotional connection that is an important element in creating a caring environment.

"Recognizing the teachable moment" is a complex cognitive stage initiated by "noticing the superficial cues and signs", and this property requires full attention to both the *caring about* and *caring for* learning pieces. The nurse educators identified obvious, tangible cues using various techniques, such as observing students while enacting caring, following student-patient interactions, asking students for their reflections about certain situations, listening to students' stories involving both *caring for* and *caring about*, and determining students' skills proficiency and affective engagement. In the findings, some educators described more obvious skill-related cues, while others described both skill-related and emotion-related ones.

As well, "the body language and the eye contact" of the students are essential indicators of the comfort level in engaging in a learning situation. It is recognized being "comfortable" differs from person to person, so knowing the students in their normal status without anxiety provides the baseline for assessing their body language and eye contact. However, nurse

educators noted that the students' problem was not their nervousness, but rather being unable to communicate and interact with patients. Educators' ability to read students' body language and eye contact requires the full attention to the students' physical responses as well as being with the student in the learning moment. One nurse educator described it as "their [students] physical presence in how they respond…. [Like] if they're kind of setback, formal, almost like resistant" (Educator 5, p. 120, line 16). Additionally, "the amount of eye contact that they make with the individual is another way to recognize the students' struggles. In addition, the degree and extent of eye contact may be affected by the culture of the student and / or the patient, so knowing the students' backgrounds could enhance understanding of this concern.

"Assessing the verbal communication" is another critical property in "recognizing superficial cues" by focusing on what and how the students interact and communicate with their patients and educators. According to the findings, knowing the level of student engagement is possible by assessing the nature of the questions that students asked their patients. The students' compassion and empathy towards the patients' experiences, is another way of measuring the level of the student engagement. The findings show that nurse educators emphasized that students' attitudes and judgment of patients' experiences, choices, and behaviors are crucial elements in understanding a person's perspective. In their assessments of students, nurse educators considered students' verbal empathy while talking about their patients' experiences or while reporting their patients' reactions or choices toward specific interventions or therapeutic decisions. Furthermore, as the nurse educators focus on student-patient interaction, they attend to the students' interaction avoidance behaviors or their ignoring of patients or their families while applying nursing tasks. This indicator of disengagement could again be linked to the ability to

establish an attachment with the person and the understanding of the importance of the professional relationships.

The findings show that after noticing the superficial cues, nurse educators tend to "understand and accurately read *hidden* cues". They look for less obvious cues to build a deeper understanding of the student's behavior. To gain this understanding, nurse educators depend on knowing the students' background**.** They emphasized that knowing their students on both a professional and personal level is a good way to understand their behavior and responses in a learning situation. The professional level includes knowledge of the students' year of study and previous clinical experiences in similar or different situations or unit. The personal experiences include knowledge of where student's come from (e.g., international students, etc.) and their personal perspectives of a specific situation. The findings show that nurse educators try to *know* their students both before and throughout their clinical rotation. At the same time, however, they also noted that contextual constraints (time, number of students, being new to the unit, etc.) often affect the opportunities to get to know their students. In addition, pursuing clarification and searching for understanding of students cues through discussion with students questions may be necessary. The questions could include: *What is going on?* or *What do you feel?* These open-ended inquiries would give the students a chance to reflect on the specific learning situation, but again the scenario is affected by the level of student-educator attachment. In addition, findings show that the personality of the student plays a major role in the level of accepting or resisting feedback from their educators.

Participants noted that once they understand student superficial and underlying cues, nurse educators start "recognizing and linking the context to the students' needs" based on such elements as the student's knowledge, the nature of the situation, the course objectives, etc. Nurse

educators reported that the complexity of the patient's situation and the student level of knowledge and skills are all critical elements that affect the assessment or evaluation of the students' level of engagement in a learning situation. Indeed, as participants reported "reflecting on [an individual] student's experience and the context" of the learning situation are essential criteria for planning the next teaching action steps. Reflecting on the student's experience includes present and past knowledge and experiences and anticipated future experiences, while the personal characteristics include personality, background, thinking style, "where they come from", their wellbeing, etc. Additionally, educators noted that they must also spend some time reflecting on the context of the learning situation to assess its complexity and factors affecting the student's learning process. Further, participants added that knowing about each student's experiences and personality type is critical for understanding their cues and responses. Once known, these responses then need to be reflected on in order to plan the instructional actions.

To conclude this section, "recognizing the teachable moment" is the second concept of the process of teaching caring as a multidimensional phenomenon. It is defined as the cognitive stage and includes various cognitive activities that relate to recognizing, understanding, and reflecting on the students' level of engaging in a learning situation. "Recognizing the teachable moment" is a complex concept that involves four main properties: "noticing the superficial cues and signs", "understanding and accurately reading the cues", "recognizing and linking the context to the students' needs", and "reflecting on the student's experience and the context". Overall, the concept of "recognizing the teachable moment" is essential for planning the teaching action stage.

Concept 3: Seizing and Acting on the Teachable Moment

The third concept of the process of teaching caring as a multidimensional phenomenon is "seizing and acting on the teachable moment". Defined as the action stage, this concept involves four teaching approaches: role modeling, facilitating, engaging personal and professional knowledge base, and evaluating. "Seizing and acting on the teachable moment" usually comes after *recognizing the teachable moment*, but as mentioned previously, in some cases educators described *creating a teachable moment* after assessing the student's learning needs by asking questions or by evaluating the student's performance. In other words, this action stage was at times *created* by educators to facilitate teaching *caring about* while teaching *caring for*.

The findings show that nurse educators value "role modeling" as the optimal teaching approach in both teaching, *caring for* (skills) and teaching *caring about* (social- emotional interaction involving the affective domain). It is demonstrating caring concepts for students to observe and reflect on. "Role modeling" is the main approach used by the nurse educators to model the appropriate communication, professional interaction, and performing psychomotor skills. Bandura (1977) describes social learning as a continually mutual interaction between a person and the environment. It is a process of learning by observing another – the role model – and is influenced by the relationship between a role model and learners as well as the learners' ability, the learners' motivation, and the relevance of what is modelled. In nursing education, the role-modeling process requires the full attention of the personal and contextual factors that affect the professional and humanistic development of the nursing students (Nouri et al., 2014). Although positive role modeling is key to teaching caring concepts based on the findings of this study, negative role modeling also has a crucial impact on the student learning experience. The nurse educators in this study reported that one of the main challenges in teaching was when their students observe, and learn from, a negative role model in their clinical rotations. This point will

be linked to the challenges of the fourth concept "facing, and handling, challenges", which will be discussed in the next section.

Positive role modeling of social-emotional interaction involving affective domain – *caring about* – while doing or performing nursing tasks of *caring for* is a very critical element to reflect and introduce the multidimensionality of the caring concept. "Facilitating" the learning experience by enabling the student to engage and learn is the second approach of the action concept. Guiding the students through the learning experience is one technique often used to help facilitate the teachable moment and there are numerous other instructional methods to enhance teaching caring as a multidimensional phenomenon. These include having *conversations* with students, *asking questions*, and having *debriefings* to build both of the caring concepts within students. The approach used on the interaction of the nurse educators and students, which includes having conversations that aim to understand the students' perspectives and provide the students with a chance to seek clarification.

Having a discussion with students and having them debrief both during and after a learning situation are instructional tools for nurse educators to introduce both caring concepts. "Facilitating" also provides the nurse educator with a tool to assess and recognize the students' learning needs, weaknesses, and strengths. Clearly that there is a link between using "facilitating" as an approach and teaching the second concept of teaching caring as a multidimensional phenomenon "recognizing the teachable moment", especially with regard to "understanding and accurately reading the cues". At this stage, the nurse educator seeks clarification to understand the students' needs. In other words, asking questions could help the educators clarify the students' understanding and help to introduce and facilitate the subject matter to the students.

