Student mental health nurses' understanding of recovery: a phenomenographic study

Abstract

Aim: To explore the variation in mental health nursing students' understanding of recovery.

Background: Within mental health practice clinical understanding of recovery has been challenged with a new understanding based on the individualised experiences of the person, often referred to as personal recovery. Despite international policy endorsement, practice has been slow to embrace the principles of personal recovery, and little is known about student nurses' understanding of the concept.

Design: Qualitative phenomenographic study

Method: In-depth semi-structured interviews including discussion of a clinical scenario, were conducted with 13 pre-registration student nurses. Data was analysed iteratively using a seven stage phenomenographic framework, identifying categories of description and the outcome space.

Results: Analysis revealed a branched outcome space with four qualitatively distinct ways of understanding recovery. Branch one can be broadly aligned to clinical recovery and contains one category only, 'Recovery as Clinical Improvement'. It is distinctly different from branch two which contains three categories on a continuum, which represent more and less complete ways of understanding personal recovery: 'Recovery as Making Progress', 'Recovery as Managing to Live Well' and 'Recovery as Learning to Live Differently'. Most participants demonstrated understanding in the less sophisticated categories.

Conclusion:
Recovery is central to mental health nursing, yet this study suggests it is a problematic concept for students. Features of personal recovery can be found in the second branch of the outcome space, with the most sophisticated category 'Learning to Live Differently' best representing the principles of recovery espoused in nursing literature and international policy. Phenomenography has allowed a more complex picture to emerge, replacing the dichotomy between clinical and personal recovery and enabling a differentiation between more and less complete ways of understanding personal recovery. This study addresses the lack of attention given to student nurse experiences of recovery.

The insights support educators, both in clinical and academic settings, to address personal recovery in more explicit way where partial understanding can be explored.

Key Words

Recovery, phenomenography, nurse education

1. Background

Recovery is a key concept in mental health practice. Traditionally it has been understood within a clinical model, associated with a return to a former state of health and focused on eliminating disease and reducing symptoms (Bellack, 2006). Based on the rights of individuals to define their own circumstances and take control over their own lives, a new understanding of recovery has emerged more recently. This approach is often referred to as 'personal' recovery as opposed to the traditional understanding of 'clinical' recovery. Personal recovery is associated with the subjective experiences of the person and is described as a process of making sense of what has happened, living with and growing beyond the limits of mental health problems in constructing a positive personal identity (Anthony, 1993; Deegan, 1993). It is underpinned by a set of values recognising the person's right to build a meaningful life for themselves, not one pre-determined by health or social care professionals.

While personal recovery is unique to each individual, key themes emerge from the literature. Recovery is depicted as a non-linear journey with emphasis on hope, personal strengths and (re)building a positive self-image through personal goal setting, rather than returning to pre-illness state. It is also a social process whereby a person connects with others through supportive relationships and meaningful activity (Kartolova-O'Doherty et al.,

2012; Kidd et al., 2015; Leamy et al., 2011; Onken et al., 2007; Jacob et al., 2017). Such changed understanding has required mental health professionals to adapt their ways of working to support service users in achieving their recovery goals (Henderson & Jackson, 2017). Literature emphasises recovery-oriented practice, identified as embracing a person-centred approach, working in partnership with the person and collaborative partnerships with other professionals (Chester et al. 2016, Jacob et al. 2017, Hornik-Lurie et al., 2018). Combatting stigma, maintaining a positive attitude and promoting hope and self-determination (Waldemar et al., 2016) are also seen as key.

Globally, mental health care reforms range from paternalistic approaches to person-centred approaches (Hornik-Lurie et al., 2018). However, personal recovery has become a central tenet of mental health policy in countries such as the UK, Australia, New Zealand and the United States. The Chief Nursing Officer for England advised that the key principles of personal recovery should inform all areas of mental health nursing (Department of Health, 2006), and elsewhere policies that support the adoption of these principles in mental health practice use the term recovery synonymously with personal recovery (Australian Government, 2010; Ministry of Health, 2016). There is therefore an increasing expectation that recovery and recovery-orientated practice are integral parts of mental health nursing.

