Listening to elders’ stories: Transforming nursing students’ perceptions about gerontology nursing

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Candidate's Declaration

I hereby declare that the work herein, now submitted as a thesis for the degree of Doctor of Philosophy by Research of the Charles Darwin University, is the result of my own investigations, and all references to ideas and work of other researchers have been specifically acknowledged. I hereby certify that the work embodied in this thesis has not already been accepted in substance for any degree, and is not being currently submitted in candidature for any other degree.

Signature of Candidate: ________________________________

Date: ________________________________
Abstract

When teaching gerontology nursing to nursing students, their preconceived ideas, biases and prejudices associated with ageing become barriers to effective learning and caring for elders. Nursing literature recommends that gerontology nursing educators address these challenges by providing nursing students with positive learning experiences with well elders. Listening to elders’ stories has been shown to be a positive experience but little is known about how the experience impacts nursing students.

This thesis explores the experiences of 15 baccalaureate nursing students in Hawai‘i who were interviewed to share their experiences listening to elders tell their stories. Using the methodology of narrative inquiry and the method of life story, each audio taped interview was restored into a narrative text and analysed for emerging themes. The major theme of liminal spaces represents the transitions that occurred throughout the nursing students’ stories. The conceptual framework of cultural safety and the philosophical position of Martin Buber informed this study of gerontology nursing education and practice in relation to the balance of power in the care of elders and the nurturing of relationship.

The key findings indicate that the nursing students were transformed both personally and professionally by listening to the stories of elders. Consequently, they discovered that the experience changed their attitudes and improved the way they provided nursing care to elders. This supports the desired outcomes of gerontology nursing education and confirms that listening to elders’ stories is a valuable educational strategy.

Key words: cultural safety, elders, gerontology nursing, nursing students, life stories, narrative inquiry
Dedication

This thesis is dedicated to my parents,

both heroes to me,

each with memorable stories that have shaped my life.
Acknowledgments

It is a joy to extend my gratitude and thanks to those who helped me along the way.

I am extremely grateful to the 15 nursing students who gave their precious time and shared with me the gift of their stories. You taught me to treasure my own stories all the more. With a greater sense of appreciation I now realise how the stories that I heard growing up taught me valuable lessons that helped me stay the course and complete this thesis.

I learned about taking a stand from stories about my grandmother’s response to injustice, the importance of family from my grandfather’s story of the birth of his children, the delight and desire to learn new things from my mother’s stories about her childhood, and from my father I learned about the courage to bring freedom to those in harm’s way.

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# Table of Contents

Candidate’s declaration................................................................. ii
Abstract...................................................................................................... iii
Dedication............................................................................................... iv
Acknowledgments..................................................................................... v
List of Figures............................................................................................ xi
List of Tables.............................................................................................. xi

## Chapter One  Introduction and positioning of the study ................. 1

1.1 Aims and objectives of the study.................................................. 4
1.2 Justification for the study............................................................. 5
1.3 Background to the study............................................................... 7
   1.3.1 Teaching gerontology nursing.............................................. 7
   1.3.2 Gerontology nursing curriculum revision.............................. 11
   1.3.3 Employing life stories as an education strategy .................... 13
1.4 Coming to know about cultural safety........................................... 15
1.5 Overview of the thesis................................................................. 21
1.6 Summary of the chapter............................................................... 23

## Chapter Two  Review and critique of the literature....................... 24

2.1 Search strategy................................................................................. 26
2.2 Ageing and nursing students....................................................... 29
   2.2.1 Social context of ageing...................................................... 29
   2.2.2 Attitudes of nursing students towards ageing and ageism........... 36
2.3 Addressing ageism through nursing education............................. 43
   2.3.1 Gerontology nursing through the lens of cultural safety............ 43
   2.3.2 Pedagogical strategies to address ageism............................. 48
   2.3.2.1 Didactic................................................................................. 49
Chapter Three  Methodology, method and design

3.1 Relationship and the philosophical positioning of Martin Buber

3.2 Narrative inquiry

3.2.1 Narrative inquiry as methodology

3.2.2 Meaning of experience

3.2.3 Dimensions

3.2.3.1 Place

3.2.2.2 Temporality

3.2.2.3 Sociality

3.3 Life story as method

3.3.1 Life stories in education and nursing

3.4 Rigour and life story

3.4.1 Credibility, transferability, trustworthiness and reflexivity

3.5 Design of the study

3.5.1 Recruitment of participants

3.5.2 Use of an intermediary

3.5.3 Engagement in the recruitment process

3.5.3.1 Confidentiality and informed consent

3.5.4 Maintaining cultural safety in the research process

3.5.5 Gathering of the stories from the participants

3.5.5.1 Story listening

3.5.5.2 Story telling

3.6 Analysis and interpretation of the stories

3.6.1 Transcribed interviews

3.6.2 Analysis and interpretation of the stories

3.6.2.1 Representing their stories
3.6.2.2 Restorying: writing the narratives…………………………….. 108
3.6.2.3 Thematic analysis across the stories…………………………….. 112
3.6.2.3.1 Development of themes………………………………………… 113
3.7 Summary of the chapter……………………………………………… 116

Chapter Four  Individual stories…………………………………………… 118
4.1 The stories………………………………………………………………… 118
4.1.1 Jon: I wasn’t expecting that……………………………………………… 119
4.1.2 Kanewai: Good stories………………………………………………….. 122
4.1.3 Josh: Always respect them……………………………………………… 125
4.1.4 Nalani: Life changing event…………………………………………… 128
4.1.5 Clare: Passion…………………………………………………………….. 132
4.1.6 Emma: Deep Love……………………………………………………… 136
4.1.7 Ana: Living a good life………………………………………………….. 141
4.1.8 Lily: Now I understand……………………………………………….. 144
4.1.9 Kaleo: Reminiscence…………………………………………………… 148
4.1.10 Lucky: Building rapport……………………………………………….. 151
4.1.11 Malia: Giving back…………………………………………………….. 156
4.1.12 Nora: Attached…………………………………………………………. 160
4.1.13 Kira: Field trips………………………………………………………… 163
4.1.14 Julia: Captured my heart……………………………………………… 166
4.1.15 Lena: Who turned on the light?……………………………………….. 169
4.2 Summary of the chapter………………………………………………….. 174

Chapter Five  Story themes………………………………………………….. 176
5.1 Liminal spaces…………………………………………………………….. 176
5.1.1 Story space: Threshold………………………………………………….. 177
5.1.1.1 Story listening and content………………………………………….. 177
5.1.1.2 World War II…………………………………………………………….. 182
5.1.1.3 Personal struggles…………………………………………………….. 183
5.1.1.4 Advice…………………………………………………………………… 183
5.1.1.5 Obstacles and challenges .......................................................... 184
5.1.2 Light space ................................................................. 185
5.1.2.1 Being let in .......................................................... 186
5.1.2.2 Changes in elders ................................................... 188
5.1.3 Reflective space: Transformation............................................. 190
5.1.3.1 Grandparents .......................................................... 190
5.1.3.2 Life lessons ............................................................ 191
5.1.3.2.1 Life is a story .................................................... 192
5.1.3.3 Perceptions of elders transformed .................................. 192
5.1.3.4 Reflections on reflections ........................................... 193
5.1.4 Caring space: Renewed vision ............................................. 194
5.1.4.1 Like their grandparents ........................................... 195
5.1.4.2 Taking time ............................................................ 196
5.1.4.2.1 Listening as a modality of care ............................... 196
5.1.4.2.2 Collaboration .................................................... 198
5.1.4.3 Caring in the future ................................................ 198
5.2 Summary of the chapter ............................................................ 199

Chapter Six Discussion of findings ...................................................... 201
6.1 Close relationships with elders .............................................. 201
6.2 Transforming attitudes ....................................................... 204
6.3 Shaping participants’ lives .................................................. 208
6.4 Commitment to providing care to elders ................................ 209
   6.4.1 Learning to care with elders ........................................ 211
   6.4.2 Culturally safe care .................................................. 216
6.5 Summary of the chapter ....................................................... 218

Chapter Seven Conclusion ............................................................... 220
7.1 Methodological reflections .................................................... 220
7.2 Issues of power and ethics in the research process ................. 221
7.3 Key findings for nursing education and practice ................. 223
List of Figures

Figure 1  Characteristics of relationship with elders………………………….71

List of Tables

Table 1  Nursing student participant levels and gender………………………….98
Table 2  Thematic analysis approaches from Jon’s narrative text…………………107
Table 3  Three-Dimensional Space Narrative Structure…………………………110
Table 4  Three-Dimensional Space Narrative Structure: Jon-I Wasn’t Expecting That
Table 5  Early Themes: Coding notes from journal……………………………113
Table 6  Developing themes: Coding notes from journal………………………114
Table 7  Themes of participants’ experiences of transition………………………116
Chapter One Introduction and positioning of the study

When teaching gerontology nursing to nursing students, their preconceived ideas, biases, and prejudices associated with ageing can become barriers to effective learning and care of elders. Little has been done to critically examine the efforts to reduce these barriers from the student’s perspective. This thesis explores the experiences of fifteen Bachelor of Science in Nursing (BSN) students who listened to the life stories of elders as part of their coursework and through their encounters with family members and informal acquaintances. The purpose of the study was to explore the experiences of nursing students who listened to elders tell their stories and show how their experiences of listening affected their thinking and practice.

This research project contributes to nursing knowledge in a distinct way. First of all, few studies have listened to nursing students and given voice to their experiences with elders. Secondly, this research uniquely used cultural safety as the framework to inform the study and address circumstances of ageism involving nursing students and elders. The consequences of ageism are included in the definition of culturally unsafe care which “comprises any action which diminishes, demeans, or disempowers the cultural identity or wellbeing of an individual” (Nursing Council of New Zealand [NCNZ], 2009b, p. 4).

The key findings of the study revealed that the nursing students were transformed both personally and professionally by listening to the stories of elders. Consequently, they discovered that the experience changed their attitudes and improved the way they provided nursing care to elders.

This chapter discusses my experience as a nursing faculty member and my efforts to improve gerontology nursing education which eventually culminated in the research project addressed in this thesis. The context to the research is presented with an introduction to gerontology nursing education, and identification of the aims, objectives, and justification for the study. In addition, this chapter provides background to the research project by explaining in detail my role as a nursing faculty member, and
my experience learning about cultural safety as the conceptual framework for the study. An overview of the thesis is presented and includes definitions of the terms and explanation of the language to be used in this thesis.

Increasing attention has been placed on gerontology nursing education and practice as changes in demographics indicate a worldwide growth in the number of elders (Hartford Institute for Geriatric Nursing, 2009; World Health Organization, [WHO], 2011). According to the World Health Organization (2007), this is a sign of improving global health. Not only are the numbers of elders increasing, but so are the years that elders live (Administration on Aging, 2010). Increased life expectancy is also an indicator of global health as long life is recognised to be a sign of good health (Holtz, 2008).

Throughout the world, the fastest growing segment of the world population is the group of elders 85 years old or older who live in the more developed countries (Administration on Aging, 2010; Australian Bureau of Statistics, 2010; New Zealand Guidelines Group, 2003; Statistics Canada, 2006; Statistics New Zealand Tatauranga Aotearoa, 2009; US Census Bureau, 2010a; United Nations, 2009). Elders over 85 years old have more than doubled in number within the last ten years in Australia (Australian Bureau of Statistics, 2010) and the UK (Office for National Statistics, 2010) with projections of continued increase. This holds true in the United States (US) and especially in Hawai`i which is one of the US states with the fastest growth in that age group (US Census Bureau, 2010a; Yuan, Karel, & Yuen, 2007). In the US, the population over age 85 is projected to more than triple from 2008 to 2050. (FIFARS, 2010).

The anticipated growth in numbers of elders worldwide is unprecedented and demands that the healthcare workforce prepare for the increase (United Nations, 2009). As elders “use more health care services than other age groups” (Gebhardt, Sims, & Bates, 2009, p. 245), there will be an increase in the number of older patients seen by nurses. This surge in numbers is primarily due to the ageing of the ‘baby boomers’ with the first ones having turned 65 years old in the year 2011. The over age 85 group will experience another wave of what has been called a “demographic tidal wave” after 2030.
when the ‘baby boomer’ surge joins that age group (FIFARS, 2010; Lehman & Poindexter, 2010, p. 27). This increase in numbers of elders highlights the need to educate and prepare nurses to meet the growing healthcare needs of elders. In response, nursing programs in the US and in other countries are being encouraged to strengthen and enhance gerontology nursing education at the baccalaureate level (American Association of Colleges of Nursing [AACN], 2010; National League for Nursing, 2011; Xiao, Paterson, Henderson, & Kelton, 2008). The importance of effective gerontology nursing education is summed up by Mathy Mezey, a pioneer in elder care in North America; “The population of older Americans is exploding. Geriatric patients are not one sub-group of patients but rather the core business of health systems” (Hartford Institute for Geriatric Nursing, 2009). This explosion is a universal phenomenon that impacts nearly all areas of nursing.

This research is positioned politically and socially in Hawai`i which is considered to be an environment of healthy ageing with rapidly growing numbers of elders with long life expectancies. In Hawai`i elders constitute a higher per cent of the state population and have a life expectancy 2.5 times longer than the overall national average of elders in the US population ((Lewis, Burd-Sharps, & Sachs, 2010: US Census Bureau, 2010b; WHO, 2011). When compared to Australia, the UK, Canada, and New Zealand, the percent of elders in Hawai`i is only less than in the UK (Office of National Statistics, 2010). Of the aforementioned countries, only Australia has a higher life expectancy than Hawai`i (WHO, 2011). The numbers of elders and the statistics for life expectancy in states or countries with Indigenous populations do not accurately reflect Indigenous elders due to their high prevalence of health disparities (Braun, Mokauau, & Browne, 2010; Cooke, Mitrou, Lawrence, Guimond, & Beavon, 2007). For example, Hawaiian Indigenous elders in Hawai`i have a life expectancy approximately six years less than the state average (Braun et al., 2010).

On the other hand, Hawai`i also reflects the stereotypical attitudes toward ageing that are prevalent throughout the US and in other Western countries such as the United Kingdom, Canada, Australia, and New Zealand (Cann & Dean, 2009; Gullette, 2011;
Kiata & Kerse, 2005; Minichiello & Coulson, 2005; Palmore, 2004). A nation’s increase in modernisation directly correlates with the imitation of Western culture and an increase in societal attitudes of ageism (World Health Organization, [WHO], 2002). Attitudes of disrespect and acts of rudeness toward elders are widespread. Ageism becomes normative and has been described as part of the “social fabric” (Hendricks, 2005), to the degree that it permeates healthcare and its institutions as well as individuals. Nursing students, as members of society, reflect and bring ageist attitudes with them to their care of elders (Aday & Campbell, 1995; Cozort, 2008). Attitudes that stereotype elders as frail, uninteresting and incompetent, isolate and marginalise them and diminish the quality of their healthcare (Butler, 2006; Coudin & Alexopoulos, 2010; Higgins, Van der Piet, Slater, & Peek, 2007; Levy & Banaji, 2004; Levy, Slade, Kunzel, & Kasl, 2002; New Zealand Group Guidelines, 2003). The manner in which nursing education impacts the attitudes of nursing students is central to the aims and objectives of the study.

The purpose of the study was to explore the experiences of nursing students who listened to elders tell their stories and show how their experiences of listening affected their thinking and practice.

1.1 Aims and objectives of the study

The overall aim of this study was to learn firsthand from nursing students how their experiences affected their thinking and practice when they listened to elders in a one-on-one interaction. I was interested in finding out about the experience from the viewpoint of the nursing students. As a nursing faculty member it was important to learn from the recipients of instruction if the experience was worthwhile for them as part of the gerontology nursing coursework. As a conceptual framework cultural safety informed the research and the understanding of the students’ experiences. If the impact was beneficial to their nursing education and enhanced the way in which treated elders, the findings would be informative for future planning of gerontology nursing education. These ideas led to the development of the specific questions to be addressed in this study:
• How does the experience of listening to elders’ stories impact on nursing students?

• Will the experience of listening to elders’ stories assist nursing students to feel more comfortable talking with elders?

• Does listening lead to a shift in attitudes, beliefs and values of the student nurse towards elders, and if so, how might efforts to incorporate listening experiences be applied in education and practice?

The research questions directly informed the way in which this study was designed and conducted. By using the methodology of narrative inquiry and the method of life story the nature of story itself was inherent in the design and gave participants a voice to talk about the experience. Conversational interviews enabled participants to have the freedom to talk about a variety of experiences and to reflect on their nursing practice. The use of narrative analysis to identify themes of the stories enabled me to determine the meanings of individual experiences as well as shared and divergent meanings between the participants (van Manen, 1990). Narrative inquiry, life story and narrative analysis fit well with the purpose of discovering meaning in the stories of the participants’ experiences (Riessman, 1993).

1.2 Justification for the study

This study contributes to the body of knowledge of gerontology nursing education by exploring the experiences of nursing students listening to elders’ stories, applying cultural safety to gerontology nursing education, and examining what it means to establish a relationship with elders.

From a review and critique of nursing literature, I found that no other studies had been conducted that involved listening to nursing students talk about their experiences after they have listened to the life stories of elders. Most studies had used surveys and measurement tools (Parchment, 2002; Shellman, 2007; Walsh et al., 2007). Even those that collected qualitative data through open-ended responses used written methods such
as questionnaires to determine the students’ reactions (Fox & Wold, 1996; Shellman, 2006; Walsh et al., 2007).

As the numbers of elders continue to grow more opportunities will become available for students to hear their life stories (FIFARS, 2010). Elders enjoy telling their stories to interested listeners and the act of reminiscing is therapeutic for their own healthy developmental growth. Nursing educators have provided opportunities for students to listen to life stories in different forms but this is the first study of its kind to examine the meaning of the experience for nursing students when they personally listen to elders tell their stories (Clark, 2002; Fox & Wold, 1996; Schenk, Davis, & Murray, 2008; Schwartz & Abbott, 2006; Walker, Newcomb, & Cagle, 2005; Welford, 2007).

Numerous studies have been conducted to examine nursing students’ attitudes toward elders (Celik, Kapucu, Tuna, & Akkus, 2010; de la Rue, 2003; Haight, Christ, & Dias, 1994; Hweidi & Al-Obeisat, 2006; Kotzabassaki, Vardaki, Andrea, & Parissopoulos, 2002; Lee, 2009; McLafferty & Morrison, 2004; Moyle, 2003b; Roberts, Hearn, & Holman, 2003; Ryan & McCauley, 2004/2005; Zambrini, Moraru, Hanna, Kalache, & Nunez, 2008), but few have personally interviewed them to establish if a particular educational activity had changed their attitudes (Celik et al., 2010; Kotzabassaki et al., 2002). The negative, ageist views that continue to pervade the nursing care of elders must be addressed in nursing education to improve the health care system (de la Rue, 2003; Moyle, 2003b; Zambrini et al., 2008). It is important to know what, if any, educational activities make an impact on the attitudes of nursing students toward elders.

Also unique to this study is the application of cultural safety to gerontology nursing education and practice. As a concept that addresses vulnerable or marginalised groups, cultural safety has not been previously applied to the lack of power, marginalisation and negativity directed toward elders who are healthy or independent. This research supplements studies that have only concentrated on frail elders or general patient populations (Richardson, 2010; Wilson & Neville, 2009). Cultural safety is the conceptual framework for this study, viewing ageism, ageing, and gerontology nursing
from the standpoint of its underlying principles. These principles of protection, participation, and partnership foster nursing care that is less ageist and culturally safe.

Lastly, this study analyses the factors that promote and prevent nursing students’ and elders’ relationships by bringing together the concept of cultural safety with the philosophical position of relationship according to Martin Buber (1965, 1970). Again, as far as I know, this approach has not been attempted before. Both cultural safety and Buber’s philosophical position contribute to understanding the relational aspects of nursing with elders.

As more and more elders receive care and dominate the clientele in healthcare (Gebhardt et al., 2009), it is essential for nurse educators to know which educational experiences promote positive relationships with elders. This thesis contributes to the efforts to provide effective nursing education and care that is beneficial and respectful to elders. My experiences as a gerontology nursing faculty member establish the background for this study.

1.3 Background to the study

Teaching gerontology nursing for the last 17 years, I have grappled with challenges to effectively prepare nursing students to meet the healthcare needs of the rising number of elders. I have had the opportunity to learn firsthand how students think about and observe how they value elders in the community and in their care. This chapter provides my teaching experiences as background for this study and provides a context for my relationship as a faculty member researching nursing students.

1.3.1 Teaching gerontology nursing

In my role as a nursing faculty member I have served as the head of the gerontology nursing program and as a course coordinator in a Hawai`i university BSN program. I taught alongside the other gerontology nursing faculty and developed the curriculum for the didactic lecture content. I also designed and coordinated the on-campus classroom and community-based clinical course. The lecture content had a holistic approach focusing on the psychosocial and physical aspects of ageing emphasising normal ageing
and healthy adaptation to risks and diseases that are prevalent in the older population. For instance, the presentation of normal ageing changes in the cardiovascular system included the subsequent high risk for both hypertension and orthostatic hypotension. Ways in which the elder could reduce these risks and their impact of these conditions were addressed. The content included exploring ageism as a reflection of the social context of ageing. The didactic lecture content was based on the National Gerontological Nursing Association (NGNA) outline of core curriculum for gerontology nursing education (Luggen & Meiner, 2001) and the Geriatric Nursing Education Consortium (GNEC) Faculty Guide (American Association of Colleges of Nursing & The John A. Hartford Foundation Institute for Geriatric Nursing, 2007). The NGNA resource emphasised a holistic approach to gerontology that addressed the myths and stereotypes of ageing and negative attitudes toward elders in addition to health promotion and ageing changes, major health problems, elder abuse, and end-of-life care. The GNEC curriculum guide provided instructional resources for BSN gerontology curriculum on the topics of heart disease, diabetes, mental health, atypical presentations of disease, and geriatric syndromes (e. g., incontinence, dementia).

For many years it was commonplace for gerontology nursing students to undertake their clinical placements in long-term care facilities, also referred to as nursing homes or aged residential care facilities (e. g., Duke University, New York University, Radford University). However, the emerging trends of holistic care and care of elders in nursing education have caused some gerontology nursing programs (e. g., Valparaiso University, University of Rhode Island) to provide models of healthy ageing into the clinical component (American Association of Colleges of Nursing, 2004). These changes have provided opportunities for nursing students to interact with more independent elders who represent the majority, given that only 4% of elders are institutionalised in the US (Administration on Aging, 2010).

The clinical gerontology course utilised experiential activities in a small group classroom setting where the students also discussed and reflected on their experiences in the community. Having oversight of the clinical course, I coordinated the selection of
community service learning activities with the agencies and the students. Students selected from a variety of activities which provided health education or services to elders, including support groups, Senior Olympics, senior health fairs, blood pressure and nutrition clinics, along with government agencies that allocated funding for elder services. In both the lecture and clinical courses, my contact with gerontology nursing students extended beyond those in my particular classes to include personal and or email and phone contacts with all of the 120-140 students each semester. In my role as the gerontology course coordinator, it was often necessary for students to contact me to make changes in their community service learning assignments or if they needed suggestions for finding a senior companion.

Each gerontology nursing student was also responsible for visiting an elder living independently in the community. The objective of the assignment was for students to spend time with the elder on their own terms and experience a companion-like relationship, thus the elder was called a senior companion. Students were encouraged to visit someone who was cognitively intact and not a close relative. The nursing student visited an elder an average of 6-8 times over the course of the semester. By talking with them about their life and participating in activities with them in their home or in the community they were able to learn what it was like to age. Students were encouraged to inquire about the elder’s interests in leisure activities, their social support system, health needs, spirituality and life history as potential topics to initiate the conversation. Ideas for each of the topics and sample spirituality questions were available for the students in the course materials.

The gerontology nursing students also had opportunities to talk to and listen to elders in the community based activities. The foundational assumption of community service learning activities was that they were mutually beneficial with the student providing service through friendship, companionship and reminiscence or to an agency which served elders, while the nursing student benefitted by learning about elders and their lives. Through these activities students became aware of the agencies and services that elders utilised to maintain their quality of life.
The gerontology nursing lecture and clinical courses were required core components for the BSN program. Requiring gerontology as a stand-alone course continues to be the least commonly used format to teach gerontology nursing in US nursing education (Dodge, 2007). Over 90% of the nursing programs in the US integrate gerontology nursing content throughout the BSN coursework (Berman et al., 2005). Even though a coexisting stand-alone course with an integrative approach has been shown to be the most effective, only about 30% of nursing programs include a stand-alone gerontology nursing course (AACN, 2010; Berman et al., 2005; Page, 2009; Thornlow et al., 2006; Whitireia New Zealand, 2011). The core competencies for BSN nursing education in the US recommend that nursing students be prepared to care for at-risk patients such as the frail elderly and “recognize the impact of attitudes, values, and expectations on the care of…frail older adults” (American Association of Colleges of Nursing, [AACN], 2008, p. 28). These guidelines specify the care of frail elders as opposed to the broader standards in other countries that provide care for older people in various healthcare settings (Canadian Nurses Association, 2010; Nursing Council of New Zealand, 2005; Nursing and Midwifery Council, 2010) or patients of all ages (Australian Nursing and Midwifery Council, 2005). In 2010, specific gerontology nursing competencies were released that address the needs of all elders to be integrated into didactic and clinical curricula throughout baccalaureate nursing programs and stand alone gerontology nursing courses (AACN, 2010).

The BSN degree plan consisted of 1 ½ years of general education and prerequisite science courses before starting the clinical based nursing courses. There were five levels (semesters) of nursing coursework and gerontology was placed in Level 2 which correlated with the first semester of the Junior year. The placement of gerontology nursing strategically built on the previous Level 1 nursing courses of health assessment, nursing concepts and therapeutic communication. It is noteworthy that in Level 1, the nursing students experienced their first clinical course applying beginning nursing skills in a long-term care facility. They provided care to dependent patients with multiple co-morbidities such as urinary incontinence, cerebrovascular accident (CVA), dementia, and diabetes. Nursing educators have reported that having nursing students care for frail
or dependent elders early on in their coursework can positively or negatively impact on their perceptions of ageing (Aud, Bostick, Marek, & McDaniel, 2006; Brown, Nolan, Davies, Nolan, & Keady, 2008; Rowland & Shoemake, 1995). Nursing students conveyed feelings of negativity toward elders after working in settings that reflected those views (Aud et al., 2006) and students expressed “less positive feelings” after their experiences in nursing homes (Rowland & Shoemake, 1995, p. 743). The specific impact of working with dependent elders is elaborated on further in Chapter Two.

The needs of elders and the changing trends in gerontology nursing have been emphasised in the ongoing process of program evaluation and revision. Keeping the course content current and relevant to the undergraduate nursing students has been considered in the revision of the curriculum.

1.3.2 Gerontology nursing curriculum revision

The gerontology nursing program described in the previous section came about as a result of curriculum changes which shifted its focus to healthy ageing. For many years nursing students were surveyed by gerontology nursing faculty to find out their attitudes toward ageing. Their views were shown to be stereotypical and similar to nursing students in other programs. For example, they did not perceive old age or long life as a sign of health. Instead old age was viewed negatively, primarily as a time of decline and dependence (McLafferty & Morrison, 2004; Moyle, 2003b). Negative views of ageing often translated into a lack of interest in the course content. This disinterest was frequently verbalised by students the first day of class during open discussions. They commented that “gerontology was not important”, “I don’t want to spend time changing adult briefs”, and “all elders are eventually going to become senile.” By the end of the course some students felt better informed while others still did not think gerontology content was relevant to their nursing practice. Finding interesting ways to engage students was only part of the challenge. The other part was to create a curriculum that positively impacted on the nursing students’ experience in working with elders. Ultimately the priority was to counter ageist beliefs, a trend emerging more and more in
the nursing literature (Cozort, 2008; de la Rue, 2003; Lovell, 2006; Parkinson, 2010; Williams, Anderson, & Day, 2007).

Ageism runs counter to the core values of professional nursing that are fundamental to baccalaureate nursing education. Nursing students are taught that values such as autonomy, dignity and social justice are foundational to providing individualised, patient-centred care, care that promotes self-determination and does not discriminate (AACN, 2008; Baillie & Gallagher, 2008; Dempsey, French, Hillage, & Wilson, 2009; Fowler, 2008; International Council for Nurses, 2012; Manley, Hills, & Marriot, 2011; McCormack, Dewing, & McCance, 2008). These values are intended to be broadly applied to all areas and specialties of nursing care in order to foster the nursing student’s caring and therapeutic relationships with patients. Ageist attitudes create a barrier for the nursing student to apply these professional values when caring for elders. The consequence is that they do not receive the care they need and deserve. Elders who encounter negative attitudes experience a decline in their health, which in turn reinforces ageist views (Coudin & Alexopoulos, 2010; Gething, Fethney, McKee, Goff, Churchward & Slade, 2002; Kang & Chasteen, 2009; Levy, Ashman, & Dror, 2000; Minichiello et al., 2000; Phelan, 2008). Reducing ageist beliefs of nursing students can benefit elders by improving the quality of nursing care and ultimately their quality of life (Braithwaite, 2004).

Efforts to dispel myths of ageing were introduced into the curriculum primarily by exploring how the media misrepresents and shapes society’s views of ageing (Pasupathi & Lockenhoff, 2004). Teaching students about normal ageing changes helped to correct misconceptions which are often portrayed through the media (e.g. television programs, commercials). Television commercials that portrayed elders in need of assistance for confusion, urinary incontinence and mobility limitations were recognised as misleading. Students came to recognise that not all elders experienced dementia or frailty.

Trends and changes in nursing education have resulted in shifting to more patient-centred and holistic care as well as responding to the ageing demographics of the healthcare population. The growing field of gerontology nursing education reflects
those changes with a move away from geriatrics, the study of diseases of the aged, to a gerontology focus which includes addressing the social, psychosocial and ethical aspects of ageing (Blais, Mikolaj, Jedlicka, Strayer, & Stanek, 2006; Burbank, Dowling-Castronovo, Crowther, & Capezuti, 2006; Cozort, 2008; Wykle & Gueldner, 2011).

I have experienced firsthand the shift from a biomedical model to a more holistic approach in gerontology nursing education. For many years, the gerontology nursing students only encountered the sickest, most dependent elders in long-term care during their clinical rotations. During a period of curriculum revision and shifting to a healthy ageing emphasis, changes were made to discontinue the use of long-term care clinical sites and place students in settings with more active and independent elders. With greater opportunities to interact, the nursing students were able to talk story which is a common phrase used in Hawai‘i to describe “a personal style of communication through storytelling and informal sharing” (Davis, 2010, p. 242). It is the Hawaiian practice of enjoying conversation which includes listening to the life stories of elders (Affonso, Shibuya, & Frueh, 2007; Noland, Hiura, & Engebretson, 2005).

1.3.3 Employing life stories as an educational strategy

Listening to life stories started out as a positive experience comprising of interacting with elders in the community rather than an intentional educational strategy in the gerontology nursing courses. Due to an influx of nursing student enrolment one year, community service learning sites became scarce. As a solution to placement shortages, I put together an alternate plan to have a group of students visit World War II veteran groups such as Women Accepted for Volunteer Emergency Service (WAVES), the Japanese-American 442nd Regimental Combat Team, and Pearl Harbor survivors to interact with elders and learn from them about their life histories.

The life story that inspired me to seriously consider the impact of listening to stories came from a combat veteran of World War II, a Pearl Harbor Survivor. I met him with a small group of gerontology nursing students at the USS Arizona Memorial and he told
us his story. He skimmed over the part when he was onboard a ship as it was bombed in Pearl Harbor. Instead, he emphasised his story of healing. He attributed his recovery from injuries and a second chance at life to the actions of the nurses. He explained that it was not just the physical healing but their moments of listening and their encouragement to tell his story that saved his life (R. Fiske, personal communication, October 2003.)

The students who heard the story of the veteran expressed positive comments, stated how privileged they felt to have met him and to have heard his story. The story, however, did not end there. A few months later, at the very time when this elder had been scheduled to speak with another group of gerontology nursing students, he was being buried at Punchbowl Cemetery of the Pacific.

Despite the increasing mortality of World War II veterans dying at a rate of about 850 per day in the US (US Department of Veterans Affairs, 2010), the White House Conference on Aging (2005) specified that the veterans of World War II, most of whom are aged 85 years and older, “will continue to increase steadily, reaching nearly 1.4 million by 2012” (p. 2). As the 85 years and older cohort continues to increase so will the need for nurses who are educated to meet the healthcare needs of older adults.

These are also the adults who are the most likely to become clients in healthcare settings. Those 85 years and older have a higher percent of emergency department visits, acute care hospital days, length of stay in long-term care facilities, and care in out-patient clinics in the US and UK (Collerton et al., 2009; Jagger et al., 2011; US Department of Health and Human Services, 2009). As the incidence of chronic illness increases with age, these elders will require ongoing care. About 80% of them have one or more chronic illnesses with heart disease, hypertension, dementia, and arthritis being some of the most common conditions (Australian Bureau of Statistics, 2010; Collerton et al., 2009; New Zealand Group Guidelines, 2003; Statistics Canada, 2006; US Department of Health and Human Services, 2007). Nursing students will continue to encounter more of this cohort of elders in all areas of healthcare and in community activities.
The experience the nursing students had with Pearl Harbor survivors and veterans of World War II provides an example of a positive experience for a particular group of students outside of a healthcare setting. As a result, going to the USS Arizona Memorial and listening to stories became a popular option as one of their community service learning activities. During end of course conferences and through written evaluations students who chose the activity said they were glad they did. This led me to ask myself, “What difference did this experience have for the students?” “Were their attitudes toward elders changed in any way?” “Did it make them a better nurse?” “Should these activities be required for all gerontology nursing students?”

Nursing educators Kirkpatrick and Brown (2004) and McNeill, Shattell, Rossen, and Bartlett (2008) indicate that listening to the life story of an elder can be a positive experience for nursing students in various settings including mental health and geriatric nursing. Students listened to the stories of elders in continual care mental health settings and in their homes when they provided one-on-one community service to the elders. As part of the clinical placement requirements students in both of those specialty settings were given assignments to reflect on their experiences. They wrote that listening to the life story of an elder heightened their respect and was an enjoyable activity. Shellman (2006) studied nursing students who received reminiscence education with information on reminiscence and communication techniques and used it in their community health rotation. The students benefited from the experience with a sense of increased confidence and comfort with elders. This is helpful because positive experiences have been shown to reduce ageism and reducing ageism has been described as an imperative in gerontology nursing education. The possibility of confronting and addressing ageism from a new perspective came about when I learned about the concept of cultural safety.

1.4 Coming to know about cultural safety

My own understanding of how to teach gerontology was further changed after I met the late Irihapeti Ramsden, a leading Maori nursing educator from New Zealand. She was a keynote speaker at the Transcultural Nursing Research Conference in Queensland,
Australia in 2000 where I was one of the presenters. I never saw nursing in the same way after I first met her and heard her speak. She spoke about the role of the nurse as the servant to the client. The imagery was similar to the ideals of dedication and service in nursing, but this presentation was life-changing for me. My whole understanding of nursing was turned upside down. I realised that my efforts to teach students about being patient-centred never took into account the power differential between the nurse and the patient. In a gentle yet compelling voice the speaker described the damaging misuse of power in nursing. She spoke about the tendency of nurses to see themselves as the norm and the patients as “other.” This attitude has the potential to put clients at risk by maintaining a position of dominance and inequality that contributes to existing health disparities. Her challenge to nurses was to change their mindset and to shift the power differential to the client if they wanted to provide care that was beneficial. This was my introduction to cultural safety.

The concept of cultural safety originated within professional nursing in New Zealand where it became integrated in nursing education and compulsory content in licensure examinations in 1992 (Ramsden, 2002; Richardson & Williams, 2007). It has its roots in the historical context of New Zealand, and more specifically in the colonisation of Maori (Indigenous people of New Zealand) by English settlers following the signing of the Treaty of Waitangi in 1840 between the Maori and the British Crown (Ramsden, 2002). The concept of cultural safety is based on upholding the principles of the Treaty of Waitangi which granted self-determination to Maori, including for healthcare. Its principles focus on partnership, participation and protection resulting in self-determination (NCNZ, 2009b; Wood & Schwass, 1993).

According to the NCNZ (2009b), cultural safety is defined as: “The effective nursing practice of a person or family from another culture, and is determined by the patient or family” (p. 4). The patient is the one most familiar with their cultural reality; therefore, it is the client, not the nurse who decides if the care is culturally safe. In this way the power is shifted to the recipient of care and healthcare care is determined by the patient or consumer in partnership with the healthcare provider.
As a conceptual framework, cultural safety has provided me with a new vision of nursing and nursing education. As I went back to the classroom teaching gerontology I shifted my thinking regarding the standards of care for elders. Self-determination was no longer to be viewed as the nurse allowing the elder patient “to make their own care decisions” (Ebersole, Hess, Touhy, & Jett, 2005, p. 16), but self-determination was now about the nurse being willing to give up his/her power to enable the client’s wishes and decisions to be the central determinant of care.

This transfer of power from student to patient fits well with gerontology nursing standards, the nursing process, and the Patient Self-Determination Act (American Nurses Association [ANA], 2010b; Ebersole, et al, 2005). The Patient Self-Determination Act is a law in the US that gives patients the right to participate in and direct their own healthcare decisions (Ulrich, 1999).

In my teaching, however, I have found that many nursing students hesitated to enable elders to have control over their care. They routinely chose to do things to or for elders, rather than with them. Often the steps of the nursing process (e.g. assessment, diagnosis, planning, intervention and evaluation) are overlooked and nursing students develop a plan of care without consulting the elder patient, thinking that they knew what is best for the patient (American Nurses Association, [ANA], 2010a). Students can become frustrated when their plans for the older patient do not work, or elder patients do not agree with them, and the students have to revise the plan.

I noticed that after nursing students became familiar with myths of ageing and learned about ageism, they displayed what is called the “new ageism” (Bytheway, 1995). Their response was sympathetic and protective of elders, so much so that they did more for them, acting in a paternalistic manner (i.e. colonising). The nursing students continued to make decisions for elders and did not relinquish power to them (Hendricks, 2005).

The definition of cultural safety recognises ageism as a factor which contributes to unsafe and ineffective nursing care (NCNZ, 2009b; Polascbek, 1998; Ramsden, 1997; Wilson & Neville, 2009). Cultural safety and efforts to reduce ageism are closely linked
as ethical imperatives for developing caring relationships that counter marginalisation and oppression (McEldowney & Connor, 2011; Rees, King and Schmitz, 2009; Woods, 2010). The literature supports the premise that due to ageism elders are a generation who do not consistently receive nursing care that is of their choice but who would benefit if they did (Angus & Reeve, 2006; Palmore, 1999). This is the exact opposite of cultural safety: “safe service to be defined by those who receive the service” (NCNZ, 2009b, p. 5). The terms used to describe culturally unsafe care and the terms to describe ageist behaviours and attitudes are very similar (e.g. dismiss, dominate, patronise). “Dismissing the voice” of elders (Moyle, 2003b, p. 19) and viewing the ageing patient as “other” are forms of ageism. Bytheway (1995) maintains that in order to combat ageism the “us-them” mentality toward elders must be abandoned. Cultural safety asserts that the shift in power to the patient gives them self-determination and enhances their care which concurs with efforts to reduce ageism by addressing the issue of power within the relationship (Angus & Reeve, 2006). This includes working with elders by “being with” not just “doing for” (Hanson & Taylor, 2000; Strickland, 1996). The behaviours of nurses that demean and dismiss elders’ personal healthcare desires support the idea that culturally unsafe care is far too prevalent in gerontology nursing.

Nursing and gerontology literature on attitudes toward elders demonstrates that nurses and nursing students reflect ageist beliefs and assumptions which have contributed to the mindset about knowing what is best for older clients. (McLafferty & Morrison, 2004; Palmore, 1999; Pasupathi & Lockenhoff, 2004; Roach, 2000; Tuckett, 2006). These behaviours result from stereotypical views of elders as dependent, and negative views of ageing (Moyle, 2003b). Whatever the reason for these actions, nursing educators and gerontologists make it clear that there are ways to counter negative images of ageing (Burbank, et al., 2006; Cozort, 2008; de la Rue, 2003; Ferrario, Freeman, Nell, & Scheel, 2008; Herdman, 2001; Levy, 2001; Lovell, 2006; Palmore, 1999). These include exposing students to positive images, having them experience high quality contact with elders, getting to know them as individuals, and learning about the historical context of their lives. Countering ageist attitudes that elders are dependent and uninvolved can help in returning the power of care to the client. Viewing
gerontology through the lens of cultural safety helped me to recognise the importance of addressing the power imbalance between the students and elders. In an effort to counter ageism and reduce the power imbalance, I sought out experiences for the students that were positive and that could be carried out with instead of for the elder.

The process of teaching cultural safety in baccalaureate nursing programs has been written about and studied by nurse educators. Self-examination and reflection have been identified as key strategies to promote culturally safe education and practice (McEldowney, et al., 2006; Ramsden & Papps, 1996; Richardson & Carryer, 2005; Wood & Schwass, 1993). As part of their instruction on cultural safety, nursing students in New Zealand identified and examined their attitudes and beliefs to become more open-minded and respectful of clients who were different to them (Ramsden & Papps, 1996). Shaping nursing students’ attitudes could be a difficult process if their attitudes are strongly linked to their own self-concept (Wood & Schwass, 1993). McEldowney et al. (2006) found that when nurse educators used practice exemplars to teach reflection it enabled students to shift their thinking and better understand cultural safety. Richardson interviewed nurse educators who taught cultural safety and found that nursing students benefitted from a supportive learning environment as they became self-conscious of their attitudes toward others and self-aware about shifting power to the person receiving care in the nurse-patient relationship (Richardson & Carryer, 2005).

In addition to being taught in nursing education, cultural safety can be applied to nursing practice and research. When the principles of cultural safety are applied to research, it is necessary to address the power differential that exists between the researcher and the participants (Wilson & Neville, 2009). For the purpose of this study, the way in which I shifted the locus of power was by collaborating with the participants as we made decisions about the interview process and by listening to their voices as they shared their experiences with me. The way cultural safety was applied to the interviews and the creation of the participants’ stories are explained in detail in Chapters Three, Six and Seven.
Cultural safety is a well-established concept in education, practice and research; however, there is a lack of research which applies cultural safety to elders in the general population. Up until now, cultural safety has not been applied to a study as a conceptual framework addressing ageism and the resulting power imbalance experienced by elders who are independent. As previously mentioned, when nursing students listened to veterans’ stories it introduced me to the value of life stories and led me to blend life stories with cultural safety as a conceptual framework for this thesis. The body of nursing knowledge is limited on the use of the educational strategy of nursing students listening to the stories of elders. This study makes a unique contribution to nursing’s body of knowledge by including the perspective of nursing students who used life stories in their gerontology nursing course. Blending the practice of listening to elder’s life stories with cultural safety in nursing education warranted investigation contributes to the developing knowledge and practice of gerontology nursing education and practice.

Initially, cultural safety was “a response to the poor health states of Indigenous New Zealanders but has since been broadened to encompass a wide range of cultural determinants” (Richardson & Williams, 2007, p. 699). In this context, the word ‘culture’ in cultural safety can also refer to a cohort of people determined by their age or generation (NCNZ, 2009b). In this way, cultural safety can be applied to care of the older generation (Jungersen, 2002; Ramsden, 2002; Richardson, 2010; Richardson & Carryer, 2005; Wilson & Neville, 2008; Woods, 2010).

Cultural safety characterises all forms of oppression and discrimination as culturally unsafe and this includes the marginalisation and objectification of patients due to stereotyping (Rees et al., 2009). Culturally unsafe practices that “diminish, demean and disempower” (NZCN, 2005, p. 4) an individual perpetuate socially constructed stereotypes that prevent cultural groups from receiving quality healthcare. Cultural safety begins by challenging the assumptions of the dominant society that perpetuate stereotypes such as ageism. Stereotyping and power are mutually reinforcing because stereotyping exerts control, maintaining and justifying the status quo (Fiske, 1993). The
predominant stereotypes of elders downplay their ability to make sound and rational decisions. Instead, ageist views cloud the judgement of nurses by confusing decision making on another’s behalf with caring. Historically, cultural safety has questioned the way in which nurses exercise their authority over patients when they take on the “we know best attitude” of the dominant healthcare culture (Greenwood, Wright, & Nielsen, 2006, p. 206; Henderson, 2003). Cultural safety promotes effective nursing care that is determined by the patient rather than determined by the preconceived ideas of the nurse (NCNZ, 2009b).

Issues of marginalisation, diminished care, and powerlessness that are a result of ageism became clearer to me with the inclusion of cultural safety as the conceptual framework for this study. The marginalisation of elders and lack of control over their own decisions that can result from ageism, is the antithesis of cultural safety which strives to reduce marginalisation and promote participation and self-determination in the provision of health care. The loss of power associated with ageism can be regained by applying the principles of cultural safety to healthcare practice. Cultural safety shifts the locus of power from the caregiver, such as the nurse, to the care receiver, which in this case is the elder.

1.5 Overview of the thesis

The word ‘gerontology’ is used to define the study of ageing and elders (Tabloski, 2010). The term ‘elder’ has limited and specific meanings in many global settings. In traditional usage it is a general expression for older adults or a title that signifies one who is valued for their wisdom (Rosowsky, 2005). Elder is used in this way within Indigenous groups in the US, Canada, New Zealand, and Australia (Choy, Mokuau, Braun, & Browne, 2008; Jervis, 2010; McConchie, 2003; Papuni & Bartlett, 2006; Young, 2008). Current use of the term in nursing and gerontology literature gives it a broader application which includes all older adults, generally referring to those over 65 years old (Jitramontree & Schoenfelder, 2010; Minichiello, Browne, & Kendig, 2000; Shellman, 2007; Thomas & Johansson, 2003; Thornlow, Latimer, Kingsborough, & Arietti, 2006; Walsh, Chen, Hacker, & Broschard, 2007; Wangmo, Ewen, Webb,
This term also conveys a positive view of ageing and refers to an older person with honor and respect (Schacter-Shalomi & Miller, 1997).

In this thesis the term ‘nursing student’ refers to BSN students. The terms nursing faculty, instructor, and educator all refer to a nurse who instructs BSN students in either the classroom or clinical sites. A variety of terms such as Native Hawaiian, Kanaka Maoli or Hawaiian are acceptable to represent the Indigenous people of Hawai`i (Braun et al., 2010; Choy et al., 2008; Davis, 2010; Oneha, 2001). For the purpose of this thesis the general term Hawaiian is used.

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Australian English spelling is used throughout this thesis except for when citing direct quotes which remain true to the original source. The American Psychological Association (2010) standards for style have been used throughout the thesis.

In Chapter One I have introduced the background and context to the study. An overview of my role as nursing faculty and experience teaching gerontology nursing includes the challenges of addressing ageism. I have described how my ideas about nursing education have changed and evolved as I was introduced to the concept of cultural safety and listening to life stories. As more students began to listen to the stories of elders I felt challenged to find out whether this was a valuable activity in gerontology nursing education.

Chapter Two reviews the key literature related to gerontology nursing education, ageism, cultural safety and life stories. The context of ageing within society and efforts to reduce ageism in nursing education are addressed along with the various uses of stories. Reducing ageism, the promotion of cultural safety and listening to life stories are shown to share in the promotion of relationships.

The different components of the research process are described in Chapter Three. The rationale for choosing the research methodology of narrative inquiry and the method of life story explain how they are situated within the study. The philosophical position of relationship according to Buber and the conceptual framework of cultural safety inform the study and the research process. The ethical considerations of the study surrounding
the recruitment and interviewing of the participants are discussed in relation to my dual role as researcher and nursing faculty. The specific process of restorying or retelling the participant interview transcripts into narrative texts is described along with the process of interpretation and analysis of the stories.

Chapter Four contains the 15 participant narrative texts created from their interview transcripts. Each of the stories stand alone, yet they also share many commonalities. The names of participants were replaced with pseudonyms.