The third approach of the action concept is "engaging a personal and professional knowledge base". This approach is defined as using one's knowledge base as a foundation to enhance teaching both caring concepts in the moment. The findings show that the nurse educators use their previous learning experience as a student along with their early experience as a nurse educator as a foundation for understanding/ anticipating how students might respond to specific learning situations. This engagement of professional and personal knowledge was particularly prevalent nurse educators' narratives on teaching the *caring about* concept and how to establish professional relationships with their students, and between students and their patients.

"Evaluation" is the fourth approach in the action concept. This approach is defined as assessing the strengths and limitations of students through their learning experiences and includes educators setting their expectations of students, getting feedback from the patients, assessing student assignments, and assessing student-patient interaction. The findings show that nurse educators used different approaches to evaluate students. While the nature of the psychomotor learning domain included very specific and visible indicators for assessing and evaluating *caring for* skills, evaluating methods of *caring about* concept depended on how nurse educators defined and ranked the importance of *caring about* elements. Specifically, nurse educators set and evaluated their expectations based on their own definitions of the *caring about* concept and their teaching approaches. They also used patient feedback, student reports, student-patient interactions and debriefings to evaluate the students' engagement level based on what they expected from the student. These expectations arose from the nurse educators' *personal* knowledge, experiences, and beliefs.

Clearly, the findings show that teaching *caring about* as an affective domain is complex, as described above, and depends on the nurse educators' personal creativity to stimulate the affective domain components including attitudes, beliefs, values, feelings and emotions (Billings & Halstead, 2009). Therefore, to teach the *caring about* concept *while* teaching *caring for* often requires teaching strategies that confirm and shift the students' perspective, attitudes, and beliefs of the *caring concept*. This shifting gives *both* caring concepts the same attention and introduces professional caring as a multidimensional concept that includes nursing interventions and professional therapeutic relationships as keys to providing holistic nursing care.

Concept 4. Facing and Dealing with Challenges

The findings show that the fourth concept of teaching caring as a multidimensional phenomenon is "facing and dealing with challenges". This concept appeared during the teaching process and/or during the evaluation phase and includes actions that both *recognize* challenges within a particular situation and find ways to adjust the teaching situation. "Facing and dealing with challenges" includes five properties; recognizing resistance and struggles, facing limitations, reflecting on the student's personality and teaching approach, handling different levels of challenges, and reinforcing and motivating.

The findings show that nurse educators described "recognizing learning resistance & struggles" as the main property to overcome the challenges in teaching caring as a multidimensional phenomenon. Identifying and understanding students' struggles and oppositional responses and barriers to learning both caring concepts are critical elements in planning teaching solutions to enhance the learning experience. Resistance to learning was an obvious challenge for most nurse educators in this study, and from their perspective, there are many reasons for it, such as the students' focus on learning the visible physical skills more than

the nurse-patient relationship and interaction, and their preference to learn what they believe to be more as 'nursing work'. Another reason for learning resistance was described by nurse educators as the students' lack of understanding of the patients' perspective. Lacking an understanding of others' perspectives is a huge challenge in providing professional caring and becomes a barrier to knowing the patient and to understanding the patient's perspectives and needs (Ahonen, 2013).

Nurse educators also described students' personalities as a reason for learning resistance and teaching limitations. The findings show that nurse educators are often unable to confirm whether students are internalizing the values of professional relationships while providing physical interventions. Indeed, nurse educators' narratives note their concerns that students may not be internalizing the values of nurse-patient interactions but might instead only be feigning compassion because of the presence of their nurse educators.

At the same time, nurse educators identified two types of struggles that may affect students' learning experiences and limit their level of engagement with their patients. The first is the students' lack of ability to interact, communicate, ask appropriate questions, and reflect and share their thoughts in the classroom or clinical setting. The second type of struggle concerns the influence of negative role models in the practice setting, and how these negative models impact the students' current perspectives and future attitudes of the caring concepts. This point got a good deal of attention from the nurse educators and they described ways they use to help reduce the effect of negative role modeling by debriefing and discussing personal attitudes versus professional values. Ahonen (2013) argues "discussing these observations in post-conference debriefings held with faculty and students immediately after clinical experiences provides important learning opportunities, whether perceived as positive or negative" (p. 3).

The findings show that "facing limitations" is another property in the fourth concept of "facing and dealing with challenges" when teaching caring as a multidimensional phenomenon. Teaching limitations affect educators' ability to teach caring concepts and are described by nurse educators mainly as *first* having an unclear approach to teaching the *caring about* concept, which then becomes a limitation to *combining caring about* and *caring for*. Nurse educators indicated that having little of no continuity with students (e.g., only working with a student for one session) to follow their learning development also is a limitation when trying to combine teaching caring concepts. Having little time and a large number of students is also a limitation.

At the same time, findings show that "reflecting on student's responses and/or the teaching approaches" provides a positive strategy for "facing and handling challenges". These reflections helped nurse educators understand the reasons for students' learning resistance and struggles as well as the teaching approach limitations. Understanding these challenges then gave nurse educators the tools to handle the challenges. The findings show that nurse educators addressed the challenging situations on two levels: (a) "handling *superficial level* challenges" by managing the situation, preventing distress, and making it easy for the students; and (b) "handling *underlying level* challenges" by engaging in discussions to address the factors triggering student fears, shifting the perspective to accept the challenges instead of giving up, and, in doing so, making it a secure experience. In addition, this approach involved "reinforcing & motivating". Through the teaching process, nurse educators engaged strategies to continue to strengthen the students and encourage them to understand the meaning of *caring* as a multidimensional phenomenon that includes *caring for* skills and *caring about* qualities.

Teaching Caring: A Continuous Process

The findings show that the process of teaching caring as a multidimensional phenomenon is integrated and continuous. The process involves all four previously delineated concepts of "conceptualizing caring concepts", "recognizing the teachable moment", "seizing and acting on the teachable moment", and "facing and dealing with the challenges". The process also includes a two-ended continuum comprised of different levels of connecting and engaging. *Connecting* refers to the nurse educator's actions taken to manage, rather than understand, the student's learning situation. In contrast, *engaging* refers to the nurse educator's actions taken to build students' understanding and to shift the students' perspectives about a learning situation (Figure 1). Nurse educators used each component to varying degree depending on the learning situation

Participants noted many types of factors affecting learning situations, including the nature of the situation, the students' reaction and responses to the situation, and the context. Illustrations 2 and 3 (Illustration 2, P173: Illustration 3, p.174) show some of the internal and external contextual challenges that affect the teaching approach. In Illustration 2, which involves internal contextual challenges, the nurse educator used authority to enforce personal/ professional values and beliefs to limit the patient's distress and gave less attention to shifting the students' perspectives. In contrast, in Illustration 3, which involves external contextual challenges, the nurse educator used authority to manage (connect) the situation to protect and limit the educator's distress, with less attention paid to the student's understanding.

Although there are external and internal contextual challenges in Illustrations 2 and 3, Illustrations 1 and 4 (Illustration 1, p.172; Illustration 4, p.175) reflect learning struggles and different teaching approaches. In Illustration 4, which involves a student-struggle, the nurse educator manages (connects) the situation without understanding the true nature of the student's struggles and therefore did not focus on shifting the student's perspective. However, in

Illustration 1, which involves a student struggle, the nurse educator understood the situation and facilitated the student's understanding (engaging) by using role modeling. Clearly, each educator's reaction in each illustration reflects a different level of understanding of the student's learning needs and the context of the situation and therefore different levels of connecting and engaging actions.