While this changed perspective has been widely endorsed in mental health policy, there are indications that recovery is not clearly understood by clinical staff. Attitudes to adopting recovery-orientated practices differ and transformation of services has been slow (Cleary et al., 2013; Jacob et al., 2017). The complexity of the concept and the re-defining of a familiar term has led to confusion over meaning (Repper & Perkins, 2017), with uncertainty

regarding what constitutes recovery-orientated practice and its operationalisation (Cusack et al., 2017). The “palpable enthusiasm for recovery-orientated practice” (Chester et al., 2016, p.280) has been contrasted with the lack of shared understanding of what recovery means in nursing practice (Le Boutillier et al., 2015). Staff have been shown to prioritise clinically orientated treatment packages with a focus on stabilising illness, providing medication and psycho-education (Waldemar et al., 2016) and maintaining conceptions of indicators of recovery as returning to ‘normal’, pre-illness level of functioning (Chester et al., 2016). Stuber et al. (2014) found a perceived lack of competencies pertaining to areas of recovery-orientated practice such as helping individuals identify stressors and personal goals. In contrast, Le Boutillier et al. (2015) found that where recovery-orientated practice was evident, staff addressed social factors such as relationships, provided practical support and supported hope.

In summary, the literature indicates a disparity between aspirations and achievement of recovery-orientated practice (Chester et al., 2016), with the rhetoric of recovery being applied without clear understanding of what this means in practice (Le Boutillier et al., 2015). It suggests that the reasons for this disparity lie in the complexity of recovery as a concept and in the engrained nature of customary practices.

To date studies considering experiences of recovery have focused predominantly on nurses holding a professional qualification (e.g., Cleary et al., 2013; Cusack et al., 2017). However, if the principles of personal recovery are expected to underpin contemporary approaches to mental health nursing, it is crucial that attention is given to nursing students (Perlman et al., 2017). This is when the concept is first introduced and foundations for recovery-orientated

practice are laid. Student mental health nurses occupy a unique position, splitting their learning experiences between educational and clinical settings, where they are expected to contribute to both. Within educational settings they may be introduced to contemporary conceptualisations of personal recovery and recovery-orientated practice; in clinical practice they may encounter traditional practices not necessarily in line with current policies and models. The aim of this study therefore was to explore student mental health nurses' understandings of recovery.

2. Methods

2.1 Design

Phenomenography (Marton, 1981) is concerned with the variation in the ways in which phenomena are experienced. Rooted in a non-dualistic ontology, it assumes that people cannot be seen as separate from the aspects of the world they experience (Han & Ellis, 2019). Rather than focusing on individuals, phenomenography aims to describe collective experiences of a phenomenon and the qualitatively different ways of understanding it (Marton & Pang, 2008). These differing understandings are represented by the researcher in a set of related 'categories of description', which together make up the 'outcome space'. Each category of description describes a distinctively different way of experiencing the phenomenon, whilst the outcome space demonstrates the logical relationships between these categories (Cousin, 2008).

Phenomenography is associated with research on conceptual understanding, particularly in higher education. While less established in nursing research, there is growing evidence of phenomenographic studies about patients' and nurses' understandings, including those of student nurses (e.g., Sterner et al., 2019).

2.2 Participants

All students (n=240) enrolled on a BSc Mental Health Nursing programme at one UK university were invited to participate in the study via email. Thirteen student nurses, 11 female and 2 males aged between 21-42 years (average: 27 years), volunteered. Participants were at varying stages of the second and third year of the programme and had received university-based teaching on personal recovery concepts, threaded through the mental health-specific modules within the curriculum. All participants had mental health clinical practice experience, albeit in different placements.

2.3 Data Collection

Approval from the School of Education Ethics Committee was obtained. Participants received an information letter, gave oral and written consent and were aware that they could withdraw at any point. Data was collected through one semi-structured interview per participant, which included questions based around a written clinical scenario (see table 1). This allowed consideration of a concrete case with responses discussed during the interview. In line with phenomenographic research, responses to questions were followed up with further questions to elicit meaning (Han & Ellis, 2019). The interviews were audio-recorded and transcribed verbatim.

1. **Introductions**
   Welcome, explanation of process. Clarify consent, understanding of information, issues of confidentiality.
2. **General warm up discussion**
   Example: tell me a little about where you are in the programme at the minute
3. **Learning about Recovery at university**
   Example questions: Have you come across topics in the programme related to recovery so far?
   What kind of things have helped/ hindered your understanding of recovery?
4. **Experiences of Recovery in practice**
   Example question: Could you tell me about an example from practice when you have been involved in/ or witnessed someone using an intervention that you did/didn't feel was very recovery orientated
5. **Ideas about recovery**
   Example question: If you were describing what recovery is to someone not involved in healthcare, what would you say?
6. **Impact of learning about Recovery**
   Example question: How has recovery influenced your ideas about nursing?
7. **Any additional student comments**
   Example question: Is there anything that we haven't talked about that you think is important in relation to recovery?