Chapter Five presents the interpretation of the participants’ stories using thematic analysis. The development of the resulting theme of liminal spaces and four subthemes of story space, light space, reflective space and renewed vision are presented and discussed with examples from the participants’ narrative texts and literature supporting the interpretation of the stories.

Chapter Six provides an examination of the key findings from the study in light of the literature. Findings are based on the participants’ interview transcripts, narrative texts, resulting themes and personal insights. Culturally safe nursing care is also explained as applied to the care of elders.

Chapter Seven concludes the thesis with methodological reflections, issues of power and ethics in the research process, key findings for nursing education and practice, implications of the study, research possibilities and final reflections.

1.6 Summary of the chapter

In order to keep nursing education current and up-to-date with the increasing ageing of the client population, gerontology nursing education requires careful evaluation of the way in which it is taught. My experience teaching gerontology nursing raised questions about how nursing students’ attitudes influence the health outcomes of elders. This prompted me explore the use of life stories both as an educational strategy and as a research method to give voice to nursing students’ perceptions of listening to elders. The next chapter critically reviews key nursing literature to identify what was already known about ageism and the attitudes of nursing students in nursing education prior to
the study. Different teaching strategies including the use of life stories within gerontology nursing are examined. The chapter begins with a description of how the literature review was conducted.
Chapter Two Review and critique of the literature

This chapter begins with an introduction to the topics selected for the literature review and how it was conducted. The review of the literature examined concepts of ageing, ageism, nursing education and the nurse-elder relationship, and concluding with a summary of the review.

The identification of literature to inform this study began by searching the topics related to the research questions. My review of the literature on teaching gerontology and listening to life stories began with a few key words that related to nursing students and their attitudes toward elders. As the search and review unfolded, each article and book led me to other sources, many of which were early or classic articles on gerontology, nursing education, or stories. For example, Shellman’s (2006) article on nursing education discusses reminiscence and ageism and referred me to the writings of Butler (1969) on ageism. However, it became very clear early on, that I was travelling in ‘uncharted territory’. As I focused my search more specifically on nursing students talking about their experiences listening to elders, there was an evident lack of research on this topic. A second area of focus, the conceptual framework of cultural safety as a way to view nursing care of well elders, was nonexistent in the research literature. These findings reinforced the rationale and justification for this study and led me to search further and examine specific concepts related to the relationship of nursing students and elders.

The attitudes of nursing students toward elders were a significant focus. The positive and negative attitudes of nursing students were examined with most scrutiny being given to the negative attitudes and the factors that contribute to ageism. Also of particular interest was how these negative attitudes were being addressed in nursing education. It became important to delve deeper into the background and origins of ageism in nursing students both within the context of nursing but also as members of society at large. This approach was supported by incorporating the principles of cultural safety which expanded my perspective of not only exploring the issue of power as it related to the nurse-elder relationship but also about how power plays a part in the
social context of ageing and ageism. Research on power and ageing included addressing the role of “other” in the nurse-elder relationship. Writings on relationship, power and attitudes toward ageing were present both within the field of nursing (e.g. Hage & Lorenson, 2005; Henderson, 1994; Palviainen, Hietala, Routasalo, Suominen, & Hupli, 2003; Phelan, 2008; Polifroni, 2010) and addressed in greater depth by writers from education (e.g. Koren et al., 2008; Rosowsky, 2005) and the social sciences (e.g. Angus & Reeve, 2006; Butler, 2006; Cuddy, Norton, & Fiske, 2005; Levy & Banaji, 2004; Nelson; 2005; Palmore, 2005; Powell, 2006).

It was clear that within nursing education, efforts were being made to identify and counter ageism by modifying gerontology curriculum in the classroom, utilising particular clinical sites, incorporating self-reflection, and promoting interactions with a variety of older adults (Burbank et al., 2006; de la Rue, 2003; Ferrario et al., 2008). Enhancing the nurse-patient relationship and improving the nursing care of elders were the primary goals. A recommended teaching strategy, for example, was the use of stories in gerontology nursing education.

2.1 Search strategy

I began to search for relevant literature by using computer generated databases related to nursing, ageing and education. The databases included CINAHL (Cumulative Index of Nursing & Allied Health Literature); Health Source: Nursing/Academic edition; ERIC (Education Resources Information Center), Education Research, SocINDEX; and, PsycNET Psychology & Behavioral Science Collection.

I used the following key search words: nursing students, elder, elderly, older adults, older people, life stories, stories, reminiscence, attitudes, ageism, ageing, cultural safety, gerontology and nursing education.

The search for articles was limited to those in English and published within the last 15 years (1994-2010) to get an overview of theory and practice in nursing education and research and gerontology. The earlier works of some key writers were included for context and perspective. For example, the early work of Robert Butler (1969), who first
coined the term “ageism”, was a valuable primary source. Other authors such as Foucault (1980, 1995), Buber (1965, 1970), Kleinman (1988), and Wood and Schwass (1993) provided insight from early and classic writings on power, stories, and cultural safety.

I also used resources that were available to me through Hawai‘i universities, Victoria University of Wellington (New Zealand), Charles Darwin University (Australia) and the library systems in the US States of Hawai‘i and Washington. The Australian Digital Theses Program database and Proquest (the International Digital Dissertation and Theses database) were used to review relevant masters’ and doctoral theses in nursing worldwide. New Zealand, Australia, and US universities and public libraries were used to obtain books related to the key word subjects. Amazon.com was used to identify the most recently published texts. Bibliographies of articles and books were informative sources of earlier writings. Colleagues and peers assisted in the review by suggesting and sharing relevant literature references.

International peer-reviewed journals and theses were the chief sources of information as well as a few substantive publications regarding the experience of ageing. Nursing journals from the US, Australia, New Zealand, Canada and the UK were the most plentiful on the key study topics and thereby became the primary sources of articles. Policy and position statements of nursing associations in these countries provided a framework for the standards that guide nursing care and education. Educational journals provided a better understanding of innovations such as the use of stories, priming of positive images, and transformational learning that were also being applied to nursing education (Bennett & Gaines, 2010; Coulter, Michael, & Poyner, 2007; Gattuso & Saw, 1998; Schenk, Davis & Murray, 2008; Taylor, 2007). Writings from nursing as well as the social science fields of psychology, sociology, social work, gerontology, and education provided a historical and present day perspective on ageism (e.g. Butler, 1969, 2002; Bytheway, 1995; Cann & Dean, 2009; Gullette, 2011; Levy, 2004; Nelson, 2005; Palmore, 1999, 2005; Wilkinson & Ferraro, 2004). Cultural safety information and studies were retrieved from journals in nursing and from a few other healthcare specialties such as physical therapy and occupational therapy (Jungersten, 2002; Mann, McCallin, &
Smith, 2006). Fundamental to cultural safety, the concept of power was researched as it related to caring relationships in the fields of nursing, sociology, psychology and education (Australian Psychological Society [APS], 2000; Fiske, 1997; Foucault, 1995; Freire, 2000; Henderson, 1994, 2003; hooks, 1994, 2010; Palmer, 2007; Palviainen et al., 2003; Polifroni, 2010; Powell, 2006).

Review and critique of the literature revealed that there were some shared and recurring themes emerging. The most prominent theme was relationship. Nursing, psychology, social work and education all recognised relationship as being at the core of their professional interactions. A positive relationship with a client is the key to providing care, therapy and education (Nelson, 2005; Hagarty & Patusky, 2003; Schwartz & Abbott, 2007; Tarlier, 2004). I broadened the search to take into account factors that support and nurture relationships, especially in professional settings. Citations in articles and books led me to discourses in philosophy that shared other common themes related to relationships such as power, listening, attitudes, and “other”. For instance, nursing authors discussed the imbalance of power in nurse-patient relationships from the perspective of Foucault (Henderson, 1994; Henderson, 2003; Polifroni, 2010). Also, the philosophy of Martin Buber gave a broader perspective and support to ideas and recommendations found in the literature related to the research questions of this study. Buber’s understanding of listening as “embracing the other” was applicable to the central focus of this study related to listening to elders (Buber, 1965; Gordon, 2011). The philosophical position of relationship according to Buber is discussed with more detail in Chapter Three related to the methodology, method and design of the study.

Further review of the literature expanded to focus specifically on nursing students and elders. The attitudes of nursing students toward elders are explored as well as the ensuing impact on their relationships with elders. Society’s views on ageing, ageism and the attitudes of nursing students are also examined.
2.2 Ageing and nursing students

This review of key literature included an examination of society’s views on ageing in order to provide a context to the ongoing socialisation of nursing students and what is known about how it can affect their views of elders. This is followed by a review of literature on ageism within nursing, concentrating on the attitudes and beliefs of nursing students. Recommendations and studies on reducing ageism through specific teaching strategies were summarised. In addition, there is a review of the writings on cultural safety and its application to gerontology nursing education.

2.2.1 Social context of ageing and ageism

Discussions on the social context of ageing and ageism have been spearheaded by experts in the fields of medicine (Butler, 1969, 2006, 2008), gerontology (Bytheway, 1995, 2005; Palmore, 1999, 2001, 2004), psychology (Braithwaite, 1993, 2004; Levy, 2001; Nelson, 2004) and sociology (Powell, 2006). Through research and education, these experts have drawn attention to the effects of ageism on elders and their quality of life. Continuing public debates and research have addressed the impact of misconceptions about ageing and ageism on public policy and healthcare (Levy et al, 2002; Powell, 2006). Specific actions to reduce the negative influence of ageism focused on education and positive interactions with older adults.

Despite efforts over recent years to promote “healthy aging” the most pervasive images of ageing within society continue to be negative and stereotypical (Angus and Reeve, 2006). In 1969, Butler began the discussion on the “systematic stereotyping and discrimination against people because they are old” (Butler, 2008, p. 40). He defines this process as ageism, calling it a form of bigotry and was prompted to publicly address this issue when a group protesting plans for senior housing in their neighbourhood made disparaging comments such as, “Who wants all those old people around?” (Butler, 1969, p. 243).

Butler (1969, 2010), as a psychiatric geriatrician, and Palmore (1999, 2005), as a sociological gerontologist, have been in the forefront of efforts to educate professionals
and the public on ageism. Butler’s (2009, 2010) extensive research on normal ageing, longevity and geriatrics supported his work to combat ageism and advocate for the rights of elders (ILC, 2006). At about the same time as Butler (1969), Palmore (2005) began research on ageist stereotypes. Palmore’s (2001) greatest contribution has been the development of quizzes and surveys to help people recognise their ageist prejudices and to research the incidence of ageism.

Ageism is an issue of human and civil rights that takes the form of domination achieved by restricting the rights and freedoms that come with being an adult (Braithwaite, 2004; Butler, 2005). Palmore (2005) believes ageism to be a widespread “social disease” from which no one is immune as it begins in childhood. Children begin to display stereotypical attitudes and ageist beliefs toward elders before they enter school and mirror those of adults who associate loss of physical and cognitive abilities with ageing (Gilbert & Rickett, 2008; Kwong See & Heller, 2005; Montepare & Zebrowitz, 2004).

Ageist views that equate value with youth and perceive ageing as negative and undesirable have created a profitable market for anti-ageing products to reduce, reverse, deny or delay ageing (ILC, 2006; Braithwaite, 2004). Efforts to deny ageing contribute to and stem from a fear of ageing. Martens et al., (2004) studied college students and found a direct correlation between fears of ageing and death that resulted in distancing from elders. As ageism is perpetuated more elders become victimized and seen in a negative light by non-elderly (Martens et al., 2005). Negative stereotypes help younger adults deny the threat of ageing by blaming elders for their circumstance or avoiding them altogether (Braithwaite, 2004; Montepare & Zebrowitz, 2004; Nelson, 2005; Palmore, 1999).

Existing public debate has stirred up fears that ageing baby boomers will become dependent and be an economic burden on society (Johnstone & Kanitsaki, 2009; Katz, 1996). The majority of elders in the US, UK and Canada are independent with over half of those over 85 years old reporting no physical limitations (Administration on Aging, 2010; Butler, 2008; Jagger et al., 2010; Minichiello et al., 2000; Statistics Canada, 2006). Only 4% of elders in the US are institutionalised at any given time with the
majority of them living in their own homes and making significant contributions to society (Administration on Aging, 2010; Blais et al., 2006; Eliopoulos, 2010). Butler (2008) describes this fear of ageing as a paradox of long life, pointing out that mass longevity is a great human achievement. Yet when the question of the sustainability of an ageing society is discussed, longevity creates an opportunity in the public debate for blame and scapegoating of older adults. Once elders retire they are regarded by some as a burden by contributing less to the tax base and drawing on government monies for pensions or retirement benefits. Yet if they are employed, they are perceived as usurping job opportunities that belong to the young. This view of ageing is a form of ageism called alarmist demography which characterises elders as a detriment to society rather than a valuable asset (ILC, 2006; Katz, 1996). Johnstone and Kanitsaki (2009) assert that nurses have a professional responsibility to contribute to this discussion on demographic alarmism and its impact on elders.

The Alliance for Aging Research (1997) has attempted to discredit the belief that elders are a burden by addressing the “problems and associated societal costs incurred by the elderly” (p. 17). Their research concludes that ageing is not the cause of rising healthcare costs. Rather it is the development of new medications and advanced technology for the early diagnosis and treatment of diseases (ILC, 2006). There is evidence that the prevalence of chronic illnesses, most common in old age (arthritis, cardiovascular disease, stroke, and emphysema), have declined in the past ten years with the most significant reduction in the oldest and frailest elders (Alliance for Aging Research, 1997; Manton, Xu, & Lamb, 2006).

Discussions within the fields of sociology, social work, and nursing have proposed that constructive changes in healthcare have inadvertently contributed to society’s labelling of elders as dependent. The establishment of social services for older adults, such as Medicare in the US, puts them in the position of becoming a dependent person in need of assistance (Powell, 2006). This perpetuates both society’s ageist view of elders being equated with dependency as well as the elder’s view of themselves as a dependent (Powell, 2006). Second, the shift in healthcare from the biomedical model (geriatrics) to
a more holistic approach to care (gerontology) has increased the amount of clinical observation or surveillance (Powell, 2006). The growing number of assessment tools specifically designed for the older adult supply sources of assessment data (knowledge) for the nurse “expert” to interpret (Hartford Institute for Geriatric Nursing, 2010; McEldowney, 2010; Mor, 2004; New Zealand Guidelines Group, 2003). The relationship of knowledge with power described by Foucault (1980, 1995) has informed understanding of the impact of increased surveillance on ageing (Henderson, 2003, Powell, 2006). As a social theorist, Foucault observed the practices in institutions of modern medicine that wield power. He found that advances in science have led to increased monitoring and the classification of clients (Foucault, 1980, 1994; Foucault & Gordon, 1977; Foucault & Rabinow, 1984). Based on Foucault’s understanding of society, surveillance leads to acquisition of knowledge and power by the expert, positioning elders as dependent and in need of oversight. Surveillance, known as the “expert gaze,” is always on the watch for evidence of “high risk”. This professional gaze also objectifies the elder and categorises them as a potential problem (Powell, 2006). In addition to problematising ageing, the “expert gaze” is mechanistic and limits the quality of the meaningful nurse-patient relationship (Henderson, 1994).

What constitutes ageism may vary country to country; however, in North America, Australia, Africa, Europe, Asia, and the Middle East the most common descriptors of ageism are forms of disrespect and discrimination (Jonson & Larsson, 2009; McGuire, Klein, & Chen, 2008; Minichiello et al., 2000; Palmore, 2001, 2004; Peachey, 1999; van den Heuvel & van Santvoort, 2011; World Health Organization, 2002). When elders were surveyed to determine the prevalence of ageism, it was found in three different studies that ageism was widespread in the US and Canada (McGuire et al., 2008; Palmore, 2001, 2004). Using Palmore’s Ageism Survey over 850 elders from three different studies were asked to indicate whether they had experienced any of 20 forms of ageism (Palmore (2001, 2004; McGuire et al., 2008). Findings consistently showed that over 80% of older adults had experiences of ageism more than once that included being made fun of; insulted; patronised; disrespected; ignored; denied medical care; their ailments being attributed to age; and assumed to be incapable of
understanding what was being said (McGuire et al., 2008; Palmore, 2001, 2004). A qualitative study in Australia interviewed elders to examine their perceptions of how ageism impacted on their lives (Minichiello et al., 2000) with similar experiences when compared to the previously mentioned studies (McGuire et al., 2008, Palmore, 2001, 2004). Elders explained that the most negative encounters of ageism were in personal interactions that included “derogatory comments”, being “patronised”, and “treated with impatience or indifference” (Minichiello et al., 2000, p. 267). They described how they felt powerless to challenge ageist incidents and often internalised negative views of ageing. Some elders intentionally tried to portray positive views of ageing to counter the negative stereotypes.

Adverse effects of ageism on older adults can be both physiological and psychological. The physical impact of ageism on elders can include a decline in lifespan or increased blood pressure and a “decrease in cardiovascular response to stress” (Levy, 2001; Levy, Ashman, & Dror, 2000; Levy et al., 2002). Memory recall performance declines when elders who identify strongly with their age-group are exposed to negative stereotypes (Kang & Chasteen, 2009; Levy & Banaji, 2004). In addition, when ageing is perceived as a time of loss and deterioration elders experience “repeated innuendo that [their] futures no longer matter” (Vaillant, 2002, p. 36). They are seen as “past the use-by date” (Feldman, 1999, p. 42). According to Gullette (2004, 2011) when elders are bombarded with ageist views that equate advancing years with decline, the consequences can be deadly. The potential effect on older adults includes envisioning themselves as a likely burden to their families and society. This can lead to suicide as a way for elders to eliminate distress and avoid the psychological pain associated with dependency (Gullette, 2011, Schneidman, 2001). Hage and Lorenson (2005) suggest that the myths and stereotypes of ageism have generated a form of oppression of elders and that “the oppressed have internalised the oppressor’s world and made it their own” (p. 238). Conversely, older adults exposed to positive ageing stereotypes experience a positive impact in that the individual comes to believe and act in accordance with the positive view (Bennett & Gaines, 2010; Levy, 2001; Levy & Leifheit-Limson). The impact of ageism on older adults can be a self-fulfilling prophecy in which they accept
and adopt either a positive image of ageing or a negative view fueled by myth and stereotype (APS, 2000; Gething et al., 2002; Levy & Leifheit-Limson, 2009).

Stereotypes of ageing can be classified as positive or negative but even the positive attributes bring with them an overgeneralisation that categorises all older people as a homogenous group lacking diversity and individuality. The stereotyping of elders “helps us to avoid the time-consuming and effortful task of coming to know a person as an individual rather than as an exemplar of a group” (Rosowsky, 2005, p. 56). Over-idealisation assumes that all elders are “wise” or “spiritually evolved” (Rosowsky, 2005, p. 55). “Benevolent prejudice” is a form of stereotype that is both positive and negative. For instance, perceiving elders as warm and friendly, but through an attitude of pity can carry with it a negative connotation that they are at the same time weak and unproductive or incompetent (Cuddy et al., 2005, p. 268). Negative stereotypes of older adults as weak, incompetent, sick, frail, confused and dependent can easily be internalised causing elders to decrease their independence and can negatively impact their health and access to care (Cuddy & Fiske, 2005). Internalising these myths can cause them to falsely believe that a symptom is due to ageing, leaving it unchecked when it may be, in fact, caused by a disease that is treatable. When a younger person believes that illness is a result of ageing, they perceive of older adults as “other” through disassociation and marginalise them (Angus and Reeve, 2006; Braithwaite, 2004; Kite & Wagner, 2004; Montepare & Zebrowitz, 2004; Nelson, 2005; Walker et al, 2005). When younger adults perceive of older adults as different than themselves they “subtly cease to identify with their elders as human beings” (Butler, 2002, p. 12). When elders are insulted, ignored, or marginalized they experience a violation of basic human rights (Braithwaite, 2004; McGuire et al., 2008; Minichiello et al., 2000; Palmore, 2001, 2004; Palmore, Branch, & Harris, 2005; WHO, 2002).

Ageism affects not only the older person but also society as a whole (International Longevity Center-USA [ILC], 2006; Butler, 2008; Kelchner, 1999). Ageist attitudes view the “welfare and humanity of older adults as less important than younger adults” and leads “some younger adults to neglect, exploit or otherwise abuse older adults”
Ageism that involves the coercive use of power can be a direct cause of abuse (Phelan, 2008). Elder abuse is often unreported, yet the need for elder abuse shelters reflects the severity of the problem (ILC, 2006, pp. 59, 113; Powell, 2006). Reports of sexual abuse are most often ignored due to stereotypes that elders are asexual and unattractive (Pasupathi & Lockenhoff, 2004). Stereotypes of vulnerability make older adults likely targets of scams and financial abuse. The US Senate Special Committee on Aging has proposed the Elder Justice Act to address financial fraud and other types of elder abuse (Kohl, 2010).

Within healthcare and the social sciences, the prevailing response to ageism has been to find ways to combat it, starting with an increased awareness of the problem (Angus & Reeve, 2006; Butler, 2002, 2009; Bytheway, 1995, 2005; Cuddy & Fiske, 2004; Eastman, 2010; Levy, 2001; Nelson, 2004, 2005; Palmore, 1999, 2005; Parkinson, 2010; Rosowsky, 2005). Using The Facts on Aging Quiz (Palmore, 1999) to assess ageist beliefs, education was identified as the main variable that made a consistent positive difference in the quiz scores (Palmore, 2005). Palmore’s findings are foundational to this thesis which studies the impact of a particular educational activity on the attitudes of nursing students toward elders.

Recommendations to prevent and reduce ageism include education, contact, and specific types of interactions with elders. Based on studies in geriatrics and gerontology, Rosowsky (2005) adds that the education of healthcare professionals should include opportunities for exposure to positive images of ageing that challenge stereotypes, especially the fostering of interactions and “familiarity with healthy, nonpathological aging” (p. 57). The educational activity of listening to elders involves having personal contact in a way that impacts on the nursing students’ attitudes.

Angus and Reeve (2006) have been instrumental in public policy and education in opposing stereotypes of elders in Australia. They concur with Rosowsky (2005) that increased contact with older adults with varieties of characteristics and capabilities can foster an understanding of elders as individuals and help to combat ageism. When elders are treated as individuals they are given a greater chance to make their own decisions by
being “active participants in their own aging experience” (Angus & Reeve, 2006, p. 150). Just as cultural safety addresses power (NCNZ, 2009b), Angus and Reeve (2006) and Henderson (2003) believe that treating older adults as individuals includes addressing the power relationship they have with professionals. Bytheway (1995, 2005) has researched ageism in the UK and suggests that using more inclusive terms about interactions with elders such as ‘we’ versus ‘us-them’ promoted a broader, more universal approach to ageing and reduced stereotyping (p. 118). This approach also has the effect of shifting the concern from the individual elder to the future of one’s own ageing (Bytheway, 1995). The ‘we’ approach to ageing has become the basis of a recent appeal to the public in the fight against ageism launched by the National Health Service in the United Kingdom (Parkinson, 2010). Baby boomers who fear that they will experience the same poor ageist standards of care as their parents have challenged the attitudes of future generations and “may be the reason that patronising and paternalistic, abusive and atrocious health and social care will, by 2030, be consigned to the research files of social historians” (Eastman, 2010, p. 8; Parkinson, 2010). However, at this time ageism still abounds even within the caring professions.

2.2.2. Attitudes of nursing students towards ageing and ageism

Many references in the literature indicate concern that ageism continues to spread among healthcare professionals, including nurses (Bernard, 1998; Cozort, 2008, de la Rue, 2003; Magoteaux & Bonnivier, 2009; Weir, 2004; Williams et al., 2007). Studies of the attitudes of nursing students toward elders have been conducted internationally indicating similar patterns of findings from seven different countries (Celik et al., 2010; de la Rue 2003; Haight et al., 1994; Hweidi & Al-Obeisat, 2006; Kotzabassaki et al., 2002; Lee, 2009; Moyle, 2003b; McLafferty & Morrison, 2004; Roberts et al., 2003; Ryan & McCauley, 2004/2005; Zambrini et al., 2008). A variety of methods (e. g. questionnaires, surveys, Likert scales, interviews, focus groups, diaries, art) were used to study nursing students’ attitudes toward elders and identify factors that contributed to their attitudes. Relationships with grandparents, interaction with older adults and personal feelings about ageing were shown to significantly impact the attitudes of
nursing students (Haight et al., 1994; Kotzabassaki et al., 2002). Findings indicated that
nursing students held both positive and negative attitudes toward elders and ageing and
that their views were compounded by ageist behaviours observed in nursing staff and
faculty (Aday & Campbell, 1995; de la Rue, 2005; McLafferty & Morrison, 2005).

Ageism weakens the ability of the nurse to show a positive and interested attitude
toward meeting the needs of elders (Lovell, 2006). The concern is that nurses with
ageist views will negatively impact the health care and quality of life of elders (de la
Rue, 2003; Geting et al., 2002; Levy, Ashman, & Dror, 2000; Lovell, 2006;
Magoteaux & Bonnivier, 2009).

It is useful to narrow the focus of this discussion to distinguish between attitudes of
nursing students toward elders and attitudes of nursing students toward providing care
to elders (McKinlay & Cowan, 2003; Pursey & Luker, 1995). Some research studies on
ageism have addressed both simultaneously as if they are one and the same (Herdman,
nursing students in Hong Kong about their reasons for choosing nursing and views of
caring for elders after each student ranked their workplace preferences. This study
challenged linking nursing students’ career choices with negative attitudes while
ignoring the social context and settings associated with elder care. Findings showed that
disinterest in providing care to older adults stemmed from the heavy workload,
opportunities for future careers goals, and feeling inadequately prepared, with no clear
relationship between attitudes towards caring for elders and career preferences.

Several studies focused on finding ways to interest nursing students in caring for elders
rather than finding out their attitudes toward them (Henderson, Xiao, Sieglof, Kelton,
& Paterson, 2008; Higgins, Van Der Riet, Slater, & Paterson, 2007; Lovell, 2006;
associating “low status” of settings that specialise in caring for elders is a result of
ageism. However, nurses encounter older adults in all areas of nursing, from the
emergency department to sports medicine. As mentioned in Chapter One, the attitudes
of nursing students are the topic of discussion therefore findings specifically focused on
views toward working in eldercare settings and nursing job preferences will not be included.

Published studies on nursing students and ageism were most prevalent from Australia, UK and US. Yet, when the search was narrowed to research studies identifying the attitudes of nursing students toward elders and ageing, the results showed a more diverse worldwide interest in the topic. Key studies identifying the attitudes of nursing students toward elders have been conducted in the US (Haight et al., 1994; Lee, 2009; Ryan & McCauley, 2004/2005), Australia (de la Rue 2003; Moyle, 2003b), United Kingdom (McLafferty & Morrison, 2004; Roberts et al., 2003), Turkey (Celik et al., 2010), Greece (Kotzabassaki et al., 2002), Spain (Zambrini et al., 2008), and Jordan (Hweidi & Al-Obeisat, 2006). These studies demonstrate the widespread and subtle impact of Western society on ageism and how nursing students mirror society’s views on ageing.

Two studies found that nursing students reflect negative views of ageing (Moyle, 2003b; Zambrini et al., 2008). Through the use of structured questionnaires, Moyle (2003b) identified nursing students’ views of elders and concluded that students were continuing society’s myth of ageing as a time of frailty and declining health. The students associated declining health with ageing with specific characteristics that were not due to ageing but due to disease such as dementia, loss of mobility and incontinence. Zambrini et al. (2008) also identified negative views in an interdisciplinary study on the attitudes of nursing and health care students using the Aged Semantic Differential Scale (ASDS) to measure attitudes and quantify bias toward older adults (Rosencranz & McNevin, 1969). When compared to other disciplines (e.g. dentistry, medicine, occupational therapy, physical therapy, psychology and social work), nursing students had the lowest scores measuring attitudes toward elders’ self-determination and were least likely to take action to promote self-determination.

Other studies also identified a range of positive attitudes (Celik et al., 2010; Haight et al., 1994; Hweidi & Al-Obeisat, 2006; Lee, 2009; Roberts et al., 2003). Hweidi and Al-Obeisat (2006) identified “marginally positive” attitudes of Jordanian nursing students.
using the Kogan’s Attitude Toward Old People Scale (KOP). This tool assesses people’s attitudes using a Likert scale of paired positive and negative statements about older adults (Kogan, 1961). Marginal attitudes reflected a shift from the more positive traditional Jordanian view of elders which were attributed to the increasing influence of Western values that have “impacted on peoples’ attitudes toward elderly” (Hweidi & Al-Obeisat, p. 27). Celik et al. (2010) also attributed Turkish nursing students’ attitudes to the impact of social changes such as more women being employed and the growth of the nuclear family. Results of focus group interviews showed that most of the students had negative views about ageing and defined ageing as a negative process. However, a majority of students also expressed some positive attitudes, concurring with the traditional Turkish view of elders “as a source of wisdom and guidance” (p. 27). These findings are relevant and consistent with data that show “that this mixed stereotype crosses national and cultural boundaries; ageism is pan-cultural” (Cuddy & Fiske, 2005, p. 268). Older adults in both collectivistic and individualistic countries in Europe and Asia have been found to be stereotyped as warm and incompetent (Cuddy et al, 2009).

In the US, Ryan and McCauley (2004/2005) found that, using the KOP and the Palmore’s Facts on Aging Quiz (FAQ), nursing students did not have positive attitudes toward elders. The FAQ uses multiple choice questions to assess a person’s knowledge and attitudes toward the aged. Using the same instruments, Lee (2009) studied the attitudes of nursing students using journal entries in addition to both the KOP and FAQ instruments. Nursing students showed more positive than negative views with a negative bias that was stronger than their pro-ageing bias. Journal entries supported the positive attitudes and anti-ageing bias of the findings. One significant correlation was that nursing students who communicated regularly with elders had more positive attitudes toward them. Lee (2009) concludes that nursing students relied on their experiences with elders more than their feelings and biases alone. Other studies used the same tools to study nursing students who were close to their grandparents (Haight et al., 1994; Kotzabassaki et al., 2002). Haight et al. (1994) used the KOP and the ASDS in a longitudinal study showing a positive relationship between positive attitudes of ageing and a close relationship with a grandparent. Kotzabassaki et al. (2002) conducted a pilot
study using semi-structured interviews with nursing students who associated elders with negative feelings of loneliness and grouchyiness “due to their age” (p. 5). Positive feelings such as love, gratitude, and affection were also expressed toward elders which were the same descriptors used to describe close relationships with their grandparents. Similar to Haight’s study, it was concluded that close relationships with grandparents positively impact on attitudes toward ageing. Mixtures of positive and negative attitudes were also revealed in a unique study by Roberts et al. (2003).

Roberts et al. (2003) used a creative method to study nursing students’ feelings about ageing by having them imagine and draw themselves at age 76 and describe their pictures. The drawings in the study showed feelings of heterogeneity in ageing and ambivalence with both positive and negative features, but with “positive indicators outweighing the negative” (p. 18) Positive images were described as happy, in tune and content in contrast to negative descriptors of feeling sad, depressed, tired, not looking forward to old age, and no image drawn because it was “too hard to imagine myself old” (p.17). Roberts et al. (2003) speculates that these “largely positive images may be self-protective, a form of denial used as a defence to aid coping with their experiences” (p. 18). Separating oneself, parents, and grandparents from the outgroup of elders “becomes a form of discrimination, a type of ‘them and us’” (Roberts et al., 2003, p. 18). These conclusions are supported by Butler (2008) who believes that ambivalent feelings toward ageing are a result of fear and describes denial as linked to ageism when people refuse to believe that they are ageing. Not only do fear and denial contribute to ageism, but ageism also creates fear and distaste for the ageing process. Ageism becomes a form of oppression that demeans elders and the perpetrator who applies ageist stereotypes to them self as they age (Bytheway, 1995; Cruikshank, 2009). The potential for fear of ageing and its relationship with ageism was addressed in de la Rue’s study about students’ attitudes toward ageism.

de la Rue (2003) identified nursing students’ personal fears of ageing. One student said, “I’m actually terrified of getting old…that is scary” (p. 12). These findings were a result of focus groups, reflective diaries and an adapted Braithwaite scale used to study the
attitudes and perceptions of nursing students. The Braithwaite scale is a questionnaire in which participants respond to statements on elders, ageing and ageism with ratings from agreement-to-disagreement (Braithwaite, Lynd-Stevenson, & Pigram, 1993). In addition to fear, the findings also showed an “acute self-awareness of ageism”, their own ageist attitudes, as well as an overall positive attitude toward elders. Focus group discussions centred on students’ personal upbringing and experiences with older family members followed by identification of ageist care practices they had observed in registered nurses (RNs) during their clinical practice. The behaviours that nursing students observed in RNs included inadequate assessment, paternalism, disempowerment, and lack of respect toward elders.

McLafferty and Morrison (2004) found similar results in a study that examined whether negative attitudes and beliefs toward elders persist. A comparison was made of comments made by nursing students and RNs, each in their own focus groups. Nursing students revealed less positive attitudes toward older adults than RNs. The RNs attributed the nursing students’ attitudes to inadequate preparation to care for elders and by focusing heavily on the negative aspects of ageing associated with disease. However, nursing students discussed how RNs labelled, patronised and infantilised elders. One nursing student described an RN calling them “old wrinklies” (p. 450). The use of words that are demeaning perpetuate stereotypes and marginalise elders (Pipher, 1999). The findings of McLafferty’s and de la Rue’s research studies illustrated how RNs and nursing instructors can inadvertently model ageist beliefs and behaviours to nursing students.

Studies of the actions and attitudes of nurses toward elders have also confirmed the behaviours that nursing students observed in RNs (Brown & Draper, 2003; Courtney, Tong, & Walsh, 2000; Gething et al., 2002; McLafferty & Morrison, 2004). There are “clear patterns of misconception and stereotyping among nurses in regard to aging and older people” (Gething et al., 2002, p. 78). Elders are devalued and their capabilities are underestimated (Gething et al., 2002). Nurses unnecessarily perform tasks for older persons which promote dependence jeopardising their independence. It is often easier
‘to do’ for elder patients than to let them maintain the level of independence they had when they were admitted to the hospital (Courtney et al., 2000, p. 63; Thornton, 2002).

In addition to labelling elder patients, studies have shown that infantilising speech referred to as baby talk or elderspeak is commonplace when nurses and nursing students talk to elders (Brown & Draper, 2003). Infantilisation of elders is not only disparaging but also abusive (Kosberg & Garcia, 1995; Phelan, 2008). Elderspeak is characterised by a high pitch, simplicity of vocabulary, repetitions and a slow rate of speaking (Brown & Draper, 2003; Cruikshank, 2009, p. 145, Pasupathi & Lockenhoff, 2004, p. 225). This type of patronising speech is an ineffective form of communication, reflects negative stereotypes, triggers elders’ perceptions of themselves as cognitively impaired and is a form of psychological elder abuse (Kemper & Harden, 1999; Kemper, Finter-Urczyk, Ferrell, Harden, & Billington, 1998; Nussbaum, Pitts, Huber, Krieger, & Ohs, 2005; Williams, 2006). According to an active elder, comments such as “What do you expect at your age, dear?” suggest ageism and “have the potential to reduce her ability and confidence to maintain control over her life” (Feldman, 1999, p. 271). Elderspeak further marginalises and isolates elders through ineffective communication.

As with nursing students, RNs also hold both positive and negative attitudes toward elders (Higgins et al., 2007). RNs who possessed more accurate knowledge of ageing had more positive attitudes. The reverse was also found to be true that nurses who had the most misconceptions about ageing had the most negative attitudes (Gething et al., 2002). The positive relationship between the knowledge of ageing and attitudes toward elders reinforces the value of education that nursing students receive about ageing.

The presence of both positive and negative attitudes toward elders in nursing students and nurses has been well established. Levy et al. (2002) point out that it is the negative attitudes that are the most pervasive and are of greatest concern. The negative attitudes that nursing students displayed and are exposed to can be best addressed through effective education. Education is vital to dispelling misconceptions and stereotypes (Palmore, 2005). “A nurse who operates under false beliefs about the attributes and capabilities of older people is less likely to detect factors affecting well-being that could
be readily addressed” (Gething et al., 2002, p. 78). It is critical that nursing students receive education that opposes and counters the ageism that is so prevalent.

2.3  Addressing ageism through nursing education

The growing volume of research on ageism concurs that ageism has a negative impact on the health of elders and that education is the key to the elimination of ageist beliefs and attitudes that have taken root in nursing (Gething et al., 2002; Palmore, 2005). This discussion focuses on how cultural safety informs an educational strategy to address the stereotypes and attitudes of nursing students and how it can be applied to ageism. Pedagogical strategies to address ageism within didactic and experiential gerontology nursing education are discussed including the way in which stories have played a role in the education of nurses.

2.3.1  Gerontology nursing through the lens of cultural safety

Cultural safety is a concept that has been instrumental in educating nurses about the impact of attitudes and power on nursing relationships (McEldowney & Connor, 2011; NCNZ, 2009b; Ramsden, 2002; Richardson & Carryer, 2005; Richardson & MacGibbon, 2010; Woods, 2010). As mentioned earlier in Chapter One, the review of literature explores the context of using cultural safety as the conceptual framework for this research study to inform gerontology nursing education. Cultural safety addresses the balance of power and informs nursing care that upholds the rights of all clients.

The broad definition of cultural safety can be applied “to any person or group of people who may differ from the nurse/midwife” (DeSouza, 2008, p. 129). This perspective on culture focuses on the uniqueness of the individual (Cortis, 2008; Richardson & Williams, 2007). Viewing culture as more than just ethnicity serves to prevent the nurse from viewing a client’s culture with a checklist mentality which can lead to the false assumption that one can know another’s beliefs and values. Nurses should assume the position that “we are not the experts in others’ territories” (Greenwood, et al., 2006, p. 212).
Evidence of this broader definition of cultural safety has developed rapidly in the last few years. Nursing literature reflects the application of cultural safety to a wide range of clients who have been regarded as members of a specific ‘culture’ that are vulnerable or marginalised. During this process of literature review, it became clear that despite the growing body of literature on cultural safety, applying cultural safety to elders is an issue that lacks both discussion and research.

By focusing on the cultural and social context of power within society and the bicultural nurse-patient relationship, cultural safety places the responsibility on the nurse for examining his/her own cultural position and balance of power within the nurse-patient relationship through a process of self-reflection (Anderson et al., 2003; McEldowney, et al., 2006; NCNZ, 2009b; Richardson & Williams, 2007). The nurse needs to make a conscious shift away from the ethnocentric view which regards the patient as ‘different’ or as ‘other’ in order to recognise that the patient’s culture “is in fact the ‘norm’ and the health care culture is what is ‘foreign’ or ‘other’” (Richardson & Williams, 2007). The patient is the one most familiar with their cultural reality; therefore, it is the client, not the nurse who determines if the care is culturally safe. Culturally unsafe practices that “diminish, demean and disempower” (NZCN, 2005, p. 4) an individual, perpetuate socially constructed stereotypes that prevent cultural groups from receiving quality healthcare. In contrast, culturally safe nurses recognise and respect the rights of all clients (Wood & Schwass, 1993). The concept of cultural safety “provides recognition of the indices of power inherent in any interaction and the potential for disparity and inequality in any relationship” (Richardson & Williams, 2007, p. 699). Ramsden (2002) noted that unless a person feels safe and has the “power to do so”, they cannot fully access the rights guaranteed to them (p. 9.1).

With cultural safety having its origin in the historical and social context of New Zealand, it is significant that nursing leaders in New Zealand have supported not only the definition of culture to include groups of non-ethnic origin but also the transferability of cultural safety to extend to healthcare outside of New Zealand (Cortis, 2008; Greenwood, et al., 2006; Richardson, 2004; Richardson & Carryer, 2005; Wood
& Schwass, 1993; Woods, 2010). The dissemination of cultural safety knowledge and practice has become “globally recognized” (Richardson & Williams 2007, p. 706). Nursing organisations and councils in both Australia and Canada incorporate cultural safety in their standards of nursing practice (Aboriginal Nurses Association of Canada, 2009; Canadian Nurses Association, 2010; Commonwealth Department of Education, Science and Training, 2010; Congress of Aboriginal & Torres Islander Strait Islander Nurses, 2010; McKay, 2002). In the US, the National League for Nursing (2009), a nursing education accrediting body, has proposed that cultural safety be taught to all nurses. Even though cultural safety is distinctly different than transcultural nursing, nursing educators in the US have included cultural safety as an essential concept nurses need to learn as part of the core curriculum for transcultural nursing and cultural competence (Douglas & Pacquiao, 2010; Expert Panel on Global Nursing & Health, 2010).

Transcultural nursing is a specialty within nursing that was established in the US as a blend of anthropology and nursing (Leininger, 1978). Effective nursing care attends to the cultural diversities (differences) and universalities (similarities) between and within cultures that can be ascertained by a cultural assessment (Andrews & Boyle, 2012; Leininger & McFarland, 2002). The goal of transcultural nursing is to learn from the client what their values and practices are related to caring and health in order to provide culturally specific or culturally competent nursing care. In contrast, cultural safety comes from the historical perspective of Maori nurses who sought to address the health disparities of the Indigenous clients (Ramsden, 2002). Cultural safety focuses on the nurse’s responsibility to identify how his/her cultural background and position of power as a nurse can impact on the care of a client. Rather than becoming knowledgeable about the client’s culture, the position is that the nurse can only truly know his/her own culture and is able to shift the balance of power by relying on the recipient of care to determine if the care is culturally safe (NCNZ, 2009b).

Studies on cultural safety in New Zealand have concentrated on Maori and non-Maori relationships and also addressed the broader definition of culture outside the context of
ethnicity related to the cultural determinants of disability, religion, gender, sexual orientation and age (Adams, Braun, & McCreanor, 2010; Baker, 2007; Bennett, 2007; De & Richardson, 2008; Dietsch, Shackleton, Davies, McLeon & Alston, 2010; Garrod, 2002; Neville & Adams, 2010). Garrod (2002) described the practice of cultural safety as applicable to anyone who is not part of the culture of nursing when he specifically explored the power differential and minority status experienced by people with physical or mental disabilities. This was one of the earlier studies that applied the concept to a non-ethnic population. Other cultural determinants of cultural safety have been studied addressing the religious experience of Muslim immigrants in Canada (Baker, 2007), and gender with the studies of the stigma and prejudice experienced by women with HIV and AIDS (Bennett, 2007) and the abuse of power when midwives bully women with verbal abuse and intimidation (Dietsch et al., 2010). Neville and Adams (2010) and Adams et al. (2010) address cultural safety and sexual orientation within their studies on homophobia experienced by homosexual men. A study on the paternalistic use of power in the care of children showed that cultural safety can be applied to the cultural determinant of a specific age group (De & Richardson, 2008). The broader application of cultural safety to non-ethnic groups gives further credence to its significance for elders who are often marginalised.

Cultural safety also confronts positions within society that marginalise and exclude others such as with ageism of elders (Polaschek, 1998). However, the literature review on elders and cultural safety showed that the concept has only been applied to elders of specific ethnicities or those who are dependent and frail or experiencing cognitive impairment (Kiata and Kerse, 2005; Notter, Spikker, & Stomp, 2004; Struthers, Martin & Leaney, 2009; Wilson and Neville, 2009). Cultural safety was described as an essential approach to equalise relationships of health practitioners with older adults to prevent and address elder abuse in the Indigenous First Nations population of Canada (Struthers, Martin & Leaney, 2009). Kiata and Kerse (2005) conducted a field study on intercultural differences in eldercare between Pacific Island care assistants and Pakeha (European) residential care elders in New Zealand. It was concluded that culturally safe care requires caregivers to be aware of cultural differences as part of a reciprocal caring
relationship. In the Netherlands, cultural safety has shaped the care of elders with dementia who were assigned to residential care units that reflected the urban center or religion of their upbringing or according to their ethnic heritage (Notter, Spikker, & Stomp, 2004). Wilson and Neville (2009) studied older adults with delirium and determined that their care was ageist and culturally unsafe. Elders were problematised based on their diagnosis with associated clinical and economic problems rather than recognised as individuals within their sociocultural context. It was recommended that nurses need to reflect on the nature of the relationship with elder patients and include these patients as active participants in their care.

In each of the above mentioned studies, older adults embodied the stereotype of inevitable dependency. Dependent elders are often stigmatised by factors caused by disease states rather than by age alone. In these situations the degree of choice and preference on the part of the elders was limited and the power remained predominantly in the hands of the nurse making the decisions. Cultural safety works to shift the power imbalance from the health care provider to the care receiver. Suominen, Kovasin, and Ketola (1997) describe different experiences of power within the nurse-patient relationship with older patients experiencing a paralysing type of power described as “patient as inmate” (p. 188). Elders can feel paralysed as a consequence of organisational power exerted over them when they are deemed to be in need, either of social welfare or physical care as examples. Palviainin et al. (2003) determined that nurses in long-term care facilities exercised power over elders by withholding information, incontinence pads, and care in order to cut costs and maintain a routine. Power was misused to the extent that it proved to be elder mistreatment. In contrast, cultural safety more closely reflects the type of power termed “patient as consumer” in a reciprocal relationship where the needs of both the patient and the nurse are met with “mutual satisfaction” (Suominen et al. 1997, p. 188). The principles of cultural safety are characterised by the positive shift of power that empowers the patient, making them both a participant and partner in their health care.
Cultural safety is built on the basic human rights of respect, dignity, autonomy, and empowerment (Phiri, Dietsch, & Bonner, 2010). Each of these concepts are foundational to efforts to improve the health and care of elders (Bevan, 2001; Brocklehurst & Laureson, 2008; Ford, Haug, Stang, Gaines, Noelker, & Jones, 2000; Hage & Lorensen, 2005; Jacelon, Connelly, Brown, Proulx, & Vo, 2004; Tuckett, 2006; Valikmaki, Haapsaari, Katajisto, & Suhonen, 2008; WHO, 2002). Ageist behaviours and the negative use of power deny these human rights to elders.

Even though the aforementioned characteristics of human rights are inherent in cultural safety and recognised as critical elements for the health of older adults, the concept is not applied to elders who are independent. This leaves out the majority of the fastest growing age group in society. Despite the fact that elders experience culturally unsafe care in the form of stereotyping, objectification and marginalisation, the concept of culturally safe care is noticeably absent from nursing literature related to healthy elders and gerontology nursing education (Phelan, 2008). Cultural safety is a conceptual framework that can be used to inform pedagogical strategies and address ageism in gerontology nursing education (Ramsden, 2002).

The principles of cultural safety, the history of its use, and the disregard for elders based solely on their age, support the premise that gerontology nursing should not only be viewed through the lens of cultural safety, but employ the concept as a standard for care and educational pedagogy (McEldowney & Connor, 2011; Ramsden, 2002). A critique of specific pedagogical strategies that address ageism is addressed in the following section.

2.3.2 Pedagogical strategies to address ageism

There are two dominant themes in the nursing literature on ageism. The first theme concentrates on reducing ageist attitudes and developing positive ones. The second theme explores correcting misconceptions of ageing with effective change in gerontology nursing education. These two themes are addressed in studies to discern the most effective means to make changes in didactic content as well as in the selection of
experiential activities for nursing students in baccalaureate courses. The use of elders’ stories is included in this discussion.

2.3.2.1 Didactic

Recommendations abound in the US, Canada, New Zealand, Australia and the UK with suggestions to emphasise and increase gerontology nursing content in curricula (American Association of Colleges of Nursing & Hartford Institute for Geriatric Nursing, 2010; Aud, et al., 2006; Baumbush & Andrusyszyn, 2002; Blais et al., 2006; Clendon, 2011; Cozort, 2008; Ferrario, et al, 2008; Koren et al., 2008; Pearson, Nay, Koch, & Ward, 2001; Royal College of Nursing, 2008; Williams et al, 2007; Xiao et al., 2008). However, study results are mixed and indicate that gerontologic knowledge promotes, reduces or does nothing to shape the attitudes of nursing students toward ageing and elders (Aud et al., 2006; Burbank et al., 2006; Koren et al., 2008; Williams et al., 2007). Several authors concur that there needs to be a greater emphasis on age-related changes of ageing in the didactic content so that nurses understand the difference between normal ageing and disease processes (Boltz et al., 2008; Gething et al., 2002; Magoteaux & Bonnivier, 2009; Thornlow, et al., 2006). Nurses who maintain false beliefs about what constitutes normal aging may fail to detect abnormalities in need of intervention (Gething et al., 2002; Koren et al., 2008). For instance, information on the atypical presentation of elders with conditions such as pneumonia or urinary tract infections is recommended to prevent assessments from being distorted by “ageist misconceptions” (Magoteaux & Bonnivier, 2009, p. 19). Delirium can be mistaken for normal ageing instead of an early sign of infection. Other content that is deemed to be essential is the appropriate use of language regarding terminology and vocabulary as well as the actual tone and manner of speaking words free from the practice of elderspeak (Brown & Draper, 2003). The choice of words when speaking about elders is acknowledged to be as important as the way in which nurses speak to them.