Teaching Caring Concepts and Critical Thinking

This hidden process of teaching caring as a multidimensional phenomenon includes the basic skills of *critical thinking*. Critical thinking is "the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action" (Paul & Elder, 2008). Critical thinking includes two components: first, a set of information- and belief- generating and processing skills; and second, the practice of using those skills to guide behavior based on intellectual commitment. This component is affected by how the information is gained and experienced, how skills are applied and repeated, and how satisfied the practitioners are with the knowledge and practice outcomes (Paul & Elder, 2008).

Each concept of the process of teaching caring as a multidimensional phenomenon symbolizes two or more of the critical thinking elements. First, "conceptualizing caring concepts" involves comprehension, analysis and synthesis of caring concepts. The nurse educators in this study defined each caring concept based on their previous, and current knowledge and experiences (comprehension). These definitions of the caring concepts then generated the nurse educators' approaches to teach *caring for* and *caring about*. Although nurse educators identified *caring for* as a concrete and tangible concept that they could teach from their

tangible knowledge and experience (comprehension), they defined the *caring about* concept and the way of teaching it as being based mainly on their experiential knowledge. For them, *caring about* required a comprehensive understanding (comprehension) gained from their personal experience that included elements of interpreting, clarifying, and understanding the nature of both concepts (analysis) along with their beliefs (synthesis).

Second, the concept of "recognizing the teachable moment" involves comprehension, application, analysis and synthesis of the students' cues, signs and responses toward a learning situation. The findings illustrate that "recognizing" is a cognitive stage in which nurse educators use cognitive activities to observe (application), recognize and understand (comprehension) very specific visible cues of non-visible learning struggles. The nurse educators then analyze (analysis) these cues and link (synthesis) them to the students' learning needs.

Third, the "seizing and acting on the teachable moment" concept involves comprehension, application, and evaluation. The findings show that in this "action stage", the nurse educators plan instructional approaches based on what they have concluded from the "cognitive stage" (comprehension). The nurse educators then apply one or more of the teaching approaches, role modeling and/or facilitation (application). They also include evaluation as a tool of assessment both throughout and following the learning process (evaluation).

Fourth, the "facing the challenges" concept involves comprehension, application, analysis, and synthesis. The findings show that nurse educators, at this point, were involved in both cognitive and action stages. This included recognizing and analyzing the students' struggles and resistance (comprehension and analysis) and recognizing limitations of the teaching approaches (application and evaluation). Furthermore, it involved handling these challenges by

acting on the learning situation based on analyzing and understanding the students' needs (analysis and synthesis).

Teaching Caring Concepts and Emotional Intelligence

As described in Chapter 2, teaching nursing caring requires emotional intelligence. Nursing students' learning experiences may be improved by integrating emotional intelligence skills into their clinical practice, as this may help them to cope with the emotional demands of the health care environment (Beauvais et al., 2011). In this study, the findings show that the process of teaching caring as a multidimensional phenomenon concept involves emotional intelligence skills. Goleman (1995) identifies four categories of skills within emotional intelligence: *self-awareness*, which includes accurate self-assessment and self-confidence; *social awareness*, which includes empathy, organizational awareness and service; *self-management*, which includes self-control, transparency, adaptability, achievement, initiative and optimism; and *relations' management*, which includes inspiration, influence, developing other, change catalyst, conflict management, teamwork and collaboration.

In the process of teaching caring as a multidimensional phenomenon, the nurse educators described how they focus on knowing the students' background and reflect on their personalities and experiences as a baseline to set their expectations and achieve their learning needs. Through these baselines, the students start to understand their positions as learners and develop *self-awareness* skills about their abilities, skills, attitudes, feelings and values. Also, the findings show that the nurse educators described how they encourage the students to interact with their patients while providing physical caring. These interactions include knowing the person, knowing how the person perceives his experience (empathy), and having a contextual understanding of the situation. Here, the students are learning *social awareness* skills.

In addition, the findings show that nurse educators used each learning experience to shift the students' perspectives to assist them to internalize new values about the caring concepts and understand and control their own feelings and values, which involves *self-management* skills. Lastly, nurse educators described that they encouraged, facilitated, and role modelled professional relationships to their students to truly be with/ know and engage with patients to help meet their needs. This involved *relations management*. Although nurse educators did not describe these skills as 'emotional intelligence skills', the data reflected specific elements in their teaching approaches regarding they were involved in teaching caring concepts and specifically in teaching the *caring about* concept. Clearly, emotional intelligence skills were viewed as essential elements in teaching caring as a multidimensional phenomenon.

Similarly, the teaching relationship between the nurse educators and students also involves emotional intelligence skills. While the findings contain little data about the *self-awareness* of educators because, in this study, the researcher avoided any questions that might have led to a personal evaluation, nevertheless, many narratives self- described their abilities, limitations and compassions while teaching caring concepts. Also, at the *social awareness* level, the findings reflect situations in which nurse educators described empathy toward their students, understanding their students' weaknesses and limitations, and being mindful of their professional responsibilities. Regarding *self-management*, the findings also reflect that nurse educators had awareness and control of their limitations and abilities in facing and handling personal challenges and conflicts. Finally, in *relations' management*, nurse educators described in their narratives their efforts to influence their students' learning experiences, help to develop their students, manage any conflicts, and work with the students to handle the challenges. As described in Chapter 2, educators' emotional intelligence may directly or indirectly influence

how they foster emotional intelligence in nursing students (Allen et al., 2012). Also, Jenkins (2006) states that the faculty's ability to perceive, understand and facilitate emotions through their interaction with students may positively influence the learning environment as well as the students' learning process.

Teaching the *Caring About* Concept as a Hidden Curriculum

Based on the findings, it is clear that there is a definitive process of teaching *caring about* while teaching *caring for*. This process of teaching caring has a well- articulated, formalized approach that includes teaching knowledge and skills, which is defined as teaching *caring for*, and a more intangible, affective approach that includes emotional-social interaction, involving emotional intelligence, defined here as teaching *caring about*. This informal teaching of the *caring about* concept is considered a hidden curriculum that reflects the nurse educators' values, beliefs and perspectives to the students through their teaching journey.

The hidden curriculum is defined as "the unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school…. The hidden curriculum consists of the unspoken or implicit academic, social, and cultural messages that are communicated to students while they are in school" (The glossary of education reforms, 2014). In teaching the *caring about* concept, there were obvious diversities in the participants' teaching approaches. These diversities come from the lack of specificity and intangibility of the components of the effective domain involved in teaching the *caring about* concept, and from having no defined instructional method to direct their teaching.