Written Scenario provided to students at beginning of interview and discussed within interview:

Darren is currently under the care of a Community Mental Health Team following a formal hospital admission, necessitated by Darren attempting to take his own life in response to voices he was hearing. He has been home now for several weeks and has been feeling well recently, although he continues to experience some voice hearing. He is spending time doing voluntary work in preparation for returning to employment. He lives on his own but has regular contact with his elderly mother who lives nearby and for who he provides support. Although prescribed Risperidone, Darren has expressed a distrust of medication and is not currently taking it as prescribed. He is continuing to attend appointments, and as the community nurse you are meeting with him today. In relation to the above scenario, please consider the following questions:

a. What do you see as the main issues regarding Darren's current situation?
b. What nursing interventions would you consider at this time?
c. What might the main issues be for Darren over the next few weeks that you would plan interventions for?

Table 1. Interview schedule

2.4 Data Analysis

Dahlgren and Fallsberg's (1991) phenomenographic seven-stage process underpinned the analysis. This involved selecting, comparing and grouping quotes, in a gradual shift from individual transcripts to constructing a collective 'pool of meanings' (Marton 1988), which brings together differing understandings of recovery as one set illustrated by extracts from all interviews. Emerging categories of description were articulated, labelled and iteratively checked against the transcripts by the first author, identifying differences between categories, similarities within categories and relationships between categories.

Categorisations were discussed with the second author, and the constant iterative and dialogic process provided rigour as it ensured checking of interpretations and prevented any desire to move on too quickly. In phenomenographic studies full variation of understandings present within the group should be captured (Marton & Booth, 1997). This was felt to be reached after analysis of 10 interviews. This was confirmed when further analysis of the final three interviews found no new categories emerging from the iterative process.

The credibility and trustworthiness of phenomenographic findings are demonstrated in the presentation of the outcome space and the justification of the claims made about it (Cope, 2002). The categories within the outcome space presented here are formed from the meanings present in the interviews. Extracts are included to permit informed scrutiny. Additional rigour was provided by a journal kept by the lead author who actively reflected on the research process and her positionality as a nursing lecturer known to participants. These considerations of the potential impact on data collection and analysis added a layer of reflexivity to this interpretivist study.

3. Findings

A branched outcome space with four categories of description emerged, which depicts recovery as being understood in two distinct ways (see Figure 1).

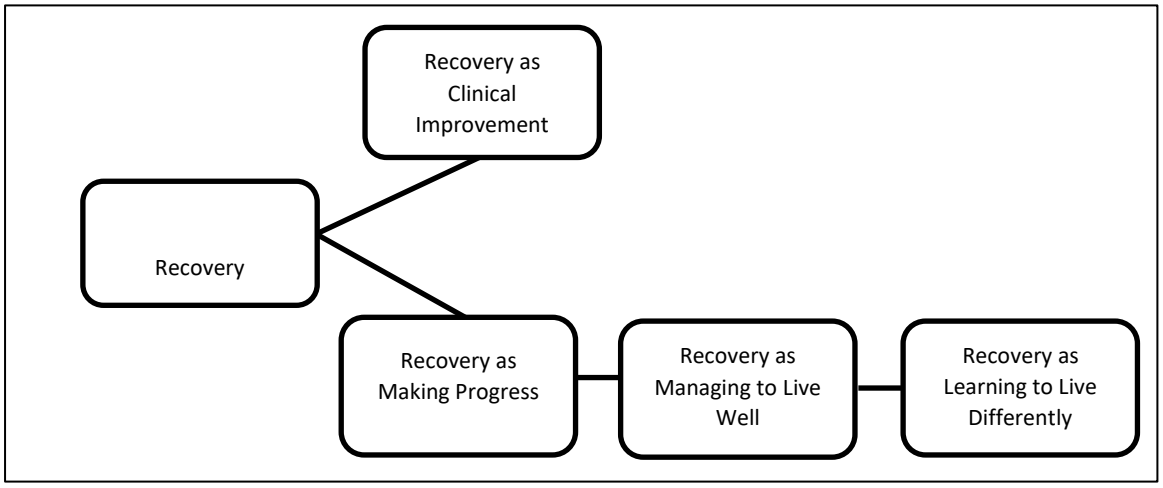

Figure One: The Outcome Space

Branch one contains only one category ‘Recovery as Clinical Improvement’, whilst branch two contains three hierarchical categories, ‘Recovery as Making Progress’, ‘Recovery as Managing to Live Well’ and ‘Recovery as Learning to Live Differently’. The use of a continuum in branch 2 demonstrates the relationship between the three categories. The most simplistic of these, ‘Recovery as Making Progress’, demonstrates the least sophisticated understanding of recovery. As awareness broadens the categories hold more complex ways of understanding, with ‘Recovery as Learning to Live Differently’ the most sophisticated.