Discussions are ongoing as to whether it is more beneficial to have gerontologic content integrated throughout the curriculum or presented as a stand-alone course (Blais et al., 2006; Holroyd, Dahlke, Fehr, Jung, & Hunter, 2009; Koren et al., 2008; McMinn, 1996;
Xiao et al., 2008). Williams et al. (2007) found that nursing students’ knowledge and attitudes did not significantly change after four years of an integrated gerontology nursing curriculum, while Aday and Campbell (1995) found positive attitudinal changes.

Ultimately the literature on gerontology nursing education is inconclusive about whether the suggested changes in didactic content are sufficient to positively change the attitudes of nursing students. Vaillant (2002) makes the point that it is commonplace for students to study human development and learn that reaching the oldest and highest level of Erikson’s stages of development is “progress not decline” (p. 43), yet students’ attitudes continue to associate normal ageing with decline (Moyle, 2003b). Cultural views of ageing impact on how nursing students react to ideas about lifespan development. Some cultural groups do not fear dependency or identify inactivity as a negative behaviour of elders (Cruikshank, 2009; Mehrotra & Wagner, 2009). In cultures such as American Indians and Latinos where oral tradition and interdependence are strong, it is the accepted role of the elder to be less physically active or self-reliant (Cruikshank, 2009). Views such as these contribute to the way in which nursing students experience didactic and clinical learning.

Addressing the introduction of gerontology nursing content, Ferrario, et al. (2008) conducted an exploratory-descriptive study of nursing students’ attitudes with didactic and clinical experiences that were modified to emphasise healthy ageing. The didactic content enhancements replaced the myths and stereotypes of ageing with normal ageing changes and positive aspects of ageing. Clinical settings incorporated a broad spectrum of interactions with well elders in the community as well as those who were acutely, chronically and critically ill. Findings of Palmore’s FAQ and open-ended questionnaires showed that the nursing students who received the curriculum enhancement developed more positive attitudes toward ageing and older persons than the nursing students who did not have the experience. Also using the FAQ, Parchment (2002) found an increase in positive bias toward elders after nursing students participated in a class that introduced content on “successful aging”. The course involved one class on the
demographic and physical changes of ageing along with the myths of ageing, classroom discussion, and concurrent experiential activities.

2.3.2.2 Experiential

The nursing literature on gerontology nursing education is clear that the changes in gerontology content (e.g. myths and stereotypes, healthy ageing) alone have not produced a radical positive change in the attitudes of nursing students toward ageing and elders. Acquisition of knowledge must be supplemented with affective and experiential elements of education that exposes nursing students to healthy, positive role models of ageing. As Thornlow et al. (2006) state, “interactions with well elders address ageism issues better than traditional modalities” (p. 30).

Self-reflection in combination with a variety of contacts, and communication with well elders have been shown to bring about the necessary shift in attitude that encourages nursing students to acknowledge elders as heterogeneous, active participants in their own health care. Various studies on reducing ageism and enhancing nursing education have strongly endorsed the incorporation of self-reflection in gerontology nursing activities (de la Rue, 2003; McNeill, et al., 2008; Roberts et al, 2003). Self-reflection can be a positive practice that nurtures realistic views of ageing and internalises learning. Reflection can lead to transformation. Personal reflection and discussion brings about deeper thinking. The reality of an individual’s life becomes more real by reflecting on their life stories (Hunt & Swiggum, 2007).

When reflexivity, journaling and self-reflection are incorporated into nursing education they help students to develop attitudes of caring, to think critically about their own values and attitudes, to set aside a previously held belief and replace it with a new viewpoint (Binding, Morck, & Moules, 2010; Esterhuizen & Freshwater, 2008; Lindsay, Kell, Ouellette, & Westall, 2010; Zimmerman & Phillips, 2000). Not only is it important for nursing students to reflect on their experiences with elders, but also on their own feelings and concerns about ageing and growing older themselves (Cozort, 2008; McKinlay & Cowan, 2003). With self-reflection as a part of the experience, students’ false impressions
about ageing fade away as they encounter elders who are active and healthy (Cozort, 2008; Thornlow et al., 2006).

Positive exposure to older adults challenges nursing students’ stereotypical attitudes toward age (Henderson et al., 2008). Exposing students to positive role models and encouraging nursing students to question traditional practices assists them to think critically and reflect on their own views and behaviours (Thornlow et al., 2006). A longitudinal study using focus groups, surveys and case studies determined that the attitudes of nursing students toward elders were more positive with experiences in enriched and positive environment for learning and care (Brown et al., 2008). Enriched settings had extensive resources for the nursing students to provide care to elders, opportunities for positive interactions with them and were staffed by nurses who valued older persons by treating each as an individual. The enriched settings also exposed nursing students to nurses who applied gerontology content, welcomed the opportunity to mentor nursing students, and were happy to be caring for elders (Brown et al., 2008).

In contrast, Rowland and Shoemake (1995) describe how nursing students in another study became more negative toward elders after a clinical placement in a nursing home. They used a pre- and post-test survey where students selected from a list of words and phrases such as sociable, withdrawn, educable, to describe their feelings toward older adults. Findings revealed a significant change with the rejection and selection of particular terms. Post-test results indicate that more nursing students chose ‘dirty’ and less chose ‘clean’, ‘helpful’, and ‘knowledgeable’ than in the pre-test. Interestingly, the increase in negative feelings did not correlate with any change in their desire to provide care to elders. It is not clear which factors in the experience brought about the negative perceptions.

Interactions with elders that nursing students perceive as positive are the most beneficial but even more so if interactions are with elders who are active and independent. Aud et al. (2006) conducted a study over the course of six semesters that measured changes in attitudes and knowledge using Palmore’s FAQ and the Health Education Systems Incorporated (HESI) Gerontological Exams (GERI). Results showed that after
completing a gerontology nursing course with both didactic content and clinical experiences in an independent living retirement community, nursing home, and home health care for frail elders, students’ knowledge increased while attitudes did not change (Aud et al., 2006). Students commented on the clinical experiences and said afterwards that they felt more comfortable working with elders. In reference to the retirement community one student commented, “It’s good to get away from the stereotypes of aging” (p. 78). This comment describes the difference the student experienced when she worked with independent elders.

The need for exposure to well elders was further confirmed by an experimental study in Florida that used the Palmore’s FAQ to measure changes in attitudes of nursing students after didactic and experiential changes in the course (Parchment, 2002). Nursing students participated in a clinical experience with elders in a hospital setting, and ageing simulation exercises. Ageing changes were simulated with the use of blurred vision glasses, gloves, and an audio recording of hearing impairments. Despite the increase in positive bias at the completion of this course, students’ negative bias did not decrease after these experiences. It was recommended that nursing students work first with well elders to provide a positive baseline experience (Parchment, 2002). This suggestion is again supported by Burbank et al. (2006) who undertook an informal survey of nursing students before and after spending time with older adults in wellness settings. An analysis of the survey results and focus group comments showed a marked increase in positive descriptors of elders and a decrease in the negative descriptors of them.

Experiential activities that use ageing simulation to facilitate understanding of challenges particular elders face are both cautioned against and recommended (Boland, 1999; Van Son & Fitzgerald, 2012). Cozort (2008) reported that the use of goggles and other items to simulate visual and physical impairment has the capacity to reinforce negative stereotypes of dependency and loss. Even though the exercises are intended to foster understanding of ageing changes, they reinforce the myth that disease is due to ageing by simulating dyspnea, arthritis, glaucoma and cataracts (Pacala, Boult, & Hepburn, 2006; Wood, 2003). On the other hand, Thornlow et al. (2006) found that
sensory deprivation exercises sensitised students to the ageing process and resulted in improved attitudes according to Kogan’s Attitude Scale (KOP) scores. These findings concur with my experiences teaching gerontology nursing. After using elaborate simulation games and tools to simulate ageing, students expressed feelings of sadness about ageing. The exercises were discontinued or used only to help students understand particular disease-states.

Examples of positive experiences with well elders in the community, such as one-on-one relationships over time, through visiting them or working on projects together have been shown to cultivate positive attitudes toward elders (Blais et al., 2006; Butler, 2008; Cozort, 2008; Ebersole et al., 2005; Ferrario et al., 2008; Fox & Wold, 1996; Kirkpatrick & Brown, 2004; McNeill et al., 2008; Schwartz & Abbott, 2007; Shellman, 2006; Thornlow et al., 2006; Walsh et al., 2008).

Walsh et al. (2008) conducted a pilot study on the attitudes of nursing students after making “friendly visits” to an older adult at a senior centre over the semester. A comparison of KOP scale scores before and after the visits showed a positive change in attitudes along with positive responses to a post-visit questionnaire. Nursing students commented that the friendly visits experience was enjoyable for them and the elders.

Nursing students have been encouraged to use reminiscence and life review as an approach to interact with elders. In a quasi-experimental study nursing students in the northeast US were given education on strategies to implement reminiscence during their conversations with older persons (Shellman, 2007). The Eldercare Cultural Self-efficacy Scale (ECSES) is a Likert-type scale that measures nursing students’ confidence caring for elders from four different ethnic or racial groups. The ECSES findings showed an increase in nursing students’ confidence to provide care to older adults of the group they met with for reminiscence activities. It was proposed that the use of reminiscence enables nursing students to view elders in a more positive way (Shellman, 2007). An earlier qualitative study by Shellman (2006) surveyed nursing students after using reminiscence with elders. Responses to an open-ended
questionnaire showed that nursing students who utilised reminiscence developed better listening skills and felt more connected to their older clients.

Schwartz and Abbott (2007) were part of a group of nursing faculty in the US who conducted an educational project with reminiscence education to promote individualised care to patients. It was determined that listening to the stories of patients helped to develop respect and a sense of mutuality in the therapeutic relationship. One nursing student noted, “It sometimes is better to listen to our patient instead of asking all the questions or doing all the tests and procedures on them” (Schwartz & Abbott, 2007, p. 183). Getting to know the patient’s story through reminiscence or life review was deemed to be beneficial to the patient and to the nurse.

Reminiscence helps nursing students to bridge the gap between generations and passes on important life events, values, and beliefs (Soltys & Kunz, 2007). These exchanges enhance awareness of the individuality of each person in the context of their own history (Soltys & Kunz, 2007). Encouraging elders to reminisce and to look back at events in their life has been established as a therapeutic nursing intervention that promotes psychological wellbeing (Ebersole, et al., 2005; Kunz, 2007; Shellman, 2007). Reminiscence assists elders to accomplish the developmental tasks of old age and achieve integrity versus despair by successfully finding meaning and purpose in one’s life (Soltys & Kunz, 2007, Touhy & Jett, 2010).

Clinical assignments that include interactive discussions with well, independent elders have a positive impact on the attitudes of nursing students toward elders. In addition to fostering positive attitudes, positive experiences with well, independent elders also have been shown to dispel negative attitudes and stereotypes (Cozort, 2006; Ferrario et al., 2008; Fox & Wold, 1996).

Numerous authors have discussed that in addition to experiences being positive “education must convey that elders are individuals each with their own unique personality” (Clarke, Hanson, & Ross, 2003; Fox & Wold, 1996; Freshwater & Stickley, 2004; Gething et al., 2002, p. 78; Higgins et al., 2007). Getting to know elders as
individuals assists nursing students to grasp the concept that with age comes increasing heterogeneity and less homogeneity. Combating stereotypes of any kind contributes to individualised, person-centred care that focuses on the specific needs of the elder (Clarke et al., 2008; Fox & Wold, 1996; Shellman, 2007).

Learning about elders as individuals enables the nursing student “to see behind the ‘mask’ of aging, illness or disability” (Clarke et al., 2003, p. 698). This can be done by creating opportunities for nursing students to establish relationships with elders that involve dialogue (Freshwater & Stickley, 2004). The use of personal approaches such as case studies, storytelling, and narrative experiences of elders have also been recommended to help nurses better understand the perspectives of elders (Higgins et al., 2007).

2.3.2.3 Learning elders’ stories

Stories have been used in education and in healthcare in various forms such as illness narratives (Carpenter, 2010; Kleinman, 1988; Smith & Liehr, 2005), case studies (Clark, 2002; Schwartz & Abbott, 2007), life stories (Haber, 2006, 2008; McNeill et al., 2008; Schenk et al., 2008; Steffen, 1997), films (Azzaline, 2012; Kirkpatrick & Brown, 2004; Walker et al., 2005), and literature (Kirkpatrick & Brown, 2004; Walker et al., 2005) for many different reasons. The use of stories run the gamut from being a tool for data collection (Evans & Severtsen, 2001; Pacquiao, 2008) to the therapeutic use of reminiscence (Fox & Wold, 1996; Schwartz & Abbott, 2007; Shellman, 2007) and storytelling (Clarke et al., 2003; Hirst & Raffin, 2001; Hunter, 2008; Schwartz & Abbott, 2007; Sorrell, 2000). The different ways in which nursing students learn about elders’ stories impact on nursing education and nursing care.

Kleinman’s text, The Illness Narratives (1988) popularised the use of stories to help health care providers and medical students identify the psychosocial context of illness and the perspective of the patient when making a diagnosis and treatment decisions. Narratives of this type tell a story and provide information about the meaning of living with a particular disease diagnosis. In the same way in nursing, story theory is based on the premise of trying to understand what a patient’s life is like with a specific health
condition through story (Smith & Liehr, 2005). The “increasing popularity of narratives as data” (Steffen, 1997, p. 99) reflects a shift from a biomedical model of health care to a holistic model that takes into account all facets of a person’s life that give it quality and meaning.

The power of using stories is well recognised in nursing education. Nurse educators have lauded the use of stories as a way to strengthen the nurse-patient relationship (Hirst & Raffin, 2001; McNeill et al., 2008; Pacquaio, 2008; Sorrell, 2000). McNeill et al. (2008) describe the effect when nursing students were given an elder patient’s social history without access to the medical charts to keep the initial focus of communication on relationship building. “Not only did the students learn to develop a relationship with the older adult, but they learned to appreciate the value of life, the importance of listening and the rich and varied life stories of older adults” (p. 271). Stories involve listening in a way that helps to create a shared world between the student and the storyteller (Sorrell, 2000). Storytelling gives the power of telling to the storyteller, not to the listener. Pacquiao (2008) regards the use of stories as essential in discerning values and beliefs of clients, and in giving the nurse “the ability to see the world from the point of view of the other” (p. 190). Stories also have “the ability to transform older adults into valued teachers” (Hirst & Raffin, 2001, p. 27).

Quite often stories are used in nursing in a manner similar to The Illness Narratives (Kleinman, 1988) for intentional, goal-oriented reasons such as information for assessment or diagnosis (Evans & Severtsen, 2001). When stories are used as part of an examination to assess and collect information, the practice reduces its potential to create a caring and relational moment. Assessment and diagnosis are an essential part of nursing practice. However, when the story focuses on a disease or health-related problem, the primary focus is not one of relationship. Strategies to develop a more holistic and relational approach have been recommended to counter the task oriented tendency that emphasises the expert gaze (Ellis-Hill, 2011). Bowles (1995) reports that the assessment and acquisition of clinical information distances nurses from their
patients and that in contrast story telling personalises and adds meaning to nursing knowledge.

Nursing students have been shown to place greater value on tasks, regarding them as the “real ‘role’ of nursing” (Stevens & Crouch, 1998, p. 10) rather than caring which was “described by the students as ‘basic’ nursing” (Stevens & Crouch, 1998, p. 15). Pacquiao (2008) describes the educational strategy of listening to the stories of others as caring by preventing objectification and reducing the person to the task at hand. Listening becomes an act of “caring for the individual who is telling the story by providing a vehicle for looking over his or her life” (Maloney, 1995, p. 108). Hunter (2008) proposes that storytelling is a worthwhile teaching strategy that can help students integrate the art and science of nursing practice.

Schwartz and Abbott’s (2007) study about the use of stories in nursing education revealed that memorable stories communicate meaning in a lasting way as explained by one participant, “I may forget your name and the specifics of what you said but I will not forget your story and how it made me feel” (p. 181). Stories have always played a vital part in the oral tradition of handing down wisdom and culture from older to younger generations (Haber, 2006, 2008; Kirkpatrick & Brown, 2004; Kunz, 2007; Touhy & Jett, 2010) so it is fitting that the use of stories has become recognised as an important practice in gerontology nursing education (Clark, 2002). Oral histories, life stories and reminiscence are different forms of elders’ stories that “can capture the essence of experiences over time which are truly authentic and invaluable in understanding the person for whom we care” (Welford, 2007, p. 33). Stories provide a holistic view of elders that support quality nursing care (Hirst & Raffin, 2001).

As de la Rue (2003) studied the attitudes of nursing students, she also asked the students to make recommendations that could be implemented in nursing education “for the purpose of minimising any possibility of ageism in future practice as an RN” (p. 13). The students suggested that it would help nursing students to be assigned to “collect the life history of the healthy older person” (p. 13).
This is much different from common practices that have been studied in contemporary nursing education. Nursing faculty have appraised the impact of stories on elders by using film, videos, children’s and adult literature, manufactured case studies, and recorded and written life histories with beneficial results (Clark, 2002; Fox & Wold, 1996; Schenk et al., 2008; Schwartz & Abbott, 2006; Walker et al, 2005; Welford, 2007). Activities that give nursing students the perspective of elders as individuals with varied and unique stories have helped students make the shift from an attitude of “us-them” to an orientation of “we” (Fox & Wold, 1996). Being able to appreciate elders, their lives, and their stories, provides a sense of commonality and identification with them.

Kirkpatrick and Brown (2004) introduced nursing students to the stories of elders through literature and films. Students’ journal entries indicated that learning the stories of well elders was a positive experience. Nursing students who read and retold life histories of elders to each other in class also responded enthusiastically to the activity certain that what they learned about ageing will help them in “providing person-centred care” (Clarke et al., 2003; McCormack, 2003; Manley et al., 2011; Welford, 2007, p. 34). Person-centred care is a model of care that stresses learning about the person as an individual, showing respect, and recognising the person’s right to make informed decisions (Kitwood, 1997; Manley et al., 2011; McCormack, 2003, 2004).

Other nursing faculty used only stories that were spoken acknowledging that “hearing another person’s own words has a beneficial impact that lingers, long after class is over” by personalising the elder (Schenk et al., 2008, p. p. 146). Watching and discussing video narratives of elders exposed ageism, gave nursing students opportunities to experience the lives of healthy elders and helped students to connect with them and better understand their needs (Walker et al., 2005). However, these particular studies did not adopt the suggestion of de la Rue (2003) to be present and actually “collect” the story from an elder. Using pre-collected stories does not establish relationship or generate an appreciation of the individuality of a particular elder.

It is evident from the review of nursing literature that nursing faculty perceived that listening to elders tell their stories provided a positive benefit to nursing students (Hirst &
Raffin, 2001; Fox & Wold, 1998; Kirkpatrick & Brown, 2004; McNeill et al, 2008; Parchment, 2002; Schwartz & Abbott, 2007; Shellman, 2006; Walsh et al., 2008). They appreciate the wealth of insight and historical stories they hear (Fox & Wold, 1998) demonstrating the power of stories to transform elders into teachers (Hirst & Raffin, 2001). Being present and listening attentively can also be a positive experience for the elder. Elders feel valued and respected when nurses take the time to listen to elders share their “memories and life stories” (Touhy & Jett, 2010, p. 42).

The impact of elders’ stories on nursing students has been evaluated primarily by a limited variety of methods: open-ended questionnaires (Shellman, 2006; Walsh et al., 2008), journal entries (Fox & Wold, 1996; Kirkpatrick & Brown, 2004; McNeill et al., 2008; Schwartz & Abbott, 2007), clinical post-conference discussions (Schwartz & Abbott, 2007), Palmore’s FAQ (Parchment, 2002) and KOP scale (Walsh et al., 2008).

Prior to the research cited above (with the exception of Fox and Wold, 1996), Hirst and Raffin (2001) concluded in their article on the power in stories that:

Nurses have listened to stories for many years; however they have not documented their effectiveness or outcomes because the power of stories has not been acknowledged. More research in this area would be valuable. Nurses are now beginning to ask questions such as...Do stories affect nurses’ attitudes toward older adults? (p. 29).

Even today, the literature continues to demonstrate a lack of research in nursing education regarding students’ perceptions of the meaning of their experience of listening to elders’ stories.

2.4 Summary of literature review

The review of literature confirms the presence of ageism within healthcare and more specifically in nursing students. Ageism is a concern that is being addressed within nursing education using different pedagogical strategies. Incorporating positive views of ageing that demonstrate healthy ageing into the curriculum have been successful. Positive interactions with elders such as listening to stories are positive experiences for
nursing students. There is, however, little research into the meaning of the experience for the nursing student.

Gerontology nursing was also reviewed in the context of cultural safety. The literature indicated that there has been limited research or discussion in regard to cultural safety and a specific age group or generation. Cultural safety has only been applied to elders who were frail or ill.

In reviewing literature on society’s views of elders, ageism, nursing, nursing education cultural safety, and interactions with elders, each section of this chapter shares with the other the idea of relationship. Many aspects of relationship have been characterised by attitudes or actions that prevent the establishment of relationship, while others are likely to promote and maintain relationship with elders.

Studies showed how to assist nurses and nursing students to establish a relationship that will be beneficial and therapeutic to elders. The contrasting attitudes and actions are akin to opposing forces which elders experience within the healthcare arena. For instance, when an elder is believed to be a burden it can hinder relationship while the opposite attitudes of valuing and respecting elders are more likely to help build relationship. Establishing relationship is central to the role of the nurse. Ageist attitudes and behaviours are a social barrier for nurses and nursing students in a caring and therapeutic nursing relationship with elders. Relationships with clients reduce the likelihood that nursing tasks and skills will be mechanical and rote. More important than the attitude toward elders is the attitude toward the relationship. Nurses who maintain their position of domination over elders would improve the care by transferring power to the elder, a critical principle found in cultural safety. Paternalism gets in the way of relationship while interactions that involve mutuality and reciprocity foster relationships of participation and partnership. The key characteristics that promote relationship in this literature review have been instrumental in the design of this study.
Interactions that provide opportunities for nursing students to get to know elders as individuals foster caring relationships. Listening to elders contributes to relationship more than the collection of data and surveillance which focuses primarily on diagnosis. Listening to stories in particular has been described as a positive experience for nursing students. It is not clear from the literature what makes certain experiences positive ones when nursing students listen to elders. Even more specifically, little is known about the impact of elders’ stories on the beliefs and attitudes of nursing students toward the care of elders. The significance of this literature review is that it reveals what is lacking or absent from nursing knowledge and justifies efforts to explore the meaning of nursing students’ experiences listening to elders tell their stories as viewed through the lens of cultural safety.
Chapter Three  Methodology, method and design

In this chapter narrative inquiry is discussed and justified as the appropriate methodology for this qualitative study of nursing students’ perceptions after having listened to the life stories of elders. Also the decision to use life story as the method for finding meaning in the participants’ experiences are explained along with issues of rigour and ethics that guided the design and research process. Further discussion includes how the conceptual framework of cultural safety and Buber’s philosophical position of relationship informed the construction and completion of the study. Finally, the implementation of the study with the gathering of stories from the participants and the subsequent interpretation and analysis of the stories are explained.

This study serves to address the lack of nursing research that gives voice to nursing students’ perspectives of their experience. The aims and objectives of this study were to find out how the experience of listening to elders’ stories impacted on nursing students; whether the experience helped nursing students feel more comfortable talking with elders; and if the experience led to a shift in attitudes and beliefs toward elders and how these shifts could be applied in practice. The use of narrative inquiry and life story as the method for this study provided a dynamic context in which to identify, explore and articulate the meaning that the nursing students ascribed to the experience of listening to elders tell their stories.

It is fitting that narrative inquiry focuses on the meaning of experience while life story provides a means to hear the participants’ story in their own words. My decision to use narrative inquiry as the methodology stemmed from the underlying premise that meaning can be expressed and understood through story. As the nursing students shared their unique perspectives about listening to the stories of elders, they were able to formulate and express the meaning of the experience. Giving voice to the students played a substantial role in determining the value of listening to elders that had not been
previously well understood from the students’ point of view. Listening to elders’ stories carried with it the potential to change attitudes and the way in which elders are treated. The design of this study addressed the concerns within nursing education about the attitudes of nursing students that are discussed in Chapter Two. Finding the meaning of the students’ experiences revealed how elders are perceived and treated due to the ageist attitudes and misconceptions held by nursing students. Nursing literature identified listening to elders' stories as positive experiences for nursing students. Positive experiences with elders produce more positive attitudes and more realistic views of elders. Finding out if listening to elders’ stories was a positive experience and if it had the ability to positively change the attitudes of nursing student may contribute to the literature on teaching in gerontological nursing. The concept of cultural safety provided a framework to address the impact of negative attitudes such as ageism on the nurse-elder relationship. Attitudes of paternalism and behaviours that marginalise elders were exposed as destructive and counterproductive. The principles of protection, participation, partnership within cultural safety provided a context to identify attitudes and behaviours that were culturally safe and caring toward elders. Cultural safety also guided the research in an ethically sound way by promoting a balance of power in the researcher-participant relationship. The position of Martin Buber provided further context for what constituted relation in caring and research relationships.

3.1 Relationship and the philosophical position of Martin Buber

Caring relationships are central to professional gerontological nursing practice (ANA, 2010). The gerontological nurse establishes a caring relationship with elders by establishing trust and working together to positively impact on the elders’ health and wellbeing (Moyle, 2003a). Similarly, research relationships involve mutual trust and support between researchers and the study participants (Ferguson, Myrick, and Yonge, 2006).

For the purpose of this study, the philosophical position of relationship was informed by the thinking of Martin Buber (1965, 1970). The way in which Buber understands a
relationship of dialogue has greatly influenced nursing, gerontology and education. The awareness of dialogue as a mutual interaction contributed to the development of the concept that the nurse should be fully present in a nurse-patient relationship (Doona, Haggarty, & Chase, 1997). The idea of working with elders as people rather than as objects was shaped by Buber’s concept of genuine dialogue (Kitwood, 1997). His philosophy of dialogical education has been applied to the teacher-student relationship in adult education (Guilherme & Morgan, 2009). In dialogical education learning takes place through a shared experience rather than by the “authoritative transmission of knowledge” (Shim, 2008. p. 525). Buber’s writings identify elements of a dialogical relationship that support the collaborative relationship within narrative inquiry and the relationship of a nurse and an elder patient. The elements of mutuality, reciprocity, trust, and listening are fundamental to a dialogical relationship and are essential for the relationships of a researcher-participant and a nurse-elder to flourish (Buber, 1965, 1970).

According to Friedman (1960), an American translator and authority on Buber, Martin Buber’s philosophy of life as dialogue was shaped by his Jewish upbringing and subsequently by Hasidic teachings that emphasised the spirituality of the religious experience. As a student of philosophy he was also influenced by the moral philosophy of Kant, existential philosophers Nietzsche and Kierkegaard, mystic theologian Eckhart, and physician-theologian Schweitzer. Kant’s (2002) concept of infinity in space and time and Nietzsche’s (Nietzsche & Kaufmann, 1995) view of time as an infinite sequence of finite time periods, led Buber to conclude that a person can be connected to others and to the eternal through being. Kierkegaard believes that each person can be in direct relation with God and can thus address God using the intimate term of “Thou” (Kierkegaard & Lowrie, 1969). Eckhart emphasises the mystical experience of relationship that creates a sense of unity with another person or with God (Buber, 1965; Koren, 2010). Together these ideas contributed to Buber’s development of the relation of “I-It” and “I-Thou” (Friedman, 1983). As a friend of Schweitzer, Buber was influenced by Schweitzer’s reverence for life and how he embodied what Buber envisioned as a life of dialogue (Friedman, 1983; Glatzer & Mendes-Flohr, 1996).
Buber (1970) perceives the nature of human existence to be one of dialogue where “actual life is encounter” (p.62). Accordingly, actual life takes place in a relationship of genuine dialogue. Genuine dialogue becomes possible with an attitude of I-Thou, when each participant looks toward the other. It is a mutual relationship of reciprocity and openness; one in which listening is essential. In contrast, when a person does not listen and treats another as an object, it becomes an I-It relationship. It is Buber’s position that an individual comes into being and becomes whole through a “life of dialogue” (1965, p. 20).

Buber describes relation as in flux – that is going between experiences of I-It and I-Thou in a way that can be applied to nursing. There are times when a patient is best served when the nurse focuses on the diagnosis or immediate intervention, especially in acute conditions when physical needs become paramount to sustaining life. These interactions characterise an I-It relationship. However, at other times in nursing it is appropriate to nurture trust and relationship through genuine dialogue, a time when the relationship has the potential to be I-Thou. When providing care to elders genuine dialogue occurs when both the nurse and the elder are present in the moment, respectful, and listening wholeheartedly to each other. Once either steps away from genuine dialogue to focus on the differences of each other or the relationship, it is no longer an I-Thou encounter. A superficial identification of another person based on a few characteristics objectifies them and formulates a stereotype, creating a distance between the two people (Buber, 1970; Dossey & Keegan, 2009). In contrast Buber describes dialogue as being “concerned with the wholeness of the person” (Buber, 1965, p. 22).

Buber’s philosophy of dialogue has greatly influenced nursing (de Vries, 2004; Dickinson, Smythe, & Spence, 2006; Esterhuizen, 2009; Greenwood, 2007; Hanesbo, 2004; Hanson & Taylor, 2000; Love, 2008; Maata, 2006; McCormack, 2004; McCormack & McCance, 2010; McMahon & Christopher, 2011; Westin & Danielson, 2007; Zerwekh, 1997), including cultural safety (Dyck & Kearns, 1995; Southwick, 2001; Spence, 1999) and closely related fields such as gerontology (Kitwood, 1997; Malloy & Hadjistavropoulos, 2004; McCormack, 2004; McIntyre, 2003) and education.
Within each of these fields the philosophy of Buber has been applied to emphasise the perspective and personhood of the patient, the elder and the student in a relationship of dialogue. Most significantly his idea of being present as a way of caring has been credited as the basis for therapeutic presence and relational care in nursing practice (Greenwood, 2007; McMahon & Christopher, 2011; Watson, 2008; Zerwekh, 1997). The nurse’s caring presence acknowledges and affirms the personhood of the patient (Dossey & Keegan, 2009; Kirby, 2003).

It is Buber’s concept of relational interaction and presence that prompted me to incorporate his position into this thesis. As I sought to study and understand nursing students’ attitudes and interactions with elders, I recalled his writings from a philosophy class I took as a nursing student. The idea of perceiving a patient as ‘other’ and objectifying them in a relationship of ‘I-It’ explained how elders are treated (Kramer, 2003). This insight led me to delve more deeply into Buber’s philosophy. The counterpart of relation that accepts the person as an individual is a critical aspect of a caring relationship between nursing students and elders. This awareness is confirmed by the impact Buber has on nursing practice.

Key concepts attributed to Buber such as the attitudes of I-It and I-Thou shape the way nurses interact with patients by incorporating the benefits of dialogue in mutual and reciprocal relationships (Buber, 1965, 1970). Hanson and Taylor (2000) draw on Buber to differentiate the manner in which nurses relate to patients as ‘doing-with’ or I-It and ‘being-with’ or I-Thou. In the relation of I-Thou the nurse is self-aware, engaged and present in contrast to the relation of I-It which is developed through focusing on tasks.

Nursing has also benefitted from Buber’s influence in the field of gerontology. The works of Kitwood (1997) explored the nature of being for elders with dementia. He used the relation of I-It to describe how dementia patients are often objectified, yet if they are treated as a person with the potential for relationship they can experience genuine interaction like that of I-Thou. Consequently, the influence of Buber on
gerontology became the origin of “person-centred care” which is now integrated into nursing education and practice (McCormack, 2004; McCormack & McCance, 2010). As a result of Buber’s vision of personhood and being human, elders with dementia continue to be acknowledged as deserving of care that is personal and includes effective pain management (Hanesbo, 2004; Malloy, 2004).

Within nursing research, the writings of Buber (1965, 1970) have also informed the subject matter and implementation of research. His philosophy of relation has been used to support discussions on ‘I-Thou’ relationships (de Vries, 2004; Galvin & Todres, 2011) and to interpret research findings involving mutual, reciprocal relationships in nursing practice (de Vries, 2004; Dickinson et al., 2006; Westin & Danielson, 2007). The reciprocal nature of the researcher-participant relationship in phenomenological research has also been described according to Buber (Holloway & Freshwater, 2007; Thomas & Pollio, 2002). Southwick (2001) integrated aspects of Buber’s relationship of dialogue into her research method by forming an interview schema with stages of being, becoming and belonging to study how women became nurses. Her reconstruction of the experience of marginality used being to represent Buber’s ‘I’ in relation, becoming to represent the hyphen as being in between or in the margins, and belonging as ‘Thou’. Southwick’s work addressed both Buber and cultural safety by aligning an ‘I-Thou’ relationship of a person in the margins of society with the intent of cultural safety to address marginalisation.

Buber has indirectly impacted cultural safety through others who have expanded on his work. Paulo Freire, for example, was greatly influenced by Buber in a way that shaped his writings on dialogue, empowerment, oppression and pedagogy. Freire (2000) was an influential Brazilian educational philosopher who saw “education as the practice of freedom” (p. 87). He believes that through education the oppressed become aware of their social situation and are empowered to transform society. In contrast, Buber stresses that the purpose of education is to develop the character of individuals which in turn benefits the community (Buber, 1965). Building on Buber’s ideas about dialogue and the relation of I-It and I-Thou, Freire regards dialogue as a method of education in
which the educator and the student learn together (Bartlett, 2005; Freire, 2000). Like Buber, Freire proposes that learning should be relational and interactive instead of with lectures or by rote memorisation (Bartlett, 2005; Buber, 1960; Shor & Freire, 1987). This method served to challenge existing roles of domination in the classroom and within society. Freire (2000) maintains that dialogue is a way of knowing that can transform the world when people meet in a relationship of cooperation. His perspective on dialogue and social change has directly impacted on cultural safety in nursing education (McEldowney, 2002; Ramsden, 2002; Richardson, 2010). Cultural safety was informed by Freire (2000) as experiences of oppression and privilege were applied to Maori health and the existing power structure within nursing education (Ramsden, 2002). In addition, critical reflection and consciousness-raising have been implemented to bring about social change through cultural safety in nursing education and practice (Freire, 2005; McEldowney, 2002; Ramsden, 2002; Richardson, 2010).

In addition to impacting on the concept of cultural safety and nursing education through the work of Freire (2000), Buber’s philosophy of dialogue is integral to education theory and practice today (Guilherme & Morgan, 2009). Buber envisions the educator as present and engaged in a mutual dialogue with students (McHenry, 1997). Instead of dispensing knowledge, the role of the educator is to invite students to learn through encounter. The educator and the students share the experience of learning and each brings with them their own background which provides a context to the subject matter (Guilherme & Morgan, 2009). Through dialogue and with mutual respect the educator gives up some of their power in order to understand the experience from the point of view of the student (Buber, 1965). Buber acknowledges that the relation of I-Thou is one sided in this type of relationship with a child but can be more reciprocal in adult education (Guilherme & Morgan, 2009). Just as in nursing and with elders, the respect and dignity that is essential for a relation of mutuality is important in education. When Buber’s philosophy of dialogue is applied to the fields of nursing, ageing and education, the outcome is that mutual dialogue and encounter are vital to treat others as valuable human beings. Uniquely, cultural safety and this philosophy of dialogue also maintain some of the same ideas.
Buber’s view of relationship shares much in common with cultural safety, the theoretical framework for this thesis. Although the philosophy of dialogue and the concept of cultural safety originated from different backgrounds, they share many of the same principles and ideals about what constitutes a relationship. Culturally safe care and genuine dialogue consist of interactions that are reciprocal and mutual within a balance of power that acknowledges each person as contributing to the relationship.

While Buber’s position developed from a Jewish European, theological and philosophical setting, the concept of cultural safety arose from the historical context of a South Pacific nation (New Zealand) that had been colonised by the British. The desired outcome of cultural safety is to educate nurses to provide safe nursing care. Just as the nurse strives to protect patients’ physical safety, psychological integrity and ethical rights, the purpose of cultural safety is to provide care that gives patients the power to maintain their culture and determine their own destiny regarding healthcare. Buber, on the other hand, seeks to understand what it means to be human.

The premise of cultural safety is that relationships are bicultural and between two people usually describing the relationship of the nurse and the client (Richardson, 2004). Buber characterises genuine relationship to be between two individuals who are in dialogue (Buber, 1965). It is at this point that the two begin to converge. Both models acknowledge that dialogue that is mutual and reciprocal promotes a relationship which Buber would identify as I-Thou (Buber, 1965, 1970; Duke, Connor, & McEldowney, 2009). The differences that exist between each person are to be respected and acknowledged but are not the basis for the interaction. Marginalisation or distancing occurs between the two when labels of difference are applied and objectification takes place, such as in Buber’s relation of I-It (Buber, 1970). Buber contends that true mutuality and reciprocity is difficult to achieve in a patient-caregiver role (1965). A nurse who demonstrates cultural safety in practice reflects on his/her own beliefs and position of power to reduce the imbalance. Similarly, this is what Buber prescribed for the educator to do as they acknowledged their own background in order to connect with students (Buber, 1965). The principles of cultural safety which are self-determination,
the protection of a person’s values and beliefs, participation in the relationship together, and partnership, correspond to Buber’s idea of the two being participants in a shared relationship (NCNZ, 2009b). I believe that Buber would affirm the definition of culturally safe practice that neither “diminishes, demeans or disempowers the cultural identity and wellbeing of an individual” as a component of an I-Thou relationship (NCNZ, 2009b, p. 4).

These two models of relationship, Buber’s philosophy of dialogue and cultural safety, contribute to the discussion at the end of Chapter Two regarding the position of relationship in this study. Characteristics that contribute to or inhibit relationship are taken from Buber’s writings, cultural safety, and the review of the literature and presented in Figure 1. It is divided into two columns with the left column representing characteristics that promote or strengthen relationship (e.g., knowledge of ageing, autonomy, reminiscence) and the right column represents those that prevent or weaken relationship.
relationship (e.g., stereotypes, pity, paternalism). Qualities such as participation, dialogue, mutuality and reciprocity reflect both Buber’s philosophy of dialogue and principles of cultural safety. Figure 1 also includes protection, partnership and balance of power which correspond to ways in which cultural safety promotes relationship. In the centre is a spiral representing relationship with an elder. The characteristics circle around the centre in constant motion and in tension with each other creating relationship according to what the elder wants. The contrasting forces that promote or prevent relationship are dynamic and changing just as Buber describes the natural fluctuation that occurs between I-It and I-Thou. For a nurse to become culturally safe movement toward a mutual relationship begins with both self-awareness and recognition of the characteristics in Figure 1 that prevent relationship. Relationship is the key to the philosophical, theoretical and method of this research project.

This philosophical position of relationship also contributes to the design and method of the research by reinforcing the mutuality of relationship within narrative inquiry. The nature of the I-Thou relationship shares some of the features of narrative inquiry and life story such as an atmosphere of openness, being present and recognising each other as co-contributors to the relationship or story in progress. The relationship within narrative inquiry is also one in flux, where the researcher and participant move between different moments in time during conversation and the creation of the story narrative. The nature of this relationship contains similar characteristics that promote relationship for the nurse-elder or the I-Thou relationship such as mutual respect, attentive listening, and reciprocity. Listening shows that the person telling the story is valued. The I-Thou encounter also includes moments that are timeless when one person is speaking and another is listening and both are so engaged that they become oblivious to the outside world and their surroundings. Those moments during the interviews of nursing students were memorable. I recall moments when I was listening so intently to the words of the participants that I had to collect my thoughts or refer to the interview guide to continue.
The role of the researcher as the listener combined with two-way interaction with the participant embodies the “dialogic” nature of narrative inquiry (Caine & Steeves, 2009; Kim, 2008).

3.2 Narrative inquiry

Narrative inquiry, with its origin in the narrative position of qualitative research, has become a field of research in its own right (Clandinin & Connelly, 2000; Elbaz-Luwisch, 2010; Lindsay, 2006). The methodology of narrative inquiry falls under the overarching umbrella of narrative research. The lines of differentiation between the two blur as researchers attempt to define what makes narrative inquiry a distinct research methodology. For example, Kim (2008) uses the terms narrative inquiry and narrative research interchangeably. Narrative research is described by scholars as the study of stories (Polkinghorne, 2007) or the study of any narrative material (Lieblich, Tuval-Mashiach, & Zilber, 1998).

There are assorted meanings of what constitutes a narrative. Narrative can be described as an event or a sequence of events told by a narrator (Abbott, 2002; Riessman, 2008). This includes stories such as fairy tales, novels, historical accounts (Polkinghorne, 2007), or expressions of story that include dance, mime, comics, song, painting, drama and film (Abbott, 2002; Hurwitz, Greenhalgh, & Skultans, 2004; Riessman, 2008). Narratives are studied to reveal truth and to find the meaning of experience (Bruner, 2004; Polkinghorne, 2007; Riessman, 2008).

Narrative research has contributed to the emergence of therapies that draw on narratives to find meaning in life and to promote wellness including narrative therapy in psychology (Brown & Augusta-Scott, 2007; White & Epston, 1990) and reminiscence in gerontology (Kenyon & Randall, 1997). Different narrative points of view have given rise to various modes of narrative research across the disciplines. For example, the development of narrative pedagogy in nursing education uses student and teacher stories to shape pedagogy (Diekelmann, 2001; Ironside, 2006), narrative-based medicine makes use of patient stories to study determinants of health (Hurwitz et al.,
2004) and narrative gerontology studies ageing from the point of view of the elder (Kenyon, Clark & de Vries, 2001). Connelly and Clandinin (1990) first introduced the term narrative inquiry as a narrative research methodology in the field of education. Narrative inquiry continues to broaden its application as an interpretive research methodology in education (Kitchen, Parker, & Pushor, 2011; Trahar, 2009) and throughout health and social sciences in the fields of psychology (Josselson, 2009), social work (Wells, 2011), anthropology (Bateson, 1994), and nursing (Barton, 2006; Lindsay, 2006; McEldowney, 2002).

In narrative inquiry emphasis is placed on the verbal expression of story through words (Josselson, 1996). Narrative expressions of story can include biography (Lieblich, 2004), autobiography (Phillion, 2001), life story (Atkinson, 2007; Etherington, 2009), storytelling (Coulter et al., 2007), photographs (Harrison, 2002), and diaries (Riley & Hawe, 2005). The way in which stories are gathered has grown out of the participatory research movement with the active involvement of those who are the subjects of the research (Trahar, 2009).

3.2.1 Narrative inquiry as methodology

Narrative inquiry is a relational research methodology that encompasses story as the way to represent lived experience. Pinnegar and Daynes (2007) regard narrative inquiry as “the most compelling and appropriate way to study human interaction” (p. 6), studying the experience as the participant lived it (Clandinin & Rosiek, 2007). This approach to studying lived experience is dynamic, interactive and collaborative and includes both the researcher and the participant in the formation of the narrative. As each interprets the narrative from their own perspective they incorporate their thoughts, feelings and observations (Garro & Mattingly, 2000). According to Bruner (1991) these experiences and the memory of them are organised in the form of narrative. Narrative is the way human experience is made meaningful and allows for an expression of that meaning to others (Polkinghorne, 1988). The narrative construction of reality is the basis for the stories we tell others about our human interactions (Bruner, 1991). In narrative inquiry the story is the fundamental unit that expresses the human experience.
(Pinnegar & Daynes, 2007). Clandinin and Rosiek (2007) equate stories with “a portal, through which experiences of the world are interpreted and made meaningful” (p. 38). As the researcher inquires about an experience, participants reflect and generate meaning, relating the experience as a story. To paraphrase Bruner (2004), it is through story that life becomes narrative and narrative becomes life. Narrative inquiry encompasses the methodological study of experience as story as well as the method that is being studied. As the story is told the meaning that is ascribed to the experience unfolds within the context of three dimensions of place, temporality, and sociality (Clandinin & Connelly, 2000). The exploration of the meaning of experience and the three dimensions of context are described in the next subsection.

3.2.2 Meaning of experience

With its roots in the literary form of narrative as being layered with meaning (Harmon & Holman, 2003), narrative inquiry is closely connected to the meaning of experience (Bruner, 1986; Clandinin & Connelly, 2000; Clandinin & Rosiek, 2007; Polkinghorne, 1995; Riessman, 2008; Widdershoven, 1993). Narrative inquiry is an appropriate methodology to study the meaning that nursing students ascribe to their experiences. The selection of a methodology reflects the particular view of experience and on the phenomena under study which in this case revolves around the experience of student nurses listening to elders’ stories. As the researcher encourages the participants to think about and remember their experience, the participants formulate a story to express the meaning they attach to the experience of listening to elders tell their stories.

According to van Manen (1990) the meaning of the experience can only be realised by looking back and reflecting on it. Making meaning is an active process. Meaning is “not an object” that can be observed; it is fluid and changing (Polkinghorne, 1995, p. 1). Van Manen (1990) describes the process of constructing meaning as the consciousness breathing “meaning in a to and fro movement” between the past and the present (p. 36). As each experience is appraised in relation to another experience, meaning is generated and continues to evolve over time. Meaning is formed through contemplation and by the translation of thoughts into words. Consequently, the act of telling a story about an
experience is the act of giving meaning to the experience (Hendry, 2007). The forming of the story or the narrative creates the meaning that can be studied through narrative inquiry.

### 3.2.3 Dimensions

Within each person’s story are multiple contextual dimensions. Narrative inquiry values the dimensions of context that are embedded in each story making meaning more apparent (Atkinson, 1998; Chase, 2011; Clandinin & Connelly, 2000; Riessman, 2008; Widdershoven, 1993). Baynham (2003) contends that context is not the backdrop to the story; rather it “is the story” (p. 351). The storyteller’s use of context breathes life into the story by providing a setting or plot and characters that are part of the experience (Frank, 2010; Kramp, 2004).

According to Clandinin and Connelly (2000) narrative inquirers view experience and the experience of narrative inquiry as multidimensional, composed of place, temporality (time) and sociality (interaction). To research one’s experience is “to experience an experience” by incorporating these three contextual dimensions (Clandinin & Connelly, 2000, p. 30). Each of these dimensions overlaps and intersects the other to enrich the understanding and meaning of experience.

#### 3.2.3.1 Place

Place consists of the specific site where the participant interacts with the narrative inquirer as well as the settings of the events in the narratives (Clandinin & Rosiek, 2007). The place or sequence of places where the inquiry takes place and where the stories take place are important to the understanding and interpretation of experience. The qualities of place impact on an understanding of the lived experienced and the way in which the experience is told (Clandinin & Rosiek, 2007). Understanding place provides a context to the circumstance from which the experiences transpired. The location where the interviews take place is just as important as the specific locale and setting of the stories that the nursing students talked about. The research interviews for this study took place in Hawai‘i, which for many of the nursing students was “their
place”, their `aina (land). In the sociocultural context of Hawai‘i, place includes a unique understanding that touches on the temporality of experience spanning the confines of time as well as the sociality of experience which includes personal and social contexts. In Hawai‘i, the traditional sense of place shapes one’s self-identity and includes an awareness of ancestors who have gone before and a sacred connection to the `aina as the source of life in the past, the present and for future generations (Kanehele, 1992; Oneha, 2001).