There are four reasons behind identifying teaching the *caring about* concept as a hidden curriculum. First, although *caring about* is defined theoretically in the nursing literature as a moral imperative (Morse et al., 1990), moral obligation (Gout, 1983), and 'being with' a and '

knowing' (Swanson, 1990), there are no tangible/ concrete instructions of how to teach it. In the findings, the nurse educators indicated that there are no specific identified approaches that they can adopt to teach the *caring about* concept. Second, the *caring for* concept is dominant in comparison to the *caring about* concept because it is visible and tangible. Clearly, there was a challenge to overcome the influence of this domination and articulate the *caring about*. Third, although there is a general agreement on the importance of teaching *caring about* and *caring for* to students, differences were noted in *how* to teach the concepts theoretically and practically. Participants perceived the two caring concepts from their personal and professional experiences, and thus teaching it based on how they personally, learned it, valued it

The fourth reason why teaching the concept of *caring about* is a hidden curriculum is the caring culture's impact on the clinical environment. We can call this providing care as one has been socialized. Socialization is a term used to define the effect of group culture on a new person who is joining the group, defined as "processes by which people acquire the values, attitudes, interest, skills and knowledge – in short the culture – current in groups of which they are, or seek to become, a member" (Merton et al., 1957 p. 28). This socialization process deeply affects students' learning processes in clinical settings. Hafferty and Franks (1994) emphasized that students are learning and internalizing what the new culture value, and learn the strategies and the techniques to organize these values. The findings show that nurse educators try to limit the impact of the negative role modeling that focuses solely on the *caring for* concept while sidelining *caring about*. Consequently, what the students learn from their educators might be dismissed when observing and imitating what the clinical setting culture offers them.

Implications

This section will highlight the main implications from this study related to theory, research, and

nursing education.

Implications for Theory

Theoretically, most of the nursing theories are focused on the knowledge and skills of the caring concepts (cognitive and psychomotor domains). While a limited few nursing theories do focus on the social-emotional component of the caring concept (e.g., the Watson theory and the Swanson Model of Caring), there is a limited emphasis on the teaching aspect. This limitation appeared in particular in teaching the affective part (the social-emotional element) of caring, so nursing education mainly relies on frameworks built on the cognitive and the psychomotor aspects of caring.

When Morse et al. (1991) examined the caring concept in-depth, they recommended that the caring concept needs further development if it is to be applicable to the art and science of nursing. Also, Swanson and Wojnar (2004) emphasized that finding the time for healing spaces is a challenge in the healthcare system because it is basically built on the biomedical model, social-political values, personal accountability, and cost containment. This study's findings support the critique of the dominance of cognitive and psychomotor frameworks of caring in nursing theory, education and practice, which give more attention to teach and practice nursing knowledge and skills and less attention to the social-emotional element. In this study, however, the framework provided an integrated, multidimensional theoretical understanding of the overlapping impacts of personal perspectives, personal experiences, professional interaction, and the social context of teaching caring concepts in the nursing profession.

This study supports the idea that we need more comprehensive theoretical frameworks to better understand the complex nature of the caring concept in the nursing profession specifically as well as in the healthcare professions generally. In particular, it points to expanding the theoretical

lens to include how nurse educators perceive the caring concepts and their teaching of both concepts, and how they conceptualize these perspectives. The study findings demonstrate that teaching caring as a multidimensional phenomenon is a non-linear process that includes formal and informal teaching approaches built on the educators' knowledge, experiences, and beliefs. Throughout this process, they were using critical thinking skills as instructional engagement and emotional intelligence as human interaction. Utilizing these two well-known frameworks in the process of teaching caring concepts may be useful for fostering a deeper understanding of how to overcome the challenges of teaching the affective domain of caring.

Implications for Future Research

Further experimental research is needed to test the process of teaching caring as a multidimensional phenomenon in order to understand the process in-depth and to explore the practical side of the teaching process. In addition, experiments will help to identify the factors influencing the teaching engagement continuum. Given the complexity of the teaching process of teaching *caring about* while teaching *caring for*, there are many factors that could affect this addition to the curriculum, including internal or external contextual challenges or the educators' values and beliefs around the learning situation. Investigating these factors will provide a theoretical model that could be linked with this study's finding to enhance the process of teaching caring concepts and overcome the challenges.

Further research is needed to examine the framework of teaching caring as a multidimensional phenomenon of the students' learning process and from the students' perspectives. This study's findings point to creating a caring environment and understanding each student's background and personality as elements of the concepts of the teaching process. Therefore, examining the nurse students' perceptions will add more theoretical dimensions that

include the learners' perceptions and beliefs.

Implications for nursing education

The study's findings also point to implications for additional practice-based research. Given that teaching caring concepts in this study are a complex process of cognitive, action and attitudes stages in the nurse educators' daily teaching experience, this process could be used as a guideline to enhance nursing education. According to Dee Fink (2013), the interactive nature of significant learning includes foundational knowledge, application, integration, human dimensions, caring, and 'learning how to learn'. This learning taxonomy provides clear components for the learning process.

At the same time, the framework of the process of teaching caring as a multidimensional phenomenon provides clear components of teaching the nature of caring concepts as a complex learning matter. Using the process of teaching caring as a multidimensional phenomenon will provide nurse educators with a language that articulates the social-emotional aspects of caring as well as the knowledge and skills aspects. Furthermore, it provides nurse educators with well-identified stages of understanding, analyzing, reflecting, acting and evaluating the affective domain as well as the cognitive and psychomotor domains. The findings suggest that nurse educators could teach *caring about* while teaching *caring for* as two components within one teaching process that includes critical thinking and emotional intelligence. Thus, the process of teaching caring concepts provides nurse educators with a theoretical framework that explicates the complexity of the cognitive, psychomotor and affective learning domains and helps to give attention to each domain based on its nature.

Conclusion

This study represents the nurse educators' perspectives of teaching *caring about* while teaching *caring for* to undergraduate nursing students and provides a unique insight into the process of teaching caring as a multidimensional phenomenon. In fact, the process of teaching caring emerged from the participants'' data as a group, despite some individual participants stating that they were unable to identify what their teaching process involved. They used their knowledge, experiences and beliefs to develop an approach to teaching holistic caring and handle the challenges on a continuum ranging from *connecting* to *engaging*.

The examples set by nurse educators remind us that teaching the caring concepts, as a multidimensional phenomenon requires giving full attention to the cognitive, psychomotor and affective domains. Now that the framework has been articulated, it is important that it be tested to determine whether it is effective in improving the *teaching* and *learning* aspects of caring as a multidimensional phenomenon. In addition, it is also important that this framework of teaching caring as a multidimensional phenomenon be tasted to determine whether it affects the teacher, student, and patient outcomes. Such research would play a critical role for ensuring; first the patients feel cared for and cared about (essential indictors of patient satisfaction). Evidence shows that patient outcomes are affected by caring -physical caring- and by their relationship and connectedness with nurses -emotional and social caring (Larrabee et al., 2004). Second, such an approach would help nurses feel satisfied and competent and less emotional burnout. Indeed, CNA (2003) stated that when nurses are prevented from practicing in a truly caring way, they often experience ethical distress. Lastly, evidence shows that nurse- patient interaction is critical in many ways, as it influences future decisions to access healthcare and patient adherence to treatment. Such actions further improve health outcomes and reduce the cost of services (Palese et al., 2011).

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APPENDIX. 1

CONSENT FORM

Study Title: The Process of Teaching Caring as a Multidimensional Phenomenon in Undergraduate Nursing Programs

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Introduction:

You are invited to take part in a research study being conducted by Latifah Almater who is a PhD student in the School of Nursing at Dalhousie University. Participation in the study is voluntary. Even if you participate, you may withdraw from the study at any time for any reason. This consent form includes information about what the study involves; your role; the benefits, risks or discomforts that you might experience.

If you have any questions or concerns (before, during, and after the interview) please contact the principal researcher.

Purpose and outline of the research study:

Nursing care involves caring for and caring about. *Caring for* includes the work responsibilities that focus on organization, routines, and guidelines regarding practice, as well as those involved in managing equipment and the environment. In contrast, *caring about* patients includes the moral obligation that focuses on genuineness, feelings, intuition, beliefs, insight and personal values.

The purpose of the study is to explore and understand undergraduate nurse educators' perspectives regarding the processes involved in teaching *caring about* while teaching *caring for* to nursing students, it also involves exploring the challenges and opportunities within faculty experiences.