3.1 Category of Description 1-Recovery as Clinical Improvement

Within this category there is a focus on reduction of symptoms, with stability of the condition viewed as key to recovery. The person is understood as having a diagnosis that requires professional treatment; the nurse is viewed as the professional with expert knowledge. A main indicator of improvement is reduced risk. Recovery is viewed within an organisational context with nursing having contributed to recovery if the person can be referred on or discharged. Pharmacological interventions are considered a priority, with interventions delivered by the nurse to the person as a passive recipient of care.

> Frankie: it’s about promoting the medication, make sure they’re using it correctly. That they understand it, the benefits of it … then like promoting things like social inclusion.

Across all categories of description, recovery is viewed as being different for everyone. However, within this category uniqueness is viewed as a result of the diverse range of symptoms people may experience:

> Jordan: if they've got an illness what sort it is, the symptoms. Someone might have schizophrenia but they might have the positive symptoms and you might meet someone who has the negative symptoms so you can't treat both the same.

As illness and symptom presentation determine treatment, diagnosis is also viewed as impacting on recovery, with recovery not possible for some.

> Alex: It's different with dementia because obviously some of these people aren't going to recover… some of them, their symptoms are so far down the spectrum.

3.2 Category of Description 2- Recovery as Making Progress

'Recovery as Making Progress' is the least sophisticated category within the continuum structure of branch 2. Here recovery is understood as the person being able to resume 'normal' life and adopt usual roles. This is individual to the person, depending on their previous roles, hobbies, and abilities. Behaviour change is observed by the nurse and compared to previous behaviour to demonstrate improvement.

> Taylor: when she first came into services, she made cards and stuff like that. She used to go out with her friends, drive. She stopped doing all of that … when it got to the point where she was discharged, she was doing everything that she would usually do and more.

The nurse-patient relationship is recognised as important in fostering an atmosphere of 'working together' to agree goals and interventions; however, this is within boundaries set by the nurse.

> Jordan: … the person knows how unwell they are, if you do it with them, you're offering your support, at least you're working with them…. it's setting boundaries and making them realistic.

Although elements of shared decision-making are accepted in relation to goals and interventions, this only operates within boundaries of what is viewed as appropriate by the professional; the power of decision-making ultimately lies with the professional as Jordan describes the nurse as setting realistic boundaries.

Relapse is interpreted as a backward step in that recovery stops and the person is unwell again, sometimes in a cyclical pattern:

> Frankie: you can recover but there's always that chance that something is going to happen, and you will relapse. …Just because you've recovered doesn't mean you can't relapse and then recover.

Nursing interventions include a range of approaches which predominantly support the person to maintain or regain independence, as increasing ability to self-care is viewed as a sign of progress.

> Charlie: I care for a lady …I know other people are going in and making her sandwiches, but I don't. I'll say I'll give you a hand but I'm not doing it for you… if she's quite capable

why do it for her otherwise she's going to lose her independence, she's going to lose something about herself.

Within this category conflicts were experienced when the principles of personal recovery were not demonstrated by other staff, limiting the student nurse's own approach.

3.3 Category of Description 3- Recovery as Managing to Live Well

Within this category recovery is understood as living a meaningful life despite symptoms of illness or difficult issues in the person's life. The person is fulfilled by activities, roles and relationships, and is able to take responsibility for what they choose to do. Living well is defined by the person rather than the professional.

Chris: I'd just say recovery isn't about changing a person to what you think is better, it's about what they think is better...it's about what they think their life is and not what I think their life should be….

Wellness is maintained with stability of behaviours; where negative experiences occur, this is viewed as interrupting the recovery journey. Nursing interventions are person- centred, with a focus on the person rather than the illness, and individual choices are respected.

Mel: Basically, I think a person cannot recover if the intervention from the nurse or the doctor isn't dealing with them and like basically 100% focused on them as a person, because you can say anything to the person but if you're not actually listening to what they're saying and how they're feeling then you're not actually going to be helping them.

Working with the individual's personal choices, the nurse facilitates the person to make decisions. The professional offers an opinion based on their expert knowledge; however, within this category it is understood that the person has the ability and right to make choices of their own regarding treatment options.

> Sal: It's part of your job to ask that … When would they be happy and when would they feel they were well enough to not need nursing care anymore or stop involvement with services.

Compared to previous categories, there is a significant shift of approach in relation to risk. Rather than the nurse managing risk, a focus on developing the person's ability to manage risk themselves is evident.

> Jamie: … I would be concerned about having only one protective factor…and I would be keen to identify other protective factors so that there's not just one, in case anything happened.