3.2.3.2 Temporality

Temporality is a way of thinking about events and their meanings as happening over time: in the past, the present, and in the future (Clandinin & Rosiek, 2007). Influenced by the writings of John Dewey (1997), narrative inquirers recognise that experiences are continuous (Caine & Steeves, 2009; Polkinghorne, 1995). Every experience is formed by experiences of the past and will shape the experiences yet to come (Clandinin & Connelly, 2000). A narrative is a representation of experience and meaning as it “unfolds through time” (Clandinin & Rosiek, 2007, p. 40). Viewing experience as temporal provides depth to understanding the process of the research. Several interviews of the nursing students contained responses that initially seemed to be tangential and off the topic. However, as the tangents developed it became clear that these comments were not only on the subject, but were temporal shifts rich with storied examples of how understanding an experience goes back and forth between different periods of time with different experiences influencing each other. The nursing student participants also suggested that their recent experiences impacted on future ones. Clandinin and Connelly (2000) include researchers in the experience of temporality. Researchers cannot help but remember their own stories from the past and the present while imagining possible plotlines or sequence of events to come. These remembered stories contribute to the context of the researcher and the sociality of experience in narrative inquiry.

As the nursing students recollected their experiences listening to elders and told their stories, they often shared portions of the elders’ stories to provide a framework to their
feelings and observations. Even though the elders are not part of the interactive
development of the narrative, they are always present but in the background. The elders
are like ‘shadow participants’ who occupy a space surrounding and connecting to the
participant (R. McEldowney, personal communication, September 2011).
Encompassing the temporality of the experience and the sociality of interaction, the
elders who told their stories to the participants are designated as shadow participants.

3.2.3.3 Sociality

Sociality acknowledges that experiences are influenced by personal and social
conditions. Both researchers and participants interact with their surroundings, the
environment, circumstances and people that make up their world (Clandinin & Rosiek,
2007). The concept of temporality represents how the context of sociality is represented
in both the past and present with potential in the future. Narrative inquiry does not only
focus on individual experiences but acknowledges the underlying narratives that have
shaped the person’s life leading up to and shaping that particular experience (Clandinin
& Rosiek, 2007). Personal context and characteristics of the researcher and the
participant and the way in which they interact also affect how the narrative develops.

Another aspect of sociality is the relational nature of narrative inquiry (Caine &
Steeves, 2009; Criag & Huber, 2007; Josselson, 2007; Riessman, 2008). Not only does
context impact on the researchers and participants as individuals but also between them
and together as they collaborate. The context of the researcher is additionally informed
by the literature and theory framing the study. Narrative inquirers “are in relationship,
negotiating purposes, next steps, outcomes, texts and other concerns that go into an
inquiry relationship” (Clandinin & Rosiek, 2007, p.70). The researcher recognises the
power and status differentials of the relationship, being sure to “research with rather
than on” (Clandinin & Rosiek, 2007, p. 61). This position of reciprocal relationship
closely parallels the description of providing care to elders in Chapter One as “being
with” not just “doing for” (Hanson & Taylor, 2000). Narrative inquiry includes the
negotiation of power where the researcher relinquishes power and lets the storyteller tell
their story (Riessman, 2008). At times during the interviews nursing students would
ramble and lose track of their original thoughts. Giving little or no redirection it was possible to let the nursing students determine the direction of the story telling. By keeping redirection to a minimum and letting nursing students have control over the telling, there were times when the expression of their thoughts became more spontaneous coming back to their point with added context and clarity. Yet there were also times when the nursing students specifically asked for redirection or validation that what they were saying was relevant.

The conversation and interaction between the researcher and the participant create a space for narrative inquiry which facilitates reflection and generates the expression of meaning (Polkinghorne, 1995). Narrative inquiry becomes “simultaneously a description of and intervention into human experience” (Clandinin & Rosiek, 2007, p. 44). The result is a co-produced and jointly constructed story created by both the researcher and participant (Connelly & Clandinin, 1990; Riessman, 2008). Life story is a method that supports this co-creational process.

### 3.3 Life story as method

Life story is a method of narrative inquiry that focuses on the meaning of lived experience and can be a collaborative effort. This method of narrative research focuses on understanding “participants’ individual lives and stories about their lives as lived” (McEldowney, 2002, p. 40). It was an appropriate choice to find out firsthand from nursing students what they thought about their experiences and it gave them a voice in the telling of their own story. The method of life story leaves the choice of the story and the manner in which it is told up to the teller (Atkinson, 2002). Unlike other forms of story such as biography and life history that also communicate life experience, life story “retains the voice of the storyteller” (Atkinson, 2007, p. 228). Life story is an approach that can be used in most settings with different types of stories yet all life stories stem from the nature of story itself.

According to Atkinson (1998) storytelling is a way in which we communicate. “We often think in story form, speak in story form, and bring meaning to our lives through
story” (p. 1). Across the generations, the disciplines, and cultures, stories are a way to share life meanings, imaginings and experiences with each other. For example, telling stories about life experiences transmits values and preserves traditions (Atkinson, 2007; Baddeley & Singer, 2007; Coulter et al., 2007).

Schenk et al. (2008) maintain that, “Story telling has always been a fabric of our society, a method of conveying our history, our context, and our personhood” (p. 241-242). Story telling is more than just imparting knowledge or giving a lesson. It involves interactive dialogue engaging both the teller and the listener as a story is shared (Banks-Wallace, 1998). As each person tells their story it puts the pieces of the experience into a whole and helps to better understand the feelings about the experience and the meaning it holds (Atkinson, 1995). As the story is formed so is meaning created (Lai, 2010). The telling of a story also implies an audience or a listener since it is through mutual interaction that life and story take on meaning (Lai, 2010). Coles (1989) emphasises that the value of stories includes the relationship that is nurtured as the teller and the listener interact as part of the storytelling process. Stories serve various functions which can be enjoyed by the teller and the listener. In addition to finding meaning in life and promoting relationship, stories can also serve to educate, heal, and transform (Atkinson, 1995).

3.3.1 Life stories in education and nursing

Life stories are a form of autobiography that communicate lived experience and focus on particular aspects of a person’s life. The stories that are expressed through life story reflect what is “most real” and “most important” about the experience being shared (Atkinson, 2007). Meaning is constructed as the memories and feelings from these experiences become integrated and connected to the present (McAdams, 2001). Consequently, life stories can bring new insights to both the teller and the listener of the story.

Within the field of education life stories have been used to study and find “new ways of knowing in teaching and learning” (Atkinson, 2007, p. 228). Life stories can be a
teaching or learning strategy within education (Connelly & Clandinin, 1999; Drake, 2006; Huber, Murphy & Clandinin, 2003; Lemmer, 2009; Pfahl & Wiessner, 2007). Educational studies of women’s life stories found that the construction and expression of stories was a learning experience that transformed the way the women thought about themselves and the life transitions they described (Lemmer, 2009; Stroobants, 2005). In adult education life stories have been used as a teaching strategy with students telling their stories individually to educators and collectively to each other in class (Pfahl & Wiessner, 2007). In addition to learning about themselves, adult students build relationships with each other and learn about other ways of life which help them to problem solve and to rebuild their communities (Pfahl & Wiessner, 2007). Life stories have also contributed to educational reform in a study of mathematics teachers (Drake, 2006). The teachers shared the life experiences that shaped the way they thought about math. Insights from these stories were then utilised in the redesigning of the mathematics curriculum.

The telling and listening to life stories has become an intervention in various areas of nursing such as with elders (Clarke et al., 2003), persons with learning disabilities (Hewitt, 2000), people with dementia (Hanesbo & Kihlgren, 2004), and those who have experienced loss (Yang, 2008). Life stories have brought nurses, patients, and family members closer together and empower the story teller (Clarke et al., 2003; Hanesbo & Kihlgren, 2004; Yang, 2008). Yang (2008) found that using life stories to study the impact of divorce on motherhood helped the women to reflect on their loss, find meaning in their suffering, and to feel empowered. The participants’ stories also identified community resources to which nurses can refer divorced women. In gerontology and nursing, life stories play a part in promoting interaction between generations and finding meaning in life. It is both a developmentally sound practice which supports the cultural stereotype that elders are wise storytellers who teach and share knowledge with younger generations (Baddeley & Singer, 2007; Touhy & Jett, 2010). The life stories of elders remain fluid and evolve as the telling of life stories promotes integrity and relationship (Clarke et al., 2003). The subfield of narrative gerontology has utilised life story as one of many methods in narrative development.
that focuses on the therapeutic effects of life review and reminiscence (Atkinson, 2007; Randall & Kenyon, 2004).

Life stories have been instrumental for innovation in nursing education and research (Caldwell, 2007; McEldowney, 2002; McNeill et al., 2008: Russell, 2009; Williams & Holmes, 2005). Russell (2009) conducted a study in a nursing home using the method of life story to reconstruct conversations and stories of residents with dementia. The resulting distinct and different stories indicate that elders with dementia retain their individuality. Williams and Holmes (2005) and Caldwell (2007) used life story with methodologies in which they were both members of the group being studied. Literary theories and local folklore have also been instrumental in interpreting the life stories of mothers of children with developmental problems (Williams & Holmes, 2005). Caldwell (2007) used heuristic inquiry as a member of a community of nurse practitioners where she took on the role of the storyteller of their life stories. McEldowney (2002) collected life stories of nurse educators over a two year period to study the way they were teaching for social change in nursing. A story map of ideas was developed as a framework for gathering and interpreting life stories (McEldowney, 2002). Participants referred to the story maps to guide them as they told their stories.

In the field of narrative inquiry, life story can be defined as, “the story a person chooses to tell about their life…what is remembered of it, and what the teller wants others to know of it, usually as a result of a guided interview by another” (Atkinson, 1998, p. 8). Most commonly life stories are a collection of stories spanning many decades throughout an entire life. However, a life story can also be chapters or episodes of experiences of a certain topic or a moment from one’s life. Both varieties of life story were a part of this study. The nursing students recalled listening to elders’ stories of particular moments as well as stories that covered decades of their lives. The stories told by the nursing students, on the other hand, covered various topics but focused on experiences listening to elders tell their stories. They also included reflections on how these stories made them think about other elders in their lives.
This study used Atkinson’s (2002) template of the life story interview which he describes as a three-stage process that focuses on protecting the voice of the storyteller. The stages of “preinterview”, “doing the interview” and “postinterview” each contain guidelines to assist the researcher (Atkinson, 2007). In the first step of the process the purpose of the study was communicated to potential participants while preparing questions and recording equipment. In the next stage the interview took place as the researcher assisted the participants to become aware of the meaning of their stories by using open-ended reflective questions (Atkinson, 1998). Lastly, the interview was transcribed and reformed by eliminating the voice of the researcher. The text of the story was read to identify themes and connections within the story that conveyed its meaning and related to specific research questions (Atkinson, 2007).

Riley and Hawe (2005) make the distinction between narratives and stories saying that participants tell stories and narratives are produced when the stories are analyzed. The terms ‘narratives’ and ‘stories’ can be easily confused and are often interchanged. In this particular study the stories are expressed by the nursing students as they tell of their experiences listening to the life stories of elders. The narratives are created through the analysis and interpretation by the researcher and verification by the participants.

In a literary sense there is a story within a story: a framework or framing story (Harmon & Holman, 2003). This type of story tells of the impact of a particular narrative, the life story of an elder, on the experience of a nursing student. Consequently the story expressed by the nursing student becomes the framework story, the primary story to be interpreted and analysed for meaning.

The interpretation and the analysis of the story are aspects of the research process that contribute to the quality of the life story narrative. This next section discusses the rigour of narrative inquiry and life story research.

3.4 Rigour and life story

Narrative research uses criteria for the evaluation of rigour that are unique to its own paradigm. The traditional standards of reliability and validity pertaining to quantitative
methods do not apply to narrative inquiry and life story research. Rather than being objective and measureable, narratives are subjective and contextual. Narrative research makes “claims about the meaning life events hold for people. It makes claims about how people understand situations, others, and themselves” (Polkinghorne, 2007, p. 476). It is up to the researcher to justify the claims that are made as well as evaluate the way in which the interpretation came about. Riessman (1993, 2008) and Clandinin and Connelly (2000) maintain that criteria to judge narrative inquiry are not prescribed, but should be carefully selected based on the specific research problem. Additionally, the criteria should reflect the ability to evaluate whether the purpose of the study was appropriate for the method (Dodge, Ospina, & Foldy, 2005).

Polkinghorne (2007) recommends that researchers draw from criteria that already exist. Lincoln and Guba (1985) established a set of terms for criteria known as credibility, transferability, dependability to affirm the trustworthiness of research. Trustworthiness critiques the soundness of the methodology (Holloway & Freshwater, 2007, Sandelowski, 1993). Credibility evaluates the representation of the participant’s perspective and the description of the research process. Transferability or the fittingness of the study appraises the applicability of the findings. Dependability analyses the consistency of the process that led to the conclusions and the ability to follow the methods that were used. Confirmability examines whether the conclusions achieve the aims of the study and the ability to track the course of the research. Koch and Harrington (1998) add that reflexivity adds to trustworthiness by reviewing the role of the researcher.

The choice of criteria is complicated by the lack of consensus regarding the exact meaning of terms to describe criteria (McHolland & Wallace, 2003). For example, Riessman (2008) and Lieblich et al. (1998) value coherence in narrative research. Lieblich et al. (1998) differentiate between internal and external coherence which describes how parts fit together within a study and outwardly in relation to existing theories. Riessman understands coherence to be global, local, and themal according to the way a study addresses the researcher’s goals and beliefs, the content of the narrative
and the themes within them. There is considerable overlap between the terms with similar uses or meanings. Mulholland and Wallace (2003) contend that criteria fall within three categories of evaluation. The first addresses the integrity of the research process comprising of adequacy (Clandinin & Connelly, 2000), credibility (Lincoln & Guba, 1985), fidelity (Blumenfeld-Jones, 1995), and trustworthiness (Lincoln & Guba, 1985; Mishler, 1990). These criteria are legitimised by many of the same features such as involvement of the participants in the interpretive process, evidence of the researcher’s voice, and the way in which the study was carried out (McHolland & Wallace, 2003). The second set examines the value of the knowledge that is generated with criteria of believability (Blumenfeld-Jones, 1995), plausibility (Clandinin & Connelly, 2000), transferability (Lincoln & Guba), and verisimilitude or apparency (van Maanen, 2011). These criteria suggest that the text is convincing. The third set is related to the relevance and benefit of the study (McHolland & Wallace, 2003). Measures of authenticity (Clandinin & Connelly, 2000; Frank, 2010), confirmability (Lincoln & Guba, 1985), and dependability (Lincoln & Guba, 1985) indicate that the research serves a purpose. Mulholland and Wallace (2003) assert that the manner in which narrative stories are retold can also increase the value and quality of narrative inquiry, supporting both the value of the knowledge and the relevance of the study. For instance, the use of restorying adds to the voice of the participants by enabling access to a “level of meaning” that was not apparent during the living of the experience (Mulholland & Wallace, 2003, p. 6). Restorying also enhances legitimation of the narrative findings by adding a “richness of understanding” (Mulholland & Wallace, 2003, p. 21). The criteria of credibility, transferability, trustworthiness and reflexivity are discussed further as they relate specifically to this thesis.

3.4.1 Credibility, transferability, trustworthiness and reflexivity

Credibility, transferability, trustworthiness and reflexivity have been selected to enhance the qualitative rigour and validity of the use of life story in this study. Together these criteria represent the totality of the research study. Trustworthiness and credibility address the integrity of the methodology and method of the research as well as the
integrity of the interpretation. Transferability assesses the value of the research and reflexivity highlights the voice of the researcher as a co-participant in the research. Collectively these criteria address the claims of rigour that are a part of this life story and narrative inquiry.

Credibility judges the interpretation and writing of the narrative texts. One way to do this is with member checks (Lincoln & Guba, 1985; Polit & Beck, 2008; Ryan, 2007). Member checks are used to have the participants confirm what has been heard by the researcher. Participants formally check the transcripts or narrative texts for accuracy or informally through verbal clarification (Polit & Beck, 2008). However, other researchers recommend that if member checks are done after the data analysis they threaten the validity and weaken the trustworthiness (Carlson, 2010; Sandelowski, 1993; Watt, 2007). In this study, informal member checks were conducted in the form of clarification of the storied responses during and at the close of each conversation with the participants. Each of the participants was also given a copy of their story in written narrative form to confirm that it accurately reflected the conversational interview (Carlson, 2010). Respecting the feedback from the participants reflects culturally safe research in which the participant decides what is communicated (Wilson & Neville, 2009). Only one participant suggested a change to the narrative text which did not change the meaning or content of the story.

Interviewing students who have all taken the same gerontology nursing course that I have coordinated or taught may have constitute a threat to the credibility of their stories. Unconsciously or consciously the students came to the interviews with ideas that were expressed to reflect the perspective of the gerontology nursing course content. During the interviews one student acknowledged that what she was saying reflected ideas she had learned in gerontology class. She mentioned the overprescription of medications to elders and the normal ageing changes of slower receptivity to the hearing and receiving of information. She summed up her comments by saying, “I think it’s everything you taught only regurgitated … but then, I’m preaching to the choir”. Other aspects of credibility include a methodology, method and participants that accurately reflect the
research questions. The method of retelling participants’ stories that includes using their own words provides context (as in Chapter One) and strengthens the credibility of the study. As Mulholland and Wallace (2003) explain, “the best entry to the participants’ world is found in stories in which the participants’ voices are heard. Participants’ words convey some meanings better than researchers’ words” (p. 21).

Transferability evaluates the potential for the research findings to have meaning for the reader. This requires that the data and information provided be substantiated or ‘fit’ enough for the reader to understand and discern ‘truth’ in the findings (Lincoln & Guba, 1985; Ryan, 2007). The process of identification of patterns and themes within the transcripts are a part of this data. Background information in Chapter One identifies experiences teaching gerontology nursing that support concerns about the care of elders. The literature review in Chapter Two forms the basis for what is known about teaching gerontology nursing and the attitudes of nursing students. Transcript and narrative text excerpts are included in the identification of themes in Chapter Five. In Chapter Six a discussion of the themes in relation to theory presents the development of the findings. The adequacy of the sample and range of data collected also contribute to the transferability of the findings and can best be done with purposeful sampling (Lincoln & Guba, 1985). For this study, only those participants who were unencumbered and met the criteria of having listened to the stories of elders were considered. The diversity of the participants contributed to a wide range of perspectives within the findings. Interpretation of the narrative text and relating it to other theory and literature is a method of retelling that legitimises the research text for the reader (Mulholland & Wallace, 2003).

Trustworthiness makes clear the perspective of the researcher’s goals and personal reasons for doing the research. This requires a transparency of the background that has led to the formulation of the research questions and the study (Watt, 2007). In Chapter One the background to the study included a discussion of experiences and questions about teaching gerontology nursing that helped to form the aims and objectives of the study. A journal which included log activities as well as reflective thoughts on the
process of the research was maintained to provide transparency of my biases and actions as a researcher. Keeping a log is part of developing and maintaining the audit trail of audiotapes and transcripts which contributes to trustworthiness of the research study (Lincoln & Guba, 1985).

Reflexivity shows the reader what is going on during the research process (Holloway & Freshwater, 2007). Clandinin and Connelly (2000) and Elbaz-Luwisch (2010) also refer to this as “wakefulness” in which the researcher is aware of his/her own position in the telling of the story and in relation to the participants as well as being true to the participants’ stories. Reminiscent of the principle of protection in cultural safety, wakefulness includes watching “over the gates to the private property of participants’ stories” (Elbaz-Luwisch, 2010, p. 276). The details of what was happening during the process were written down in journal entries. Each step of the process was documented with reflection and self-appraisal including what happened during each interview, decisions made, and ideas for what worked well and what did not (Janesick, 2004). For instance after one of the interviews I thought about the writings of Hendry (2007) on narrative research relationships and wrote in my journal:

I’m wondering if the story she told really fits the study. I had the chance a few times to redirect the focus but hesitated. She was so passionate about what she was saying … Hendry talks about the sacredness of the experience of “meaning making” for the story teller. It seems that the way in which research is conducted models respect by not objectifying and dehumanising the story-giving choices. This would be squelching the story and the story telling. By going with the flow of the participant I can make it more participatory than researcher-driven. There’s a bigger picture. It’s more than me collecting information.

10/27/2009

The ongoing exposure to related literature and interaction with peers and supervisors provides for more opportunities to reflect on the theoretical basis of the study. Excerpts of the journal writings are included in the thesis to promote qualitative rigour by making the process as well as the thoughts of the researcher clear to the reader. As discussed
earlier, in this chapter I have worked to make transparent my relationship with the participants and my efforts to avoid any semblance of paternalism or misuse of authority as a faculty member. The stories of the study along with the participants’ stories add to the rigour and robustness of the research project ((Mulholland & Wallace, 2003).

3.5 Design of the study

The design of this study is not only formed by the philosophical view of relationship, the nature of narrative inquiry and life story, but also by the considerations of ethics approval, informed consent of the participants, recruitment of the participants and the gathering of the stories. Each of these elements of the study design are discussed in addition to ways in which culturally safe research was maintained throughout the process.

As a nurse researcher, I was guided by the American Nurses Association’s Code of Ethics for Nurses (Fowler, 2008) regarding the ethical protection of participants in research. The directives of this document indicate ways to protect the rights of research participants which were contained in the consent form (refer Appendix A) and participant information form (refer Appendix B), as well as requiring approval by a qualified review board. When this study was proposed and conducted I was a PhD student at Victoria University of Wellington (VUW) in New Zealand with plans to interview nursing students that were currently enrolled at a Hawai`i university. Human Ethics Committee approval was first obtained from VUW, April 11, 2009 (refer Appendix C) and followed shortly thereafter with approval from the Institutional Review Board at the Hawai`i university, April 15, 2009 (refer Appendix D).

3.5.1 Recruitment of participants

In light of my position as a nursing faculty member in the same university as the nursing students to be interviewed, it became important to address ethical concerns in the engagement and recruitment of participants. Ferguson et al. (2006) confirm that nursing student participants are essential to include in the research of pertinent topics
and should not be excluded from nursing research conducted by nursing faculty. Nursing faculty are placed in a role of dual agency when students in the same school become research participants. As an educator in a fiduciary role of trust and confidence as well as evaluator, the role of nursing researcher brings with it ethical challenges. These challenges involve issues of power on the part of the researcher and vulnerability for the student. Faculty should be attentive to ensure “that students are not coerced or perceive that they have been coerced to participate” (Ferguson et al., 2006, p. 706). Eliminating my control or authority over the outcome of their coursework was one way this was ensured. Eligible participants were limited to only those students who were not enrolled in a course I taught or coordinated during the course of the research.

### 3.5.2 Use of an intermediary

Involving a neutral party to assist in the recruitment of participants reduces the possibility of role conflict, conflict of interest and coercion. In this study utilising an intermediary in the recruitment process reduced the “effects of faculty power in the relationship” (Ferguson et al., 2006, p. 707). A fellow nursing faculty member agreed to act as intermediary. Like most of the nursing faculty, the intermediary taught multiple levels of students, and therefore, knew some of the participants prior to the study. First, I gave her a list of ineligible participants, which were the nursing students who were enrolled in classes I would be teaching in the upcoming semester. Her phone number and email address were listed alongside mine on the flyers (refer Appendix E) as a contact person in the recruitment of participants during the start of the 2009 summer semester. The intermediary was prepared with copies of the participant information form (refer Appendix B) to give to students who expressed interest in participating in the study. The target was to recruit at least twelve nursing students in Level 5, who were completing the last semester of their BSN program. The idea was that by the last semester the students in Level 5 would have had the most time to reflect on their experiences and role as a nurse before being interviewed. A minimum of twelve participants was decided to provide adequate variation of themes in the narrative analysis (Guest, Bunce, and Johnson, 2006).
Human Ethics Committee and Institutional Review Board approvals were obtained toward the end of the school semester. At the start of summer session in June 2009, permission was granted to post flyers on-campus. They were put on bulletin boards and given to the Level 5 instructors to be available for the students. However, neither the intermediary nor I received any emails or calls in response to the flyers.

Follow-up conversations with the nursing instructors who taught these classes shed some light on the student response. Only nine eligible nursing students were enrolled during that summer session and many of the posted flyers “disappeared” from the on-campus bulletin boards. The instructors suggested that Level 5 students have “senioritis” and may have felt overwhelmed which could have contributed to their lack of response. It became clear that it was necessary to reevaluate and revise the process of recruitment of participants for the next semester which was one month later.

Enlarging the pool of potential nursing students was the first consideration. After consultation with my dissertation supervisor, I expanded the eligible participant pool from just Level 5 nursing students to also include those from Levels 3 and 4. All of these students would have completed their Level 2 gerontology nursing coursework and consequently increased the number of potential participants from the 9 to a possible pool of about 200.

Second, further evaluation of the recruitment process involved a review of the literature on the ethics of being proactive and involved in the recruitment of student participants as well as the retention of participants. Nursing researchers point out that the influence of the relationship between researchers and potential participants has both benefits and drawbacks (Ferguson et al., 2006; Orb, Eisenhauer, & Wynaden, 2001). The preexisting level of trust and imbalance of power between nursing educators and student participants impacts on the interactions (Ferguson et al., 2006). This relationship of trust requires a concerted effort to protect the participant from coercion yet also supports the development of a partnership to gain knowledge through research. The benefit for the participant previously knowing the researcher is that trust is more easily established, although a perception of more pressure to participate due to the prior teacher-student
relationship can also exist. This perception of pressure “might arise from the inherent power relationship between learners and their educators” (Ferguson et al., 2006, p. 707). Adler and Adler (2003) assert that “researchers may lessen respondent resistance by trying to equalize the status differentials and power inequalities between themselves and their respondents” (p. 168). In the context of this study, the power differential was reduced but not eliminated by excluding nursing students who would be subject to a teacher-student relationship that involved assessment or evaluation. However, it was not possible to eliminate the power differential in levels of knowledge and skills between a nursing faculty member and a nursing student. Further, students may also be motivated “to participate to please faculty with whom students have positive relationships” (Ferguson et al., 2006, p. 707).

The benefit for the participant not knowing the researcher results in less pressure to participate. A lack of prior relationship actually facilitates access if the interview is perceived as anonymous and transitory with a sense of “ironic security in detachment, leading to self-disclosure” (Adler & Adler, 2003, p. 161).

In addition to recruitment, retention of interested participants was just as important to consider. Prior to the onset of participant recruitment, three potentially eligible nursing students had asked me about my studies and expressed interest in taking part in the interviews. But when recruitment began, they did not make contact with me or the intermediary or respond to inquiries.

Respondents can be categorised as “unwary” or “wary” depending upon their circumstance. Unwary respondents can include previous students with nothing at stake, frustrated or malcontents, needy respondents craving attention or support, or those who feel empowered by participating and contributing to change. Wary respondents are reluctant to grant access, such as the three students mentioned, or those who are resistant and agree to be interviewed but withhold information leaving gaps in the data (Adler & Adler, 2003). The pros and cons of the researcher knowing the potential participants led to new strategies for recruitment and retention with the goal of successfully attaining interviews.
The method and timing of publicity were also identified as significant factors. The flyers were redone to provide more clarity and attractiveness with less wording and new graphics which included a picture of an elder telling a story (refer Appendix E). The use of an intermediary continued with only one of the nursing student participants contacting her to say that he would be contacting me.

3.5.3 Engagement in the recruitment process

The most significant strategy was the decision to become more engaged with the potential participants by being more visible and to emphasise their role in the process as an opportunity to learn about research from the perspective of the participant and to contribute to the development of nursing education (Fergusson et al., 2006). Being more proactive and engaged started with contacting the faculty members teaching Level 3, 4, and 5 classes of potentially eligible participants. The faculty responded positively to my requests to visit their classes to invite the nursing students to participate. I made nine visits to classrooms during September and October 2009, with very positive responses from the students. The very first respondent heard my announcement in the classroom and emailed me from her Blackberry before I had left the room. This response concurred with Rubin and Rubin (2005) that respondents “are more willing to talk to you if they know you…and what your project is about” (p. 89). With each classroom visit I became more aware of the importance of clear wording and the timing of the announcements. Students’ questions from the first visits helped me to better prepare for the subsequent visits. One student asked if they had to go out and find an elder with a story. In order to avoid any further misunderstanding I included my response to that question in subsequent announcements. I also discovered that the timing of the invitation to participate was an important factor. When I visited one class, following an announcement about graduation details or immediately before a quiz was given, there were no respondents to my invitation on those days.

I also intentionally made myself more visible and spent more time sitting outside on-campus where students congregated to talk to each other and to faculty. When students asked me how I was doing, I would tell them I was enjoying doing research, which
often led to their curious questions and some asked if they could participate. These conversations were discrete with the intent of protecting the identity of students who were expressing interest. Detailed conversations about getting them copies and signing the participant information forms (refer Appendix B) and consent forms (refer Appendix A) were held in private meeting areas or via email or telephone. This process resulted in the recruitment of 15 participants to the study.

### 3.5.3.1 Confidentiality and informed consent

Other ethical principles guiding this study were to promote confidentiality and reduce any risk to the participants in accordance with the guidelines and approval of the VUW Human Ethics Committee, the Hawai`i university Institutional Review Board, and the Code of Ethics for Nurses (Fowler, 2008). Before signing the consent form, participants were informed of the purpose and use to be made of the interview data collected and given the option to discontinue participation at any time.

The risk of harm to the student was minimal, although carrying the potential that participation may trigger uncomfortable memories (Orb et al., 2001). If the participant experienced emotional distress while recalling their experience listening to an elder’s life story, the conversation would cease and the participant would be given the option to take a break, continue at a later time, or to withdraw from the study. Referral information and assistance to arrange to contact a counsellor would be offered. It is the “moral obligation of researchers to refer participants to counselling or ensure that they have gained control of the situation by talking” (Orb et al., 2001, p. 94; Shamoo & Resnik, 2009). Counselling referral cards were collected from the Hawai`i university counselling centre but none were needed. Only one participant became emotional but declined the option to take a break or be given referral information for counselling services.

Participants were informed that their names and any identifiers that were unique to them would be removed and pseudonyms would be used in order to protect their identity in the transcripts and written report of the study. They were offered the option to choose a
pseudonym or have one assigned and a small number of participants were happy to choose their own. Names were selected that were gender specific but otherwise selected as random representations of the type of first names commonly found in the university student population. I chose only names with positive etymological connotations. For example, I selected the name Nalani which means gracious instead of choosing Dolores which means sorrows. The female participants’ pseudonyms were Ana, Clare, Emma, Julia, Kira, Lena, Lily, Lucky, Malia, Nalani and Nora. The men were Jon, Josh, Kaleo and Kanewai. Providing confidentiality for the nursing students was also extended to the elders who told their stories. Some of the more common last names listed in the Honolulu phonebook were selected as pseudonyms for the elders. The few identifiers of elders within the students’ stories were coded and eliminated according to the guidelines of the American Privacy Act known as the Health Insurance Portability and Accountability Act (HIPAA) (US Government Printing Office, 1996).

The participant information and consent forms, transcripts and audiotapes have all been kept secure in a locked filing cabinet since December 2009 and will continue to be until 2014 when the forms and transcripts will be shredded and the audiotapes erased. In January 2010 it was an added challenge when my family and I moved from Hawai`i to the mainland US. I kept all the data and forms with me in my carry-on luggage to assure security and privacy of the information until I placed them in the locked cabinet in my new home.

3.5.4 Maintaining cultural safety in the research

With cultural safety as the conceptual framework for this study, it was fitting to further address the power differential within the educator/nurse researcher-student relationship by incorporating culturally safe research into the research design. Culturally safe research is founded on the principles of the Treaty of Waitangi and should promote a relationship of partnership and reciprocity (Kearns & Dyck, 2005). The researcher should listen to the voices of the participants. Therefore, participants’ preferences for time and location of interviews were honoured. Participants were listened to and after they had spoken, questions of clarification were asked to emphasise and affirm their
voice in the narratives. Most often clarification was asked about where or when the events they were describing took place. Reciprocity was addressed by giving participants the authority to decide whether to exclude any portions of the conversations from the texts or to withdraw at any stage. None of the participants opted to exclude any portion of what they said. Being mindful of the cultural background of the participants, I sought to be respectful and make the atmosphere relaxed and comfortable for the participants. Before the start of each interview I offered the participants bottled water and allowed time for talk story as a way of showing hospitality and appreciation. The option to have a companion or a translator present would have been accommodated but was not the preference of any of the participants.

### 3.5.5 Gathering the stories from the participants

Fifteen nursing students who had listened to life stories of elders participated in interviews that were conducted from October to December 2009. Each of the participants had already completed gerontology nursing coursework in Level 2 of their nursing program at the Hawai‘i university. Thirteen of the 15 interviews were held on-the university campus in empty classrooms or outside at tables away from other students. The other two interviews took place off-campus when the participants requested to meet in coffee shops near their homes. Despite the public locale, the interviews were very private conversations not easily overheard by others.

Prior to each interview the participant information form (refer Appendix B) and consent form (refer Appendix A) were discussed, reviewing the purpose of the study, the potential benefit or risk to each participant, as well as the opportunity to decline or withdraw at any time. I reminded them that they were the experts in this study and that I was appreciative of them taking time to participate. Rubin and Rubin (2005) identify this as one way to help balance the power differential. At the same time, I tried to avoid overwhelming participants with too much information and allowed time for participants to ask questions about the research process or the research itself both before and after the interviews. The participants were the most interested in how many interviews were
being done and how I managed my time conducting research and teaching. Responses to their queries were factual and continued until their questions were answered.

The day before each interview a reminder email was sent to each participant as pre-arranged which provided an opportunity for any last minute scheduling changes. All but one of the participants had previously known me as their teacher, but they all knew that I was the gerontology nursing course coordinator. Their previous relationship with me and their awareness of my views on ageing from curriculum content certainly impacted on their conversations and responses in the interviews. According to Ferguson et al. (2006), participants may be hesitant to express negative or “disapproving opinions directly to those faculty who have designed and/or implemented the learning approach” (p. 709). Student participants may also want to please faculty that they are acquainted with, “saying what they perceive faculty want to hear” (Ferguson et al., 2006, p. 709). To reduce the possibility of student responses being forced or contrived, I reinforced that I wanted to hear their perspective because the student’s voice about listening to elders’ stories had not been heard before.

The 15 participants represented different stages of the nursing school program, with some in Level 3 which was the second semester in their Junior year to students in Level 5 which was their last semester. The eight participants in Level 5 were the majority with five others in Level 4 and two in Level 3.

In addition to representing a cross section of levels, there was also a mix in gender with 11 female and 4 male participants. Of the 15 participants, the majority were female and in Level 5 completing their capstone courses in their last semester before graduation. As seen in Table 1, the gender composition of the participants paralleled the percentage of female and male students in the nursing program at the time of the interviews. The 11 female participates (Ana, Clare, Emma, Julia, Kira, Lena, Lily, Lucky, Malia, Nalani, Nora) represented 73.3% of the participants which was slightly lower than the 80-85% of the females in the program. The 4 male participants (Kaleo, Kanewai, Jon, Josh) were 26.7% of the participants which was a little higher than the overall 15-20% of the male nursing students program wide.
The ethnic background of the participants was varied and reflected the multiethnic make up of both Hawai`i and the student population in the nursing program. Due to its history, immigration, and high rate of mixed, marriages there is no ethnic or racial majority in Hawai`i (McDermott & Andrade, 2011). Hawai`i is the most ethnically diverse state in the US with the highest rate of multiracial residents (US Census Bureau, 2010b). Over 40% of those living in Hawai`i identify themselves as a mixture of three or more races or ethnicities (Okamura, 2008). The background of the participants could not be easily differentiated even if they were labelled according to ethnicity. The ethnicity with the highest prevalence in the nursing program was itself Filipino representing a variety of mixed backgrounds, cultural differences, and regional language groups of the Philippines. For instance, one participant was born in the Philippines but was from the mainland US. Another participant was also ethnically Filipino and was born in the US mainland. Other participants were Filipino, part-Filipino and had lived only in Hawai`i. Some of the participants were only Caucasian or part-Caucasian but from different regions or cultures in the US and Hawai`i. One participant mentioned their part-Italian background. Some of the students were Hawaiian mixed with other races and ethnicities. The majority of the participants were mixed ethnically identifying with more than one ethnic group with varying degrees of association with their ethnic cultures. The fact that many of the participants spoke in

<table>
<thead>
<tr>
<th>Level</th>
<th>#</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>5</td>
<td>Kaleo</td>
<td>Ana, Clare, Emma, Julia</td>
</tr>
<tr>
<td>Level 4</td>
<td>2</td>
<td></td>
<td>Malia, Nalani</td>
</tr>
<tr>
<td>Level 5</td>
<td>8</td>
<td>Jon, Josh, Kanewai</td>
<td>Kira, Lena, Lily, Lucky, Nora</td>
</tr>
<tr>
<td>Total Participants</td>
<td>15</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>73.3%</td>
<td>Compared to program-wide 80-85% female at that time</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>26.7%</td>
<td>Compared to program-wide 15-20% male at that time</td>
</tr>
</tbody>
</table>
Pidgin English at times during the interviews reflected the ‘local’ culture of Hawai‘i. Most of all they identified strongly with the knowledge, beliefs and traditions of the culture of nursing and were in various stages of learning what they were (Suominen et al., 1997).

Only a few of the elders, the shadow participants, were identified ethnically or culturally by the participants. Some elders were Hawaiian; one was identified as Japanese-American; several were from the Philippines, while others were relatives of the nursing students which meant they had similar backgrounds. The issue of differences in ethnicity between the participants and the elders never came up during the interviews. The only difference the participants identified was that the elders were significantly older than them.

3.5.5.1 Story listening

The participants started off by describing what Kenyon (2003) calls the art of story listening which is an interactive experience of listening to an older person tell about their life. The moments of story listening took place across a number of settings. The participants recalled a variety of situations listening to elders’ stories in different time periods of their lives ranging from their earliest childhood memories to recent encounters just prior to the interviews. Some remembered what it was like when they were children and their grandparents told them about their lives, while others related experiences that were fresh in their minds within the last few weeks when they encountered an elder in their latest clinical course. The dimension of place and situation also varied as students recalled their visits to elders in their homes, in clinical settings, and in the community either as nursing students or in their personal lives.

3.5.5.2 Story telling

The way in which participants told their stories also differed. Some stories were told as thoughtful narrated reflections of a past experience while others were detailed accounts of conversations told as if it was in the present. Most of the stories were a mix of the two approaches. The story telling was most effective when the participants told their
stories in the style that was most comfortable and meaningful for them (Atkinson, 1998). Several of the participants referred to experiences as talk story.

Talk story has its origin in both the oral tradition of Hawaiians as well as the plantation era of Hawai`i when workers from different countries came together. Talk story is a Hawaiian conversational practice that takes place before any business or nursing assessment is done. Conversations modelled after talk story are low-key and sincere. They begin with relaxed and friendly exchanges and proceed in a non-linear fashion with gradual disclosures by each person as the speakers find out what they have in common through shared experiences. Talk story is a relational form of dialogue that is reciprocal with each person listening attentively and contributing to the conversation free of dispute and usually ending on a positive note. Within families talk story also includes the sharing of stories of the past by older generations to pass on to the younger members (Affonso et al., 2007; Brislin, 2008; Ka`opua, 2008; McDermott, Tseng, & Maretzki, 1980).

Many of the participants told about their experiences listening to stories of elder family members and grandparents. Clare, Emma, Jon, Josh, and Kanewai remembered stories their grandparents told them as young children and later as adults. Other participants had no close contact with elders before they entered nursing school. Emma, Lena, Lily and Nora clearly had a negative impression of caring for frail elders based on their early clinical experiences in long-term care facilities in contrast to Clare’s very positive experience. Most participants mentioned their senior companions (Ana, Emma, Julia, Kaleo, Kanewai, Kira, Lily, Nalani, and Malia) as a story listening experience while others (Jon and Julia) mentioned elders they met during community service learning at the Kupuna ID program and a senior center aerobics exercise class for the gerontology nursing course. Emma, Lena, Lily, and Nora also heard stories from patients they cared for in other nursing school clinical assignments in medical-surgical and community health, while Lucky, Kaleo and Kanewai recalled specific encounters with elders from their clinical work experience as nursing assistants in hospitals, long-term care facilities
and in patients’ homes. A few participants mentioned personal experiences with elders at family gatherings, in recreational settings and other places of work in restaurants.

The format of the interviews was semi-structured and conversational with open-ended questions according to the interview guide (refer Appendix F). Each interview was digitally recorded. After the first two interviews I made a few changes in the way I used the guide. I wrote the following notes after the first interview:

It was hard for me to look down at the questions instead of maintaining eye contact. I need to review the guide more before the next interview. Not sure if I was too responsive or appropriately neutral. (10/21/09)

Listening to and transcribing the first two interviews immediately helped me to hear myself and notice that the students gave cues when they were ready for my comments. In addition to clear requests for confirmation that they were making sense or answering my questions, there were also pauses that implied they had finished their thoughts. Otherwise, my silent, attentive listening was all that was needed to keep them telling their stories. I began to rely less on the Interview Guide, assumed what Polkinghorne (2007) refers to as an “open listening stance” (p. 482) and let the students’ stories emerge. Only when the students had exhausted their thoughts would I refer to the guide for additional points to pursue. This shift in perspective and my actions as a researcher reflected my understanding of being in a reciprocal relationship. As we shared stories back and forth, reciprocity was fostered by the way we listened to each other. Hutchinson (1999) explains that “reciprocity does not simply mean that we share stories back and forth, but that we have an obligation to listen and tell in ways that will sustain the dignity of one another and avoid domination” (p. 93). As the gathering of participants’ stories continued, the next step in the process of analysis and interpretation was taken in a more structured manner.

3.6 Analysis and interpretation of the participants’ stories

Participants told stories in segments that formed one or several stories throughout the interview. Analysis of the stories required studying those segments individually and in
total to find meaning. Even though the stories of the participants were the object of study, the retelling of the stores by the narrative inquirer expanded the interpretation of meaning and added another level of analysis (Clandinin & Connelly, 2000; Ollerenshaw & Creswell, 2002; Polkinghorne, 2007; Riessman, 2008). Narrative inquiry focuses on understanding the meaning of the experience that can be interpreted from the analysis of the narrative.

There is currently no set standard for the practice of narrative analysis. Approaches to narrative analysis vary widely according to the particular purpose, method and methodology being applied in the study (Riessman, 1993). A distinct division exists between two modes of thinking about narrative analysis regarding structure and form versus content and context. For example, the structural analysis of narratives differentiates the elements of story and the components of speech to analyze how the story is told (Gee, 1991; Labov, 1982; Riessman, 2008). In contrast the thematic approach of analysis focuses on what is said as the researcher interprets recurring elements of the experience (Lieblich et al., 1998; Riessman, 1993, 2008; van Manen, 1990; Wiebe, 2010). A thematic approach is useful when comparing and contrasting each individual story with others to analyse for patterns within and across narratives (Riessman, 2003).

Lieblich et al. (1998) identify two perspectives of narrative analysis as “categorical” or “holistic” when examining parts of stories or studying the narrative as a whole. Different options for analysis are developed when categorical or holistic are combined with “form” or “content” to create “holistic-content”, “holistic-form”, “categorical-content”, or “categorical-form” (Lieblich et al., 1998). The holistic-content approach aims to understand the meaning of the experience. Meaning is enhanced by interpretation that applies relevant theory to the experience being studied (Atkinson, 1998; Lieblich et al., 1998). Narrative analysis and interpretation can also be expanded by employing a pluralistic approach mixing different models of analysis (Frost, 2009; Riessman, 2008). Riessman (2008) uses more than one analytical model, for example,
when she explores both form and theme by examining the organisation of the narrative before initiating thematic analysis.

The mode of analysis for this study combines strategies from the writings of van Manen (1990), Riessman (2008), and Ollerenshaw and Creswell (2002). Van Manen (1990) views the meaning of lived experience as multi-dimensional to be uncovered in narrative themes. Riessman (1993, 2008) offers guidelines for thematic analysis within and between life stories which complement van Manen’s particular approach. Ollerenshaw and Creswell (2002) present a systematic method to analyse and reform stories into narrative texts. Together these three approaches provided a multilayered analysis and interpretation which also took the interactions of the researcher and participants into consideration.

The analysis and interpretation of the participants’ stories began by organising what had been said. First the recorded interviews were transcribed, then the “essential meaning” of their stories was identified through the use of thematic analysis (Polkinghorne, 1995; Riessman, 2008; van Manen, 1990, p. 77). The transcripts were also reformed into narrative texts through the practice of restorying (Ollerenshaw & Creswell; 2002; Wiebe, 2010). Restorying contributed to the ongoing process of thematic analysis and interpretation and helped to transform the participants’ stories into a more chronological order. Each of these steps played a significant role in understanding the participants’ experiences listening to elders’ life stories.

3.6.1 Transcribed interviews

Transcribing the recorded interviews was a positive experience that afforded me the opportunity to hear the voices of the participants over and over again. I listened to each audiotape about four times before I had a literal representation of what was said. At first I debated whether to include the nonstandard English grammar or interjections but decided that they were what made it real and were part of the story. Each interview had its own pattern of repeated words and interjections, some of which I identified as cues that preceded thoughtful comments. For instance, many of the participants used the
words ‘like’ or ‘you know’ when they gave examples of what they were saying. The injections of ‘really’ or ‘oh, God’ were commonly used to convey strong feelings. During the transcribing of the interviews I began a list of codes for words that I eliminated or replaced in order to protect the privacy of each participant. For example, the specific names of participants’ places of employment were replaced with more generic descriptions of the locations such as care centre or hospital. Participants mentioned specific names of elders, churches and neighbourhoods which were removed from the text. Listening to the audiotapes was the start of the process of understanding the meaning of the participants’ stories.

### 3.6.2 Understanding the meaning of the participants’ stories

The process of understanding the meaning of the participants’ stories had several stages: transcription, analysis of the transcripts, restorying the transcripts, writing the narrative texts, and thematic analysis across the stories. The discovery of the meaning of the stories began with the transcription of the interviews. During the transcription I began to identify various similarities within and between the participants’ stories. As I read and reread the transcripts, it became clearer what they were saying individually and as part of the collective of participants (Liamputtong, 2009). Different levels of meaning emerged from their explicit words and the interpretive or underlying concepts (Boyatzis, 1998; Braun & Clark, 2006). The literal meaning expressed by the participants’ words was a different level of meaning than the implied meaning inferred by the way in which the words were spoken. For example, the excitement in Lena’s voice when she exclaimed, *Oh, my God*, was of amazement rather than concern. From there the transcripts were restoried into narrative texts from which themes and patterns were more formally constructed (Ollerenshaw & Creswell, 2002). This was a recursive process that went back and forth between these stages as additional themes and “repeated patterns of meaning” were revealed and refined (Braun & Clark, 2006, p. 86). Each of these stages are discussed in the next section with examples from Jon’s narrative text to show the process from transcription to thematic development.
3.6.2.1 Representing their stories

Transcribing each interview re-immersed me in each participant’s story. I began the preliminary analysis by writing down any key phrases or thoughts that stood out as representative of the whole story. The key phrase *I wasn’t expecting that* from Jon’s narrative represented the highlight of his story because he anticipated listening to a tired, lonely man’s story like others he had heard but that was not the case.

This process of thematic analysis for this study was based on the writings of Riessman (1993, 2008) and van Manen (1990) who systematically explore themes of narratives to discover the meaning of a person’s experience. Themes are a simplification of an experience yet they describe an aspect of the experience that is repeated within the text. Van Manen (1990) has three specific approaches to uncovering or isolating the themes within a text:

1. The wholistic or sententious approach
2. The selective or highlighting approach
3. The detailed or line-by-line approach (p. 92-93).

In the wholistic approach the text is read in its entirety and then a sentence or phrase is formulated that represents the meaning of the text as a whole. The sententious phrase should be a substantive yet concise representation of the experience. With the selective approach the text is read several times and then key phrases or sentences are marked to indicate a particular aspect of the experience being described. The detailed approach is a careful line-by-line reading to determine what each cluster or section reveals about the experience being studied. This is the starting point to develop an understanding of the experience of listening to an elder tell their story for each individual participant. Riessman (2008) refers to these clusters as “thematic stanzas or meaning units” (p. 35). Each unit context excerpts from the text with a fitting title.