This study is not designed to evaluate your teaching skills but rather to understand the process of how faculty teach caring as a multidimensional phenomenon from their perspective and experience.

This study uses a qualitative constructive grounded theory approach to explore the experiences and perspectives of the participants to gain an understanding. Participants in this study will be interviewed and asked to answer open- ended questions about their perspectives and experiences of teaching caring. All information will be coded and analyzed and then integrated into a theoretical framework that explains the phenomenon.

Who can take part in the research study?

You are invited to participate in this study if you are a faculty member (professors, associate professors, assistant professors, clinical instructors, and lecturers) in one of the three school of nursing in Nova Scotia (Dalhousie University, both Halifax and Yarmouth Campuses, Cape Breton University in Sydney, and St. Francis Xavier University in

Antigonish). Participants must be a registered nurse (RN), working either full/ part time and have taught in clinical and /or theoretical courses in an undergraduate nursing program for at least 3 years within any speciality. Participation also involves a willingness to be involved in an audio taped interview.

How many people are taking part in the study?

The number of the participants in this study is estimated to be between 25 – 30 nurse educators.

What you will be asked to do:

I will ask you to participate in a semi- structured interview to help me understand the process involved with teaching *caring about* while teaching *care for* a patient, and to explore the challenges and opportunities encountered through these teaching experiences. This study will focus on your perspective of best ways to teach *caring about* while teaching *caring for*. One question (question.9) will include a short video (3-5 minutes) involving a generic student –patient scenario. You will be asked to reflect on this situation from your perspective of best ways to teach. You are free to use the same approach as used to respond in previous questions or to add additional or clarifying information. All responses will assist in building a more complete understanding of your perspective. The face-to-face interview will be held in a private location within your university at a mutually agreeable time. The interview will take approximately 90 minutes. A second interview may be requested to clarify some points from your first interview, or to seek new information. The second interview will take approximately 30 minutes. Also, the second interview will be face-to-face interview and will be held in a private location within your university at a mutually agreeable time.

After developing an initial theatrical framework of the study the researcher will invite you to participate in a member check. The member check will include a review of the theoretical framework and the emergent concepts and then ask you whether they fit with your perspective. The theoretical framework document will be sent via email followed by a phone call at your convenience. This phone call will take approximately 30 minutes. If you wish to be involved in the member check you make option on the signature page.

Possible benefits, risks and discomforts

There are no direct benefits from the study. However, the study findings may help to articulate the process of teaching caring as a multidimensional phenomenon that include *caring about* and *caring for* in undergraduate nursing. Also, this study may lead to more research regarding this concept.

There is minimal risk involved with participation in this study. However, you may worry that this study may be used to evaluate your teaching performance. **Please be assured that this study will not evaluate your teaching performance**. Instead, it is designed to gain an understanding of your perspective regarding what you think are the best ways to teach *caring about* while teaching *caring for*. However, your interview and any information that you share with the researcher will be confidential. Also, no individual results will be shared with the respective Director of School of Nursing or other anyone else. I recognize that, you may worry that in- depth interviews may expose your inner self. While unlikely, in the case that you reveal some negative or unpleasant feelings that relate to your teaching experiences, full confidentially will be maintained. Your experience will be acknowledged. For further information of related teaching resources you can contact;

Dalhousie University Centre for Learning and Teaching

Killam Library, Suite G90

Halifax, Nova Scotia B3H 4R2

(902) 494-1622

Fax: (902) 494-3767

Cape Breton University Centre for Teaching and Learning

Office: TC 115

Phone: (902) 563-1459

Email: eileen_piovesan@cbu.ca

Teaching and Faculty Development at St Francis Xavier University

Oland Centre 142B

Phone: (902) 867-2185

Fax: (902) 867-3904

Email Us: mdunbar@stfx.ca

What you will receive for taking part:

In this study no compensation will be provided.

How your information will be protected:

Information that you share will be kept private, and only the researcher, her dissertation committee, and a specialist transcriber will have access to this information. The research team has an obligation to keep all research information private. The principal investigator and her supervisor will be the only people who have access to any records and documents that include any names and places, or any information that may lead to the identification of participants. Following the interview the audio recordings will be transcribed by a specialist transcribe who has signed an agreement of confidentiality. All

the audio recordings and the transcripts will be saved on password-protected computer files. During the data analysis stage, the dissertation team will work only with anonymized transcripts.

All the consent forms will be stored in a locked filling cabinet in a file separate from any transcripts. Each interview in this study will be audio recorded and transcribed anonymously (no names, places and events) and all audio recordings will be deleted following transcription. Participant numbers or codes (no names) will be used in all written and computerized records. Hence, no records and transcripts involving you will contain names or identifiers. All your identifying information will be kept in a separate file, in a secure place. All electronic records will be kept secure in password-protected coded files on the researcher's personal computer. All the interviews and all the information that will be shared with the researcher will be confidential and no individual findings or information will be shared with the respective Director of School of Nursing or with anyone else. Only anonymized study findings will be shared in the thesis defence, reports, presentations, and publications. Only group findings will be reported so that no one will be identified. This means that you will not be identified in any way in any reports.

The principal investigator will take all the responsibility for the participant's confidentiality. The only limits of this confidentiality include the researcher legal obligation to disclose suspected child abuse or neglect, or the abuse or neglect of an adult in need of protection. In such cases, the principal investigator will report the case to the thesis supervisor and then to the Dalhousie University Research Ethics Board.

If you decide to stop participating:

You are able to withdraw from the study any time and for any reason with no consequence to you. However, after the interview and because the analysis process started through the interview, it will be impossible to extract your information given up to that point if you withdraw from the study.

How to obtain findings:

The principal investigator will provide you with a short report of aggregate study findings when the study is completed. No individual participant or school findings will be provided. If you wish a copy of this report you can provide your contact information at the end of the signature page.

Questions

I would be pleased to talk with you about any questions or concerns you may have about the study and / or your participation in this research. If you have any concerns about your participation in this research, you may also contact the Director, Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca

Principal Investigator:

Latifah Almater, RN, PhD(c)
School of Nursing
Faculty of Health Profession
Dalhousie University
Halifax, NS B3N 0A6
Email:latifah.almater@dal.ca
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Signature Page

Project Title: The Process of Teaching Caring as a Multidimensional Phenomenon in Undergraduate Nursing Programs

Lead Researcher: Latifah Almater, PhD candidate, School of Nursing,
Faculty of Health Professions, Dalhousie University,
Halifax, NS B3N 0A6
Email: latifah.almater@dal.ca
Phone: (902) 497-1131

I, ----------have read the description of this study. I have been given the opportunity to discuss it and my questions have been answered. I understand that my participation is voluntary and that I am free to withdraw from the study at any time.

I agree to take part in this study recognizing that my interview will be audio recorded

Yes No

I give my permission to be contacted for a second interview if needed.

Yes No

I give my permission to be contacted for a member check conservation.

Yes No

I give my permission to use anonymous direct quotations in the final report, presentation or publications.

Yes No

I would like to have a copy of a short report of the study findings

Yes No

Email ----------

Phone----------

Participant's signature ---------- Date ----------

Researcher's signature ---------- Date----------

APPENDIX. 2

Interview Guide

Initial Open –ended Questions

In the following interview I am going to ask you questions about the concepts of *caring for* and *caring about*.

From your teaching experience as a faculty member in an undergraduate nursing program;

1. When you hear these two concepts (*caring about* and *caring for)* tell me what they mean to you.

2. Tell me how you would teach *caring about* while teaching *caring for*. Could you explain in detail using an ideal situation when everything goes the way you want?