With an understanding of 'Recovery as Manging to Live Well' nursing is experienced as being carried out within a context of conflicting needs, such as the needs of the service in gaining funding and managing finite resources on the one hand, and the needs of the individual in living a contented life with the appropriate professional support on the other. The constraints placed on recovery-orientated practice by the organisation are recognised, while at times organisational policy is circumvented at grassroots level to enable service users to receive the service perceived as needed.

> Taylor: ...we have to adhere to risk scores and clustering because at the end of the day if you don't do clustering you don't get your funding.....so they (clinical staff) would keep people in, not really do their clustering and keep people in services

> because they knew it would make people unwell very quickly to be taken out of services…

3.4 Category of Description 4- Recovery as Learning to Live Differently

Within this category recovery is a unique, personal journey directed by the person themselves. Within the previous second branch categories, resuming usual roles was viewed as an indicator of recovery. Here, the focus is on moving forward and becoming a different person.

> Jamie: it's like having the diagnosis, but does that matter? I think it's just you're learning to live differently. You can have big traumatic life changes, you can have a diagnosis that will probably rock your world, but you can learn to live with it, you learn to live differently… you can become a different person and that person might be just as good as, or sometimes even better than the one you were beforehand.

As a consequence, challenging the person to believe that change is possible and can have a positive outcome is one aspect of nursing interventions.

> Ali: …you're kind of helping them to get there because sometimes a lot of them think 'I'm nothing'... I think part of it is challenging them, challenging their perceptions of themselves.

Relapse should it occur is not viewed as failure. Although significant distress may be experienced, it is viewed as offering opportunities for personal growth in learning from the experience.

> Jules: I feel it's like getting from point A to point B and all the stuff in between that's the recovery part… the transformative experience of all these negative things that

> have happened as a result strengthens them as a person, and I think that is the essence of recovery for me.

Understanding how the nurse can facilitate recovery is gained from the person. This requires a level of commitment from the nurse and a 'giving of self' to the relationship. The relationship becomes a mutual learning one.

> Ali: Learning from the patients really….so just watching them, learning, listening to what they say, observing their behaviours has very much moulded what I would term recovery…It's about wanting to be interested in human beings and maybe being some sort of use to them.

Risk issues are considered in light of the person's right to self-determination. Positive risk-taking is normalised as part of people's lives and individuals are seen as having the right to make their own choices wherever possible, even if these are considered unwise by the professional, for example not accepting medication.

> Jules: …. I do think positive risk is important and then there's the element of trust thing, and I think it's the person having power and making choices but then also just in terms of learning from their own mistakes.

Within 'Recovery as Learning to Live Differently', the conflicts that can arise from practising positive risk-taking while also meeting the expectations of the organisation are recognised. Despite the need to work with different understandings of recovery, there is a clear focus on maintaining nursing practice aligned with personal recovery. Here, recovery is not only of relevance to those with mental health issues but viewed as common to human experience. In recognising their own experiences of self-discovery, participants were able to relate the journey of recovery on a personal level and used this to inform their practice.

> Jules: I thought I'd reached a point where I'd gone through this difficulty and I understand what happened and why that happened and why I'm better ……But then I think my journey, my personal journey is still going on…it's like a transformative experience, like reflection in nursing really, that learning and strengthening process.

4. Discussion

While the two branches of the outcome space broadly align to the ideas of personal and clinical recovery, the categories in the second branch reveal a much more complex picture than a simple contrast between two alternative understandings. The phenomenographic approach adopted for this study has allowed the full variation of participant understanding to emerge.

Branch one of the outcome space supports findings from the literature that mental health professionals have been slow to embrace the principles of personal recovery, as this branch demonstrates understanding aligned with the notion of clinical recovery. Key features of personal recovery and recovery-orientated practice can be found in the second branch of the outcome space across all three categories. Within this branch, as awareness broadens, the categories hold more complex ways of understanding. Whilst the literature suggests confusion and misunderstanding of what constitutes personal recovery (Waldemar et al., 2016; Le Boutillier et al., 2015; Chester et al., 2016), the categories within branch two allow for a re-interpretation of this misunderstanding as partial understanding.

Rather than focusing on individuals, phenomenography captures the collective ways of understanding a phenomenon (Marton& Pang, 2008), therefore one participant's account may contain multiple understandings. However, in this study it was possible to assign most participants to one dominant way of understanding recovery, based on a particularly high number of extracts associated with one category in their interview (see Table 2).