The story of Jon is used as an example of these three approaches as shown in Table 2. Using the wholistic approach (van Manen, 1990), the story of Jon was summarised by
the title, *I wasn’t expecting that*. I chose this phrase because it represented the moment that Jon singled out as the highlight of his experience listening to an elder and what he said he took away from the experience. With the *selective approach* (van Manen, 1990), words and phrases that represented the meaning and feelings of Jon were highlighted and can be seen in Table 2. When he listened to the elder’s stories he was *kind of amazed*. He found it *kind of shocking at first*, and it was an *eye opener* since *he wasn’t expecting* to hear about such interesting experiences. Jon’s feelings emphasised events in his story that were meaningful to him.

Themes were coded with memos to track any changes in the definition of the coding. Next, clusters of the transcript text were marked as small groups primarily related to the subplots of the story.

The first clusters were labelled with Jon’s shown in Table 2. The *line-by-line approach* (van Manen, 1990) was used to identify clusters. Subsequent clusters were identified that were more specific both within each initial cluster and throughout the participant’s story. Jon’s story clusters are identified in Table 2 as an example: World War II stories, a sports legend, stories from his grandparents and his parents’ stories about his grandparents. These cluster topics, became meaning units according to Riessman (2008), as details were added to the main points in each cluster. For example, within the meaning unit of Grandparent stories, Jon said his grandparent’s stories *taught me a lot* and they told him, *your generation is so lucky*. After completing this process, I compared the thematic clusters and meaning units and identified patterns that were shared with other stories or not in common with other stories. An example of some of the common patterns shared by Jon with other participants are listed in Table 2, such as World War II stories, grandparent’s stories and positive reactions to elders’ stories.

In addition to identifying themes and patterns, the interview transcripts were analyzed for key elements of time, place, plot and scene. These elements work together to bring order and sequence to the reconstruction of the participants’ stories into narrative texts (Connelly & Clandinin, 1990; Creswell, 2007; Ollerenshaw & Creswell, 2002).
According to Connelly and Clandinin (1990) this process known as restorying is essential to finding “further meaning” in narrative inquiry.

Table 2: Thematic analysis approaches from Jon’s narrative text

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>APPROACH</th>
<th>EXAMPLE/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Manen, 1990</td>
<td>Wholistic sententious: Represents narrative as a whole</td>
<td>Shaking his hand</td>
</tr>
<tr>
<td></td>
<td>Selective highlighting: Key phrases/stanzas</td>
<td>I was kind of amazed. Kind of shocking at first. Eye opener I wasn’t expecting that.</td>
</tr>
<tr>
<td></td>
<td>Detailed line-by-line: Clusters</td>
<td>World War II stories Sports legend Stories of grandparents</td>
</tr>
<tr>
<td>Riessman, 2008</td>
<td>Thematic stanzas/meaning units: Excerpts with fitting title</td>
<td>World War II stories Shock Part of family history Discrimination the elder experienced Been going on for awhile Sports legend Excited Felt connected to elder’s story Pretty amazing, kind of surprised Grandparents’ stories Taught me a lot, great memories Your generation is so lucky Parents’ stories Keepsake coins handed down Told him more of grandfather’s stories of trips around the world</td>
</tr>
<tr>
<td>Tweedie</td>
<td>Patterns that were shared with other participants’ narrative texts</td>
<td>World War II stories Grandparents’ stories Positive reactions</td>
</tr>
</tbody>
</table>
3.6.2.2 Restorying: Writing the narratives

Restorying is the retelling or reinventing of an existing story (Wiebe, 2010). The term refers to both narrative analysis and a person’s reinterpretation of past experience (Birren, Kenyon, Ruth, Schroots, & Svenson, 1996; Clandinin & Connelly, 2000; Craig & Wallace, 2003; Ollerenshaw & Creswell, 2002; Riessman, 2002; Wiebe, 2010). A The origin of the use of restorying is unclear. For the past 20 years restorying has been widely used in education (Birren, Kenyon, Ruth, Schroots, & Svenson, 1996; Connelly & Clandinin, 1990; Huber, Murphy, & Clandinin, 2011), narrative research (Creswell, 2007; Clandinin & Connelly, 2000; Mulholland & Wallace, 2003) and narrative therapy (Brown & Augusta-Scott, 2007; White & Epston, 1990). Rossiter (2002) attributes the use of restorying in teacher education to the influence of White and Epston (1990) who first developed narrative therapy. In the field of narrative therapy, restorying is meant to reframe the person’s view of their experiences into more positive ones (Brown & Augusta-Scott, 2007; White & Epston, 1990). According to Wiebe (2010), the earliest record of the use of restorying in education or narrative inquiry was by Clandinin and Connelly (1989) and Connelly and Clandinin (1990). Connelly and Clandinin (1990) describe restorying as the most desirable method of writing narrative texts. Restorying is compared to “broadening” or making generalisations from a story, or “burrowing” into the moment which tells the story from the point of view as the event took place (p. 11). In contrast, restorying reveals the reinterpreted meaning and significance of the experience in the present by looking back and considering possible meaning in the future.

A holistic style of restorying described by Ollerenshaw and Creswell (2002) uses the Three-Dimensional Space Narrative Structure framework of time, space and temporality in order to understand the meaning of a person’s stories. This structurally analytical device is based on Clandinin and Connelly’s (2000) three dimensional narrative understanding of lived experience as previously discussed. The researcher identifies portions of the story that involve personal and social interaction, the continuous nature
of experiences related to the past, present, and the future, and the situation and place in which the story takes place.

For the purpose of this study, the framework of Ollerenshaw and Creswell (2002) was the method utilised to restory the transcribed interviews of the participants into narrative texts. By incorporating the three dimensions of context in narrative inquiry, this framework provided consistency between the narratives as I assembled and transformed the participants’ stories into narratives that followed a chronological sequence. Retelling the participants’ stories in narrative texts added another layer of analysis and story to the already existing story-within-a-story. The story told by the elders created the story of experience told by the participants, which then became the story told by the researcher.

Based on the work of Ollerenshaw and Creswell (2002), Table 3 illustrates how these categories of experience easily organise the data for restorying. This framework uses concept headings based on the three-dimensional narrative inquiry space discussed earlier in this chapter (Clandinin & Connelly, 2000). Interaction, continuity and situation or place, correspond to the dimensions of sociality, temporality and place. Subcategories within the dimensions differentiate between personal and social interaction and contrast time in the past, the present and the future. Ollerenshaw and Creswell (2002) use the language of Clandinin and Connelly (2000) to define the subcategories and facilitate the examination of participants’ stories as they “travel … inward, outward, backward, forward, and situated in place” (p. 49). These directions of movement capture the continuity of feelings and perceptions of the participants across time as they recalled their experiences. Without changing the meanings, the wording of the definitions in the framework has been shortened for clarity and relevance to this study. These subcategories also correlate with the key elements of story which are time (continuity), plot (interaction), and place and scene (place or situation) which make up a chronological arrangement of the story themes and content within the framework.
Table 3: Three-Dimensional Space Narrative Structure

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Continuity</th>
<th>Situation/Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>Social</td>
<td>Past</td>
</tr>
<tr>
<td>Look \textit{inward} to internal conditions, feelings, responses.</td>
<td>Look \textit{outward} to conditions in the environment with other people, their assumptions and points of view.</td>
<td>Look \textit{backward} to remembered experiences, feelings, and stories from earlier times.</td>
</tr>
</tbody>
</table>

(Source: Adapted from Ollerenshaw & Creswell, 2002, p. 340.)

Analysis of the interview transcripts involved selecting data and arranging it in the Three-Dimensional Space Narrative framework. Using the temporal categories of the framework, I defined the past as any experience prior to entering the BSN program, the present as any experience while in nursing school, and the future as any experience in nursing yet to come. Deciding what specific portions of the transcript data to include in the structured framework and the narrative texts was guided by the research questions for this study.

The story of Jon, \textit{I wasn’t expecting that}, has been entered into the narrative structural device as an example of its use in Table 4. Each of the categories represent a component
of his story. Jon described a situation that was part of his gerontology nursing class. It took place at a community agency where he approached an elder standing alone. Jon’s personal feelings were of being shocked and his eyes were opened as he interacted with the man and heard his World War II stories. This reminded him of past stories told by his family and made him appreciate what he had now and would have in the future. His second interaction with this man amazed Jon when he heard about the man’s experience.

Table 4: Three-Dimensional Space Narrative Structure: *Jon – I Wasn’t Expecting That*

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Continuity</th>
<th>Situation/Place</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal</strong></td>
<td><strong>Social</strong></td>
<td><strong>Past</strong></td>
</tr>
<tr>
<td>Shocking Eye opener</td>
<td>Listened to stories of WWII veteran: hardship, discrimination</td>
<td>Family members in the military</td>
</tr>
<tr>
<td>Amazed</td>
<td>Story of meeting sports legend: Shook his hand. Fantastic for him.</td>
<td>Own favourite sports legend</td>
</tr>
<tr>
<td>You shook his hand!</td>
<td>Talking story Listened to stories on the front porch</td>
<td>Childhood experiences with grandparent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adulthood experiences with parents</td>
</tr>
</tbody>
</table>

(Source: Adapted from Ollerenshaw & Creswell, 2002)
meeting a sports legend. Jon expects to tell that story to others. Both of these stories brought back memories of interactions Jon had in his past with his grandparents and parents as he listened to them and learned to look forward to the future. This synopsis of Jon’s story is assembled in phrases and titles of themes in this framework which provided an outline to fill with detail and interpretation as I created the narrative text of his story.

Jon’s story was reorganised to highlight significant events and encounters and retold as a newly created narrative including excerpts of participant quotes. Each participant’s story was framed within the Three-Dimensional Narrative structure prior to the construction of the narrative text. The act of writing the narrative texts not only provided order to the data but it also revealed the characteristics of the circumstances that led to each participant’s experience. Individual characteristics that could possibly identify the participants were omitted or reworded to be more general. For instance, the names of specific countries, cities, or Hawaiian Islands where participants or elders were born were left out. Names of characters in the stories who were not elders have been deleted while the names of the participants and the elders who told their stories are all replaced with pseudonyms. The narrative texts offered a new interpretation of the participants’ stories and a means to further analyse themes across the stories.

Jon’s story illustrated how the methods of van Manen (1990), Riessman (2008), and Ollerenshaw and Creswell (2002) were used for preliminary analysis of the participants’ stories from transcription to restorying the narrative text. This next section elaborates on the development of specific themes within and between the participants’ stories.

### 3.6.2.3.1 Thematic analysis across the stories

As each story was reorganised into a narrative text the previous themes were revisited and revised. This was followed by more extensive comparisons of similarities between the stories. As the common themes were identified the definitions were refined and key overarching themes became apparent.
### 3.6.2.3.1 Development of themes

The development of themes began with the transcription of the interviews. As the participants’ words were being put in writing, themes and patterns began to emerge. I made notes of prevalent ideas or themes of each interview and those that recurred with the development of each transcript. The earliest themes are shown in Table 5. Each theme was defined and transcripts were marked with coding within transcripts and between each transcript for similar ideas. Passages of the transcripts were marked and classified with the names of the themes (Gibbs, 2007; Riessman, 1993). Most ideas or themes developed into subthemes that were offshoots of the original idea as they became more specific and filled with detail.

Table 5: Early themes: Coding notes from journal

<table>
<thead>
<tr>
<th>Early Themes from Interview Transcripts and Narrative texts (1/30/11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Story content</td>
</tr>
<tr>
<td>• Perceptions of elders</td>
</tr>
<tr>
<td>• Relationships with elders</td>
</tr>
<tr>
<td>• Highlights of experience listening to elders</td>
</tr>
</tbody>
</table>

The next step was to reread the transcripts to choose a thematic title that reflected the substance or a highlight of the participants’ stories as they were being reformed into narrative texts. For example Kaleo’s story was entitled *Reminiscence*. He emphasised how reminiscence enhanced his experiences listening to elders and added to their quality of life. Thematic titles also came from direct quotes of the participants. Quite often a phrase or sentence that stood out as meaningful for the participant became the thematic title, such as the title of Lily’s story, *Now I Understand*, came from her comments comparing listening to her grandparents in the past to listening to elders now. She said:

*So now I understand they’re just trying to tell me what they experienced.*
Cluster themes were identified within each story and transcript which were compared between transcripts with refinement of the definitions and titles of the themes. Finally, line by line identification of ideas and themes added to the process. Table 6 shows the development of more detailed themes such as stories, perceptions of elders, experiences with elders, the elder experience, contrasts, and participant impact.

Just as with the creation of narrative texts, focusing on the research questions helped to concentrate on the themes that were most relevant to the study. Some of the data included extraneous comments students made about plans for graduation, job prospects, and personal family matters which were not coded as elements related to the themes.

Table 6: Developing themes: Coding notes from journal

<table>
<thead>
<tr>
<th>Developing Themes from Interview Transcripts and Narrative Texts</th>
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</thead>
<tbody>
<tr>
<td>(Coding notes 3/23/11)</td>
</tr>
<tr>
<td>Stories</td>
</tr>
<tr>
<td>Limitations and challenges listening to elders</td>
</tr>
<tr>
<td>Story content</td>
</tr>
<tr>
<td>Highlights of story listening</td>
</tr>
<tr>
<td>Perceptions of elders</td>
</tr>
<tr>
<td>Before and after listening to stories</td>
</tr>
<tr>
<td>Experiences with elders</td>
</tr>
<tr>
<td>How participants met elders</td>
</tr>
<tr>
<td>Present and past experiences (grandparents, etc.)</td>
</tr>
<tr>
<td>Elder experience story</td>
</tr>
<tr>
<td>Participants’ perceived experience for elder telling story</td>
</tr>
<tr>
<td>Contrasts</td>
</tr>
<tr>
<td>Comparison of experience with nursing care of elders</td>
</tr>
<tr>
<td>(as observed by participants and related by elders)</td>
</tr>
<tr>
<td>Participant impact</td>
</tr>
<tr>
<td>Lessons learned, unexpected moments</td>
</tr>
<tr>
<td>Changed attitudes, feelings, myths and stereotypes</td>
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</tbody>
</table>

Overall, the remaining themes overlapped and also shared some common characteristics. The most predominant theme overall was that the experience of listening
to elders’ stories resulted in feelings and beliefs that were identified as transitions or changes. Some of the participants described gradual transitions while others’ experiences of change were more abrupt. In an effort to be led by the participants’ own meanings rather than my own, I used the participants’ words as a guide. I toyed with and explored the ideas of change, turning point, eye opening, adjust, difference, reevaluate, transform, newness, and shock. It became clear that there was an overarching theme of transition that started with the experience of being ready or open to and then listening to the story of an elder. I explored different terms to choose from to represent the participant’s meaning of the experience.

The idea of a threshold came to mind as I thought about transitions as going through a doorway when I recalled narrative inquiry being described as a portal, as mentioned in Chapter Three. “Stories are a portal, through which experiences of the world are interpreted and made meaningful” (Clandinin & Rosiek, 2007, p. 38). A threshold is a port of entry, a place that is neither in nor out but between. Just as a portal is an entrance or gateway, a threshold is the place from which you start. Another word for threshold is limen or liminality from the Latin meaning of threshold which is limen limina (Latin Dictionary, 2013). The concept of liminality has its origin as a state of transition between the old and the new, a state of being betwixt and between (Turner, 1967, 1969; van Gennep, 1960). The ambiguity of being in transition carries with it a sense of danger and energy that precedes change (Douglas, 1966). Auge (2008) describes the transition of crossing a threshold and being in a liminal place as when “one ‘becomes’ something more – more capable, more perceptive, more knowledgeable” (p. 4). Conroy (2004) expands on the idea of liminality by applying it to educational experiences which are outside of the mainstream and provide opportunities of transition for new discovery and learning. For the purpose of this study crossing the threshold signifies being in transition and experiencing moments of liminality.

Thus the many changes described by the participants can be called liminal spaces. They are spaces which signify different types of transitions. This idea of space is not a
physical location or an area of emptiness but rather a place of possibility. Liminal spaces afford the liminar, the occupant of the liminal space, the potential to reform their way of thinking about and responding to particular situations (Conroy, 2004). This is what happened when participants became aware of listening in a new way. Learning and discovery also came about as a result of what they learned from the elders and their stories. They experienced the possibility of relationships with elders which fostered changes in their attitudes, feelings, and actions. Each of these experiences of transition took place in liminal spaces which shared common subthemes. With the overarching theme of liminal spaces, I have divided up the common subthemes into four categories of spaces, each with their own descriptor as seen in Table 7.

The theme of liminal spaces and the subthemes of story space, light space, reflective space, and caring space are discussed with examples from participants’ stories in Chapter Five.

Table 7: Themes of participants’ experiences of transition

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Overall Theme: Liminal Spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Story space</td>
<td>Threshold</td>
</tr>
<tr>
<td>2. Light space</td>
<td>Being let in</td>
</tr>
<tr>
<td>3. Reflective space</td>
<td>Transformation</td>
</tr>
<tr>
<td>4. Caring space</td>
<td>Renewed vision</td>
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3.7 Summary of the chapter

In this chapter I have described the methodology of narrative inquiry and the method of life story as fitting ways to examine the lived experiences of nursing students. The philosophical positioning of relationship according to Buber (1965, 1970) was explored in regards to relationships in nursing practice and research. Buber’s understanding of relationship shaped the design of this study as collaborative interactions were shown to be integral to the recruitment of participants, the gathering and retelling of the stories, and the ability to maintain cultural safety in this narrative inquiry. Explanations of these
processes contributed to the rigour of the research using the criteria of credibility, transferability, trustworthiness and reflexivity. Examples of coding, thematic analysis, and restorying reflected the influence of van Manen (1990), Riessman (2008), and Ollerenshaw and Creswell (2002) on the interpretation and analysis of participants’ stories. As a result of the process of thematic analysis across the stories, the themes of liminal spaces were uncovered. These themes are supported by the narrative texts that are presented in Chapter Four.
Chapter Four  Individual stories

This chapter contains the stories of the 15 nursing student participants (Ana, Clare, Emma, Jon, Josh, Julia, Kaleo, Kanewai, Kira, Lena, Lily, Lucky, Malia, Nalani, and Nora). Each individual story is unique yet they all share the perspective of what it was like listening to an elder tell their story. For example, Kira talked about one particular experience with an elder during nursing school. The bulk of Nalani’s story was about her grandmother, while Josh shared about elder family members, patients, and casual acquaintances. The narrative texts reflect the interactive and collaborative experience of the participants and the researcher as the participants reflected on and recalled their experiences.

4.1  The stories

Each story is a composite of the participant’s interview transcript and my interpretation of their story putting it into story form. Italics are used to indicate the participants’ voices and quotation marks indicate when the participant is reflecting elders’ comments.

Some of the participants told their stories in the ‘local style’ of Pidgin English which is also called Hawai`i Creole. This form of speech is a blend of Hawaiian, English, and other languages having its origin in the plantation era of Hawai`i when workers from a variety of countries (e.g. China, Puerto Rico, Portugal, Japan, Korea, Philippines) came together to talk story (Takaki, 1984). Talk story is an example of a commonly used Pidgin phrase. Pidgin is a separate and distinct language with many speakers being completely bilingual and able to easily switch back and forth between Pidgin and Standard English (Sakoda & Siegel, 2003). The rhythm of Pidgin is lyrical with a lilt to the accent. It is primarily a spoken language with its own rules of grammar containing a mix of local vocabulary from Hawaiian and other languages introduced by the plantation workers. Also evident in the stories is the presence of medical terminology and nursing vocabulary with parenthetical explanations according to their use by the participants.
The participants’ stories begin with Jon, whose story was used in Chapter Three as an example of the restorying process. I was well acquainted with Jon and all of the participants, except for Kira, having been their Level 2 gerontology nursing instructor. Like most of the participants, Jon met on-campus for the conversational interview in an empty classroom with a sign on the door that said, ‘In conference.’ Any other locations that were used are specifically mentioned in the stories. Jon’s story is the first of 15 nursing student participant narratives. The title of each of the stories captures the meaning of each participant’s experience.

4.1.1 Jon: I wasn’t expecting that

Jon was very eager to tell me about listening to the stories of a particular elder he met during nursing school. This was the second time I heard him tell a portion of this story. The first time was when Jon spoke about it in gerontology nursing class. The enthusiasm he showed then had not diminished one bit. It was an experience that had stayed with him for over a year and now he was finishing his Level 5 classes preparing to graduate. As Jon thought about the stories of elders he had heard, he gravitated back in time to his childhood. Jon spoke very clearly and matter-of-factly as he shared his experiences.

As a young child Jon listened to his grandparents talk story on the front porch. Every time they visited they told him stories and gave him advice that he still kept in mind today. Jon recalled; My grandparents taught me a lot. He received a lot of supervision from them in his earliest years. They shared their knowledge by talking about their younger days and told Jon what he could look forward to in the future. Jon’s grandparents always said; Your generation is so lucky! Jon imagined how much different it must have been for them in the past compared to all the technology and modern amenities today. Everything was cheaper for them but still it was harder to receive money. Everything was a lot harder for them.

Jon found many similarities in the stories he heard from elders who lived then and it made him realise that we should appreciate what we have now. Jon remembered clearly
the moments with his grandparents when their pictures were taken together. They were great memories.

Jon grew up feeling close to his family. He spent his early childhood living in the Philippines until his family moved to the US. By the age of eight, his grandparents had died. But Jon’s parents kept up the reminiscence and told him more of his grandparents’ stories. He heard about his grandfather’s trips around the world. *Every time he visited a different city he collected coins.* Now that keepsake collection of coins has been handed down to Jon.

His grandfather’s travels came about as a result of being in the military. Multiple generations of Jon’s family have been in the military making him feel that it was part of the family history. Jon decided not to go into the military and studied nursing instead.

Recently, Jon went to a community centre as part of his gerontology nursing class. He explained that the centre provided services as well as activities and social interaction for elders since *they rarely got to talk to anybody* or interact with the community. Jon was assisting with a program that provided emergency identification cards to elders. He said; *I wasn’t really expecting anything.* He had experienced hearing stories from elders before. Jon went there to *do some good* for the elders and he hoped to talk to somebody for his gerontology nursing course requirements.

Jon saw an elder man in his 80s come into the centre with his family. It appeared that they just left the man alone at a table because he was tired. The elder looked bored or as if he was just waiting around. So Jon took the initiative and walked up to him and asked him to *maybe just hang out and share a couple stories.* The elder, Mr. Hamada, agreed and he started telling Jon his stories *talking about a couple experiences he had when he was in the military during World War II.* His first story was about being in combat in Europe when he got badly injured. Mr. Hamada told Jon about trying to get help but when he looked around all of his buddies were wounded or dead. Once he was rescued he required extensive care to recover from his wounds. The second story really got Jon’s attention when Mr. Hamada described the discrimination he experienced as a
Japanese-American in the US military. Mr. Hamada described his disappointment when the other soldiers looked down on him as if he had done something to them. He did not get much attention from his fellow soldiers and was basically on his own with friends who were like him. They found ways to find food they craved, creatively negotiating to trade weaponry for rice.

Even though Jon grew up hearing stories about the military and wartime from uncles and grandparents, Mr. Hamada’s stories were still shocking to hear. It was an eye opener listening to another person’s story. Jon’s response to this story echoed what he had been told by his grandparents; We do have it lucky compared to back then.

Mr. Hamada had a new story that Jon had not heard before. He told Jon about the time he personally met Babe Ruth. Being an avid baseball fan made this especially meaningful to Jon. He thought; Here’s somebody that actually got to see one of the baseball legends. Mr. Hamada had experiences in his life that were pretty amazing. Jon recalled; I wasn’t expecting that. I thought he’d say, I fought this war and probably his friends got shot, just a war story. Talking to an elder veteran like Mr. Hamada came to a good ending for Jon. He was kind of surprised.

The image Jon portrayed of Mr. Hamada and his expectations when he first saw him had a paternalistic element to it compared to his feelings toward him after hearing his story. Jon changed the way he perceived Mr. Hamada. As Jon told the story the bored looking elder he described as standing all alone now sounded animated and interesting.

For Jon the story of meeting Babe Ruth overshadowed all the other experiences told to him by Mr. Hamada. Jon asked him what it was like and Mr. Hamada told him it was fantastic … It was the best feeling in the world to get to shake someone’s hand who’s so popular. Jon was excited to have shaken Mr. Hamada’s hand and felt connected to his experience of meeting Babe Ruth. Laughing and smiling, Jon talked about shaking his hand. Wow, I got to shake your hand; you shook Babe Ruth’s hand. Now I’ve got a story to tell.
The story that Jon now had to tell was one that came from an era that he first learned about from his grandparents. He gained a new perspective when he listened to original stories from that same period of time. Not only was he surprised by this experience but he felt a connection to an elder he had never met before. He had a newfound respect for elders.

Like Jon, Kanewai also grew up listening to his grandparents’ stories. His experience listening to elders laid the foundation for how he wanted to live his life and how he understood the value and importance of stories.

4.1.2 Kanewai: Good stories

Kanewai was in Level 5 and finishing up his last semester of classes when we met on-campus for the interview. He talked openly and enthusiastically about a variety of experiences he had listening to elders before, during and after he took his gerontology nursing class. His pseudonym, Kanewai meant ‘man of the water’ in Hawaiian which fits well with his story illustrations of water and fishing.

Kanewai listened to the stories of elders on numerous occasions but only certain types of stories were memorable and mattered to him. The stories that were the most important to him were the ones that he could connect with his life experiences. He was very forthright and talked candidly about how he responded to the stories he encountered and how they related to his life.

Most of all Kanewai enjoyed listening to his grandparents’ stories about family and their life growing up. Looking back, he said; It made me feel appreciative and a lot closer to them. They had a much harder life than Kanewai and both grew up on farms. Kanewai valued their stories about working hard with what they had. He wanted to follow the outline of their life - not so much what they did but how they did it. Kanewai explained; That’s why it’s interesting to me. I can use something from it to apply to my life.

Kanewai listened attentively to stories that had those same values, especially stories of hard work like some of the fishermen in his family and their fish tales. He told the story
of his family member who was out fishing for hours, fell asleep out in the fishing boat and then woke up to a full net, the biggest set of the season. Stories like that were good but what made it so memorable was that the person in the boat was not the one telling the story; it was one of the old fishermen. Kanewai felt that sometimes they tell it so much better.

Kanewai identified that the person in the story may be too ashamed or humble to tell the story themselves – or as he exclaimed, there are the times when you almost jump off your chair because you have never heard that story before.

He remembered a time when he was with his grandfather and an elder family member told a story about Kanewai’s grandfather that he had never heard before. Those were the stories that stood out the most because the storyteller took the time to share a memory about someone that was important to him. Kanewai described feeling a strong connection to the storyteller, like he could trust him more.

I felt like they were closer to me than they were before because they’ve taken time out to bring somebody else up that I know, sharing their story that they wouldn’t normally share...It felt like they were sharing a piece of that person with everybody. And that stays with you more. It sticks with you.

Kanewai exclaimed; I just love stories! However, he was not very interested if people just talked about things he did not value like making money, having nice clothes, or fancy cars. If they spoke negatively towards others he just shut them out. For Kanewai, it is a real turn off if someone is narrow minded talking about certain races or putting people down. One time he heard a story from an elder who was talking badly about someone else. You try to think the best. But it just kind of turns me off, brings you down.

In his job as a nursing assistant it was not easy for Kanewai to listen to stories while he was working and getting paid. He listened to older patients’ stories because he cared about their health and it made them happy. It made them feel better emotionally but he did not care that much about the stories and did not take much away from it. Kanewai gave examples saying that sometimes it was the patient’s history or the story of what
happened in a car accident, sepsis, or overdose that was interesting, more so than their personal stories. There was one patient, Mr. Lewis, he felt attached to at work. *He’s really cool, just like a good guy.* So Kanewai visited him and listened to him even when he was not assigned to his care. Mr. Lewis had an interesting case that caught Kanewai’s attention.

In nursing school he thought it was great listening to the stories of elders in the hospital or in his community health clinical classes. Kanewai felt that nursing students gained a lot when they were in it for the right reasons. He was certain *it takes a big heart.* Kanewai knew that listening to elders made them feel better emotionally. He relied on what he learned about the psychosocial aspects of ageing in gerontology nursing class to explain the value of listening to elders. *They need to feel like they were giving back to the next generation* to achieve Erikson’s developmental task of generativity versus stagnation. Nurses needed a big heart to empathise with the elders. *The other part is to be genuinely interested, to actually want to know what this person is talking about.* Genuine interest encouraged elders and made them feel that *maybe life doesn’t suck so much so I can go for a walk today.*

It really depended on what kind of story it was but Kanewai felt compassion most when elders told stories about themselves that he could apply to his life. *Usually they’re sad stories.* But sometimes they were good stories. Good stories were when you could say *I’ve been there, too, or I’ve thought about that.* With those kinds of stories he felt a connection. Kanewai explained; *When people tell me those kinds of stories it’s like something I can live up to.*

Kanewai enjoyed listening to the stories of his senior companion, Mr. Medeiros. They both had similar interests. Mr. Medeiros lived the way Kanewai wanted to live, like his grandparents. The stories Mr. Medeiros told him greatly influenced Kanewai. They reconfirmed what he was doing and that he was moving in the right direction by becoming a nurse. Kanewai worked to find exactly the right words to express how these stories affected him. He said; *I really feel satisfied with what I’m doing, with this whole*
nursing thing. I feel it's not for nothing. It feels like it is meaningful. That's the word. Talking to him made me feel my life is more meaningful.

Kanewai looked at life as if it was a story going to be written in a book; If it’s going to be a boring read, it’s kind of not really worth it….You don’t need to travel the world...Doing the same thing for 40 years but just doing it well, that’s a good story in itself. Looking towards graduation he said; I already have some good stories but there are going to be more. He envisions himself working in the intensive care unit or emergency room, and possibly be a critical care flight nurse.

Reflecting on his own life, Kanewai explained; Everything I do is a story. I try to make it into a story. There is always a backdrop, then what happened, and then a conclusion. He imagined his life as a story. He liked to listen to a whole range of stories but the ones he remembered most were the good ones. Listening to good stories made Kanewai want to have stories like that. He wanted his life to be full of memorable stories.

As Kanewai told his story of listening to elders he referred to gerontology nursing content about developmental theory and examples of reminiscence that were evident in elders’ lives. The story of the elder who helped Kanewai value his own life as meaningful was a good example of the developmental theory in action as the elder contributed to Kanewai’s understanding. He knew that listening positively impacted on the health of elders by giving them an opportunity to find meaning in their own lives by sharing with others.

Just as Kanewai showed the power of stories for himself and for elders, Josh also felt his life was shaped by the stories of his grandparents and the elders he met. Josh explained how his experiences with elders as he grew up as a child and into his adulthood had influenced how he cared for elders.

4.1.3 Josh: Always respect them

Josh approached me and shared that he had some experiences talking to elders that he wanted to tell me about. We met on-campus and spent some time catching up on what he was doing in his Level 5 classes. We also enjoyed talking about places we had both
lived in and had in common. Josh began his story in a very positive way as he reflected on his education and life experiences.

Josh immediately set the stage when he described his attitude toward elders. His response to my initial question about his experiences listening to elders was; *I cherish my grandma*. He began with the elder that meant the most to him, followed by other elders who cared for him growing up such as his uncle. Then Josh made clear connections between the elders he had known and the way he cared for elder patients as a nursing student.

While his parents worked, Josh was raised by his grandmother until the age of nine. They were best friends and shared a special bond. Josh smiled as he said; *I was the favorite*. Then later other relatives and friends of the family took on the role of proxy grandparents. He referred to them as his *second grandma* and *uncle* who filled in as the only grandfather figure he ever knew. His uncle picked him up every day after school. Josh really appreciated him and listened to him tell his sometimes gruesome, but real life stories about World War II. *It was surreal* for Josh as he heard stories that were violent like in the movies. His uncle was very nonchalant and saw his military service *as a duty he just had to do*. Josh better understood why his uncle acted the way he did. For example, he would hammer nails into his shoes to preserve the soles but it was also a reminder of the sound of marching from his military days. It was all so interesting to Josh and he loved interviewing him for school assignments. *It was something you just can’t get from anyone else.*

Josh’s experience growing up ingrained in him an appreciation for elders. Just as he cherished his grandmother, Josh respected *the older culture*. He found it amazing when he talked to them. Elders had so many answers and so much knowledge of what to say based on their life experiences; Josh shared; *I always know they are better than me* because they have lived through so much. The elders Josh knew had experienced things Josh hoped he could someday. Their experiences gave them *a lot more knowledge and stories* along with an understanding of what really mattered in life. Josh recognised that a lot of the worries that younger adults had, the elders did not have because they had a
different perspective. Elders appreciated that in the end, all people have is their life and their memories.

Josh enjoyed playing golf which exposed him to a variety of people. Most of the golfers were much older than he was and he took that into consideration by being respectful and never calling them by their first names. He always talked to the golfers as they played and they got to know each other.

One conversation in particular stood out. After a few holes together a golfer in his 80s and Josh became close by talking about their shared background in sports. The golfer, Mr. Allen, was impressed with Josh’s golfing and nursing school endeavours and he shared some of his life lessons with Josh. Mr. Allen said that he would not tell his stories even to his own children unless they asked him, and that he would not brag. He advised Josh to always stay humble. Josh felt honoured that Mr. Allen was letting him in as they talked. Josh shared; I love it when elders give me advice. His father once expressed his perceptions of how Josh interacted with elders, especially the older golfers. He said; ‘You have a way of understanding people. You can respect them and get them to respect you at the same time.’

One way Josh showed respect was by listening. He commented that in nursing there was a lack of time to listen to elders but that it was still an important part of learning. Yet he noticed that some nursing students just would not listen. Josh was convinced that if nursing students listened they would better understand who their patients were and they would have more compassion. He elaborated; You have to listen to them. It’s their body you are taking care of. And they know it better. I know they know their bodies. They say this causes me gas, so okay, it does.

Josh explained that in nursing school he learned to incorporate what elders knew about themselves and their preferences as he worked to provide the best care for them. I always try to collaborate and try to catch their cues. If they want breakfast at a different time, I’ll keep it there and say, ‘hey, can we do something else in the meantime so that we’re just working together, not wasting time’.
Sometimes Josh found himself working with elders who were a little grumpy or complained. He figured they were probably going through more than he ever had and understood that it was tough enough being in the hospital. When he respected elder patients it helps with the nursing care. They appreciated it and they could sense if they were being respected or not. A benefit was that they were more compliant and willing to help with the care. Respecting elders encouraged them to be honest and to just be themselves. And that’s pretty rewarding, too, knowing that they are comfortable with you. Even though Josh was well aware of the importance of maintaining the nurse-client relationship, he still saw elders as someone else’s grandmother or grandfather. He treated them with the same respect he would afford his grandmother who he cherished. I really feel like whenever I’m talking to an elder, they are like my grandparents. Josh learned that elders had a lot of knowledge and stories, and that it was just about being there at the right time to hear them.

Like Josh, Nalani had a very close relationship with her grandmother. They both perceived elders in the same way they perceived their own grandparents. Josh and Nalani each had relationships with elders that taught them important elements of caring that they transferred to their care of elders. Josh told how he incorporated respect and collaboration into his care. Nalani’s experience with her grandmother changed her feelings toward elders. She learned how the nurse’s ability to listen could help or hinder the health of an elder.

4.1.4 Nalani: Life changing event

Nalani was a Level 4 student in the first semester of her senior year. Even though she was currently studying obstetric and paediatric nursing, her personal experience led her to share about elders. Nalani and I sat outside at a table looking up at the lush, green Pali cliffs. The vertical ridge of mountains that face the campus and dominate the view were aptly called the Pali which was the Hawaiian word for cliff.

Nalani began the conversation I want to tell you about my grandmother. Her grandmother was the main character, the plot, and the highlight of her experience
listening to an elder. Nalani spoke as a storyteller giving detail and voice to herself and
to her grandmother. She had a close relationship with her grandmother. Nalani
conveyed their feelings and ordeal last summer and how she related it to nursing. Her
captivating way of telling her story made me feel oblivious to the beautiful
surroundings. I found myself eager to hear what would happen next as the story
unfolded.

Nalani’s grandmother was the oldest of nine children. She did not finish high school
because she had to care for her brothers and sisters. It was a hard life. This was
followed by marriage, raising her own children, and then after Nalani’s grandfather
died, she raised Nalani. Listening to her grandmother’s stories of the past, Nalani
wished she could have been there. It was unfathomable to her how her grandmother
took care of everyone with so little. She used to tell Nalani; ‘I had a really hard life but
I made it better’. She was proud of raising her children and grandchildren.

Some of the stories included Nalani’s earliest years when she was too small to
remember. Nalani laughed when she repeated her grandmother’s words; You were
always with me; you were my tail. Her grandmother had worked hard and this helped
Nalani to appreciate the opportunities she had. Nalani’s grandmother had always been
active and independent. She was a driving force in Nalani’s life including encouraging
her to finish nursing school.

However, last summer everything changed when the roles were reversed. Nalani
explained, She was always there for me, so I wanted to be there for her. Her
grandmother’s health took a sudden and rapid decline. There was a big change in her,
going from good to worse. She was not managing her health very well and she did not
say anything to anyone. She was diabetic and was afraid of having high blood sugar.
She said it was getting high so she didn’t eat as much and was losing weight. Then one
day going up the step to her house she misjudged and hit her head on the door. When
Nalani saw the bruise and asked; ‘What happened?’ She said, ‘Oh, nothing’. She
noticed a change in her grandmother’s behaviour. It was out of the ordinary for her to
be worrying about what to do if something happened. Nalani immediately took her to the doctor to get assessed.

The healthcare workers took it for granted that Nalani’s grandmother could not understand what was going on. They did not take any extra time to explain to her and did not try to help her to understand. This made Nalani upset but she listened and was glad she was able to explain to her grandmother later. Nalani explained; I thought; I’m glad I’m here because if she didn’t understand, she wouldn’t get anything without my help.

Even after visiting the doctor her grandmother was scared and apprehensive. Usually she was strong in her faith saying; ‘Don’t worry about it. God will take care of everything.’ But she became more confused and didn’t really know what was going on or what to do. Nalani explained that it was really weird the way she changed so drastically just in that short amount of time.

Her grandmother admitted driving to church one Sunday even though she was not sure how she got there or how she got home. So Nalani took over and drove her everywhere including to numerous doctor visits. Her grandmother moved in with a family member because she could no longer cook for herself or remember to take her medications. As she became more and more dependent, it was difficult for Nalani. At times she would find herself upset with her grandmother.

Despite how tiring it was for Nalani, she was glad to be there for her. It was a lot for her grandmother to go through. Eventually her grandmother became so confused that at times she needed someone to stay with her when she went to the doctor. Nalani remembered how her grandmother would look at her with a blank face and she would say, ‘I don’t understand what they are saying’. It was very discouraging for her grandmother because she liked reading and going places. But when this happened she said; ‘I don’t like watching TV or going to church because it doesn’t make sense to me’. She could not understand what she was reading in her Bible. During that time Nalani’s grandmother was feeling more sad and depressed. She cried and said; ‘I can’t do
anything. *What am I here for?* Up until that summer she was really independent. *She had changed so drastically* in such a short amount of time.

Nalani’s grandmother depended on her for lots of help including medical information. Nalani helped her grandmother with her living will and to understand what happened when a person had cardiopulmonary resuscitation (CPR). Her grandmother talked about dividing up her property and what her funeral plans were. Then one day she told Nalani, *I don’t know if I’m going to be there when you graduate.* Nalani tried to be strong and responded, *No, I have two semesters left so you’re going to be here when I’m graduating. You’re going to be okay.* Inside Nalani told herself, *Oh, no, I need to hurry, but there’s no other way to do it.* She hoped that her grandmother would live much longer, but she was not convinced. Nalani never told her she thought that she was going to die. Nalani felt scared and she cried even though she told her grandmother it was *going to be okay.* It was a hard time for Nalani. All the while she took care of her grandmother and tried to remain optimistic. She reflected that *for that short time she was weak, it made me stronger.*

It was a relief when the doctors said that Nalani’s grandmother was confused due to an imbalance of her electrolytes and she would recover. Her health returned *and now she’s back to normal.*

Through the eyes of her grandmother, Nalani saw what happened to elders when they were sick. She felt she now had a connection with the elder segment of the population. Before last summer Nalani did not have that connection with elders. She cared for elders in long-term care in her Level 1 nursing course. *We fed them and we changed their briefs and made beds,* but most of the patients did not even talk. Then with her senior companion, Mr. Lau, for gerontology nursing class there was a little bit of a connection but it was only because he knew her grandfather. Mr. Lau talked highly of her grandfather which made Nalani feel jealous that she never got to know him. She explained, *The difference was that I needed my elder; he didn’t need me. I didn’t see the connection with elders until this past summer.* For Nalani, this feeling of connection was a result of a *life changing event* like she had with her grandmother.
When Nalani’s grandmother needed her she felt closer to her. She said, *It made me a better person. It turned me around and I am happy for that situation.* Nalani felt that now she *can relate* to elders and *deal with* them in a better way. Nalani learned that listening served many different purposes. Listening calmed her grandmother as she stayed alongside her throughout the health crisis. The lack of listening on the part of the healthcare workers resulted in an incomplete health assessment rather than one that could have addressed her grandmother’s immediate concerns.

This experience made Nalani want to be a better nurse and to take extra time so patients could understand. She said; *It changed me.* Nalani expressed a gentle, yet keen desire to improve the care of elders through listening. This experience also helped her relate better to elders and feel closer to them. *Now I feel like if I deal with any elders, they’re not just an old person they’re somebody’s grandmother.*

In the next story Clare, too, expressed a passion for elders. She and Nalani both had grandmothers they learned from in their adult years. Nalani learned firsthand about how elders like her grandmother were dismissed or ignored when no one listened to them. Clare learned about hope and pride from her grandmother and wanted to encourage those feelings in her elder patients. Clare was also convinced that there were positive ways to provide care for elders and that nursing students needed to learn them.

4.1.5. **Clare: Passion**

At the time of the interview Clare was a Level 3 student. She had previously completed a university degree which included an internship working with people who had Alzheimer’s disease. Clare asked me last semester when she was taking gerontology nursing if she could share with fellow students about her work with elders. Later she inquired about being a participant. For her convenience we scheduled the interview right after her presentation in gerontology nursing class.

With great feeling Clare talked about a rewarding experience she had taking a university class before she entered nursing school. She video recorded an ethnohistory
interview with her grandmother that revealed her life experiences. Listening to her grandmother tell her life story became a turning point in Clare’s life.

Clare’s grandmother lived with the family during her childhood. She was like a mom to Clare for many years while Clare’s parents worked. Clare never went to daycare, never went to preschool, and once she started school came home to her grandmother every day. As a result Clare was very close to her grandmother.

Her grandmother told her the good, the bad, and what she’s learned in life along with words of advice for Clare. Clare highlighted key moments listening to her grandmother’s life story in which her grandmother’s demeanour brightened or changed. The first moment was when her grandmother made the comment; ‘You know, I’m no spring chicken but I was a looker back then. I could have all the military guys I want’. Before she got married she liked to get all dolled up and go dancing and talk with the sailors. Her grandmother’s expression added to the vitality of the story. Clare reflected; You could just see the smile on her face reflecting back on those moments in her life when she felt in control [and] was living life to the fullest and had a lot of choices to be made.

Then she got married, had children and was surrounded by her extended family. The next highlighted moment had a much different tone. It was a very difficult time for her grandmother when her son became terminally ill after returning from serving in the military in Vietnam. Clare explained that even with the support of the whole family, the last years of her uncle’s life were hard for her grandmother. Clare’s grandmother became emotional as she talked about her son and asked Clare, Why did it happen? Clare suggested they stop and take a break. It was not easy for Clare to continue in the role of the interviewer as her grandmother poured out her life to her. Clare had trouble disconnecting from what she was feeling during those moments. It was hard not to want to intervene.

More children and then grandchildren led her grandmother to make a big decision. She decided to help raise her grandchildren. She believed that family was more important
than anything else, so she moved to be with her children and grandchildren. This was not easy because her husband did not feel the same way and chose not to join her. Just a few years later, she returned to the family home to deal with the death of her husband, Clare’s grandfather.

The highpoint of her grandmother’s life was that she was able to raise her grandchildren the way she wanted, instilling her values and beliefs. Her grandmother’s demeanour changed again when she talked about her pride in doing everything she could by taking on the role of caregiver for her grandchildren. Clare said; *It was her way of proving to herself that she could take control again. And you could see the spark in her eyes, the pride brilliantly vibrating from her.* She seemed *so proud of who she was and why she did what she did.*

Clare felt she did a good job of separating herself from her grandmother as a relative and a loved one during the interview. *I think both of us got more out of it that way.* She wanted it to be a professional ethnohistory that involved listening without giving any feedback. So before they began the interview she told her grandmother, *Pretend that I am not your grandchild, your Clare.* That was a very moving experience. It was powerful for her to listen to the life story of an elder, and not think of her as a grandmother for that moment.

Afterwards Clare realised how much her grandmother’s life had impacted on her yet how different their lives were. *I just kept thinking about my own life and what I might have gone through that I thought was terrible or horrendous. It doesn’t really seem to compare sometimes when you hear other people’s dramatic tales of death or life or love.* Hearing the events of her grandmother’s life opened Clare’s eyes to what was important. She began to reflect that life was short, something she heard many times over from elders. Clare understood that it was better to be less petty, less selfish and be more forgiving. Talking with her grandmother made her realise not to take things for granted and that life was not always easy but people can still be positive and filled with hope.
When Clare went back and watched the video interview she felt overwhelmed by how she saw her own life unfolding. The experience made her reevaluate her goals and redirect her life. *I began to see my life in retrospect and thought, well, I like doing this.* She liked listening to stories and caring about people. Clare asked herself, *How can I rearrange my passion to this person I’ve become now, these feelings that I feel?* Clare also thought about her feelings about working as a college student intern with elders. *Every day I’d come home and say I’d made a difference. It’s not enough for me to be a volunteer. I want to make a career out of it. I want to make a life out of it.* So she had decided to focus her energy and her passion on nursing as a career.

Clare believed that listening to her grandmother’s story had contributed to her outlook and enthusiasm for working with elders. Her decision to go to nursing school was reconfirmed with her first clinical experience in long-term care.

*I’ll never forget coming in late one night to do my pre-clinical. The nursing staff had gotten all the patients out before bedtime and put them in their own chairs in the hallway and they had on an ‘old school’ boom box. It was playing the song, ‘Knock Three Times on the Ceiling’ and all the nurses were just jigging around the patients getting all the patients to wiggle in their chairs.* Clare knew that she wanted to be on her chosen path and to be that nurse dancing with the patients at nine o’clock at night.

Clare said that not all days were like that. There had been some days when she had gone home and cried about patients’ situations in the hospital. One patient in particular, Mrs. Collins, her very first patient, was terminally ill with no family there to visit her. Clare recalled the sadness taking care of Mrs. Collins. *She was in so much pain and with so much anxiety. She actually asked me to take her pillow and physically suffocate her so she could die. It’s not easy working with the elderly.* The most touching issues were those of abandonment and watching people’s minds deteriorate.

When Clare took the gerontology nursing class and worked with healthy elders the next semester, it helped her to put all that sadness aside. *I knew patients were in such desperate need for somebody to listen and I could be that person to listen.* When she
thought of how hopeful and full of pride her grandmother sounded, she wanted that for her elder patients and now she knew that it was possible.

Clare felt hurt when she heard nursing students say, *I don’t want to work with the elderly. They’re gross. They’re mean and I would rather be doing anything else.* She realised that care of dependent elders consisted of hard work changing diapers and feeding people and it was not always that pleasurable. She felt the exact opposite. She just wanted to squeeze those students and say, *No, they are still people and you will be there someday. What if someone was saying that about you or your dad or your mom?* Clare felt strongly that nursing students should care. *I wanted to yell at the top of my lungs, You’re going to get old someday, too. So you better start treating others like you want to be treated.* Clare was convinced that talking one-on-one with an elder and hearing their life story would open other students’ eyes to view elders as real people with needs and that it would *dissipate and wash away their biases and judgemental attitudes* toward elders. It was Clare’s belief that *elders have experienced a lot and we can learn from them if we listen.*

The next participant also added to her learning about elders by talking to her grandmother. Clare emphasised her formal interview while Emma focused on her annual visits to her grandmother and how they continued to impact her as they both got older. Just as Clare was inspired by the life her grandmother lived, so was Emma. Coupled with what they learned in nursing school, they both became determined to make a difference in the life of elders.