    2.1 By using the same situation above, how do you know when you are fully engaged in teaching *caring about* while teaching *caring for*? OR what "cues" or "indictors" do you experience on the spot that alert you of the need to teach *caring about* while teaching *caring for*?

Intermediate Questions

3. How would you know when a student is engaging in the learning process (caring *about* while *caring for* a patient)? Can you give an example?

4. How would you know when a student is not engaging in the learning process (caring *about* while *caring for* a patient)? Can you give an example?

5. How do you know when a student has internalized the link between *caring about* and *caring for*?

6. Tell me about some of the challenges that you have experienced when teaching *caring about* while teaching *caring for*.

    6.1 Tell me about a time when you experienced challenges?

    6.2 What helped you to overcome these challenges?

7. What do you see as the benefits of teaching *caring about* while teaching *caring for*?

In terms of;

    7.1 Patient outcomes

    7.2 Student outcomes

7.3 Health care outcomes

7.4 Nursing profession outcomes

8. Tell me about some of the opportunities that could assist in teaching *caring about* while teaching *caring for, and how you could engage them*

The Simulation Video Question

9. By using this video scenario, are there anther things that come to your mind that would help me to better understand the approach you have been telling me about?

Concluding Question

10. Is there anything we have not talked about that you think it is impotent for me to know about?

APPENDIX. 3

The Student – Patient Scenario Video Description

The link of the Video

https://www.youtube.com/watch?v=htAUrbokIUQ&feature=youtu.be

Description

This link (above) includes the video of the student- patient situation that I will be using during the interview (see the interview guideline, question 9). This link is published in YouTube for education purposes under the account name *Tcthetank*. I used one portion of the original video (4 minuets), which is cut and uploaded on YouTube under my account name *Latifah AA*. The edited video is not publically available on YouTube. It is locked and only available to the individuals for whom I provided the access link.

Unfortunately, no contact information regarding the owners of the original video was available but I send a request of permission to use a portion of their video in my study as a private message via their YouTube account, but still I did not get any response.

According to the Coombe, Wershler & Zeilinger (2014) Canadian copyright law currently includes a fair dealing exception as well as specific exceptions for certain classes of works and certain users. In Section 29 of the Act provides that

> "Fair dealing for the purpose of research or private study does not infringe copyright. S.29.1 Fair dealing for the purpose of criticism or review does not infringe copyright if the following are mentioned: the source; and if given in the source, the name of the author, in the case of a work, performer, in the case of a performer's performance, maker, in the case of a sound recording, or broadcaster, in the case of a communication signal." (p. 243)

However, the original video is acknowledged and together with a link for access (This video has been trimmed from the original video on the following link: http://www.youtube.com/watch?v=V_J-sL...), and it will be sited in my study references.

This video provided a common/ generic situation for participants to consider when responding to question No. 9 (*By using this video scenario, are there anther things that come to your mind that would help me to better understand the approach you have been telling me about?).* The main objective for using this video based situation is to provide all participants opportunity to reflect on one specific situation regarding teaching *caring about* while teaching *caring for*. This video contains a generic scenario of a student carrying out a basic psychomotor task (measuring the Blood Pressure).

Reference

Coombe, R, Wershler, D. & Zeilinger, M. (2014). *Dynamic fair dealing: Creating Canadian culture online.* University of Toronto Press.

APPENDIX. 4

Member Check

Dear…

I very much appreciated your interview as part of my PhD study titled *The Process of Teaching Caring as a Multidimensional Phenomenon in Undergraduate Nursing Program.* Now that I have analyzed the data I would like to invite you to participate in the ***member check process.*** It asks you to reflect on the primary findings and model of teaching *caring for* while teaching *caring about* that have emerged from the data and whether they reflect the messages and perspectives you provided during the interview.

To gain your feedback, I would like to arrange an opportunity for a phone call. If that is not possible, I would appreciate receiving your written feedback via e-mail.

To proceed with the Member Check please review the attached **Summary of Findings** including concepts and their definitions, that emerged from the theoretical analysis of all study data, and answer these questions.

1. Do these concepts sound clear to you?

2. Do these concepts reflect the approach to teaching *caring about* while teaching *caring for* that you shared during our interview? How?

3. Do you have any comments or do you want to add anything?

Thank you for your time and consideration

Sincerely,

Latifah Almater RN, PhD (C)

PhD Program, School of Nursing,

Dalhousie University

Summary of the Primary Findings

The Process of Teaching Caring as a Multidimensional Phenomenon in Undergraduate Nursing Program.

Background

Caring is a concept defined in nursing literature in diverse ways as a human trait, a moral imperative, an affect, an interpersonal relationship, and a nursing intervention (Morse et al, 1990). Boykin & Schoenhofer (2013) define caring more specifically as a moral ideal involving commitment, knowledge, and action. *Caring for* has been defined as "a work responsibility" that includes all of the skills and actions provided by a nurse to a patient while *Caring about* has been defined as "a moral obligation" that includes all of the values, emotions and feelings that represent the professional relationship between a nurse and a patient. (Gaut, 1983: Cronqvist, Theorell, Burns & Lutzen, 2004).

The Problem

Many nurse educators are challenged when teaching caring as a multidimensional concept (Elliott & Wall, 2008; Fowler et al, 2012). They often concentrate on skills (psychomotor domain) and knowledge (cognitive domain) given the physical demands of health care and the health care system (technology, etc.) that are not only numerous but concrete/visible and thus more easily addressed (Wilby, 2011; Herbest et al, 2010). Although it is clear that the central core of nursing should not be limited to one's ability to *care for* but rather should be driven by one's ability to *care about*, what is not clear are the processes used by nurse educators to overcome the pressure to focus solely on teaching *caring for* in order to integrate *caring about* in their teaching.

The Purpose

The purpose of this study is to generate a theory that advances knowledge and furthers understanding about how undergraduate nurse educators facilitate students learning caring for and caring about simultaneously, and the challenges and opportunities encountered in this process.

Findings

Four concepts emerged from the data analysis, which addressed the process of teaching *caring about* while teaching *caring for (*Chart .1). These concepts included:

1. Conceptualizing the meaning of *caring about* and *caring for*
2. Recognizing the teachable moment
3. Seizing and acting on the teachable moment
4. Recognizing and dealing with the challenges.

A number of properties constitute the study concepts. While all participants' experiences are reflected in the concepts, not all participants identified all properties within each concept. Some participants identified just one, while others identified more than one.

1. Conceptualizing the meaning of caring concepts

The first concept provided the contextual foundation for teaching caring as a multidimensional concept. It reflects the abstract stage - defining *caring about* and *caring for* - involved in the teaching process. The other three concepts built on this contextual understanding of the two caring concepts. What emerged from the data was the notion that conceptualization includes five properties;

Caring for, defined by participants in this study as physically doing things, providing direct care, enabling, being action oriented, and having knowledge and skills.