Recovery as:	Sam Y3	Frankie Y3	Jordan Y3	Mel Y2	Alex Y2	Charlie Y2	Taylor Y3	Sim Y3	Chris Y3	Sal Y3	Ali Y3	Jamie Y3	Jules Y2
Clinical Improve-ment	✓	✓	✓	✓	✓								
Making Progress	✓	✓ •	✓ •	✓	✓ •	✓ •	✓	✓	✓	✓			
Managing to Live Well				✓	✓	✓	✓ •	✓	✓ •	✓ •	✓	✓	
Learning to Live Differently											✓ •	✓	✓ •
Understanding evident within the category is indicated by a tick, dominant understanding (if present) is indicated by a dot. Y2 – second year student Y3- third year student													

Table 2: student understanding of recovery- dominant categories

As table 2 illustrates, any assumption that more senior students might demonstrate more sophisticated understanding of recovery was not reflected by the data. Two participants demonstrating dominant understanding in the 'Recovery as Making Progress' category were nearing completion of the programme; whilst within the 'Recovery as Learning to Live Differently' category, one of the participants was near the end of second year. Only three students' accounts contained 'Recovery as Learning to Live Differently', thus it is clear that the majority of students, including seven third year students, only held partial understanding of a concept central to mental health nursing. These findings highlight

recovery as a concept which holds particular challenges for students in their learning journeys.

Bellack (2006) identifies that understandings of recovery are dependent upon the perspective and goals of those using it and the contexts in which it is used. This study echoes these findings. Within branch one, recovery within nursing is understood within an organisational context, moving the person through services as improvement occurs. This supports the view of some commentators that the grassroots ideas of personal recovery developed from the service user movement have been subverted by organisational policies which aim to control individuals through a narrow definition of recovery. This is viewed as colonisation which undermines the core principles of personal recovery (Machin and Watson, 2018), and elements of this are evidenced in branch one.

Whilst branch one emphasises illness and its treatment, branch two embraces the idea of wellness. As understanding increases in complexity, the idea of salutogenesis (Antonovsky, 1987) is incorporated into understanding. Such principles are important to recovery as it has been argued that diagnosis and professionally led treatment over-shadow and devalue personal understanding, impacting on sense of self (Kidd et al., 2015).

O'Hagan (2004) found that some professionals view personal recovery as 'esoteric nonsense', suggesting it is hard to grasp and only relevant to a minority and closed circle of people. 'Recovery as Learning to Live Differently' embraces the idea of recovery as a common human experience shared by all people and not necessarily specific to mental health. This is a point supported by Repper and Perkins (2017) who suggest that any experience of a significant life event can cause a re-evaluation of a person's life to regain

meaning and purpose. They advise that staff should consider how these experiences can be used safely and effectively to support others on their recovery journeys.

Although individualised, the recovery journey involves supportive relationships. Friends, family and peers are often considered valued helpers, particularly those who have experienced recovery themselves (Kartolova- O'Doherty et al., 2012; Kidd et al., 2015). Within this study the value of such relationships was not significantly emphasised, while the nurse-patient relationship was regarded as crucial. This focus on the professional relationship over other supportive relationships may reflect student concerns around their own ability to develop relationships rather than considering the value of others; however, a wider perspective on the nature of supportive relationships may be required to fully embrace recovery. This has implications for curricula in both university and clinically based settings.

Linked to the therapeutic relationship is partnership-working, identified as crucial in mental health practice to support recovery (Chester et al., 2016; Jacob et al., 2017). Within the category 'Making Progress', an element of partnership-working is described; however, it does not operate on true egalitarian principles. A different understanding of partnership-working is evident in in the later categories, linked to a person-centred understanding of the nature of the therapeutic relationship. Here there is understanding of the need for acceptance of the way in which the person defines recovery, recognition of their own expertise and right to self-determination, ideas central to recovery (Chester et al., 2016; Davidson et al., 2009) and recovery coaching (Davila & Secor, 2016). Recovery coaching places the person in charge of their own recovery, with a mentor guiding the recovery

journey. Within care services coaching is more widely used in substance misuse services where recovery coaches are often peer support workers (Davila & Secor, 2016). However, the findings of this study support the idea that the principles of this approach may also be applicable to wider nursing practice.

Differences of understanding can be seen in nursing interventions in relation to risk. The minimisation and management of risk by staff is particularly emphasised in branch one. It is only in 'Recovery as Learning to Live Differently' that the notion of positive risk-taking is fully understood by enabling self-determined decisions, even if these may be associated with risks. This lack of understanding related to positive risk is likely to reflect the dominant risk-adverse culture within mental health care. Organisations have sought to mitigate against risk and staff have developed defensive practices to avoid blame if things go wrong (Manuel & Crowe, 2014). Whilst positive risk-taking facilitates individuals' choices and personal responsibility, it is arguably not encouraged by the culture of organisations.