4.1.6 Emma: *Deep Love*

After having taken a few classes with me, including gerontology nursing a few months prior, she was now a Level 3 student. She also, had completed a previous college degree. This added deep insight into her reflections on her experiences. After emailing and talking to each other a few times over the semester we found a convenient time to meet on-campus for the interview.
Emma spoke openly about her experiences with elders and how they shaped her personal views and care of patients. Her feelings were heartfelt as she emphasised the importance of cherishing and nurturing relationships in life.

The closest relationship with an elder was with her grandmother. Her grandmother was always very happy when Emma phoned or visited. Since she had become a nursing student Emma recognised how good it was to talk about the past and to reminisce.

Her grandmother was the youngest in a huge family with lots of cousins, nephews and nieces. Emma’s grandmother got out old photos and told her stories about her friends and family such as her sister’s husband who was in the war. Lately Emma had noticed, *That it is more of a downer when I talk with her...because a lot of these people have passed away.* She would say, ‘*Oh, yeah, he died yesterday, or this past Fall.*’ So Emma was not sure how good it was sometimes when her grandmother sounded so pessimistic about life. Instead of ‘*Oh, he led a great life,* it was ‘Everyone around me is dying’.

Emma’s grandmother was in her 80s; she was incredibly healthy and drank green tea every day. *She definitely is not going anywhere any time soon.* Emma described her grandmother’s *appreciation for the beauty in the world. My grandmother will talk about the birds in her yard and all the different colours of the trees.* But sometimes the hardest thing for Emma while talking to her or any other elder, was trying to *remain interested because they got off on tangents or repeated themselves.*

Active in the art community Emma’s grandmother liked to paint watercolours of surrounding landscapes. She used to travel to beautiful places with Emma’s grandfather and paint. Emma reflected, *I think it has been the hardest thing for my grandma losing my grandfather and doing all these things by herself.* They knew each other since they were teenagers. *They were life partners.* It made Emma think about her own relationships and how difficult it must be to lose someone when you have been with them for so long and then you have to start over.

Talking about her grandparents made Emma think of a unique experience she had talking to an elder woman, Mrs. Kim in long-term care. She was older than her late 80s.
She was the sweetest lady. Mrs. Kim was clearly alert and oriented but unfortunately suffered from circulatory problems requiring lots of medications and restrictions. She was really feisty and had lots of energy. It bothered Mrs. Kim to be in the midst of so many confused and noisy residents, so she was happy to have someone like Emma come and talk to her and distract her from her surroundings. Mrs. Kim was very open and receptive and easy for Emma to talk to. She was really funny.

The first time Emma visited her she asked if Emma would spend the night. Mrs. Kim suggested, I was thinking I could get another mattress and you could just stay with me. I don’t sleep very well and I think if someone was here with me, it would be fun. It made Emma want to stay. Oh, I wish I could. Then the second time Emma visited, she found out that Mrs. Kim’s husband had dementia and was living on another floor. She had not seen him in a few days because she needed someone to accompany her and the nursing staff were too busy. After Emma got permission from her instructor she asked Mrs. Kim if she wanted to visit her husband. She said, Really? You can take me? That would be great. When they got there, Mr. Kim had just woken up from a nap. It was moving for Emma to watch them interact. You could tell they loved each other. Mr. Kim asked how his wife was, and then asked when their son was coming. Mrs. Kim told him, ‘He came to visit last week. He responded, ‘Oh, yeah, you’re right’. Then a couple seconds later, he asked, ‘When is our son coming to visit’? Probably ten times this went on. Each time she said the exact same thing. She was so cute and caring. Emma almost wanted to cry. It was so sad yet precious and very touching. Mrs. Kim was so appreciative of Emma for taking her to visit her husband. She had not been able to see him in such a long time. It saddened Emma to witness the quality of the life they were living. And then the next time I went to visit, the woman (Mrs. Kim) had died. My teacher told me it was not a good death ... they had tried to resuscitate her when she was a DNR (Do not resuscitate). Emma was upset and cried when she found out. But she also felt happy that she took Mrs. Kim to spend time with her husband when she did.

This experience made Emma appreciate how scary it was to be in love … it makes it really a blessing to find someone that you love that much. The amount of suffering that
went along with love was scary to Emma. *The saddest thing to me would be to have your loved one have Alzheimer’s. It would be the most challenging thing ever.* Yet she saw how patient and consistent this woman was with her husband. It was powerful to Emma. She felt humbled to witness their interactions. They had just celebrated their anniversary of over fifty years of marriage, but they were not able to spend it together. Emma walked away from that first clinical experience feeling *not too thrilled about getting old.* It was sad for her to envision people spending their last moments in a setting like that.

Emma was very much in touch with the emotions and feelings of her patients. She wanted to be sensitive to patients’ desires to spend time with family and to be there for each other. *I think a lot of times nurses I’ve noticed, get so wrapped up in skills and things they have to do for the patient. It seems like the importance of relationships and communicating with one another gets lost.* More than anything, Emma did not want to lose sight of what was important to the patient. She wanted to take care of people and help them. She elaborated, *I want to help people and not just help them because I put down an NG [nasogastric] tube or help them pee by putting in a Foley [urethral] catheter. She wanted to perform those skills competently but at the same time be sure the patients were also taken care of emotionally. I don’t know how people get numb to that. Even the nurses on the floor that day acted like it was a hassle to have her see her husband."

Emma could tell that both her grandparents and Mr. and Mrs. Kim in long-term care, experienced deep love in their lives. Even though her grandmother may have been lonely now, she had many good years with her grandfather. Those couples showed Emma that it was possible *to sustain a relationship for a long time* and still, even when they were old, care about someone deeply and more profoundly than ever before.

Thinking about her second semester when she had her senior companion elder project, Emma’s senior, Mrs. Baker was extremely active and they both got something out of the experience. Emma shared her time with Mrs. Baker, and she shared the challenges of her life with Emma. However, meeting with Mrs. Baker was more of an
inconvenience because she had to fit Emma into her busy schedule. Emma suggested that in the future nursing students should pair up with elders who were more isolated. *It would be a lot more beneficial to go into the nursing homes where people are lonely, where they don’t have people visiting them.* She remembered another elder in long-term care who sounded bored saying, *All I have now is to eat, shit and sleep. That’s what we do, that’s it.* Emma wished she had more time to spend with her to talk or reminisce. Emma was convinced that it helped elders’ quality of life and upheld what little dignity they had left.

What Emma loved most about nursing were the moments when she had time to talk to elders. She got to know them on a much deeper level. Emma found it humbling when they trust you and they let you into these intimate spaces. Those experiences gave Emma new insights that helped her live her life. She learned that when people get older, life got more challenging. *It reminds you that life is not easy.* Emma thought about Mrs. Baker who had been married twice and lost both husbands. Emma believed Mrs. Kim and Mrs. Baker were strong because of the challenges they had lived with and gone through. The example of her grandmother as she continued to travel and paint impacted Emma. *It makes me want to take care of myself, and live healthy today so that I can still be healthy later on.* This related to what she gained from her gerontology nursing course about the factors that positively and negatively impact on ageing. Emma wanted to help others and herself to live gracefully and die gracefully instead of dying in a nursing home. Having witnessed elders die alone and left alone is different than her childhood thoughts of never being alone and dying with her husband. Both her senior companion elder and her grandmother had adjusted to great loss by keeping active and socially engaged. Now Emma realised the importance of nurturing her own identity and fostering all [her] relationships. Emma reflected, *What I take away from these experiences is not to take relationships for granted. It really is the relationships that get you through everything.*

Like Emma, Ana was also motivated to live a healthy life when she learned about ageing by listening to elders. Emma focused on the social aspect of relationships that
made a life fulfilled and healthy, while Ana compared the presence of physical health to the presence of loved ones as she thought about what contributed to healthy ageing.

4.1.7 Ana: Living a good life

Ana and I stayed in touch after she completed her gerontology nursing course. When she was a Level 3 student, I often ran into her during lunchtime standing in the food line on the front lanai. The lanai, which is the Hawaiian word for patio, was an open covered space that encircled the entrance to the academic centre. When she offered to be a participant we decided to meet for an interview on campus.

Ana expressed a strong desire to do her very best as a nurse providing care to all of her patients, including elders. She spoke carefully and thoughtfully as she reflected on her feelings about elders before and after hearing the stories of two elder women, Mrs. Costa and Mrs. Roberts. The stories of each of the women and the way they lived their lives taught Ana about ageing and provided her with some life lessons she considered for herself.

Before Ana listened to the life stories of the Mrs. Costa and Mrs. Roberts, she thought of elders as just regular people. Some people are going to be demanding. Some people like to do things for themselves. You have the whole broad spectrum. If really doesn’t matter that you’re over 75...or if you are 20. To Anna, elders in a long-term care setting were going to be people who were needy because they could not function on their own anymore and they needed someone to help them. They’re not happy with their life and maybe they take it out on other people. She thought that was how it was for everyone.

Ana encountered active and independent elders when she got to know Mrs. Costa and Mrs. Roberts, each with different levels of physical and psychological health. Ana said that getting to know Mrs. Costa as her senior companion was a great and inspiring experience. Even though she was a distant in-law, Ana barely knew her. Mrs. Costa talked about her life and shed some light on their family connections. Ana noticed, She’s so much different than other older people I know. Mrs. Costa was very healthy and active and she was more likely to be a visitor in a hospital than to be a patient. Ana
believed Mrs. Costa was a good role model for her. *You know, I want to be like her when I’m that old, in my mid-70s, although I’m not quite as healthy as she is.* Ana wished she had such good dietary and exercise habits as Mrs. Costa. She went out all the time walking, going to church and to the shopping mall. Again, Ana compared Mrs. Costa with herself. *She could out walk me if she wanted to. That’s how amazing she is.*

The way Mrs. Costa lived showed Ana that health had to do with doing many things right in life, both socially and physically. She had been a caretaker to many of the family and had a lot of support from her neighbours, members of her family, and her church. Ana appreciated the positive impact of being socially engaged. *She is very well off right now in those terms and that’s been a really good example for me and I kind of think that’s what I want, too.* Mrs. Costa was pretty happy with her life, although she had told Ana that she was *ready to die*. It was not because Mrs. Costa was unhealthy or terribly unhappy but because she and her husband were together for so long. *I don’t want to say she doesn’t care anymore, but she is functional and she takes care of herself and still does the same things she did when he was alive. It was not that she did not care anymore, because she was very functional and able to take care of herself.* The way Ana understood her situation was that after Mrs. Costa had been married for so long, and she had such a good relationship with someone who really was her other half, it was kind of hard living without them. Ana reflected, *So I think about things like that and how I want that kind of stuff, too.*

Although Ana felt fortunate knowing Mrs. Costa as her senior companion she acknowledged that if it was not part of the gerontology nursing class she would not have spent time with an elder. She added, *I don’t know that my experience would have been lacking.*

Ana also had the chance to get to know Mrs. Roberts. She was in her 80s and was a personal acquaintance. Ana described Mrs. Roberts in contrast to Mrs. Costa. Mrs. Roberts had a much different life as a stay-at-home housewife. She did not socialise as much as Mrs. Costa limiting herself to her home and to her errands. Mrs. Roberts’s life was full of poor health habits. She had a poor diet, did not exercise and *was a smoker*
all her life. Surprisingly she was pretty healthy for quite some time, but then all of a sudden she was diagnosed with cancer. And by the time they caught it, it was pretty advanced and she went downhill quickly. Mrs. Roberts was doing relatively well despite all her negative health habits. She was fortunate to be alive for as long as she had been.

Ana thought more about the differences between the two women. It just showed me in the end it’s kind of going to catch up with you. Life did not seem as good for Mrs. Roberts. I know everyone has to die but I think the way that it is done can be much different. A person can die in pain or kind of go peacefully in their sleep from being old. Even healthy people get cancer, but for some people she saw that it was due to their own habits. The contrast between the Mrs. Costa and Mrs. Roberts was noticeable and like polar opposites in many areas of their lives.

Ana found it interesting to become aware of these differences in health habits, lifestyle and support systems. She easily identified the impact of health habits on physical ageing changes. For example, Mrs. Costa had wrinkles and signs of ageing but the changes were more severe in Mrs. Roberts. She was very wrinkly with loss of skin turgor from all the smoking and improper sun exposure from outside gardening.

Mrs. Roberts also had the added challenge of chronic and life threatening illnesses. For instance, Ana mentioned that it was not that easy talking with Mrs. Roberts because she was also hard of hearing, but Ana empathised with her. It’s not her fault, it’s just the way she is and I think I can see how people can be impatient with someone like her who...can’t hear very well. Ana knew Mrs. Roberts did not want to be sick or to be in the situation she was in then. Ana pondered her own position as a nurse working with elders who were ill. I kind of remind myself to be patient with patients because they’re not necessarily trying to make my life difficult. She accepted that some people tried to make others miserable just for their own entertainment. But for the most part, she believed that some patients were really struggling. Elders may not realise that they were struggling and that was the best they could do. They had lived their life in a certain way and that was how they were used to doing things. When they could not do that anymore
it was frustrating for them. Ana added, *I don’t want them to feel frustrated, so I try to be patient. I try to be understanding, sometimes even trying to put myself in their situation.*

Ana thought about what it was like in her position. She reflected on the Mrs. Roberts’s life story and how it changed her thinking. *She’s told me several times that she’s ready to go because she’s had a good life.* Mrs. Roberts was happy with what she had done, and did not really have any regrets. Sometimes she thought about whether she was a good mother or a good grandmother. *There are some things in her life that I wouldn’t want to follow, particularly the smoking and being so stuck in her home and not having much social activity, but she is still content with her life.* Mrs. Roberts was still fine with the way she lived. *So it kind of showed me that you don’t need to be afraid and be so super. You don’t have to have everything be so perfect or so ideal to still have a good life.* Ana compared the two women. Mrs. Costa was healthy but suffered the personal loss of her husband while Mrs. Roberts had cancer but enjoyed integrity and satisfaction as she neared the end of her life.

Since her gerontology nursing class Ana has cared for several patients at the end of their lives. *I think gerontology probably helped me with my acceptance of the way life is and you know no matter what you do you are going to die at some point.* Thinking about those patients and the elders she met gave her a new outlook on life valuing life a little more.

In the next story, Lily too, learned a lot about elders when she listened to their stories. Ana and Lily both felt fortunate to have heard their senior companion elders’ life stories. As a result of her experience Lily’s perspective on elders changed substantially.

**4.1.8 Lily: Now I understand**

Lily and I occasionally saw each other on the front lanai of the campus. One day she emailed me and volunteered to be a research participant. As a Level 5 student, she had just finished her complex care clinical course. Complex care was the capstone clinical course that focused on the care of patients in cardiac and intensive care units. As a
result, even though she was only two weeks away from finishing the nursing program, she had some free time to meet.

Lily was very easy to talk to with her friendly and cheerful disposition. She appeared comfortable and at ease with the conversational interview format. It was clear that Lily loved nursing and taking care of people in many different settings.

Her first semester clinical assignment made her realise that long-term care was definitely not her favourite area of nursing. She had never interacted with elders until she came to nursing school so this was a new experience. Her first reaction to working with elders was, \textit{No nursing home. No, I don’t want to just wipe butts. I don’t want to do any of that.} She was confident she knew what elders were like. \textit{They’re old, they’re ready to go and a lot of them are grouchy. And they just don’t want to have anything to do with you.}

The next semester as a gerontology nursing student it was the first time she actually listened to the story of an elder. After talking to Mrs. Ramos who was her senior companion and listening to her stories, Lily completely changed her perspective. \textit{Now I am passionate about elders.} Mrs. Ramos’s story was so interesting to her that she also began to listen to other elders.

She was a distant in-law who she had only casually met before. Lily retold Mrs. Ramos’s story growing up in the Philippines. When the Japanese invaded the Philippines during World War II her father was taken away and she, her mother, and siblings fled together. They moved to a place where nobody could find them. Consequently, Mrs. Ramos was raised in hiding not knowing what happened to her father. Finally when it was safe they came out of hiding.

Lily was shocked when she heard the story. \textit{Wow, I didn’t know that happened to you!} Mrs. Ramos continued on and shared the rest of the story which was the highlight for Lily. It was the moment when Mrs. Ramos and her family came out of hiding and were told that her father had been killed. When the story finally sank in after hearing it for the first time, Lily felt upset and sad that Mrs. Ramos lost her father so tragically and at
such a young age. The way her life story progressed was meaningful to Lily. Mrs. Ramos’s life was changed by this experience and she was motivated to work hard for a better life by taking care of her mother, going to school and getting a good job. Eventually Mrs. Ramos was sponsored and immigrated to the United States. For Lily this was an interesting story about a sad time. It taught her a good lesson which was to appreciate what you have.

Before Lily started nursing school the only time she heard elders firsthand was when she used to visit her grandparents. It was boring for her then because she was so young. Lily recalled hearing that her grandpa was in the military and lived through several wars, but he did not lose his father like Mrs. Ramos did. *Now that I’m in nursing school, I realise that what they were telling me was the same as what these other elders were telling me.* Lily understood now that her grandparents were trying to tell her about their history and their experiences, things they wanted her to know. *They’ve passed now.* After some thought Lily added, *Maybe I shouldn’t have acted that way. You kind of have to learn the hard way to realise that.*

Lily felt sad when elders told her that all they wanted was to be listened to. *They have so many stories to tell.* Lily now listened with more compassion. This experience helped her to realise that not all elders were grouchy. And if some acted grouchy maybe they did not imagine living much longer and were upset that *someone had to take care of them.* Lily thought … *It may be that when elders are grouchy it is because no one will listen to them.*

As a nursing student it had been difficult for Lily to spend as much time as she would have liked listening to patients when she had others to care for at the same time. Lily laughed, *I like to listen and I like to talk, but it is all about time management.* She had noticed that her clinical preceptors did not have time to spend with their patients when they had more than one patient to care for at a once. Lily thought it could be why some of the patients acted like, ‘*Get me this, now! Get me that now!*’ It could be because nurses did not have time to sit down and ask, ‘*What can I get for you right now?’*
Instead it was, ‘Let me get your blood pressure. I’ll be right back’. That was not the kind of care Lily wanted to provide but that’s just the way it is sometimes.

Other times it was the situation that made it difficult for Lily to listen to elders’ stories. She said that being an emotional person made it hard for her to listen to emotional stories. So if someone is telling me a story and they’re starting to tear and to cry, I try to hold it back. But if they are sniffing, it would get to me. Yet it was the emotional stories that helped Lily to put herself in their shoes and imagine what life was like for them.

Lily noticed that the hospitalised patients did not really talk about their experiences unless she took the time to speak to them first. When she did they told her about jobs they had, their family, and most importantly their grandchildren. A lot of them said they were happy to have little kids running around to carry on their legacy. Lily reiterated what she learned in gerontology nursing class and explained that the desire to leave a legacy is healthy psychological development for elders. They realise that they have lived their life and the young ones will carry on what they have started.

Lily gave a good example of this when she talked about one of the elder patients from a complex care clinical she had completed. There was one elder, Mr. Taylor who she especially thought was nice. He was retired, he travelled, and yet when he was not in the hospital he went to every one of his grandson’s football games. Mr. Taylor was so proud of what his grandson had accomplished.

Listening to elders benefited the way Lily cared for elders. Now that she was finishing nursing school she saw elders as regular human beings not the frail elders she first saw in long-term care. She tried to care for elders the way she would care for any other patient. When I listen to the way they express themselves, it tells me something about them. It impacts the way I see them as a person. For instance, Mrs. Ramos showed Lily that she was a very compassionate and sincere person and she did not take things for granted because of what happened to her father.
Lily learned what elders had been through and how they lived their lives when she listened to their stories. *It has affected the way I want to live my life from now until I get to that age.* In addition to changing the way she perceived elders, the stories she heard encouraged her to live her *life to the fullest* and to be thankful for what she has.

Just as Lily became aware of the benefit of listening to elders, she also learned some lessons for her own life. Kaleo, too, enjoyed hearing the stories of World War II. He also appreciated the advice and wisdom he gained from elders through their stories and their life experiences.

### 4.1.9 Kaleo: Reminiscence

Kaleo came to nursing school with a wealth of experience being around elders. I first heard some of his stories last semester in the gerontology nursing class. Kaleo came well prepared to share more of his experiences when we met on-campus for the interview.

Throughout our conversation it was evident that Kaleo was very inquisitive and loved to learn. As he told about his experiences listening to elders he described an ongoing cycle of learning to listen, listening to learn, and then applying what he learned by listening to and caring for the next client. His natural curiosity began at a very young age. Many times during our conversation and in different contexts, Kaleo said, *I like to learn…that’s why I love working with the elderly.*

As a child Kaleo remembered paying attention to the conversations of his parents and older adults in his home. He felt comfortable with elders and had been since he was very little. Kaleo grew up in a household that revolved around caring for ill family members and later on caring for clients. His mother modelled caring as a nursing assistant and later as a primary caregiver when she established an elder care home in their house. This upbringing taught Kaleo that empathy and compassion helped people get better, which led to his interest in healthcare and love of working with elders. He emphasised that not everyone was *used to what went on in a hospital or in a care home, what people looked like and the smells there.* Kaleo felt comfortable with elders having
grown up feeling *acculturated* to caring for them. He explained, *I’m already used to this, seeing the care that my mom gives and being able to interact with them so they feel that they have family, too.*

Kaleo felt strongly that it was important for nurses and nursing students to have experiences like he did as a nursing assistant before they went into nursing as a career. He observed that those who had that background paid more attention to call lights and showed more empathy and compassion toward the patients. Kaleo believed that it should be required to have experience spending time with elders and talking with elders in order to enter nursing school.

He explained that nursing school helped him to look beyond the barrier of the patient’s condition due to disease and get to know the person inside. One way Kaleo did this was by incorporating reminiscence into the conversation when he listened to stories. With his senior companion elder he found that reminiscence was a combination of talking story and using therapeutic communication at the same time. Kaleo’s examples reflected gerontology nursing content in which reminiscence is both an essential developmental task for elders but also a strategy that links the nurse to the elder’s past and present.

Kaleo made good use of the many benefits of reminiscence with elders. He used this technique when he listened to his senior companion, Mrs. Nakamura while she shared her childhood stories about growing up in Hawai`i during World War II, her travels, her family life and what inspired her to become a teacher.

As a nursing assistant Kaleo enjoyed listening to the stories of his elder clients and using reminiscence. He had recently worked with a very intelligent man, Mr. Wilson who was in his 80s. His mind was extremely clear as he recounted his experiences in the military during World War II. Mr. Wilson also shared his feelings of depression. Kaleo thought the cause of his depression was a lack of purpose in his life. Mr. Wilson felt like he was doing nothing and got impatient. Some of his days were spent receiving medical treatments or sitting in the doctor’s office just waiting. Other times at home Mr.
Wilson was idle because he felt weak and had to rest. His successful days as a businessman filled his thoughts with imaginary potential projects that he worked on in his dreams. It was as if in his dreams he can do anything. And then he’ll wake up.

Kaleo saw the greatest benefit of reminiscence in the way it influenced his and Mr. Wilson’s attitude. He felt that … When you are able to reminisce, you’re bringing out a lot of good memories, a lot of good times. And when you bring out these good times, it is fun. Elders in an environment that included reminiscence appeared healthier. Finding time to have talks about their travels, things they enjoy and their families made a difference in their outlook. Even when elders were having a hard day, reminiscence brought about healthy changes. And the best part was that medications were not needed to bring about that positive change. Kaleo believed that it was the interaction between the nurse and the elder that was most important. Even if you have all the book smarts and know all the medications, but if you can’t deal with the elder, he doesn’t trust you. Kaleo knew that if a nurse had empathy and compassion they were better able to work with elders. When it was time for medication or treatment the elder would welcome it and would follow what the nurse said or taught because they trusted the nurse. That is what reminiscing does; it opens up the trust and opens those good feelings.

As part of his plan of care, Kaleo intentionally used reminiscence when it was nice and quiet. As Mr. Wilson went through his storytelling, Kaleo saw how happy he was keeping busy and talking about his life. It helped Mr. Wilson to be able to share his life. He became livelier as he told his stories. Kaleo commented, I think doing that was very beneficial to him and me. We just had a good time. The time went by faster and he was able to feel energised.

Kaleo observed that Mr. Wilson was very competent despite his weakness. Sometimes they went for a walk. On occasions Kaleo drove his car and they went out to pick up something to eat. Other times they cooked meals together. Mr. Wilson also benefited because when they were cooking, they were both preparing the meal. Kaleo explained that he learned in nursing school how to promote independence and self-worth and foster an enabling process. I’m not going to do everything. I’m going to involve him and
help him to do things himself. I let him do a lot of things so he can feel a little bit more active than just doing nothing. We help each other.

Kaleo also liked to get advice from Mr. Wilson with all the experience he had in his life. Listening to people who had life experiences helped Kaleo answer questions and helped him in his own life. Now as a parent with my own kids I draw back on my experiences and things I’ve heard. For instance, Mr. Wilson shared about investing money because that was what he loved to do. Kaleo enjoyed hearing Mr. Wilson’s suggestions to keep in mind for his future. It did not even feel like work to Kaleo. He laughed when he said, I question why I’m getting paid. It’s like going to a friend’s house. They enjoyed laughing while they watched old television shows like the Honeymooners together. Kaleo sensed he was learning things that are being lost through the generations. I can name actors like Jackie Gleason. It is something I can share with my children.

When Kaleo went home at the end of the day he felt good. He thought to himself, That wasn’t a sick person even though they may have some sickness. It’s a person just like me. He expressed his desire when he gets old. I hope that one day I’m able to have someone that will take the time to talk to me.

When Kaleo incorporated reminiscence as he talked to elders he came to know them as people like himself and as individuals. He gave many examples of how reminiscence impacted elders and his care. Like Kaleo, Lucky emphasised the use of reminiscence as a valuable therapeutic tool in nursing care. While Kaleo used reminiscence in one-on-one interactions, Lucky expanded her use of reminiscence to a unique group of elders.

4.1.10 Lucky: Building rapport

When Lucky and I met on-campus we started off spending a good deal of time talking back and forth about what each of us had been doing and her plans for the future. Usually we had just waved or said hello when we saw each other. It was the first real in-depth conversation we had since she took a gerontology nursing course. She was now finishing Level 5 and making plans for her upcoming graduation and seriously thinking
about the job market. She explained, *I'm interested in gerontology... I could see myself eventually end up working with the elderly people in different ways... and there's no shortage of them... I think ICU [intensive care unit] is good for me... because I am a big picture person... and ICU is where you kind of put all the things together and you work more from head to toe... I don't know if they employ an ICU novice nurse right there... We'll see what's out there.*

Lucky had great stories to tell about working with elders. She was currently working as a nursing assistant at a continuous care centre with multiple levels of care. It included independent living, assisted living, skilled nursing, and intermediate care for dependent elders with a dedicated unit for patients with Alzheimer’s disease.

Lucky laughed and smiled as we started the conversation and throughout the interview. She felt very fortunate to have had such a wealth of experience caring for elders as a nursing assistant in care homes and in patients’ homes. The types of patients she had cared for ranged from totally independent to not being able to move at all, and from cognitively intact to late stage Alzheimer’s dementia. Most of all she loved their stories.

The story of Mrs. Tanaka, a very staid looking woman in her 90s living at the care home had a huge impact on Lucky’s outlook. Lucky described her as *feisty* after she heard her tell the story of her childhood. As a young girl Mrs. Tanaka rebelled against her parents’ wishes, did not listen to her teachers and one day escaped from school by jumping out of the window. Somehow throwing an eraser at her teacher, knocking off his glasses and getting a failed grade did not stop her from going on to become a success in life. These images caused Lucky to look at Mrs. Tanaka differently; *I saw her through new eyes.* Before she saw her as a resident, a patient, a frail little lady with multiple ailments, but after that she envisioned her as a young girl. *I was amazed,* Lucky said ... *she’s no different than teenagers today. Even though technology has changed, certain things don’t change.* Lucky recognised that she was stereotyping Mrs. Tanaka, because she was from a different generation and that she would not act like that. Even though this feisty lady had Alzheimer’s disease she remembered her
childhood and adolescence with great detail. This encounter led Lucky to wonder if other residents also had interesting stories to tell.

Lucky took it upon herself to initiate a strategy of encouraging the care home residents to tell their life stories during free time when they were gathered together. The first time she used this reminiscence strategy there were 12 residents sitting with Lucky around a table in the living room area. *They started interacting with each other,* and sharing their stories and *asking each other questions.* *Suddenly their vocabularies came back.* Lucky sensed that it benefitted the residents and helped them to have a sense of pride in themselves. She revelled in how they spoke with such positive conviction about their achievements. They might have forgotten about what they said the next minute and told the same story the next week but as it turned out she learned some interesting stories from them. Lucky no longer just thought of them as elders *sitting there waiting to die.* She found out that they all had their own *daring moments* in life. Lucky was convinced that it was a very successful activity and has been informally leading reminiscence activities ever since.

One of the elders at the table, Mrs. Chang, had late stage Alzheimer’s disease to the extent that she no longer recognised people. Lucky enjoyed listening as she told about a daring moment in her life. Mrs. Chang spoke clearly and articulately about a time years ago when she visited Oahu to visit a critically ill relative. Her family sent her to the bakery to get breakfast for everyone. On her way back with the food Mrs. Chang was *flinging it around and all of a sudden she heard airplanes up in the sky.* She saw a red sun on their sides as they were flying low. *There were hundreds of them and black smoke was all over.* Mrs. Chang had no idea what happening. Being a Sunday morning, everyone was relaxed and she thought it must be military manoeuvres. So Mrs. Chang and her family and the sick relative went to the hospital where her relative was diagnosed, treated, and sent on his way fully recovered. This happened minutes before the hospital was flooded with casualties. It was December 7, 1941, Pearl Harbor day. Mrs. Chang *said she would never forget that day.* Lucky thought to herself … *Oh, my God. You know, this was really interesting.* Mrs. Chang continued and elaborated on
what happened to her next. The schools were closed and she was one of many students sent to Pearl Harbor to help clean up. There was no time to hide the charred and dead bodies from the students. *It forced them to grow up overnight. Images of those burned bodies was too much for her.* The experience was traumatic for Mrs. Chang and she laughingly told the group that the only therapy she had for it was to talk about it. Lucky looked at her in a new light because of what she went through. Despite her dementia she remembered the day vividly. *Talking to her you’d think she was totally normal.* Lucky was so happy to have been part of the sharing and to have heard the stories. *I just loved them all. It makes me put more of my heart and soul into taking care of them.*

What Lucky learned in nursing school about the importance of touch, eye contact and body language also made a difference as she included that in her care of patients with Alzheimer’s disease. Sometimes it was hard to get them up in the morning and to the dining room to meet the deadline before the kitchen closed. Many patients were in wheelchairs and some of them were *running around while they were incontinent.* There were some who were mobile but others were already in the stage where they were tired, they slept and they did not want to get up. Once the patients were up they were willing to eat. Lucky posed the question, *So how are you going to get them up?* She believed it was not a problem for her because of the rapport that she had built with them. The patients recognised her voice and her face. They smiled and they nodded their head and they were willing to get up. Lucky attributed their response to her to the talking and communicating that was a part of the reminiscence she did with them. *When somebody tells you their story and you’re listening, you’re interacting. They cannot remember my name, but they remember this person.* She laughed and emphasised how much she enjoyed talking with elders. When she went to them and really needed their cooperation, they were willing to cooperate and consent. Lucky thought this kind of response came from putting her *heart and soul* into her work and relating to the patients as real people. Lucky said some of the nursing staff did not realise what made the difference. They were the ones who complained and could not get the residents out of bed. It was building that rapport, building that trust which was so important. How
nurses built it was up to each person, their own personality and what they put into it. Lucky emphasised that nurses had to have the heart for it.

The greatest challenge for Lucky was communicating with those elders who had trouble verbally expressing themselves, such as patients with a cerebrovascular accident (CVA), multiple sclerosis (MS) or amyotrophic lateral sclerosis (ALS). If they were able, she communicated with them through writing. Even that can be challenging but they are so eager to try to communicate with you. Lucky did not want to disappoint them even when it was hard work. When writing was not an option she used an alphabet board with a patient, Mrs. Lee and followed her eyes to the letters on the board until she blinked. Then you would painstakingly spell out each word until you get the whole sentence. For Lucky the time it took was worth it. Mrs. Lee wanted to communicate about her own life and know about Lucky’s life because as Lucky explained …she wanted to be a normal human being. So they just chatted conversationally about each other’s lives using the alphabet board.

Lucky also took care of elders in the acute care setting as a nursing student. It’s so much different being in acute care. At least as a student we have the luxury to chat with the patients a little bit more, instead of just coming in and do the IV [intravenous fluids] and out you go, or give the medication and out you go, which I have experienced and seen nurses do. Lucky understood that it was not that the nurses were not empathetic, but that they just did not have the time. The nurses had four or five patients while the nursing students only had two patients with plenty of time to talk to the patients. She considered listening to patients’ stories an important part of elder care. It helped her to see the big picture.

Lucky said she was just interested in people. I’m nosy, I guess. I’m interested in people’s lives. She was especially interested if they were elders and found it fascinating to hear about life when they were young. They were a part of history. Listening to elder’s stories is like watching a historical documentary and it is very, very enlightening.
Lucky’s exuberance about caring for elders was heightened when she began to use reminiscence in her nursing care. In contrast, Malia’s memorable experience came about when she talked to one particular elder in their home. Similarly, both Lucky and Malia saw elders differently once they heard their stories. Their prior perceptions of elders were replaced with new, more positive images.

**4.1.11 Malia: Giving back**

Malia was a Level 4 student who was very interested to share her experience with her senior companion elder. She was an exceptional storyteller. Using different voices for different characters Malia added colour to the interesting details about her experience with her elder. It was so fresh in her mind that sometimes she related conversations and thoughts as if it was happening in that moment.

When Malia took her gerontology nursing class she needed to find an elder to be her senior companion. It was a challenge figuring out who to ask. She remembered the elders that lived near her, so she talked to an elder’s grandson she knew and asked if he thought it would work out. He was sure she’ll love it. So Malia mustered up the courage to ask her neighbour, Mrs. Kealoha.

Before Malia met Mrs. Kealoha she thought she must be strict by the way she looked when she saw her drive her car. She asked herself, *How am I going to talk to her?* Malia went to her house and saw the door open just a little bit to let the air come in but for nobody to be nosy and look in her house. She knocked on the door and Mrs. Kealoha said, *Come in.* Malia thought, *Oh, this is going to be a breeze.* She walked in, introduced herself and mentioned the conversation with the grandson. Mrs. Kealoha *flat out said,* ‘No!’ Malia was surprised and disappointed. *Oh, no, now who am I going to find?* Mrs. Kealoha added, ‘You know, I’m too busy. I don’t have time…I work…I’m always on the go. And you know, I’m a very busy woman’. Malia did not know what else to do so she just sat there and talked with her instead of getting up and walking out. They talked about random things. *Maybe about ten minutes after we started talking, she says,* ‘Oh, so this class? So what do we have to do?’ Malia explained that it was exactly
what we are doing now. I’m not going to sit here with a pen or pencil and ask you questions. It’s just gonna be like this. I come over, we talk story. She added that she would visit her according to the Mrs. Kealoha’s schedule. She considered, ‘Oh, let me think about it.’ They just kept talking and then Mrs. Kealoha just turned around and said, ‘So when are you coming back’. She thought it was a good idea and clarified, We’re just going to be like this, talking story? Malia agreed and happily set up meeting times with her on Sundays when they were both home.

It was a really interesting time for Malia learning about her neighbour. Malia maintained her original impression that Mrs. Kealoha was strict, and probably so when she was younger. When they were looking at pictures of her grandkids, she was sitting there, and the grandkids were all smiling, but you could tell she was the ruler. Nobody messed with her. She was so proud of her pictures and loved talking about her family. To look at her you would not think that she went through so many miscarriages and then finally had only one child. Mrs. Kealoha raised one of her grandchildren like her own child. Malia saw another side of her. When she talked about it you could see her eyes light up, especially when she talked about from in the past.

Sometimes Mrs. Kealoha talked about something and then repeated the same story later or Malia had trouble following her train of thought. Malia thought maybe she has Alzheimer’s. One day she was trying to tell Malia about her brother. I never really understood what she was talking about. When Malia heard the same story from Mrs. Kealoha’s family member, the story made sense. Malia realised that she was a lot like her mom who would say, I’ve got to tell you before I forget. Mrs. Kealoha would talk about one thing and all of a sudden she’d be saying something else. Mrs. Kealoha was really making sense it was just that Malia was still back on what we were talking about and she’s already moved on.

Malia also experienced how talented Mrs. Kealoha was with her arts and crafts. She taught me how to make a frilly lei. Mrs. Kealoha had lots of craft supplies. Malia gave a detailed description of how she learned to make the lei. Mrs. Kealoha showed Malia
how easy it was to make, and Malia followed along as she was instructed. Malia was proud of her lei. She hung it in her car and showed it to her family.

Malia’s experiences with Mrs. Kealoha taught her to avoid stereotypes and not to make assumptions about elders. *For me, it really changes my perspective...Maybe some of them shouldn’t be driving but we cannot assume that they all cannot drive. She was 86 years old and still driving and doing a good job.* The impression Malia had of her when she drove was reinforced by the first time they met. Mrs. Kealoha appeared so stern looking. *She looks like a witch. But as I got to know her, she was loving.* It was totally different than what Malia expected. *She seemed different to me.* Malia thought she was *really nice.* Mrs. Kealoha told Malia and a family member that she was ‘so happy now’. Malia elaborated; *even her granddaughter says she seems happier.* She had something to look forward to. She liked the meetings. Her family did not visit her very often unless she needed something. *Other than that nobody went to talk story with her.*

Malia thought that listening to elders was good for nursing students because it helped them to relate to elders. She perceived elders one way and then when she heard them, she understood their history. She understood them and why they were the way they were. *You don’t really know a person until you sit down and talk with them.* Malia realised that their lives may be totally different than her own grandparents’ lives. Malia said, *It does open your eyes. You may not think so but for me it did. It definitely changed the way I viewed older people.* Malia felt humbled by the experience. She realised that the different ways elders acted could be due to the way they were feeling at that moment. It was just a part of life.

Malia said she also dealt with a lot of elders where she worked. They came in grouchy and then she remembered when she thought her senior companion must be grouchy. She laughed about it. Elders may just be set in their ways and do not want to change. Her experience dealing with Mrs. Kealoha helped her understand that it’s just human nature, and not to take it personal. *Like she said, I’m busy. You know, I’m busy, too.* So when elders came in and seemed grouchy, maybe they were busy or they just did not want to be bothered. *When they did come in and they were nice, it was good.* Malia felt
that had she not talked with her senior companion, Mrs. Kealoha, she would not have realised this. *You’re not going to have all happy seniors.* Or, maybe she thought, they just needed *somebody to come into their life and spend time with them.*

This experience was more than just a school assignment for Malia. Listening to Mrs. Kealoha reminded Malia of her grandma. *When I seen her, I thought, oh, that could be my grandmother.* The similarities were striking. Then at night Malia would think to herself *my grandma had this smell. She had that smell, the same smell that my grandma had.* It was her perfume.

Malia felt like she was with her grandma. She had so much fun. *So this is what I’ve been missing out, because my grandma died so young and I was so young. I didn’t get to experience that.* Malia was very emotional and tearful remembering. Mrs. Kealoha made Malia feel like she was a part of her family. When Malia’s grandma passed away, she thought, *okay, now moving on.* And then when she met Mrs. Kealoha, she did not think she could get close to her. *For me it was like being with my grandma. So I liked spending time with her. I liked hearing her stories, even though her stories were the same thing every time, but it was just being with her.* Her family was too busy to spend time with her. *I would think if I could spend time with my grandma, I would. You don’t realise what you have until it’s gone.* Malia never spent time with her own grandma, so she envisioned *this is like me giving back to my grandma.* Malia felt sad for Mrs. Kealoha because the family was always gone or they went to her house just to eat her food and then left. Malia had strong feelings about that. *You guys don’t realise how appreciative you should be. My grandma didn’t even live that long.*

The gerontology nursing course finished and Mrs. Kealoha died two months later. It was as if Malia came into her life for a short period of time, and as a result Mrs. Kealoha was happy. Even her daughter-in-law said, ‘*you were meant to spend time with her*.’ Malia described their relationship as good for both of them. *It’s like we helped each other. She gave me back something I could never have, and then I guess I gave back to her, too.*
In the next story Nora also developed a close relationship with an elder. Both Malia and Nora nurtured their relationships with elders by talking and taking part in activities cooperatively. They experienced a mutual benefit to the time spent together. Nora and Malia each learned new perspectives and insights that made them more sensitive to the needs of elders.

4.1.12 Nora: Attached

Nora was only weeks away from completing her last Level 5 coursework before graduation. We met for the interview on-campus and sat at a picnic table outside away from anybody or any interruption. The warm trade winds made it a very pleasant and comfortable setting. Nora bubbled over with the excitement as she talked about her community health clinical experience last summer.

Nora had a variety of clients in her community health clinical rotation. She said she had the option to go into the situation with an attitude of, *Okay, I'll just do my job.* Instead one woman in particular stood out and made a difference in how Nora saw her assignments and how she saw elders. The woman, Mrs. Young, was 97 years old and loved life. As they got to know each other, she became Nora’s favourite. Nora stressed how much she enjoyed caring for the Mrs. Young in her home and listening to her stories.

As their relationship developed Nora found herself staying longer than she stayed with her other clients. Mrs. Young was *smart; she was sharp.* She amazed Nora who described her as *top-notch.* Nora grew fond of Mrs. Young and loved listening to her stories and looking at photos. The black and white photos of her grandchildren and where she used to live reminded her of her grandmother’s photos. It was stimulating and informative to hear the stories that each photo brought to mind. Nora loved learning from Mrs. Young and being around her. She was very insightful and they had fun sharing and comparing slang from the past and the present. Mrs. Young would use words like, *those doggone things* when she talked. They compared changes in attitudes
and society from her younger years to now. Many of Mrs. Young’s characteristics and mannerisms reminded Nora of her own grandmother.

Mrs. Young’s husband and a son had both died. Her only other family lived a far distance away on the US mainland. Stories about Mrs. Young’s relationship with her husband were the most memorable to Nora. She sensed feelings of love, compassion, sadness and joy when Mrs. Young spoke about him. *Just remembering that part brought her such joy.* It was touching for Nora to hear Mrs. Young express how much she missed her husband and the closeness they had. She reminded Nora of her own marriage and how, despite the age difference, they had some things in common. Nora related to her experience as a young woman because they both got married very young. *I think I was about the same age, 19 or 21.*

One difference between them was that Nora had never experienced much death in her own family, except with her grandparents. It had not significantly affected Nora since she was not that close to them. In contrast, the death of Mrs. Young’s husband was significant. He died unexpectedly, yet she was able to get through it and endure it. *She wanted to continue on.* Nora was impressed that Mrs. Young *was still able to laugh and live life.* She was funny and always made Nora laugh.

Listening to elders like Mrs. Young impacted Nora’s views. She thought it was definitely a beneficial experience for her in nursing school. Nora learned that sometimes her own view was not always the only point of view. It became important to her to be able to understand the other person’s perspective.

Nora reflected on the greatest lesson she learned from listening to Mrs. Young. She compared the lesson to reading a book. *You can’t judge a book by its cover. It is not until you have read it and realised the context and the deep things inside, that you can know it was a good book.* Mrs. Young was definitely a good book to Nora with all the knowledge and insight she gained from her. Nora applied this lesson to her other elder clients as well. *And I think that is how it is with her or anybody…Everyone has a story*
and I think when people share their stories it is amazing. With so many different walks of life you never know what they have been through until you listen to them.

Nora came to value listening but it was not always easy for her. The greatest challenge when listening to Mrs. Young was her hearing aid. It was frustrating sometimes when they were on the bus going to her doctor appointments. Mrs. Young would be yelling at people because she could not hear very well. She would yell just to be sure Nora heard her. Nora was careful not to belittle her or make her feel ashamed. She understood why Mrs. Young was yelling and did not care if anybody else on the bus knew or not.

Despite her limitations, it was remarkable how hard Mrs. Young worked to maintain an optimum level of function. She valued both physical health and social support in her life. She ate properly even though she did not have an appetite. She ate because she knew it was important. She interacted with her neighbours because she knew how important it was and she kept in touch with her family.

Mrs. Young grew to be very precious to Nora and this motivated her to work even harder with her to preserve her independence. The three calendars Mrs. Young kept to help her remember, amused Nora … So if what she was looking for wasn’t on one, it was on the other one or the other one. Mrs. Young’s system did not always work and she needed help with her memory and mobility. Nora was concerned for Mrs. Young’s welfare because she had fallen and she lived alone. Nora wanted to help her remain independent. Her feelings of concern developed into a strong attachment as she worried about what would happen to Mrs. Young when her clinical assignment was finished. I wanted to preserve her quality of life. I was there to assist her, to be her friend.

It became apparent that Mrs. Young had some frailties and had fallen before. So Nora kept asking, What are you going to do if you go to the hospital or if you fall? Nora made sure to put away her throw rugs and reminded her to use her walker even when it was just to go a short distance. Not only did Nora want to keep Mrs. Young safe and mobile, but now she wanted to focus on increasing her independence once their time together
was coming to an end. *I didn’t want her to feel like I was always going to be there to catch her if anything happened.*

Nora emphasised their strong bond when she recalled what she said to her husband. *I told my husband that if she stayed here by herself when clinical was over; I think we’re going to adopt her. I couldn’t just let her go.* Nora said she wasn’t going to be one of those students who came in and said goodbye and that was it. *I wanted to keep her,* she laughed.

Nora was not certain if she had something to do with Mrs. Young’s final decision. Eventually she moved to the mainland to be closer to her family. Nora remembered, *She told me she was grateful that she met me.* It was a mutual feeling for both of them. Now they continue to keep in touch through letter writing. Nora really appreciated being with Mrs. Young, and she added, *I still think of her to this day.*

Like Nora, Kira also got to know an elder who was proactive in maintaining her independence in spite of her physical limitations. In both circumstances there was also heartfelt sharing about the tough times. For Nora and Kira, their experiences highlighted the resiliency and adaptation that accompanies ageing.

**4.1.13 Kira: Field trips**

Kira and I met for the first time at our interview meeting. I knew her name and she knew mine from emailing when she was a student and I was the course coordinator of gerontology nursing. The first time we talked to each other was when we arranged our meeting. She wanted to meet closer to her home rather than on-campus, so we met at a local coffee shop. Once we started talking the busyness around us was miles away. We spent some extra time at first talking story and getting to know each other a little bit. Kira was in Level 5 and was obviously happy she was less than two weeks away from completing her nursing degree. My first impression of Kira was that she really enjoyed her senior companion elder and was glad to have a chance to talk about her experience.