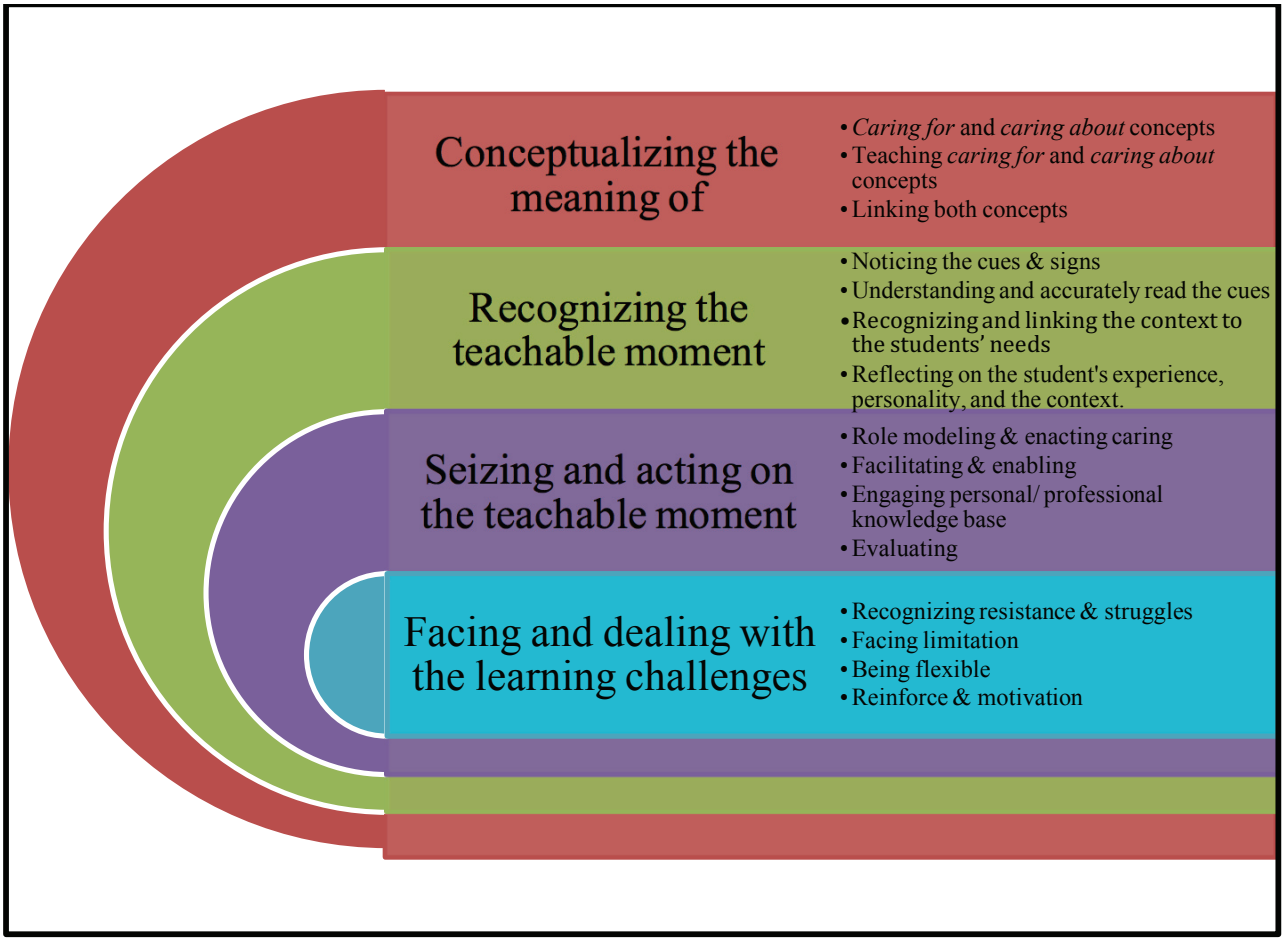

Chart.1: The Four Concepts Embedded in the Process of Teaching *Caring about* While Teaching *Caring for*

Caring about, defined by participants as engaging in a compassionate relationship and interaction, having inherent respect for the person, knowing the person, learning how the person perceives his/her experience (empathy), and having contextual understanding.

Teaching caring for defined by participant as **teaching** specific physical tasks and actions and assessing related health care knowledge and skills.

Teaching caring about. Defined by participants as **teaching** the intangible and more complex aspects, including at least one of the following:

- Encouraging interaction and establishing a professional or therapeutic relationship between student and patient,
- Encouraging students to use affective communication skills that address patients' emotional needs.
- Helping students to truly *know* their patients and understand how their patients perceive their experiences,
- Encouraging students to take time to *listen* and *be with* their patients – be emotionally present- and recognize them as human beings… not as 'patients'.

Linking teaching caring about and caring for. Although participants defined *caring about* and *caring for* as separate concepts they all agreed that they were linked. In addition, they varied in their teaching approach; some taught concepts using a sequenced approach while others used an integrated approach. All participants emphasized that teaching professional caring must link both concepts.

Some participants taught the caring concepts in an ***integrated*** way - both concepts taught together at the same time. Other participants viewed the caring concepts as one ***derived from*** the other concept. However, this linking was taught in two different ways. Some participants **taught**

caring about **first** to establish a therapeutic relationship with the patient as the way to build emotional connection and gain permission to enter the patient's physical caring space in order to introduce the *caring for* skills. In contrast, the others taught ***caring for*** **skills first** to ensure a level of competency with physical skills and as the way to establish credibility with the patient and gain permission to enter the patient's emotional space.

2. Recognizing the Teachable Moment

The second concept is defined as the cognitive stage in which educators identified cues that indicated, in the moment, how well students were able to engage in caring with the patient. This concept includes four sequenced properties:

Noticing the superficial cues and signs. This situation requires full attention to the *caring about* and *caring for* pieces. Here, educators noticed obvious, tangible cues using various techniques such as observing students while enacting caring, listening to students' stories following patient interactions, asking students about certain situations that involved both *caring for* and *caring about*. Some educators described obvious skill-related cues while others described both skill-related and emotion-related cues.

Accurately reading and understanding the underling cues. After noticing the superficial cues, educators then looked for less obvious cues to build a deeper understanding of the student's behaviour.

Recognizing and linking the context to the students' needs. After understanding the superficial and underling cues, educators recognized and linked the context to the students' needs based on such elements as the student's knowledge, the nature of the situation, the course objectives, etc..

Reflecting on the student's experience, personality, and the context. Educators then reflected on the student's experience (present, past, anticipated future), personal characteristics (personality, background, where are they come from, and thinking style, their wellbeing, etc.), and the context of this learning situation to assess its complexity and factors affecting. .

3. Seizing and Acting on the Teachable Moment.

The third concept, defined as the action stage, this concept usually comes after *recognizing the teachable moment*, but in some cases educators described creating *a teachable moment* **after** assessing the student's learning needs by asking questions or by evaluating the student's performance. In other words, this action stage was at times ***created*** by educators to impose teaching *caring about* while teaching *caring for*.

Seizing and acting on the teachable moment involves four teaching approaches;

Role modeling. Demonstrating caring for students to observe and reflect on.

Engaging personal/ professional knowledge base. Using one's knowledge base to enhance teaching in the moment

Facilitating & Enabling. Guiding the student through the learning experience

Evaluating. Assessing the strength and the limitation of the students through the learning experience

4. Facing Challenges.

The fourth concept includes actions that both *recognize* challenges within a particular situation and find ways to *adjust* the teaching situation. This concept involves facing two main obstacles: (1) Students' limitations that include such factors as learning resistance, student personality, student level of experience; and (2) Teachers' limitations that include such factors as

being in new area of practice, having new students for a limited time, having a large number of students, etc.

This concept includes four properties;

Recognizing resistance & struggles. Identifying and understanding students' struggles and oppositional responses

Facing limitation. Acknowledging the limitations affecting the educators' ability to teach (e.g. limited time, large number of students, teaching in a new area or new students).