Collaborative practice is key to addressing the multi-level support required by individuals undertaking recovery journeys (Chester et al., 2016; Jacob et al., 2016). This aspect of recovery-orientated practice is less well defined within this study as participants focused on nursing interventions within healthcare, with limited reference to community resources or external agencies. While this does not mean it is not understood as part of recovery-orientated practice, its limited inclusion within the data does suggests it may hold less importance for students. This may be reflective of their educational and clinical practice experiences and has implications for both.

5. Limitations and Implications

Since the student experience of recovery has only been captured at one point in time and first year students could not be recruited, this study also has limitations. As a single centre study with a small participant group which only represents 5% of the entire cohort, its transferability is limited. Follow-on research could build on the findings by using a longitudinal design and involving participants from several institutions. This would have the potential to uncover greater variation of experience and understanding as well as changes of understanding over time.

The partial understanding of recovery held by soon-to-be registrants has implications requiring further consideration by those educating student nurses. There is a need for curricula and teaching methods that make difficulties in learning and partial understanding of recovery and associated nursing practices explicit so that they can be explored and addressed. This may also require consideration of the understandings which clinical and university-based educators themselves hold. Discussion of uncertainties need to be not only tolerated but also encouraged, to promote a community of learning so that student nurses appreciate they are not alone in experiencing difficulty with this complex concept. Policy endorsing personal recovery alone is not sufficient to bring about change in nursing practice.

6. Conclusion

Recovery has been promoted as central to the disciplinary knowledge of mental health nursing, yet this study suggests that it is a problematic concept for students. The findings have exposed a range of qualitatively different understandings which make it possible to

differentiate between more and less complete ways of understanding personal recovery, and to identify what students with a more sophisticated understanding grasp about the concept that students with a narrower understanding do not. Thus, instead of a simple dichotomy between clinical recovery on the one hand and personal recovery on the other, a much more complex picture has emerged. Phenomenography as the approach taken to this study has been particularly useful for unearthing such nuances in understanding. Nursing and nurse education researchers may therefore be interested in adopting phenomenography more widely for studies investigating conceptions and conceptual change.

References

Australian Government (2010). National Standards for Mental Health Services. Canberra ACT: Australian Government. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10 , accessed 07.07.2020

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal, *16*, (4), 11-23.

Antonovsky, A. (1987). Unravelling the mystery of health, how people manage stress and stay well. San Francisco: Jossey- Bass.

Bellack, A. S. (2006). Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications. Schizophrenia Bulletin, *32*, 432-442.

Chester, P., Ehrlich, C., Warburton, L., Baker, D., Kendall, E., & Crompton, D. (2016). What is the work of recovery orientated practice? A systematic literature review. International Journal of Mental Health Nursing*, 25*, 270-285. doi/10.1111/inm.12241

Cleary, M., Horsfall, J., O'Hara-Aarons, M., & Hunt, G. E. (2013). Mental health nurses' views of recovery within an acute setting. International Journal of Mental Health Nursing, 22*,* 205-212. doi.org/10.1111/j.1447-0349.2012.00867.x

Cope, C. (2002). Using the analytical framework of a structure of awareness to establish validity and reliability in phenomenographic research. Proceedings of the international symposium on current issues in phenomenography. Canberra, Australia.

Cousin, G. (2008). Strategies for researching learning in higher education. GB: Routledge. doi.org/10.4324/9780203884584

Cusack, E., Killoury, F., &Nugent, L. E. (2017). The professional psychiatric/ mental health nurse: Skills competencies and supports required to adopt recovery- orientated policy in practice. Journal of Psychiatric and Mental Health Nursing, 24, 93-104. doi: 10.1111/jpm.12347

Dahlgren, L. O., & Fallsberg, M. (1991). Phenomenography as a qualitative approach in social pharmacy research. Journal of Social and Administrative Pharmacy, 8, (4), 150-156.

Davidson, L., Tondara, J., Lawless, M.S., O'Connell, M. J., & Rowe, M. (2009*).* A practical guide to recovery orientated practice. New York: Oxford University Press.

Davila, R. D., & Secor, W. B. (2016). Recovery coaching signals paradigm shift. Addiction Professional. http://www.addictionpro.com/article/recovery-coaching-signals-paradigm-shift,

Deegan P. E. (1993). Recovering our sense of value after being labelled mentally ill. Journal of Psychosocial Nursing and Mental Health Services, 31, (4), 7-11.

Department of Health (2006*).* From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing. London: Department of Health.

Han, F., & Ellis, R.A., (2019) Using Phenomenography to Tackle Key Challenges in Science Education. Frontiers in Psychology, 10, 1-10

Henderson P., & Jackson, W., (2017). Recovery in mental health: Examining the reality for professionals and service users. Mental Health Nursing, October/ November, 11-13.