For her gerontology nursing class Kira invited the grandmother of a family friend, Mrs. Silva, to be her senior companion elder. They had not met before, only spoken on the
phone once. She was nervous at their first meeting. In fact, she was kind of scared. Mrs.
Silva asked her, *Okay, what do you want to talk about?* Kira suggested starting with her
life. She did not need to make any more suggestions after that. All Kira had to do was
be quiet and listen. Mrs. Silva loved to talk. Kira explained, *I just let her go.* Kira
listened to stories of how different it was growing up in Hawai`i years ago. *She told me
her whole life story.*

There were times when Kira could not follow exactly who Mrs. Silva was talking about
or what she was referring to but she just let her keep talking. Kira would nod and listen
and she would continue with the story. *You let them go on because they’re having so
much fun talking.* Kira learned about Mrs. Silva’s life including the many places she had
lived in and travelled to around the world. She felt that *listening to someone else’s
experience was just interesting.* As they got to know each other better they became
more comfortable and Kira explained that even to this day, *We are really close.*

Mrs. Silva shared her memories and her experiences telling Kira things she had not told
others. She spoke of times that were hard for her to speak of with just anyone. Kira felt
trusted by Mrs. Silva and that strengthened their relationship. *It was good…We felt that
bond together.* Kira mentioned that Mrs. Silva benefitted by sharing her life with
someone. Besides having someone to go with her to different events she had someone
she could relate with about her life. Compared to spending time with elders in other
clinical classes Kira said, *It’s a lot different than with clients that you just take care of them and then you go.*

The time they spent together was more than the typical student-senior companion visits.
Sometimes they met at locations that were special to Mrs. Silva and were part of her
background. Together they attended presentations about places where Mrs. Silva had
visited and worked. They went to island locations reminiscent of her Hawaiiana
traditions. *A lot of it was related to hula because that was her whole life.* Their
excursions were like field trips that helped tell Mrs. Silva’s life story.
Kira noticed that despite how active Mrs. Silva was she also had chronic comorbidities that limited her at times. For instance, when they went to an event together Mrs. Silva forgot her hearing aid. She kept asking Kira, *What? What did they say? She could not really hear what was going on.* Kira learned a lot from that incident including what it was like for elders who have a hearing deficit. Mrs. Silva never dwelled on her limitations. *She fought them.* Mrs. Silva did not let them hold her back from being independent and fun. Kira described her as the *most energetic person in the world.*

Kira spent some time reflecting on how she viewed elders now. Listening to Mrs. Silva and what she lived through gave Kira a different perspective on life. It was a lot different than her experience in a long-term care facility in Level 1 where patients were dependent, and some had tracheostomies. The preconceptions she had before the experience were now broken. *You may think like other people that to hang out with an elderly person is maybe boring.* It was not boring to Kira who mentioned at least three times how fun it was. Thinking that all elders move slowly was another false misconception she held beforehand. *I mean you kind of underestimate elders...they are not as frail as you think.* Kira described her elder as the *fastest and the craziest driver* you would ever imagine. She was extremely active. Kira’s views were changed with this experience. She now believed that elders were much stronger than they looked.

As we wrapped up the conversation, I asked Kira if there was anything else she wanted to add. Her reply was that the experience of listening to elders in nursing school was valuable. She explained that when she took care of a client for a short time she did not develop a relationship with them. She elaborated on what her relationship with Mrs. Young meant to her. *It really changed my views. You can kind of feel for them and see where they are coming from. It’s different.* Whether it was about how life was during a certain time, the interesting stories, or just because elders *always have knowledge,* Kira was sure that *students can learn a lot.* She concluded with her final thoughts, *It was good. I think [spending time listening to elders] should be continued.*

Just as Kira set aside preconceptions she had before she talked to an elder, Julia did the same. They both recognised the myths and stereotypes they had of elders before they
interacted with them. The elders they met did not fit their stereotypes. Kira and Julia both came to reject the myth that associated old age with frailty.

4.1.14 Julia: Captured my heart

Julia was sitting in her Level 3 class when she emailed me that she was happy to be a participant. I remembered well her eagerness to share and join in from the semester before in gerontology nursing class. After a few rescheduled appointments we finally found a good time to meet on-campus.

Julia was very open and said a lot in a short amount of time. She dove into the interview radiating enthusiasm for learning and for meeting people. Not only did she tell her story but she made connections to her nursing school education and her own personal upbringing.

Julia came to Hawai`i from a Pacific Rim setting to become a nurse. Since her grandparents on both sides were gone she had not been around elders until nursing school. Back home she did not really talk to or spend time with elders. Instead it was just doing what they asked of her. *Because in our culture wherever you are even though they’re not your relatives, if they’re older and they tell you something, you have to do it. I’ll be going to a party, and ‘Hey, girl can you get me some rice?’ That was all the experience she had with elders.*

She labelled what had been going on in her head, her thoughts about elders when she was back home as myths. She thought elders were slower because the elders in town walked slowly. She now concluded that it was because they did not exercise. She never saw anybody walking. It was totally different there. *If you’re exercising it’s kind of shameful for them.* The foods everyone ate were high in fat and salt. And due to the high rate of diabetes their legs were messed up. Julia clarified that there were some healthy exceptions. They were some rare instances of elder men in their 80s who were fishermen and climbed coconut trees. But Julia said her eyes were opened when she came to nursing school and went through the gerontology nursing class and met several elders. *It was just ‘wow’.***
The first elder she met was, Mrs. Chang, her senior companion for gerontology nursing class. She had the opportunity to spend a lot of time with her. At first, I wasn’t excited. I just thought, oh, man, more work. Julia was worried about fitting this activity into her already full schedule. When she phoned Mrs. Chang she was relieved that she offered to meet Julia any time she was free. The first time Julia met her she captured my heart. Mrs. Chang said, Hi, welcome. You must be Julia. Then she hugged Julia. I thought, oh, wow, I want to come back here, this is fun.

Julia reflected on her experience with Mrs. Chang. She thought the experience was great and that she was awesome. I did have some stereotypes. But when I met her everything … was proven wrong.

Julia visited Mrs. Chang regularly throughout the semester and got to witness her in action caring for her husband and grandchildren. Julia observed, She’s so active. She ran a lot, up and down hills. Even though she was in her upper 70s she still worked at a job on her feet all day, came home and cared for her family. Julia knew from her own job experience that it was not easy. After the days I work I would put up my feet and just be. I’m so tired. Yet Mrs. Chang still cooked like nothing happened.

She was not at all like the myth that elders were weak. Mrs. Chang was strong. She can pick up her grandkids. Julia was impressed that Mrs. Chang never got frustrated, stayed calm, and always knew how to respond to her grandchildren. I guess it’s with life experience she knows what to do and what to say. Mrs. Chang was hard of hearing but she said there were some things you just could not help.

Julia loved the stories of travel and romance that Mrs. Chang told her. They talked about prayer and religion, times of separation and wartime. The highlight of her visits was the time she and Mrs. Chang sat down together and had coffee. We were alone and then she started crying. Mrs. Chang opened up to her and told her about the hard times of death, grief and illness in her family. She got through them by putting it up to God. Julia said it was heartwarming because, you feel trusted. Mrs. Chang said she did not really have anybody to talk to about certain things. Julia felt honoured and privileged to
be listening. Talking about the hard times in her life she advised Julia, *If you love somebody you should keep them close.* Julia concluded that in Mrs. Chang’s life *there were sad moments but she was happy.*

Julia listed more myths that she dispelled by spending time with elders. The myth that elders were depressed was one of them. Elders were weak and helpless was another myth. Spending time with a group of elders further helped Julia challenge these myths.

There were a lot of happy and active elders at the senior centre she went to for community service learning with other nursing students. Julia met some women all in their 80s and 90s during the exercise class. She thought it was funny that they were just like younger adults the way they chitchatted about what each other was wearing. One of the oldest women, Mrs. Bennett, was extremely healthy; except for some hearing loss. She was a role model for the younger elders in their 70s and 80s. It was an opportunity for Julia to interact with more active elders when Mrs. Bennett assisted the nursing students who had trouble with the exercise moves. Julia was surprised when she found out that she sewed her own clothes. Getting to know the elders at the senior center informally was helpful to Julia. They were very friendly and talked to the nursing students casually. *They hung out with them during breaks.* They talked about life to each other and to the students which created a bond and they built relationships.

Julia retained what she learned from those elders and applied it to new situations. As all of the nursing students did, Julia also took an adult health medical-surgical class the same semester as gerontology nursing. Her experiences with well elders directly impacted how she cared for her last patient in the hospital clinical rotation for medical-surgical nursing practice.

The patient, Mrs. Johnson, was an elder and disabled due to her medical condition. The nurses reported that she complained all the time. Julia’s experience with elders in gerontology nursing made a difference with Mrs. Johnson. She deliberately decided not to treat her with the attitude of, *Never mind her she always cries, she’s an old lady, she’s depressed.* She did not do that. She went to her and spoke with her. Mrs. Johnson
told Julia that the nurses did not listen to her. *I’m telling them this and that; they don’t want to listen to me.* When Julia asked what she wanted to tell the nurses, Mrs. Johnson said she just wanted to talk because she had nobody to talk to. For Julia that moment was really nice. As Julia listened, Mrs. Johnson opened up to her and explained that people treated her differently, as if she did not exist or they felt sorry for her and came up to her and started to help her. Mrs. Johnson said she could do things by herself. Julia knew that the right thing to do was to give her a sense of independence. She had read on the chart that Mrs. Johnson was to be fed by the nurse even though she said she could feed herself. So instead of feeding Mrs. Johnson, Julia just stayed with her while she fed herself her meal. Julia was determined to treat Mrs. Johnson as an individual not according to society’s myths of ageing that projected images of weakness and helplessness. To be a good nurse, *you cannot be blinded by stereotypes.*

The passion that Julia had for elders after listening to their stories was also reflected in Lena’s story. Their stories shared the rejection of myths of ageing, a fascination with elder’s stories, and application of what they learned to the care of elders. Both Julia and Lena started off with one perspective and ended up with another.

### 4.1.15 Lena: Who turned on the light?

Lena and I kept in contact with sporadic conversations about issues of nursing and education whenever we saw each other on-campus. She never failed to surprise me with a new issue or patient care concern that I had not really thought about before. For a change of pace we had the interview at a coffee shop that was away from campus and very quiet. Ready to graduate, Lena was thriving on new opportunities to learn and was enjoying her last semester of nursing school.

Lena was engaging and time passed quickly as she expounded on the plight and joys of ageing in America. She was bold and spoke passionately about her experiences with elders. Reflecting on what she had learned, Lena used images of dark and light to represent periods of change and transformation. Her pseudonym, Lena, was selected to represent her story because it meant light in Hawaiian.
As Lena began to talk, she described how uncomfortable she was during her first clinical rotation in nursing school, when all she had to do was to make beds and visit with elder patients and their families. Just pointing Lena toward a bed with an elder in it created a feeling of apprehension in her. She explained; the barrier used to be that I’d be afraid. She remembered thinking, If I go too close to them, I’m going to catch something. How do you relate to this old skeleton with some skin on it? She was disinterested and anticipated being bored out of her mind caring for elders who were probably deaf or senile.

Looking back she now understood that the prejudices she held at that time were commonplace for people who did not interact with elders or know the truth about ageing. So in my dark ages before having a gerontology class that exposed me to my first positive experiences with older persons, I thought so negatively about that population.

After talking to elders and interacting with them, things changed for Lena. All I can say is that I was like, ‘Oh, my God, who turned on the light’. All of a sudden it was stimulating for Lena to talk to elders and hear the interesting things they had to say.

Not only had Lena thought negatively about being around elders but she was also very reluctant to grow older herself. Those feelings were like an awful burden that she was carrying around for no reason. Now she found herself saying, Thank God! If it wasn’t for my education I’d still be in that stupid dark cave and fearing getting old myself. Being older than many of the other university students gave her a unique perspective. I get treated differently. It was no different than the way I used to think about older people. Lena’s experience listening to elders had changed how she viewed her own ageing, too. That’s the best thing to happen to me, is to not fear ageing. If they have something to look forward to then so do I. They can’t be all wrong.

Lena’s change of heart came about when she realised that she enjoyed talking to Mrs. Benson, an elder woman in the community who she met when she was in nursing school. Mrs. Benson was an important person who had faced a lot of suffering just to
enjoy life. Lena was impressed that she remembered with such detail her experience as a young girl living in Hawai`i during World War II. She talked about experiences that people of my generation would never know … They were on rations. They were in a blackout during the war. She lost young friends. She remembers seeing Japan bombing us. Mrs. Benson recalled the friends who died. Hearing a moving story like that was what Lena imagined she would see in a movie. Lena valued the chance to hear that war story firsthand. It’s remarkable what people go through. I don’t think you can find any stories half as interesting from any person who is young because our lives are so laid out for us and so easy.

Lena was struck by the optimism she found when she talked to elders. There was a recurring theme that today was so much better than yesterday. Elders talked about how little they had in the past as if to say, wow, your generation is really lucky. She thought that was strange because she was under the illusion that yesterday was better than today. There were never any dismal or sad reports even when elders talked about people they missed or who had died. It’s always so positive. Lena wondered why this was. It could be that those who had outlived everyone else were the positive ones and that was what sustained them to continue to live. Perhaps the ones I don’t interview are deceased because they didn’t frame things in as positive a way and it affected their health or their desire to outlive the normal age. I’ll have to do a study on that, she laughed.

Lena’s experience with elders at the end of life confirmed her impressions. Most of those patients were positive, too, contradicting what she thought. I was disappointed because I thought it would be a good lesson to learn about life and the dying and the melodrama. But it’s not there because I have these elder people who still maintain that positive outlook on life. It’s amazing. Lena described one of the more vivacious and talkative patients, Mrs. Park. She was approaching 90 yet she looked younger than Lena. Her mind was sharp. She’s brilliant. She lights up my day. Mrs. Park defied her diagnosis by being so vital and interactive. It was hard for Lena to believe that she was dying. Mrs. Park knew Lena’s name and read her nametag without any eyeglasses. She
conversed on *any subject*, talked about her *entire life, her kids, her grandchildren*, or the *news of the day.*

In contrast, another elder, Mrs. Hall, at the end of her life was nonverbal so Lena communicated with hand grasps. She learned about Mrs. Hall’s life from her family. *Her husband speaks volumes for her and there are photographs of her. When I look at the pictures of her I’m amazed how gorgeous this couple was.* The black and white photos of her in her wedding dress were from another era. Mr. Hall talked about their life together as if she was still that person today, as if she was not debilitated and bedridden. Lena commented, *but when he talks about the things she used to do and how important she was in his life I then understand why he is there every day.* Mr. Hall had been faithful because of those good memories. Listening to his memories helped Lena perceive Mrs. Hall differently but she also noticed that it helped her husband. *Memories are really healthy.* She thought it was good for him to share what he remembered.

Lena identified her experiences in other clinical settings such as medical-surgical, complex care and community health as enlightening and consistent with what she had learned. She was convinced that the self-reflection and journaling that was a part of her clinical courses played a big part in her transformation. Now whenever she approached an elder there was no longer the barrier of a negative attitude. *Everything reaffirms that most everything I thought about elders was a myth.* It was a myth perpetuated by society and especially by the media. Lena realised that many influences in her life such as friends, people in the community, media and public policy have perpetuated prejudice toward elders. She was concerned that out of *fear of the unknown* American culture bought into the media hype and accepted the images of ageing as dismal. Elders were written off as *incapacitated, outcast from society,* and assumed to be of *no use, too slow, too decrepit* and *no fun to be around anymore.* She believed the root of the problem was not listening to elders.

Lena felt that it was sad that when these elders die, people end up making the same mistakes as before because they did not listen to their stories. *The fact remains that everybody wants advice. We can get free advice from so many older people...*
advice to keep you busy 365 days [a year] for the rest of your life. She was very passionate that elders were full of great ideas and wonderful histories. They were a resource of information on how to live.

Listening was also essential for the assessment of elders. Lena was certain that nurses who understood that elders listened and conveyed their thoughts more slowly would be better prepared to interact with elders. *When you don’t understand the nuances about speed, you may miss some very critical patient findings that will make you the cause of their early demise.* Lena believed that nurses should listen and give elders time to answer, *so don’t talk a 100 miles an hour, like you do to your Chatty Cathy* (reference to a doll that talks nonstop) *friends on the phone.* Lena saw listening as a way to *repair some of the inequity in healthcare.* Much of what Lena believed she first became exposed to in her gerontology nursing class, but now she was internalising it and integrating it into her care. Acknowledging this she said *but then I’m preaching to the choir.*

Lena described how she had changed her nursing practice. Before she was task oriented but now she took more time to find out the context and the needs of her elder patients. She summed it up, living longer, elders deserved a little more time. *It’s the most important thing I’m going to say...Now every time I get a patient who is older, I don’t give a shit what time it is. I don’t care what is due. I don’t care if my cell phone’s ringing, if it’s my clinical instructor on the phone. The only thing that could make me stop doing with that older person what I was doing is a fire alarm or if they stopped breathing.* She explained that giving elders extra time was not about how much she loved them but because it was the right thing to do to be a good nurse. *Everything will work out if you follow that pattern.*

Lena concluded the interview by sharing her one lingering fear. She feared how others would treat her as she aged. She was determined to help fix the situation and make it safer to grow old. Without any elaboration but with great certainty she had a plan for herself. Right now the only safe place she saw to get old in America was within a church with a strong congregation. Lena decided to start looking for a church.
4.2 Summary of the chapter

This chapter encompasses the experience of being in the midst of stories: elders’ stories, the participants’ stories, and the researcher’s story (Clandinin & Connelly, 2000). Most striking to me as I interpreted the 15 stories were the participants’ reactions to the stories they heard, the power they found in listening to stories and the introspection that occurred in their own lives by being in the midst of the elders’ stories and retelling them.

The participants shared a wide range of feeling and emotion as they told their stories. Feelings of admiration and inspiration were coupled with astonishment and sadness. Their stories displayed a range of emotion from the first story of Jon feeling amazed by what he heard, through Emma expressing distress at what she saw, to the last story of Lena translating her fear of ageing into a passion for elders. The participants exhibited a vulnerability and openness to disclose encounters that were not always comfortable for them. They were shocked and intrigued by elders’ recollections of historical events and their personal encounters with that history. Stories during World War II were described dramatically by Jon, Josh, Lena, Lily and Lucky. The images of bombs falling, the alarming sight of dead bodies, and escape from the enemy were vivid and moving. Josh described the stories as surreal. The personal encounters elders had facing discrimination, chronic illness, and losing loved ones brought out other emotions of wonder and sadness. Emma, Josh, Julia, Lily and Nalani communicated how disturbed they were by the unprofessional nursing care they observed. The lack of concern for elder patients also shocked and amazed them but in negative ways. Overall the breadth of feeling and emotion expressed in the stories strongly conveyed meaning of the experiences.

The power of listening to elders’ stories was expressed as bringing joy to elders and had a positive impact on the participants’ lives. Kira found it easy to listen because Mrs. Silva was having so much fun talking. The topic of quality of life was repeated throughout the stories. As elders shared what meant the most to them and the lessons they had learned, Ana, Clare, Emma and Kaleo reflected on their own quality of life.
One unanticipated topic that recurred throughout the stories was that of grandparents. From childhood, to young adulthood through to adulthood, Clare, Emma, Jon, Josh, Kanewai, and Nalani recalled the role their grandparents played in shaping their views of ageing, elders and themselves. In addition, Kaleo, Malia and Kanewai noticed that meaningful relationships with grandparents and other elders were often accompanied by storytelling.

In Chapter Five, the participants’ reactions to the elders’ stories and the transitions that resulted are discussed further as part of the thematic analysis. The overarching theme of liminality with its subthemes of liminal spaces are explored.
Chapter Five Story themes

This chapter provides a discussion of how the themes developed as a result of the process of thematic analysis across the stories of the participants. Discussion of the themes gives insight and understanding to the participants’ experiences listening to the life stories of elders.

The development of themes derived from the 15 interview transcripts and narrative texts was guided by the research questions and the Three Dimensional Narrative Space format as discussed in Chapter Three. The process of identifying the themes came about through reading and rereading each participant’s transcript and story text. At first the emerging themes were broad; then they became more detailed and specific as more themes were identified adding additional variations within the themes. Finally, the analysis resulted in one overarching theme of liminal space, with four subthemes, captured the meaning of the participants’ experiences listening to elders tell their stories. The subthemes of story space, light space, reflective space and caring space each have accompanying descriptors as shown in Table 7 in Chapter Three.

5.1 Liminal spaces

The first liminal space is story space, a beginning point of entry that includes a threshold. The actual experience of listening to the story took the participants from the threshold, a point of beginning to a new experience. Hearing the story was the crux of the experience which led to the other three spaces.

The threshold represents the beginning of a journey crossing borders from one liminal space to another. In this case, the borders are the perceived and real differences between elders and the participants. Borders are in between spaces that are filled with uncertainty and possibility. According to Caine and Steeves (2009), these spaces are “places of liminality” (p. 8). Liminal spaces lack structure and support ambiguity while affording the liminar opportunities to form new ideas and get to know others differently (Huber, Murphy, & Clandinin, 2003). Before their encounters with elders the participants expressed feelings of uncertainty along with curiosity. For many of the
participants their prior experiences with elders were limited to childhood memories of family members or frail elders in decline. They had feelings of ambivalence, fear and boredom toward elders. Crossing the threshold to listen to elders was an act that carried with it the risk of experiencing what was already perceived or possibly something unknown. Once they stepped off the threshold and moved through the gateway the participants encountered interesting and fascinating stories followed by many other transitions that occurred in the other liminal spaces.

The other three spaces were part of a linear process for some of the participants, moving from one space or transition to the next. But for most of them it was a nonlinear experience that involved revisiting the spaces in no particular order throughout the experience of listening to elders tell their stories. In addition to story space, the other liminal spaces include light space, where the participant was being let in; reflective space where there was an experience of transformation; and lastly, a caring space where participants had a renewed vision of providing nursing care to elders. Each of these liminal spaces are explained further with examples from participant interviews and narrative texts. The participants’ voices are represented in italics.

5.1.1 Story space: Threshold

The first transition for the participants was when they crossed the threshold into an encounter where they heard an elder’s story. The transition into the story space began as the elder started to tell their story and the participant became a story listener. It was the combination of both of these two actions that simultaneously created the story space. The result was a range of different yet often similar stories. The subthemes of story space included the experience of listening, content of the stories themselves, the advice given by elders, and challenges that the participants experienced as a listener of stories.

5.1.1.1 Story listening and content

Participants described themselves as listening attentively and being present with the elders sharing their stories. When the participants entered the story space and became story listeners, they brought with them the skills of professional communication they
had learned in their Level 1 nursing classes. The content that was covered there included therapeutic communication and active listening. Even so, they found themselves using their communication skills and listening in a new way. They used a different form of communication than is often implemented in nursing settings where the intent is to assess and determine the elder’s health status or to collect information to answer certain questions. They were not utilising the expert gaze or constructing illness narratives (Kleinman, 1988; Powell, 2006). It was beneficial that the participants were not focused on the elder’s physical health status. Barker (2004) found that having a diagnosis in mind when listening to a life story can “obscure rather than illuminate the person’s story” (p. 18). The label of a diagnosis objectifies the person into a type of pathology or problem. The stories that the participants shared came from experiences when they were not using therapeutic communication skills intended “for the purpose of achieving identified health related goals” (Arnold & Boggs, 2011, p. 529). Instead the participants were either expecting to hear a story or heard one spontaneously.

The way in which participants listened and interacted with the elders had a direct bearing on their experience and the stories they heard. Participants very specifically focused on using the communication skill of active listening in a way that closely reflected the Nursing Intervention Classification definition of “attending closely to and attaching significance to a patient’s nonverbal and verbal messages” (Bulecheck, Butcher, & Docterman, 2008, p. 115).

Active listening also communicates value and worth of the person speaking. According to Hyde (2006), listening is one of the basic elements of the life-giving gift of acknowledgment. Appropriately, acknowledgment is described as the antidote to social death, a state which “takes place in any culture where people are slighted or marginalized because of their age” (p. 190). A study on the experience of elders being listened to showed that when a person is not listened to they feel like a nothing, the equivalent of social death (Jonas-Simpson, Mitchell, Fisher, Jones & Linscott, 2006).

Clare and Emma recognised the importance of listening when elders told them they just wanted someone to listen to them. Kagan (2008) found that “people said they wanted to
be listened to by healthcare professionals more than they desired anything else” (p. 59). The participants in this study identified listening as being meaningful when it is genuine and attentive.

Participants described themselves as listening attentively to elders and being present in ways that illustrated what is called nonegoic listening. According to Browning and Waite (2010), this act of listening takes place when the listener moves their ego aside and becomes open and receptive to the speaker. When the listener “can give full attention to the speaker, the listener will have a brand-new experience” (p. 154).

Active listening helped to establish respect and empathy which enabled the elder to “feel safe enough to disclose aspects of themselves and how they experience their life” (Hawkins & Lindsay, 2006, p. X10). Paradoxically, active listening involved attentiveness on the part of the participants as well as distancing themselves so that the elder’s voice was central to the story being told (Todd, 2003a). In this way the listener fully entered into the dialogue yet took leave because what mattered was the “speaker being able to speak” (Todd, 2003b, p. 406).

Kira’s story gave an example of how she was able to distance herself while still actively listening. When she first met Mrs. Silva they briefly talked story. Kira listened to the Mrs. Silva’s questions and told her a little about herself. Once Mrs. Silva got started talking about her life Kira said all had to do was to be quiet and listen. She explained:

*I just let her go ... she told me her whole life story.*

Hawkins and Lindsay (2006), like the participants, recognise that actively listening to stories is not always possible. The time limitations to complete assessments and specific nursing tasks often make listening unlikely to take place (Browning & Waite, 2010). Time is a great obstacle since, “stories can only be told when people have time to talk and to listen” (p. S14). Lucky recognised that time was a factor for listening to elders’ stories.

*At least as a student we have the luxury to chat with the patients a little bit more.*
Narrative gerontologists Kenyon and Randall (1997) affirm the value of elders being given time to be listened to as they tell their stories. The difficulty is that “it is not commonplace for a person to take the time to listen” (p. 27). When elders are given opportunities to tell their stories it supports positive ageing. Randall (2009) differentiates that “it is not the quantity of time we spend with someone as much as it is the quality” (p. 36). Quality time includes “compassionate” and “empowering” listening, using open-ended questions such as, “Tell me about your life” (p. 36).

Quality of listening with an introductory open-ended question was evident in Lily’s story. Not only did the type of communication shift, but also the type of relationship. Lily shifted the power in the interaction to the elder when she asked, *Can you tell me anything about your life that interests you?* She showed respect by allowing Mrs. Ramos’ voice to be heard and by listening without intent to solve a problem or look for one. Lily, in suggesting that Mrs. Ramos talk about whatever she wanted, then transferred control, and as a result this empowered the elder (Browning & Waite, 2010; Sorrell, 2000).

The approach of active listening was very successful and as a result participants received the gift of story from the elders. As the elders responded to the participants and told stories about their lives the participants became more comfortable with them. Lucky described how listening had a positive effect on her and the elders. When she listened to elders they both became more comfortable with each other which helped build rapport. According to Belcher (2009), taking the time to feel comfortable with another is the definition of establishing rapport, the pre-cursor to establishing trust. The content of the stories engaged the participants and in return they continued to offer the gift of listening. Elders also shared advice that participants welcomed and appreciated. This was the beginning of a mutual and reciprocal relationship.

This, too, was a form of listening that represented the liminality of attentive listening (Ryan, 2008; Todd, 2003b). When a person gets caught up watching a movie or lost in a story they are in a liminal space. They are present but not as aware of their surroundings and feel fully immersed in the story. Storytellers call this experience being in the
“storylistening trance” where critical thinking shuts down and the listener feels emotionally connected to the story and the storyteller (Sturm, 2000, 2010). The storylistening trance commonly alternates with moments of self-awareness and recognition of the story. The listener also experiences emotional vulnerability not knowing what will happen next in the story (Todd, 2003a). Listening becomes risky when “the listener must listen to what is not easy” (Todd, 2003a, p. 132). The risk is that it may be distressing to the listener.

When the participants listened to stories of suffering and loss they made themselves vulnerable to experiencing sadness. Clare, Emma, Kira, and Lily mentioned how hard it was to remain calm and not to cry when they heard their elders’ upsetting stories but felt strongly that those stories were the most memorable. Their feelings of shock and amazement toward the stories and the elders were in fact some of the reasons they enjoyed listening to the stories. Continuing to listen particularly during those upsetting moments sustained the trust and the relationship that developed during the process of storytelling and listening (Todd, 2003b).

The stories the elders told were varied - ranging from short anecdotes to longer in-depth life stories told over time which often included reminiscence. Emma, Lena, Malia, and Nora also looked at old photographs with elders which brought out more stories to listen to from the elders. Participants’ responses to listening to the different stories were very positive. This was a stark contrast to the comments of several participants who felt nervous or afraid before they met with their elders and expected the experience to be boring. As they listened to elders’ stories they felt excited, impressed, amazed, shocked, emotional, inspired, and surprised. Many of them said they loved listening to elders’ stories; it was enjoyable and fun.

The content of each of the stories was significant enough for the participants to recall the experience of story listening and to remember the specific stories. Elders told the participants what it was like growing up in a time that was much different. Stories of living during World War II were the most numerous, while others were about their
personal struggles and advice they wanted to share. In the liminal story space there were also obstacles and challenges to stay attentive to the elders telling their stories.

5.1.1.2 World War II

The individual accounts of historical events, in primarily those during World War II were significant for the participants. Since the elders were all 75 years or older it meant that they all lived during those years. Many of them had served in the military or had wartime experiences as civilians. Clare, Emma, Jon, Josh, Kaleo, Lily, Lena, and Lucky all heard elders tell about World War II. Lily’s story revealed an example of what it was like for an elder as a child during wartime. Lily experienced feelings of shock and then empathy toward Mrs. Ramos as her story unfolded. She retold the story of Mrs. Ramos as a young girl growing up in the Philippines fleeing, hiding and surviving the war to find out that her father had been killed.

Since many of the elders had grown up in Hawai‘i, some of their stories included the bombing of Pearl Harbor. Lucky’s and Lena’s elders described in great detail their memories of that day. Lucky said that listening to elders’ stories was like watching a historical documentary. Mrs. Chang recalled vivid details of the bombing itself:

All of a sudden she heard airplanes up in the sky. She saw a red sun on their sides as they were flying low. There were hundreds of them and black smoke was all over.

Lena said the stories she heard were like the images she would watch in a movie. Mrs. Benson also experienced firsthand what happened in Hawai‘i on December 7, 1941.

She talked about experiences that people of my generation would never know ... They were on rations. They were in a blackout during the war. She lost young friends. She remembers seeing Japan bombing us.

The elders’ stories also included their day-to-day life during peacetime and the struggles they endured in addition to the good times they enjoyed.
5.1.1.3 Personal Struggles

The most memorable personal life stories were the moving details of struggle and significant loss such as the illness or death of a loved one. Many of the elders had cared for their spouse or children with debilitating conditions and then subsequently lost some of them through death. Clare listened to her grandmother tell the story of the death of her son. Other elders shared the hardship of still having their spouse alive but not being recognised due to their dementia. Ana’s elders each had different struggles. Mrs. Costa was in good physical shape but mourned the loss of her husband. The other, Mrs. Roberts shared with Ana her loss of health and the knowledge that her life was short due to cancer but that she was happy and with her life. The contrasting life stories of Ana’s elders gave her much to ponder about the different ways in which people live and enjoy their lives. It was logical to her that the elder who had made the best health choices in life would have the best life. Ana concluded that each elder experienced a positive quality of life that the other did not. Also memorable to the participants were the pieces of advice that the elders shared with them along with their stories.

5.1.1.4 Advice

Several of the participants said they were fortunate to be the recipient of lessons learned from a long life. Mrs. Chang told Julia about how hard it was to lose a family member through death and advised her if you love someone, keep them close. Mr. Allen was impressed with Josh’s accomplishments and he counselled him, one thing I need to tell you is to always stay humble. That was a highlight of the experience for Josh and he said, I love it when elders give me advice. Lena concurred with Josh as she explained her perspective on advice from elders:

The fact remains that everybody wants advice. We can get free advice from so many older people. They can give you enough advice to keep you busy 365 days [a year] for the rest of your life.
Listening to stories or advice from elders had more to it then just attentive listening. There were numerous obstacles and challenges for the participants as they tried to stay present and engaged.

5.1.1.5 Obstacles and challenges

Participants encountered obstacles and challenges they had to overcome in order to maintain their position as a listener within the story space. Many of the participants listened to elders who had a hearing deficit. Ana, Julia and Nora stressed that this made it more difficult for them to interact and continue listening. Nora described the challenge of the experience as frustrating when Mrs. Young would yell to be heard.

Elders’ patterns of speech were challenging for Emma, Kira, and Malia. They kept listening even when their elders spoke about things they did not understand or when they repeated themselves. Lucky indicated that patients with aphasia (the inability to communicate verbally) were the hardest to listen to because it was such a slow process when they had to use methods other than their voice to communicate. Lucky felt it was worth the time it took to hear an elder patient’s life story even if it required using an alphabet board following her eyes to painstakingly spell out each word until you get a whole sentence.

The most common obstacle by far was time. Emma, Josh, Jon, Kira, Lena, Lily and Lucky said that in many settings they just did not have the time to cross the threshold and listen. Lucky explained how it was different for them being nursing students:

\begin{quote}
At least as a student we have the luxury to chat with the patients a little bit more, instead of just coming in and do the IV [intravenous fluids] and out you go, or give the medication and out you go, which I have experienced and seen nurses do.
\end{quote}

Clare, Emma, Kira and Lily also noted that when the elder became emotional telling a meaningful story it was hard to stay composed. Lily said that since she was an emotional person it was not always easy to listen to elders’ emotional stories. She explained:
So if someone is telling me a story and they’re starting to tear and to cry, I try to hold it back. But if they are sniffing, it would get to me.

Lily added that it was the emotional stories that helped her imagine what elders had gone through and to see them as a person. It was the experience of understanding what it was like for an elder that is discussed in the transition of light space.

5.1.2 Light Space

Light space represents the transition that took place when participants experienced a connection with elders and they began to become aware of and understand what the elders had gone through. Participants moved beyond perceiving elders as merely the source of an interesting story. Participants sensed they were being let in to a more personal area of the elder’s life when the elder opened up to them and they experienced trust.

The stories were exciting, emotional and held the attention of the participants, yet the transition into the light space came about when there was a connection made between the story teller and the story listener. This connection was deeper than the sharing of common experiences when talking story and closer than the emotional connection they felt while in the storylistening trance. The connection came about when the participants got to know the elders and saw what life was like through their eyes.

The idea for calling this transition ‘light space’ came from the participants’ multiple references to light and seeing in the interview transcripts. Wondering if ‘light space’ was an original term I conducted a literature and internet search and found one result that was relevant. The phrase ‘light space’ was present in the early Hasidic writings of Martin Buber. These writings were foundational to his well known works on relationship and dialogue (Buber, 1965, 1970, 1995; Friedman, 1991). Light space was in contrast to the great abyss which cannot be crossed and creates separation. Buber used the imagery of light to represent the space which fills the abyss and brings about relationship. It was in the light space where one saw hands touching and connections.
being made with one another (Buber, 1995). This confirmed that the term light space appropriately represented the theme.

The great abyss, the ultimate generation gap in this situation, was the border that was crossed by participants as they experienced relationship with an elder. The participants’ transitions in the light space had dual meaning. It was a place of connection that involved entering into a place of meeting and a place of new understanding. Participants identified changes they were experiencing as well as transitions that the elders went through as story tellers.

5.1.2.1 Being Let In

First of all the light space represented the experience of connection by being let in. Josh described how he felt listening to an elder share some of this stories and life lessons:

*I love it when elders give me advice.*

‘Being let in’ expressed the liminality of light space where barriers were let down and closeness emerged. Emma described this transition into closeness as being *let into an intimate space*. Light space was a place between being an outsider and actually becoming part of a person’s life. Dowling (2004) equates this kind of intimacy with a caring, reciprocal nurse-patient relationship that involves disclosure while getting to know each other. Other participants expressed this feeling of being let in when elders opened up to them and dialogue took place. They described a change from simply listening to a life story to feeling connected and establishing trust with their elder. Kanewai said that he felt a *strong connection* to the elders he got to know through their stories. Kaleo felt this connection arose when he listened to their stories casually or with reminiscence. His recent experience listening to Mr. Wilson’s story helped him come to realise that reminiscence was a combination of talk story and being therapeutic at the same time. Kaleo said:

*That is what reminiscing does. It opens up trust and good feelings.*
Many of these moments of connection occurred when elders disclosed the details of their lives in quiet voices, in intimate closeness, and sometimes with tears. For example, Julia explained that a highlight for her was listening to Mrs. Chang when they had coffee together. Mrs. Chang told her about the hard times of death, grief and illness in her family. They were *alone and then she started to cry.*

Mrs. Silva also shared memories with Kira and experiences that she had not told others. Kira said this strengthened their relationship and they developed a close bond which continued long after the nursing school assignment was finished. The establishment of trust and relationship that came about for the participants characterises light space as a relational space where participants felt connected and appreciative to be let in.

Secondly, these moments of connection were repeatedly described in terms related to the metaphor of light and seeing as new understanding was revealed. After participants listened to elder’s stories they described their experience as an eye opener as if it was a new way of seeing or they were seeing with new eyes. Lena transferred the metaphor of light from herself to other elders. She was able to recognise her patients as individuals and formed a connection with them.

The participants saw the elders as individuals with an identity rather than solely as an example of a homogenous group such as elders. According to Palmer (2007), the experience of having eyes opened comes about when students are no longer startled by new experiences and can be receptive to learn new ideas. Ruth and Kenyon (2004) explain that it is impossible to learn about ageing by only studying “what it is to be old” (p. 3). Getting to know the perspective of an individual elder by listening to them is considerably more educational. Instead of learning abstractly about ageing, the listener is learning what it is like to be a person who is older.

Participants learned how individual elders’ lives were influenced by historical events and how they coped with daily life over the years. Learning the way elders have lived and perceived their lives is of “vital importance, not only as a means of exploring the ageing process, but also as a guideline for the delivery of care” (Ruth & Kenyon, 2004,
p. 2). This is relevant to nursing students given that learning the perspective of elders has the potential to positively impact the care they provide. The importance of knowing the perspective of elders is that nurses project their own feelings onto patients and “interpret the situation from the perspective of what it meant for them rather than from the perspective of what it meant for the patient” (Hallberg, 2001, p. 261). It is valuable for nurses and nursing students to hear from elders about new and different experiences but also to learn their perspectives in similar life situations.

For instance, Nora was excited to hear Mrs. Young’s perspective because some of the life events closely paralleled each other. She was fascinated to hear how their similar beginnings as newlyweds compared marrying at about the same age, 19 or 21. Nora was still early in her marriage while Mrs. Young explained how she dealt with the death of her husband after a long marriage. Nora felt that understanding the elder’s point of view brought them closer together.

Lena used the image of light again to describe this enlightened view and how she felt about Mrs. Park who was at the end of life. She described Mrs. Park as brilliant and said she lights up my day.

The transitions that took place were not limited to the participants. Both the participants and the elders were changed by the connections that took place in the light space. Participants noticed an impact on the elders as they listened to them tell their stories.

5.1.2.2 Changes in elders

Participants experienced a noticeable impact on the elders’ demeanour as they listened to the elders’ stories. Malia saw a positive change in her elder, Mrs. Kealoha:

When she talked about it [grandchildren] you could see her eyes light up, especially when she talked about the past.

This change was confirmed by Mrs. Kealoha’s family:

Even her granddaughter says she seems happier.
During some of the sadder and more emotional stories, participants noted changes that were largely positive. Emma noted that even though it was a downer to hear her elders talk about the recent deaths of family and friends, they were very happy she was there to talk to them. Nora’s elder shared a touching story about her husband before he died, yet her mood was joyful. Clare had vivid examples of how her elder’s demeanour changed while telling her stories:

You could just see the spark in her eyes, the pride brilliantly vibrating from her.  
She seemed so proud of who she was and why she did what she did.

Kanewai found listening to elders’ stories became a motivational experience for the elder. He applied his knowledge of elders’ psychological development of the need for elders to feel like that they were giving back to the next generation.

Kaleo recalled from gerontology nursing class that reminiscence was healthy for elders and then he saw a change in his homebound elder client as he reminisced and told his story. Kaleo saw how pleased the elder was keeping busy and talking about his life. Mr. Wilson appeared happier and he was able to feel energised.

Lena saw that talking story and remembering was good for Mrs. Hall’s husband because his wife was dying. Lena listened to him talk about their life together:

He talks about the things she used to do and how important she was in his life.

It appeared to be a cathartic experience for him. It also helped Lena imagine Mrs. Hall differently as a young woman after her husband provided another perspective.

Participants saw what it was like for elders as they established a relationship and a sense of connection with them. They also thought about what they saw and how they felt about spending time with elders. The next liminal space is the reflective space where thoughtful reflection took place.
5.1.3 Reflective space: Transformation

The reflective space represented an opportunity and a reason to reflect. The transcripts and narrative texts revealed a recurring theme of participant reflections throughout the experience of listening to elders. The liminality of the reflective space was that it was also a transition which remained as a reflective thought or was internalised or acted on with the potential for transformation.

Participants’ stories contained moments of reflection back and forth and throughout the experience of listening to elders’ stories. Reflection took place during the listening of the stories, in between episodes of the stories, after the story listening had concluded, and during the conversational interviews for this study. Some participants had also reflected on their experiences through classwork assignments that used reflective logs and journals.

As participants reflected on the experience of listening to elders and the stories they heard, they applied it to themselves personally and professionally to elders. The most striking and unexpected patterns of reflection were about grandparents. This was surprising because there were no questions asked of them in the interviews that mentioned or suggested grandparents or relatives. They were only asked about listening to the stories of elders without any specific context. Participants also reflected on the life lessons they gained when they thought about what the elders had told them. Their perceptions of elders were changed by the process of listening and reflecting on the experience. Ultimately the ongoing process of reflection transformed the participants in many ways. For example, Lily realised that she should have listened to her grandparents while they were alive and Kanewai found that his life was more meaningful.

5.1.3.1 Grandparents

The participants expressed a strong association with their grandparents when they listened to elders. Many recalled the stories they heard and the guidance they received. Reflections on these memories led participants to conclude that growing up close to their grandparents definitely shaped their views of elders. For example, Josh learned to
respect and cherish elders based on his grandparents’ stories of living through rough times. Kanewai felt close to his grandparents and was inspired by their stories:

To follow the outline of their life, not what they did but how they did it.

Some participants thought back to when their now deceased grandparents were alive and made connections with the elders they listened to. This experience caused Lily to rethink how she thought about her grandparents when they were alive. She realised that what she had once thought of as boring was no longer and it was the same as what the elders she knew now were telling her.

Malia also thought of her grandmother when she reflected on her experience listening to her elder’s stories:

So this is what I’ve been missing out, because my grandma died so young, and I was so young, I didn’t get to experience that ... you don’t realise what you have until it’s gone ...this is like giving back to my grandma.

Clare was fortunate to continue her close relationship with her grandmother into adulthood. For Clare the impact of listening to her stories was a very concrete one. After much reflection on her grandmother’s example, Clare learned from her to be strong, positive, and do what you love. At that moment she reevaluated her career path.

I began to see my life in retrospect and thought, well, I like doing this ...I want to make a life out of [nursing].

All of the participants shared life lessons they gleaned from the stories of their grandparents, other elders, or both.

5.1.3.2 Life Lessons

As participants reflected on the stories of elders they compared them to their own lives and found lessons that they applied to their own circumstances. Many of them concluded that life was harder in the past and that they should appreciate what they had.
Others explained how some stories made them realise that challenges made you stronger, life was not easy but you could still be happy, and to live life to the fullest.

Participants also learned from elders that each life is filled with stories that can shape their lives. The participants were changed when their perceptions of elders became transformed by the experience.

5.1.3.2.1 Life is a story

Kanewai reflected on the lessons he learned about life from listening to elders’ stories. He said *good stories* gave him something to live up to and made his life more meaningful. Kanewai described his life to be a book of stories. He said, *Everything I do is a story.* He did not want his life to be a *boring read.* Listening to good stories made him want to have stories like that to tell. He wanted his life to be full of memorable stories of doing things well like some of the elders he met.

Nora used the metaphor of reading a book to describe the lesson she learned from Mrs. Young. She learned not to prejudge or assume anything about an elder.

> You can’t judge a book by its cover. Until you have read it and realised the context and the deep things inside of it, that’s when you know it is a good book.

Participants reflected on assumptions they held before and after the experience of listening to elders. Most noteworthy was the transformation of their perceptions of elders that took place.

5.1.3.3 Perceptions of elders transformed

Other reflections of the participants elaborated on the differences between their prior beliefs and perceptions of elders when they compared them to their experiences. Julia, Kira and Lena discovered that many of their preconceptions had been incorrect and labelled them as myths and stereotypes. The process of listening to stories transformed their views of ageing and elders.
For example, Kira recognised the myths she had held when she saw how active Mrs. Silva was in her day-to-day life. She concluded that elders are stronger than they may appear. Julia previously thought of most elders as weak, inactive, and depressed. When she got to know Mrs. Chang she was amazed at her happy attitude and strength.

I did have some stereotypes and stuff like that. But then when I met her everything ... was proven wrong ... She’s so active.

After interacting with elders and hearing their stories, many of the participants described having a new mindset and declared that their elders had become their role models. Instead of picturing elders stereotypically they envisioned successful ageing to be the norm. They now wanted to live long lives that were as fulfilling as their elders’. After they learned how their elders lived, Emma and Ana were inspired to live healthier lives by taking better care of themselves.

Lena also developed a new mindset. It was a transformation that she attributed to self-reflection and the journaling required for her clinical courses. Lena thought back to her feelings before she listened to elders:

If I go too close to them, I’m going to catch something. How do you relate to this old skeleton with some skin on it?

Instead she encountered elders who were interesting and optimistic, concluding that everything she had believed about elders was a myth. She realised that older people were being misunderstood and mistreated. Lena believed that the root of the problem was not listening to elders. Her reflections and those of other participants continued after the experience of listening to stories and continued during the conversational interview process.

5.1.3.4 Reflections on reflections

In some cases participants reflected and compared reflections as they shared their story. For example, as Emma related her experience listening to her grandmother’s story she recalled an elder she had cared for as a nursing student. She compared the two stories of
her grandmother’s love for her grandfather and the elder’s love for her husband. Both stories made her appreciate the precious nature of relationships in a person’s life. As Emma’s account continued to unfold it was as if she had became a part of her elder’s life story. Emma realised her elder’s separation from her husband on the dementia care unit only exacerbated her loneliness, so Emma took her in a wheelchair for a visit. The value and timeliness of Emma’s actions were reinforced by what she observed. She saw the love they shared even in illness.

*It was so sad yet precious and very touching.*

During the interview Emma continued to reflect on these two different women and came up with a new understanding of the experience. They taught her that it was possible to *sustain a relationship for a long time* and still, even when you are old, care about someone deeply or *more profoundly deeper* than ever before. Emma learned not to take relationships for granted. This lesson became important to her as Emma nurtured relationships in her own life.

The liminality of the reflective space theme is fluid and continuous. For many of the participants their reflections, the stories they heard, or the connections they made sparked a desire to make a difference in the care of elders. The fourth liminal space is the caring space.

### 5.1.4 Caring space: Renewed vision

In the caring space the participants assumed their new perspectives and created a renewed vision of care. They decided how they wanted to provide care to elders as nursing students and as registered nurses. The liminality of the caring space came about when they compared their own experiences with the care they gave in the past or the care they witnessed in practice. It was a transitional space that addressed the impact of the experience on the students’ nursing practice and answered the implied question, ‘what are you going to do now?’

As outlined by Freshwater (2008), the final state of reflection leads to action. The participants had concrete examples of how listening to elders made them more caring
along with ideas for future elders in their care. The motivation of participants to be proactive with the care of elders reflected the change in their attitudes toward elders. Discovering that the myths they had believed were not true-to-life constituted a large part of their commitment to make change. Most valuable of all was the realisation that they could connect and relate to elders. Affective learning such as this has been recognised as essential to becoming a caring nurse (Zimmerman & Philips, 2000). Experiencing a positive relationship with an elder not only taught participants how to listen, but it also taught them how to get to know an elder. They learned the meaning of the choices elders made and the reasoning behind them. The participants got to know them personally, each with their own unique personality. This experience validated the position of nurse educators endeavouring to help students distinguish elders as individuals rather than as a homogenous group (Clarke et al., 2003; Freshwater & Stickley, 2004; Gething et al., 2002; Pacquiao, 2008).