Addressing superficial level & underling level challenges. Managing challenging situations at the superficial level(e.g., change patient assignment when student expresses fear)– and at the underling level(e.g., discussing/addressing the factors triggering student fears)

Reinforce & motivate. Continue to strengthen students' understanding of the meaning of *caring* as a multidimensional concept and its link the professional relationship

In conclusion, it is clear that the process of teaching *caring about* while teaching *caring for* is a complex process. It includes a complex matrix of cognitive thought processes and actions linked to each other in four main concepts. How these concepts are engaged in teaching *caring about* while teaching *caring for* differs from educator to educator. Some educators in this study focused largely on the action stages, while others gave both actions and cognitive stages the same attention.

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APPENDIX. 5a

Participants' reflections on the student responses on the video

" the student was very thorough"

" she was smiling and she was engaged"

" the student was more interested in the patient as a person"

" she didn't feel threatened by the instructor asking her questions at all"

"I think thought the student did a pretty good job actually. I thought she was really lovely. She seemed to be very attentive to the person. She seemed to be knowledgeable of what she was doing"

"She introduced herself. She introduced her instructor. She explained what she was going to do. I thought that was adequate. It was good. "

"I got a sense of that the student cared about Mr. Martin. And she doesn't know much about him but she did gather some data about Mr. Martin"

APPENDIX. 5b

Participants' Reflections on the instructor responses on the video

"My way of teaching is actually probably similar to the instructor in that video. I kind of like to stand back and watch and let the student kind of do their thing. And then just like that instructor did, just kind of…you know, kind of speak up when I feel it's appropriate or, you know, if something is missed or even to compliment the student"

"the instructor spoke at the bedside. And I think that was totally appropriate."

"my approach is a little different from this instructor."

I mean it's interesting because the student was very attentive to the patient, and the clinical instructor really wasn't. Like you know, I don't recall but I don't think she really spoke to him in the beginning at all.

"her language was so technical that that I would find that wasn't a very good role modelling for the student"

" I just wasn't warmly enthusiastic about the instructor because I thought she was a little too standoffish"

" the nursing instructor was very good at just letting the student take charge"

"The clinical instructor left a little to be desired. I mean let's talk about all the terrible things that can go wrong, and by the way, we're leaving.

APPENDIX. 5c

Participants' reflections on the context of the learning situation on the video

"It just felt that they were finding ways to disconnect from the person at every chance. And there were so many ways he reached out. It was quite frustrating for me sitting here."

"And so I think there were missed opportunities to help him understand how…what it was going to feel like to have this blood pressure taken intermittently."

"But missing his cues. And the student is in a position where it's important to demonstrate something to the faculty."

"I was uncomfortable with the presence of the faculty. Like this is her name but she didn't connect with the person. So she didn't role model any of that. So I think she's making them both a bit nervous."

"The questions to the student, I would do all that outside the room, away from the patient, because I would want the patient to have some confidence in the student's ability to do what they're doing."

"he was engaging…or dropped a few clues that she could have followed up on to get to know him a little bit better."

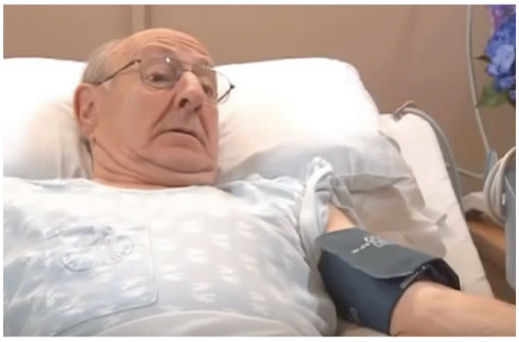
"He's bored to death, clearly. He's giving cues about that. We don't know if he's been visited or not visited or who's around or whatever. "

"The attention was specifically on the skill"

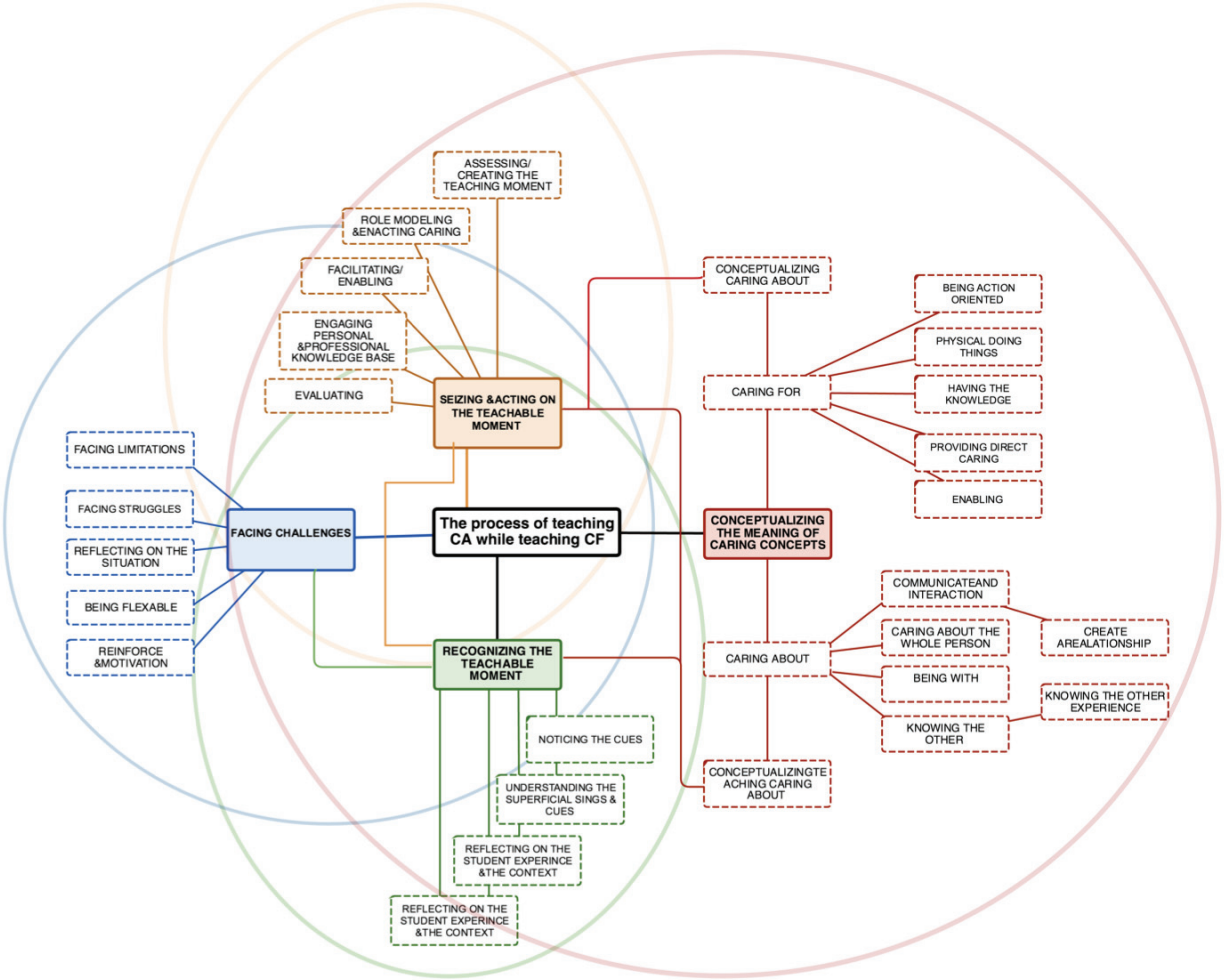
"No relationship there"

" It is frustrating, right? The patient was completely ignored "

" His concerns were just pushed aside"



APPENDIX .6



Digarm.1: Linking codes/ categories. This diagram illustrates the coding analysis.