Hornik-Lurie, T., Shalev, A., Haknazar, L., Epstein, P.G., Ziedenberg-Rehav, L., 7 Moran, G.S. (2018). Implementing recovery-oriented interventions with staff in a psychiatric hospital: A mixed-methods study. Journal of Psychiatric and Mental Health Nursing, 25, 569-581. Doi:10.1111/jpm.12502

Jacob, S., Munro, I., Taylor, B. J., & Griffiths, D., (2017). Mental health recovery: A review of the peer- reviewed literature. Collegian, *24*, 53-61. doi.org/10.1016/j.colegn.2015.08.001

Kartolova-O'Doherty Y., Stevenson C., & Higgins A., (2012). Reconnecting with life: A grounded theory study of mental health recovery in Ireland. Journal of Mental Health, 21, (2), 136-144. doi.org/10.3109/09638237.2011.621467

Kidd S., Kenny A., & McKinstry C., (2015). Exploring the meaning of recovery- orientated care: An action research study. International Journal of Mental Health Nursing, 24, 38-48. doi: 10.1111/inm.12095.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. The British Journal of Psychiatry, 199, 445-452. doi.org/10.1192/bjp.bp.110.083733

Le Boutillier, C., Chevalier, A., Lawrence, V., Leamy, M., Bird, V., Macpherson, R., Williams, J., & Slade, M., (2015). Staff understanding of recovery-orientated mental health practice: A systematic review and narrative synthesis. Implementation Science, 10, (87), 1-14. DOI 10.1186/s13012-015-0275-4

Machin, K., & Watson, E. (2018) Recovery-orientated practice. In Wright, K. & McKeown, M. (Eds). Essentials of Mental Health Nursing. London: Sage.

Manuel, J., & Crowe, M., (2014). Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. International Journal of Mental Health Nursing, 23, 336- 343. doi.org/10.1111/inm.12063

Marton, F., (1988). Phenomenography: Exploring different conceptions of reality. In P.M Fetterman, (Ed.*),* Qualitative Approaches to Evaluating Education: a silent scientific revolution. New York: Praeger.

Marton, F., (1981). Phenomenography: Describing conceptions of the world around us. Instructional Science, *10*, 177-200.

Marton, F., & Booth, S., (1997). Learning and Awareness. Mahwah NJ: Lawrence Erlbaum Associates.

Marton, F., & Pang, M. F., (2008). The Idea of phenomenography and the pedagogy of conceptual change. In Vosniadou, S. (Ed.), International Handbook of Research on Conceptual Change. London: Routledge.

Ministry of Health, (2016). Commissioning framework for mental health and addiction: A New Zealand guide. Ministry of Health.

O'Hagan, M. (2004). Recovery in New Zealand: Lessons for Australia. Australian e-Journal for the Advancement of Mental Health, 3, 1-3. DOI: 10.5172/jamh.3.1.5

Onken S.J., Craig C. M., Ridgway P., Ralph R. O., & Cook J. A. (2007). An analysis of the definitions and elements of Recovery: A review of the Literature. Psychiatric Rehabilitation Journal, 31, (1), 9-22. DOI: 10.2975/31.1.2007.9.22

Perlman, D., Patterson, C., Moxham, L., Taylor, E., Brighton, R., Sumskis, S., & Heffernan, T. (2017). Preparing Nursing Students for Care: The Impact of Recovery-orientated Clinical Placement, *Issues in Mental Health Nursing,* 38, 8, 663-668. DOI:10.1080/01612840.2017.1312650

Repper, J., & Perkins, R. E. (2017). What does the recovery approach really mean? In M. Chambers, (Ed.), Psychiatric and Mental Health Nursing: The Craft of Caring, 3rd Edition. Oxon: Routledge.

Sterner, A., Andersson Hagiwara, M., Ramstrand, N., Palmer, L. (2019). Factors developing nursing students and novice nurses' ability to provided care in acute situations. Nurse Education in Practice, 35, 135-140. DOI/10.1016/j.nepr.2019.02.005

Stuber, J., Rocha, A., Christian, A., & Johnson, D. (2014). Predictors of recovery-orientated competencies among mental health professionals in one community mental health system. Community Mental Health Journal, 50, 909-914. doi/10.1007/s10597-014-9708-9

Waldemar, A. K., Arnfred, S. M., Petersen, L., & Korsbek, L. (2016). Recovery-orientated practice in mental health inpatient settings; A literature review. Psychiatric Service, 67, (6), 596-602. doi.org/10.1176/appi.ps.201400469

No external funding

This research did not receive any specific grant from any funding agency in the public, commercial, or not-for-profit- sectors.

Conflicts of interest: none