5.1.4.1 Like their grandparents

The common theme of grandparents surfaced again as participants spoke about how they cared for elders now. Clare, Emma, Jon, Josh, Kanewai, and Nalani grew up from childhood in a close relationship with their grandparents and valued how that made a difference in their care. They felt connected to their elder patients and cared for them as if they were their own grandparents or someone else’s grandparent.

For Nalani, this new perspective came about after a life-changing experience with her grandmother. She learned firsthand what it was like when an elder entered the healthcare system. Nalani’s grandmother’s health took a sudden rapid decline. When Nalani took her for medical care the healthcare workers did not take the time to listen or to explain to her grandmother. As her health continued to deteriorate, her grandmother went from being self-sufficient to dependent and confused. Finally she was diagnosed with an electrolyte imbalance, treated, and returned to good health. Through the eyes of her grandmother Nalani saw how elders were treated and mistreated. Now she feels connected to elders through her grandmother’s experience and treats other elders as if they’re somebody’s grandmother.
Taking the extra time to listen to elders was a common theme as the participants thought about how to make a positive difference as a nurse.

5.1.4.2 Taking time

Just as participants identified lack of time as a challenge for them to listen to elder’s stories, they consistently identified time as what was lacking in the care of elders overall. The idea of having enough time relates to the temporality of experience which is continuous in nature as it spans the past, present and the future. Hoy (2009) contends that we never have enough time because the present is fleeting. The present can only be experienced in hindsight by looking at the past and looking toward the future. By reconsidering their past experiences the participants were determined to find time for elders in the future. Hoy (2009) explains that time can only arise out of the future but the way we choose to use our time comes from the past.

They observed lack of time to work with elders, to support their relationships, but most of all, like Nalani, it was lack of time to listen. The participants recounted ways in which they were being proactive to make the time and to take the time when they cared for elders.

For Emma, taking time meant being sensitive and aware of the emotional needs of elder patients. This was in contrast to the way she had observed nurses provide care:

*I think a lot of times nurses I’ve noticed get so wrapped up in skills and things they have to do for the patient. It seems like the importance of relationships and communicating with one another gets lost.*

The participants directly linked the importance of meeting the needs of elders to listening. Listening to elders was valued not only as a positive experience to hear stories but also as a way to provide meaningful nursing care.

5.1.4.2.1 Listening as a modality of care

Listening was understood by the participants as an essential modality of care. They were convinced that listening was critical to effective assessment and a caring presence.
Lena’s experiences led to her passion about taking the time to listen. She described why she shifted from being task oriented to finding out the context and the needs of elder patients. Lena explained why listening is essential for the assessment of elders.

*When you don’t understand the nuances about speed, you may miss some very critical patient findings that will make you the cause of their early demise.*

The value of listening was multifaceted. Listening helped participants understand elders’ needs and health conditions, as Lena pointed out. In addition, taking the time to listen to elders was a therapeutic and caring act on the part of the nurse. This meant listening to their stories, listening to their ideas and listening to their needs. Clare and Lily both commented on how desperately elders wanted to be listened to so they could tell their stories. They concurred that listening to stories would be part of their care even though they did not observe it being practised by others in clinical settings.

Lucky discussed how she had incorporated what she learned about reminiscence when working with care centre residents who had Alzheimer’s disease. Lucky was motivated to try reminiscence after she listened to Mrs. Tanaka’s story as a child going to school and throwing an eraser at her teacher before she jumped out a window to escape going to school. This encounter led Lucky to wonder if other residents had interesting stories to tell, too. So Lucky initiated a time of reminiscence when the residents were gathered together. They started interacting with each other, and then shared their stories and asked each other questions. Lucky sensed that it benefitted the residents and helped them to have a sense of pride in themselves. She was convinced it was a very successful activity and has been informally leading reminiscence activities ever since.

Lucky was confident that reminiscence along with her attentive listening helped develop rapport and trust with elders. She said:

*When somebody tells you their story and you’re listening, you’re interacting.*

*They cannot remember my name, but they remember this person.*

It was evident to Lucky that the elders, even when confused, became noticeably more cooperative and less agitated during their care.
Establishing trust and building rapport are essential to nursing care. Participants also identified collaboration as key to working with elders.

5.1.4.2.2 Collaboration

Several participants linked listening to elder patients with collaboration when providing patient care. Josh said that listening was a way he showed respect to elders. It also made him more compassionate toward them because he understood the elder patients better and could more easily catch their cues. His approach to working with elders was:

*I always try to collaborate and try to catch their cues.*

Julia also applied what she learned when she collaborated with her elder patient. She discovered the stereotype of inevitable dependency by listening to Mrs. Johnson. She told Julia that she would try to talk to the nurses but *they don’t want to listen to me.* People treated her as if she did not exist and would perform tasks for her she was able to do herself. Julia said she was determined to treat her as an individual not according to a stereotype. Her visions of care for elders had been transformed.

Just as Julia applied what she had learned to a specific elder patient exchange, other participants began to value what they had learned and applied it to future situations.

5.1.4.3 Caring in the future

In addition to considering the care of others, participants also speculated what it would be like for them as they age in the future. Lena no longer feared getting older but had a lingering fear of how she will be treated as she aged. This concern has strongly motivated her and other participants to work to improve providing nursing care to elders. Many of their suggestions reiterated what they had learned in their gerontology nursing courses and their experiences with elders. Their experiences reinforced the positive uses of *touch, eye contact, reminiscence, self-reflection, involving elders* in their own care, promoting *independence, talking* to elders *one-on-one,* and interacting with elders who were the most *isolated.* They felt that most importantly of all that listening was paramount.
Kaleo and Lena both hoped that they will be listened to when they are elders. Along with many other participants they clearly stated that they believed the time taken to listen to elders in nursing school was beneficial to their education and should be continued as part of the program. Clare was convinced that if nursing students listen to elders’ stories it would *dissipate and wash away their biases and judgemental attitudes* toward elders.

The mindset of the nurse plays a significant role in influencing the way elders are treated and care is provided (Polaschek, 1998). Clare proposed that listening to elders helped nursing students overcome attitudes that are stereotypical and judgemental. Listening was one of several of the participants’ suggestions for nursing care that supports the guiding principles of cultural safety (Richardson, 2010). Another idea was self-reflection which helps the nurse to challenge preconceived ideas and assumptions (McEldowney et al., 2006; Richardson, 2010). One more suggestion to involve elders in their care acknowledges the elder’s perspective (Richardson, 2010). This shifts the power to the patient and relinquishes the idea that the nurse knows what is best for the elder. These recommendations for caring indicate that the participants are capable of making a positive impact on the future of providing care to elders.

### 5.2 Summary of the chapter

The liminal spaces of story, light, reflection and caring represented the themes that were identified in the stories of the participants. Each of these liminal spaces reflected the accounts of the participants as they told their stories and explained the meaning of their experiences. The liminal spaces also consisted of the learning that took place for the participants. Learning was ongoing making it a constant state of transition. Each of the liminal spaces - story space, light space, reflective space, and caring space involved the liminality of learning and listening to stories. These themes represent the meaning of the experiences the participants shared in their stories.

It was unexpected that the participants reflected on their childhood and adulthood experiences with their grandparents when they were interviewed about listening to
elders. They had not been asked about grandparents, only about elders in general. Participants believed the stories and life lessons they learned from their grandparents and elders were valuable for them as nursing students. Reflection on their experiences led them to the realisation that their attitudes and beliefs about elders were changed. As a result of hearing new stories, feeling connected to elders and changed attitudes, the participants created new visions of the care they want to provide to elders. A section from the narrative text of Kaleo’s story summarised the transitions that the participants experienced:

As he talked about his experiences listening to elders he described an ongoing cycle of learning to listen, listening to learn, and applying what he learned by listening to and providing care to the next client.

In the next chapter (Chapter Six) I discuss four key findings that have resulted from the thematic analysis and interpretation of the participants’ stories and narrative texts.
Chapter Six  Discussion of findings

This study explored the experiences of nursing students who listened to elders tell their stories and shows how the experience of listening affected their thinking and practice. The thematic analysis and interpretation of the participants’ stories revealed the meaning and impact of the experiences on the participants. Key findings are discussed related to relevant literature and my own personal insights as a nurse faculty member teaching gerontology nursing within a BSN program in the US.

Listening to elders’ stories was a dynamic process for the participants as their feelings and responses changed over time. It was a positive experience that elicited interesting stories, laughter and strong emotions as they moved through the liminal spaces of transition that led to transformation. In addition, four key findings indicated that participants developed close relationships with elders, dispelled myths and stereotypes of ageing, shaped their personal lives, and became committed to improve the nursing care of elders. Each of these key findings revealed ways in which the participants and their views were transformed by their experiences.

6.1 Close relationships with elders

Participants did not anticipate developing close relationships with elders. In fact, Julia and Kira expressed nervousness about meeting elders and Lena stated outright that she was afraid of being near them. As they listened to elders’ stories they found that trust was established and relationships were created.

The foundation for initiating a relationship was laid when participants got to know some of the elders for the first time with talk story. For those who lived in Hawai‘i for a long period of time it was a natural way of speaking to ask each other questions and affirm that they had something in common through a mutual experience (Ka‘opua, 2008). For Hawaiian elders, “talk story helps to open the door” to build a relationship with health providers (Davis, 2010, p. 242). Participants such as Kira introduced the components of a mutual and reciprocal relationship at the start by shifting the control of the conversation to the elder. A level of trust was also introduced by acknowledging the
elders with respect through active listening. As discussed in Chapter Five, when participants were immersed in the storylistening trance, they had a glimpse of what it was like to feel connected to the elder telling the story. Listening to and graciously receiving advice communicated value toward the elders as well as what was being shared. Together each of these experiences created the possibility for a deeper relationship to come.

Many of the characteristics of these experiences with elders were previously identified in Chapter Three (refer Figure 1) as key to promoting relationship. In their stories participants made reference to many of the same characteristics such as mutuality, respect, caring, empathy, control, and listening. They identified additional characteristics from their experiences that helped to build relationships with elders which included having an open heart, trust, closeness, building rapport, connectedness, compassion, intimacy, and feeling a bond.

Participants described having the heart to truly listen to elders and how it enabled them to experience relationships of trust and closeness. In professional nursing practice listening is the basis for all meaningful relationships (Jonas-Simpson et al., 2006). Browning and Waite (2010) recognised that for the nurse to open her heart and be fully present “it takes courage” (p. 151). As the participants continued to listen to elders, trust resulted as a natural consequence of the rapport that had been established when they first began to listen (Belcher, 2009). Hunter (2006) explained that listening to stories with an open heart was perceived as caring by the story teller and when accompanied by active listening it promoted a relationship between the nurse and the story teller.

Participants expressed feeling an even greater closeness and connection when they listened to stories elders had not told others or stories that evoked emotion. When elders shared extremely personal and intimate details of their lives it was a humbling experience for the participants and they felt honoured and privileged to be included in the elder’s life. Sorrell (2000) proposed that, “stories help to create a shared world between nursing students and their patients” (p. 38).
For the participants, it was not the story that brought them to this deeper level of connection but the shared experience of having established trust that enabled the elder to disclose such personal and intimate moments in their life. This experience is supported by Haight (2001) who said that the sharing of life stories as acts of intimacy and caring allows nurses and patients, or elders, to forge connections with each other. Listening to emotional stories also develops empathy in the nurse along with an awareness of the story teller as an individual. Todd (2003b) added that as a relationship develops sustained trust is maintained not by the content of what is being said but by the closeness that comes about when the listener shows regard for the teller and is attentive to them as an individual.

The experiences of the participants included interaction and dialogue with elders which also served to change the balance of power in the relationship. According to Bergum (2003), when nurses engage in relationships of listening and dialogue the power imbalance found in professional relationships changes; “power loses its power” (p. 126). Todd (2003b) described this as part of the inherent asymmetry of relation as the voice of the speaker takes primacy. For example when Clare resisted the temptation to interject comments during her elder’s stories, she relinquished her power and it shifted toward the elder. Canales (2000) posits that power can be destructive to a relationship when it is exclusionary or beneficial when inclusionary. Exclusionary power dominates and oppresses, while inclusionary power is shared power. Inclusionary power can be used in a positive way within the relationship which “is an essential component for developing mutually empowering relationships between nurses and clients” (Canales, 2000, p. 28). With inclusionary power the nurse is in a position to “see the world from the other’s perspective” (Canales, 2000, p. 25).

The transition that each participant experienced with elders was similar to Buber’s concept of relationship. He believed the nature of relation with others is in a constant state of flux moving back and forth between the attitude of I-It and I-Thou (Buber, 1970). He used the imagery of a narrow ridge to represent the space of the in-between where the I and the Thou meet (Buber, 1965). When two people have the attitude of I-
Thou, they confirm the value of each other’s existence by being wholly present and thus create relationship.

As the participants began in the position of I-It they were listening to an interesting story and the story was central to the experience. Listening is indeed the starting point. Buber (1965) recognised that listening was vital to the formation of a mutual relationship of openness and dialogue. When the act of listening and the establishment of rapport began for the participant and the elder, dialogue transpired and the transition moved closer to I-Thou. As the elder trusted the participant the stories they shared were more personal. The participant was let into the elder’s world and reciprocally the participant let the elder into their world. It was a simultaneous act of encounter, a relationship of I-Thou. The I-Thou relationship enabled the participants to understand life from the perspective of an elder.

Feeling connected to elders made the participants feel more comfortable with them. To hear wonderful stories, to be part of a mutually close relationship with elders, and to learn firsthand what life was like for them affected the participants deeply. These encounters helped participants to enjoy elders as individuals rather than as members of a homogenous group. As discussed in Chapter Two, nursing authors recognised getting to know elders as individuals as vital to gerontology nursing education (Clarke et al., 2003). For the participants to have so easily, and for many, in a short period of time, been able to develop relationships with elders increases the likelihood of future encounters culminating in relationships that highlight the uniqueness of individual elders.

### 6.2 Transforming attitudes

Getting to know elders as individuals together with opportunities to reflect on experiences contributed to the attitudinal changes of the participants. Critical reflection played a central role in the attitude shifts that included the dispelling of myths and stereotypes of elders and ageing. The relevance of reflection is discussed to provide a context to the changes that took place.
As nursing students, the participants were familiar with reflection and reflective practice. Reflection was introduced to them early on in their nursing program as part of professional practice (ANA, 2010a). When nurses or nursing students reflect on experiences they compare them to past experiences and knowledge that they have already acquired. In other words, reflection is a way to integrate what is already known with new situations. The participants’ experiences of reflection directly corresponded to stages of reflective practice (Freshwater, 2008). The participants experienced surprise when they were drawn in and interested by the elders’ stories. Next they were open to new information that could be gained by reflecting and analysing the situations. And finally they developed new perspectives which provided continuity to what they learned in the past, the present and with potential for how they would act as nurses in the future.

The nature of being in a state of transition such as reflection holds within it an “inherent opposition to the dominant views of society” (Froggatt, 1997, p. 125) and the potential to “challenge oppression” and “throw off dominant ideologies” (Freshwater, 2005, p. 186). As previously discussed in Chapter Two, it is clear that nursing students believed and acted in accordance with many of the dominant views of society that view ageing according to false myths and stereotypes. However, after the experience of listening to the stories of elders, many of the participants’ well-established ageist views were transformed.

Several of the participants reflected with great depth and critically assessed the circumstances that contributed to their misconceptions. Critical reflection addresses not only the biases and assumptions that are held, but how they are perpetuated by issues of power and authority within the circumstances of the relationship (Brookfield, 2009; Esterhuizen & Freshwater, 2008). The specific changes that occurred with critical reflection were the result of a dynamic process in which the participants created a reflective space “within which to view their espoused theories, beliefs and values alongside their theories in action with the intent of uncovering contradictions” (Esterhuizen & Freshwater, 2008, p. 8.)
According to Angus and Reeve (2006), it is not easy to overturn rigid and embedded attitudes of ageism. Ageist attitudes and beliefs play a key role in asserting power over the way in which elders are viewed and treated. When the reality of one’s experience does not match the underlying assumptions that are held there is dissonance or a disorienting dilemma (Mezirow, 1991). Stolder, Hydo, Zorn, and Bottoms (2007) refer to feelings of dissonance as painful when upon reflection one’s own views seem fraudulent. Dissonance often leads to pivotal or liminal moments within nursing education that promote transformational change and learning (Faulk & Morris, 2010; Mezirow, 1991, 2000).

Listening to the stories of elders and getting to know them was transformational for the participants. Their perceptions of elders were dramatically changed. They saw for themselves that all elders were not dependent, weak, slow or confused. Instead the participants found themselves looking for opportunities to fit in to busy schedules of elders who were independent, strong, fast, and alert.

According to Taylor (2009), critical thinking refers to “questioning the integrity of deeply held assumptions and beliefs based on prior experience” (p. 7). All of the participants had prior experiences with totally dependent elders in a long-term care setting. For many of them, these experiences reinforced negative ageist assumptions and beliefs. The critical element of reflection and transformation was most evident in the stories of Lena and Julia. As part of their transformation they recognised the powers that continued to reinforce ageism. Lena described feeling apprehensive and afraid of providing care to elders assuming that they were all deaf and senile. Lena described her transformation by first analysing the source of her previously held misconceptions about elders as a result of images and prejudices perpetuated by society and the media. She had a startling revelation that, everything reaffirms that most everything I thought about elders was a myth. Then she recalled her experience in her gerontology nursing class listening to stories and her realisation that she had changed. Lena described an awful burden she had been carrying around by believing the myths and stereotypes of ageing.
When Lena listened to elders’ *amazing* and *remarkable* stories, she encountered a disorienting dilemma (Mezirow, 1991). The dissonant incongruity of Lena’s experience transformed her fear of ageing and the aged into a passion for listening to and caring about elders. As her fear of ageing lessened, her ability to communicate successfully with elders grew (Tabloski, 2010). Her description of her transformation was a clear contrast to her past *dark ages in a stupid dark cave:*

*That’s the best thing to happen to me, is to not fear ageing. If they have something to look forward to then so do I. They can’t be all wrong.*

Julia also identified her previously held assumptions about ageing as untrue. The effect of her transformation was that she defied the external authority in the healthcare setting that was imposing dependency for one of her elder patients. Julia deliberately ignored the nursing order on the chart. Julia was determined to make the elder the priority rather than the assigned task at hand. Her critical reflection caused her to “call into question the power relationships that allow or promote, one set of practices considered to be technically effective” (Brookfield, 2009, p. 126). Instead of abiding by the authority of the patient’s care plan to feed the elder patient, she made a new plan. Julia did not want to be *blinded* by stereotypes, but instead treated her as an individual. Julia’s transformation and conviction to do what was best is an exemplar of the consequence of critical reflection.

The transformations that took place for the participants were epiphanal moments for them. These were turning points in the way they perceived themselves as nursing students and the way they perceived elders. When the participants reinterpreted their previous beliefs and experiences in light of what they had learned from elders and their stories, they began to think like a gerontology nurse. The realisation that the myths and stereotypes they believed were incorrect and detrimental to the care of elders is a threshold concept. It is a core concept that is integral to working with elders. Threshold concepts come from liminal spaces and are “akin to a portal opening up a new and previously inaccessible way of thinking about something. It represents a transformed way of understanding or interpreting, or viewing something without which the learner
cannot progress” (Meyer & Land, 2003, p. 1). The learner of the threshold concept was in a state of transition from the time they were exposed to the concept until it was acquired (Schwartzman, 2010). During this period of time the learner wavers between their old and new ways of thinking (Meyer & Land, 2005). For example Lena and Julia probably learned about normal ageing changes and stereotypes of ageing from gerontology nursing course content. However, they may not have fully understood the impact and relevance to nursing practice until they listened to the stories of elders and had the opportunity to critically reflect on the experience.

Dispelling myths and stereotypes not only disarms ageism but also reinforces the image of elders as distinct individuals. Participants learned firsthand from elders that they were not the stereotypes that they had imagined. The elders’ strength of character as well as physical abilities eliminated many of the stereotypical labels the participants had previously applied to elders. The importance of reducing ageism has been discussed in Chapter Two as valuable to the promotion of health and quality patient care to elders. Furthermore, the participants’ experiences transformed them and gave integrity to the elders’ voices. The value and integrity of the elders’ voices and lives shaped the participants’ personal views and life choices.

6.3 Shaping participants’ lives

The perception of elders as having worth and value in the way they led their lives and the stories they told influenced the participants. The elders’ stories shaped the lives of the participants by guiding the decisions they made, the way they perceived meaning in life, and by providing examples of lives that were active and fulfilled. This finding, although beyond the intent of the research, demonstrated that listening to elders had other far-reaching impact on the participants.

Most of the stories told by elders communicated a high quality of life to the participants. As the participants saw that healthy ageing was a possibility they began to think about and imagine how they wanted their own lives to unfold. Clare, Emma, Kaleo and Lena wanted to be physically healthy and socially active, and to be listened to as they got
older. Ana, Clare, Emma and Kira specifically identified their grandmothers or their senior companions as their role models for ageing. The participants listened to stories of lives and struggles and hardships yet they were lives that were satisfying and fulfilled.

The participants were inspired by the lives elders led and the way they adapted to the happy events of falling in love and having grandchildren as well as the horrors of war and the sadness of death. Clare changed her career path to nursing after listening to her grandmother’s stories and learning the value of loving what you do because life is short. Ana also recognised the value of a life that was meaningful and without regret when even Mrs. Costa, who was terminally ill, conveyed that her life was complete.

On a more practical note, Kaleo felt he was experiencing history through Mr. Wilson that he wanted to share with his children. Ana, Clare and Emma were inspired to live healthier lives based on the active examples of elders and the impact of illness on the quality of their lives. As a result, participants became motivated to make positive changes in their own lives as well as the lives of elders.

6.4 Commitment to providing nursing care to elders

Listening to stories of elders was instrumental in motivating the participants to shift from a stereotypically driven expert gaze to a commitment to provide nursing care that focused on elders as individuals. Participants developed new strategies of care with elders, began to care about their own ageing, and created ideas for educating nursing students to provide nursing care to elders. Their strategies, ideas and actions demonstrated ways to work with elders that was culturally safe.

Participants identified taking time, listening, and collaboration as the key elements of providing care to elders. Clare, Emma, Josh, Julia, Lena, Lily, Lucky, and Nalani observed nurses and their peers as task-oriented and with a lack of time for elders. Unfortunately a lack of time for nurses to listen attentively to elders has become commonplace in the delivery of healthcare (Baillie & Gallagher, 2008; Beckett, Gilbertson, & Greenwood, 2007; Browning & Waite, 2010; Jonas-Simpson et al., 2006; McCabe, 2004; Richardson & MacGibbon, 2010). Browning and Waite (2010)
concurred saying that nurses cannot be caring when they are preoccupied with tasks and “trying to listen while at the same time assessing and framing a reply…One cannot do all these at the same time and pay attention to someone in need” (p. 151). Pressure from management for nurses to perform faster to meet target goals with less staff has contributed to a lack of time available to spend with each patient (Baillie & Gallagher, 2008). Another explanation came from a study of nurses’ attitudes toward elders which indicated that when nurses did not have time for elders it was often because they left their care to last. They were acting on their negative attitudes to wield their authority and marginalise elders (Higgins et al., 2007). As a result of participants’ observations and experiences, they resolved to make taking the time to listen to elders a priority. Taking time made it possible to listen attentively in a way that was meaningful.

The positive responses that participants experienced when they listened to elders and shared stories in dialogue reinforced that it was well worth the time. Kaleo was convinced that the advantages of reminiscence far out weighed the time that was required. For Malia, the changes she saw in her senior companion when they talked story and reminisced were confirmed by the elder’s family. The elder’s encouraging response made the time Malia spent with her even more worthwhile.

The participants were convinced that elders were having fun, benefitting and teaching them at the same time. These positive responses confirmed what they had learned about reminiscence contributing to the health and wellbeing of elders. All of these perceptions strengthened their desire to take time to listen.

Listening to elders and acknowledging them as individuals underscored the ability of elders to not only make their own choices but to actually direct how they want to orchestrate their lives. Participants gave wonderful examples of how they collaborated with elder patients. The caring relationship focused on ‘being with’ rather than ‘doing for’ (Hanson & Taylor, 2000; Strickland, 1996). Taking time to partner with elders in planning care made it easier and more rewarding for both the elder and the nursing student. Angus and Reeve (2006) made a similar distinction between advising and deciding for elders. For only the elders “can judge whether a particular plan of action is
acceptable” (p. 149). As Josh summed up the need to hear the voice of elders and to give them choice:

You have to listen to them. It’s their body you are taking care of and they know it best.

Nalani’s experience with her grandmother taught her what it was like when an elder was not listened to by healthcare providers as her health worsened before it got better. This experience created within Nalani a compassionate determination to make sure that her elder patients do not have such a negative experience as her grandmother had. Her plan of care now included listening to elders and giving them the chance to have their voices heard. It is disheartening that elders continue to be treated as unintelligent and unimportant (Cann & Dean, 2009). Disregarding elders is also an ethical issue when it comes to circumstances of patient’s rights and informed consent (Wright, 2007). Emma related an experience when she found out that one of her elder patients had died. She was rightfully bothered when she was informed that members of the healthcare team did not listen to her elder’s last request:

I was really upset and my teacher told me it was not a good death. They had tried to resuscitate her when she was a DNR (Do not resuscitate).

Ludwick and Silva (2003) assert that nurses do not respect and support the dying wishes of elders when they do not first examine their own biases toward elders. Otherwise such as in this predicament, they can find themselves in violation of the Code of Ethics provision for patient self-determination (Ludwick & Silva, 2003; Fowler, 2008). This and other participant examples showed that taking time to listen had important benefits for them as well as significantly impacting the quality of life for elders.

6.4.1 Learning to care with elders

Kaleo and Lena were motivated by their experiences with elders to think about the future of nursing education. They had a personal concern about how they will be treated when they became elders someday. Knowing what they knew now, they made it clear that each of them planned to take time to listen. They will encourage elders to tell their
stories because it is good for elders, but also because they as caregivers also benefitted as recipients of the life lessons shared by elders. The participants shared multiple examples of how listening to elders through dialogue was a mutually beneficial activity. They made a point of saying they hoped that nurses will listen to them when they are in need of care as an elder.

Their newfound interest in how nurses treat elders and how it impacts them personally helped them form recommendations for nursing education. All of them agreed that listening to the stories of elders should be continued as part of the nursing curriculum. Emma had the same opinion but suggested that listening to elders should take place in long-term care facilities where elders are isolated and the need is greatest. Her recommendation was deeply felt and expressed great compassion. However, even though elders benefit from being listened to, the primary intent of the activity was to learn about ageing and educate the nursing student in the best way possible to challenge ageist stereotypes.

This study has shown that active, healthy and articulate elders have a positive impact on nursing students. Many of the participants commented that their first clinical course in long-term care facilities did not make them feel comfortable around elders and that it perpetuated negative stereotypes of ageing. Lily’s image of elders from her nursing home experience was not a positive one compared to her experience with an active, healthy elder. She came away from that experiencing wanting nothing to do with eldercare.

As mentioned in Chapter Two, nursing literature showed that nursing students’ negative views of ageing did not improve in nursing home settings and that positive experiences with healthy elders were recommended before working with more complex and frail elders (Aud et al., 2006; Henderson et al., 2008; Parchment, 2002; Rowland & Shoemake, 1995; Thornlow et al., 2006).

Currently there are two schools of thought on the use of long-term care facilities as clinical sites to teach about ageing and the nursing care of elders. The geriatric nursing
approach focuses on age-related changes, geriatric syndromes and assessment, with an emphasis on hospitalised and institutionalised elders. Many of the Nursing Improving Care for HealthSystem Elders (NICHE) hospitals and long-term care facilities that implement cutting edge nursing interventions with elders are recognised to be the highest calibre training sites for this approach (Boltz et al, 2008). The other approach to nursing education is gerontology nursing which is based on a holistic wellness approach to ageing with a psychosocial, physical and sociological point of emphasis on more active elder experiences. Both approaches are concerned with and address the issues of ageism and elders.

The content in the nursing program at the university where the students studied is a blend of the two, emphasising a wellness approach along with content on normal age-related changes, the conditions most common with age, and atypical presentations of disease. As mentioned in Chapter One, at this university gerontology nursing students were previously removed from gerontology nursing clinical assignments in long-term care sites. This was done in an attempt to counter the negative views of ageing perpetuated by their exposure only to dependent elders in their Level 1 clinical course. In its place they were introduced to community based clinical experiences which included contact with independent, active and cognitively intact elders. Listening to elders in long-term care facilities provides opportunities for students to learn about chronic illness and institutionalised care more than about ageing.

Kaleo recommended a change in admission requirements to nursing school. His position was that his experience as a nursing assistant provided him an opportunity to get to know elders. He also mentioned that from a young age he was exposed to elders with varying levels of function as they were cared for in his home by his mother which shaped his perspective. Kaleo suggested that if all nursing students were nursing assistants prior to nursing school they would be more comfortable with elders. In my mind this idea also has merit. Those with nursing assistant experience would be familiar with basic nursing skills and exposure to elders. Kaleo’s idea was supported by a study conducted in South Australia. Henderson et al. (2008) surveyed over 250 beginning
nursing students to determine their attitudes toward elders and working with them. Prior to the first day of classes, students ranked areas of preference for nursing practice and rated disagreement and agreement with attitudinal statements about elders and ageing. Those nursing students who had previously worked caring for elders had more positive attitudes toward elders. In contrast, Happell (2002) surveyed nursing students at the beginning and end of their nursing programs and found that working in nursing homes or other aged care settings negatively influence their attitudes toward elders. In my experience many nursing students who were nursing assistants were more comfortable with elders but held strong beliefs that ageing unavoidably resulted in dependency. It was necessary to emphasise to those students that it was worth their effort to work to prevent illness or dependency because it would help achieve an active and long life rather than inevitable dependency.

The final participant recommendation was made by Lena regarding the process of learning. She was adamant that reflective journaling required for her clinical courses helped transform her from being afraid of elders to embracing them. Lena’s comments reinforced what was currently being done in the nursing program (e.g. critical incident reports, reflective logs, journals) and countered the end of course comments made by other nursing students that reflective writings felt like busy work. She described why she thought nursing student’ learning would be enhanced if they did more self-reflective journaling of their experiences with elders. Lena explained how journaling enables nursing students to reflect on their lived experience and inform their practice through the narrative that is created (Blake, 2005).

The importance Lena placed on journaling was supported by the nursing standard of reflective practice (AACN, 2008; ANA, 2010; Australian Nursing and Midwifery Council, 2005; Canadian Nurses Association, 2008; Nursing Council of New Zealand, [NCNZ], 2009a; Nursing and Midwifery Council, 2008). The other recommendations participants made such as listening, collaboration, attention to their own health, and the improvement of care of elders directly corresponded with the competencies that are essential for a professional nurse (AACN, 2008; ANA, 2010a; Australian Nursing and
Midwifery Council, 2005; Canadian Nurses Association, 2010; NCNZ, 2009a; Fowler, 2008; Nursing and Midwifery Council, 2008). Participants recognised that listening was key to caring and collaborating with elders. Listening, however, was noticeably absent from the American Nurses Association’s (2001) gerontological nursing standards. Without listening it would be difficult for collaboration to take place. It is encouraging to note that listening has been recently recognised as essential to healing and effectiveness as a gerontological nurse now that it is included in the most recent edition of the gerontological nursing standards (ANA, 2010b).

The determination and commitment of the participants to make a difference for elders in the way they cared for them came from a sense of conscientiousness and rightfulness. Todd (2003b) explains in the context of listening that once a listener has engaged with another and heard their concerns or sufferings, the listener is in a position of ethical obligation to respond. For example, Mrs. Johnson told Julia that the nurses don’t want to listen to me. Julia responded rightfully by asking her what she wanted to tell them.

Emma gave an example of being conscientious and caring based on what she heard from Mrs. Kim who told her that she had not spent time with her husband on a nearby floor because the nurses were too busy. Emma responded responsibly by getting permission and taking Mrs. Kim to visit her husband. Emma responded to Mrs. Kim’s feelings of separation when she brought them together.

As a nurse, “practising care is a moral imperative, which puts the perspectives of the clients above service values” (McEldowney & Connor, 2011). This was one of the lessons that participants learned from the elders and their stories. As Lena concluded, providing care to elders in the context of who they are and listening to them was the way to be a good nurse.

Providing care to a patient in the context of who they are can be enhanced by incorporating the concept of cultural safety. Throughout the participants’ experiences there were many examples of how learning the context of the elders constituted interactions that were potentially culturally safe.
6.4.2 Culturally safe care

The ideals of care that the participants espoused for elders strongly resembled culturally safe care. They described encounters that represented the principles of cultural safety such as a shift in the balance of power, protection, participation, and partnership. The participants provided good examples of how cultural safety can be applied to the care of elders.

One of the first steps for nurses to become culturally safe calls for examining one’s “own beliefs, values and assumptions about other people” (McEldowney & Connor, 2011; NCNZ, 2009b; Papps & Ramsden, 1996, p. 493). Participants were familiar with and engaged in self-reflection throughout their experiences, most significantly when they thought about what their perceptions of elders were prior to listening to elders’ stories and how those perceptions changed.

Attending to the “locus of control” within the nurse-patient relationship is fundamental to culturally safe care (Duke et al., 2009, p. 43). The active and “nongoic way of listening” that participants made use of recognised that the patients, not the nurse were “the ultimate authorities on their own experiences” (Browning & Waite, 2010, p. 156). When Lily suggested the elder tell a story about whatever was interesting to her, she relinquished her power and it shifted toward the elder. An example of protection of an elder’s quality of life took place when Kaleo and Lucky encouraged the use of reminiscence because the elders enjoyed it and it benefitted their health and wellbeing. Participants respected the elders’ values and did not challenge or question their views. Giving elders choices and establishing respectful, trusting, mutual relationships reflected the principle of participation. These interactions reflected Buber’s idea of a reciprocal relationship in genuine dialogue (Buber, 1965). From a young age Josh learned to respect elders. He expressed how he made it part of his mutual relationship with them:
One thing that I make sure to do is that I always respect them, that I don’t call them by their first name. I make sure that I call them by whatever they want me to call them.

A mutual relationship also consisted of one that was ‘being with’ rather than ‘doing to’ as in a “tick-box target orientated context” (Buber, 1965, 1970; Aranda & Jones, 2010, p. 254; Hanson & Taylor, 2001). For instance Malia made a point of explaining to her senior companion that she would not be acting in a task oriented way when she visited her:

It’s not going to be me asking you questions. I’m not going to sit here with a pen or pencil and ask you questions. It’s just gonna be like this…I come over, we talk story.

Using the informal style of talk story provided an “atmosphere of mutual respect” and promoted a relationship of reciprocity that was perceived as caring (Davis, 2010, p. 242).

Partnership was evident when participants described not only giving elders choices but honouring them and working together to plan the day. Josh exemplified partnership when he said he willingly scheduled the events of the day based on the preferences of the elder. As Richardson and MacGibbon (2010) described culturally safe practice, Josh “created the space for the person to express their needs” (p. 59). Julia’s actions distinguished herself from the culturally unsafe nurse who tends “to look at patients who won’t do what we want them to do and think ‘What is wrong with them?’” (Richardson & MacGibbon, 2010, p. 54). Instead of worrying about disrupting the prescribed routine and exercising power over the elder, Julia disregarded the order to feed the elder and gave the elder the cutlery she wanted to feed herself. Both Josh and Julia rejected the hegemonic position that has been taught to some nursing students that they, as the nurse, were “the only real tools needed for observation and decision-making” (Polifroni, 2010, p. 11). These and other participant stories depicted aspects of
cultural safety. However, without the perspective of the elders as the receivers of care, they reflect only a partial understanding of culturally safe care.

Applying the framework of cultural safety to gerontology nursing education and to the nursing care of a marginalised group such as elders has been valuable in this study. The consequence was that the analysis and interpretation of the participants’ stories revealed a shift of power toward the elders which is essential to providing culturally safe care.

The passion and motivation of the participants to provide individualised and meaningful care to elders was a positive outcome of the experience. If listening to stories can transform attitudes in addition to transforming care, it becomes an extremely meaningful exercise. A nurse who is committed and determined to provide quality care can influence others by modelling this attitude of caring. The recommendations the participants made for nursing education demonstrates keen awareness of the needs of elders.

6.5 Summary of the chapter

The term ‘storycatcher’ has been used to describe what happens when a person listens to a story that stays with them or changes them (Baldwin, 2005). The findings of this research project described how the participants became storycatchers by listening to stories and were changed. The participants experienced a close relationship with an elder, transformed attitudes that reflected new realities of ageing, influenced their personal lives, and made a commitment to provide quality nursing care. They were changed by listening attentively and by the close connections with elders that could be described by Buber (1970) as a relationship of I and Thou with elements of mutuality and trust. It became evident from participants’ stories that listening and connecting were “powerful agents” in the provision of their care that was both healing and compassionate (Browning & Waite, 2010). Throughout the participants’ stories, their interactions and nursing care demonstrated how cultural safety can be applied to the elder population to improve care and promote relationship.
Listening to the stories of participants gave me a new perspective as I compared what I thought before the study to the findings that came after. I felt strongly that the experience of listening to elders would have a positive impact on the participants but I did not know exactly how it would take place. It is now clear that listening to stories was a means not only to learn interesting information but; more importantly to establish meaningful relationships with elders, dispel myths and stereotypes, personally inspire the nursing students, and motivate them to make improvements in the nursing care of elders. Not only did they make improvements but they provided care that challenged the status quo in order to benefit elders. The fervent commitment of the participants to make a difference in the lives of elders built on the other key findings and showed that the impact of listening to elder’s stories was directly related to the desired outcomes of gerontology nursing education. These findings supported the educational activity of listening to elders’ stories and drew attention to the complexity of the value of the experience. As a result, the participants developed new perspectives which provided continuity to what they learned in the past, the present and with potential for how they act as nurses in the future.

In Chapter Seven, the thesis is concluded with reflections on the study methodology, key findings, implications of the findings, future research possibilities, and final thoughts.
Chapter Seven Conclusion

“Draw your chair up close to the edge of the precipice and I’ll tell you a story”
(Fitzgerald, 1945, p. 191).

This quote captures the essence of this research project which has been about the experience of listening to stories; the stories of elders, and the stories of the nursing student participants. Most of all the study revealed how the participants were transformed and changed when they drew their chairs up close to elders and listened to what they had to say.

This chapter concludes the thesis with final reflections of the methodology, issues of power related to the research process, key findings, implications of the findings with recommendations for education, practice and further research, and some personal reflections.

7.1 Methodological reflections

The purpose of this study was to gain a better understanding of the meaning of the experience of nursing students listening to the stories of elders. The ultimate goal was to contribute to the developing knowledge and practice of gerontology nursing education. Nursing literature and my own experience as a nursing faculty member showed that positive experiences with elders made positive changes in nursing students’ care of elders. This research project effectively determined that listening to elders’ stories was one of those positive experiences and what the impact was on the nursing students.

It was appropriate to use the method of life story and methodology of narrative inquiry to find out the meanings that the participants ascribed to the educational experience of listening to elders. The process of narrative inquiry also provided insight into the benefits and outcomes of the teaching and learning strategies of life stories.

As the participants told their stories of their experiences, it also gave them a chance to reflect and to connect their thoughts and actions about the past to the present. The three dimensional aspects of narrative inquiry greatly contributed to the analysis and
interpretation of the participant interviews. The dimensions of temporality, sociality, and place paralleled the participants’ experiences. Their stories spanned the past, present and the future while they shared some of their earliest childhood memories listening to elders through to how they imagined their future as a professional nurse.

The three dimensional nature of narrative inquiry also lent itself to restorying the interviews into narrative texts. The use of the Three-Dimensional Space Narrative Structure restorying framework helped to organise the stories as I tried to keep them true to the voices of the participants (Ollerenshaw & Creswell, 2002). Here it became even more evident that there were layers of stories within stories. It was in the restorying process that three stories emerged: the life story of the elder shadow participant, the life story experience of the participant, and my retelling of their stories in which I played a part.

This study demonstrates the shared aims of narrative inquiry, life story and restorying as a unique process by which the experiences of nursing students were studied and understood. Together each of these aspects of the design of the study complemented each other to support the expression of the nursing students’ voices regarding their personal and student experiences that contributed to the care of elders.

7.2 Issues of power and ethics in the research process

Insofar as this study was informed by cultural safety, I was mindful of the power imbalance of the researcher-participant relationship. Interviews were conducted on the participants’ terms and effort was taken for their voices to be heard (Wilson & Neville, 2009). Factors such as these which promote culturally safe research also dovetailed with the applicable ethical considerations of relinquishing power and involving the participants while being attentive to their rights to privacy.

During the research process I acknowledged the impact of my dual role as nursing faculty and researcher in the same program as the nursing students. The use of an intermediary gave the potential participants the option to inquire about participating from a neutral party. In my attempt to avoid any impression of coercion I found that I
was too far removed from the recruitment process. I readjusted how I disseminated the invitation to participate and became more actively involved by speaking to classes of nursing students and informing them of what being a participant entailed. The results yielded 15 very willing nursing student participants.

I was also aware of the potential effect of my preexisting relationship with the participants. I had spent time with nursing students as their gerontology instructor in both large lecture classes and in small group classroom discussions. As the gerontology course coordinator, students also met with me regarding issues they could not resolve with their gerontology faculty members and for matters related to student conduct and academic honesty. In addition, I taught other nursing classes which involved travelling with students to other Hawaiian islands and US states.

Only those students who were not taking classes I taught or oversaw were eligible to participate. They all knew of me as the course coordinator for the gerontology nursing courses and my viewpoint on the care of elders. Even after the first interview I asked myself if what was being said was simply what they thought I would be pleased to hear. Were their responses a product of what has been called a prepared mind? (Lowes & Weeks, 2006). As I began listening to the interviews and transcribing them, I found that the participants described application beyond rote knowledge. The participants gave specific instances of how they changed their care after listening to elders’ stories. This demonstrated that they had a deeper understanding than the information they gleaned from class. In Julia’s story, for example, she explained how she changed her care of elders by promoting self-determination and independence when she worked with an elder who wanted to feed herself. I also realised that for those participants who had just completed their gerontology nursing coursework, the information they learned from gerontology nursing class would be fresh in their minds. If they were simply repeating what they thought I believed, their actions and attitudes would not likely be sustained over time. As it turned out, even those participants who were in their last semester of the nursing program shared similar stories which demonstrated an effect that lasted for a year or more.
The similarity of participant reactions to their experiences made me think carefully about what had taken place. I realised that it was possible that only those participants who had a positive experience were interested in volunteering to participate in the study. That could also be a result of friends encouraging friends to participate. Their views might be very similar if they were friends with each other because they had comparable personalities or ideas.

The last consideration to be discussed was maintaining confidentiality and privacy of the nursing student participants and the elder shadow participants. Despite the large size of the nursing program (about 1600 BSN students), it functioned as a small community where everyone knew each other. Although pseudonyms were used in order to protect the confidentiality of the students, many of the participants openly talked about their participation with fellow students and faculty members. In fact one participant wrote a letter to one of her instructors about her positive experience being interviewed. Any personal information that I thought other students, staff or faculty members would be able to identify with the participants was deleted or replaced with general terms. The same was true for the stories of the elders where details were deleted or restated in generic language to protect their privacy.

The experience of interviewing the participants, listening to the transcripts and restorying them into narrative texts was a very enjoyable experience for me. I became so immersed in their stories that I no longer thought of them by their real names but thought of them only by their pseudonyms. The participants received the gift of story from the elders and they passed their own stories on to me. The stories of the participants are treasures that contributed to my understanding of their experiences and led to significant key findings.

### 7.3 Key findings for nursing education and practice

The four most significant key findings that were identified consist of the participants’ establishment of relationships, changes in their attitudes toward elders, the impact of the elders’ stories on the participants’ personal lives, and their fervent commitment to
improve the nursing care of elders. These findings directly corresponded to the research questions that formed the study. The question most central to the study was, “What was the impact of listening to elders’ stories on nursing students?” This question was answered with multiple examples from the stories that were foundational to the findings.

The key findings do not exist in isolation but with each overlapping and influencing another. As explained in Chapter Five, the liminal spaces that represented the transitions the students experienced were also in flux and interrelated. The relationships that developed from listening to elders’ stories were enhanced by the way their own personal lives were being shaped as well as the transformation of their attitudes that were also taking place. The practice of reflection supported the change in attitudes as well as the impact the experience had on their personal views and life choices. The participants’ concern for elders and their care was heightened by the negative experiences expressed by the elders and actions the participants observed.

A variety of affirming terms were used by the participants to describe how they felt when they heard the elders’ stories and about the stories themselves. It was as if the participants knew the elders’ ages but had not correlated that they were alive during many historic events. The stories the participants remembered with the greatest detail were different scenarios and personal experiences during World War II. The feelings the participants had toward the stories spilled over into their feelings concerning spending time with elders. They felt at ease and comfortable around elders and eventually connected with them and developed close relationships. Through listening, the stories themselves, and the depth of sharing that took place, the relationships that were established opened the participants’ eyes to the elders’ perspectives. This enabled them to recognise elders as individuals and value what they had to say.

The experience exposed the participants to elders and their stories that contradicted the stereotypes of ageing. Even though the participants knew elders who substantiated the myths and stereotypes, the elders they listened to defied them and changed the way the participants viewed ageing. Getting to know healthy and cognitively intact elders had
the greatest impact on the attitudes of the participants. The experiences visibly challenged the participants’ images of frailty and disability as normative ageing. The negative stereotypes of ageing were replaced with more positive views that led to attitudinal changes in the participants. They no longer dreaded elders or ageing itself. The attitudinal change was so significant that many of the participants equated the way they felt toward elders as equal to the love and admiration they had for their own grandparents. The presence of the participants’ grandparents throughout the stories was also significant.

The impact of the elders and their stories on the participants extended to their personal lives. Their perceptions of what constituted a good life, a life worth living and meaning were shaped by the stories, the actions and the advice that elders shared with them.

The experience of listening to elders’ stories and the transformation that took place when attitudes and values were changed led to an ardent commitment to change the way the participants cared for elders. They made a point of saying they did not want to model themselves after nurses who disrespected or disregarded elders in any way. The participants were determined that they would give time to elders to find out what their needs were and to give them a voice to make decisions about their own healthcare. The participants decided that listening was one way to show respect. Another approach was to take the time to understand elders and to ensure that they were heard by others.

Together these findings illustrated the duality of the experience which was both ontological and epistemological in nature. The terminology of the themes depicted the process as beginning with the participants being present, being let in, and feeling connected. They encountered what it was like to be in a relationship of I-Thou, to be thoughtful, transformed and caring. In contrast the participants utilised and gained knowledge as they consciously incorporated active listening, reminiscence, and reflection. They learned new stories, debunked myths and stereotypes, and came to know what was caring to an elder. The experience of listening to elders’ stories was a combination of being and knowing that helped the participants learn how to be and practise as a nurse.
It was unanimous that the experience was a positive one for the participants. They wholeheartedly recommended that nursing students should continue to listen to the stories of elders who will help them to dispel their myths and stereotypes of ageing.

7.4 Implications of the study for nursing education and practice

Listening to the participants’ stories give me much food for thought as I explored the implications for nursing education, practice and research. The participants provided me with insights into their world as nursing students and what facilitated their learning and interactions with elders.

Ultimately, the experiences of nursing students listening to elders tell their stories were valuable and educational. The experiences positively impacted nursing students’ attitudes, their perceptions of elders, fostered relationships with elders, and inspired them to change the way they worked with and advocated for elders. Listening to life stories provided content that informed and shaped nursing students’ views of health and ageing. Nursing students should be given opportunities in their undergraduate programs to listen to elders’ life stories that are not for the purpose of assessment. The ability to genuinely listen and experience a connection with elders positively impacted their nursing care when listening and getting to know the elder was the intent. The value of this practice is specific to the underlying principles of gerontology nursing care and easy to implement in both education and practice. The growing number of elders will be positively impacted and nursing students will have their ageist stereotypes and myths about ageing challenged and replaced with more realistic views of elders.

It would be most useful to have nursing students listen to the stories earlier in nursing programs so they obtain the greatest benefit. The experience sets a positive tone and helps students to perceive all elders more realistically in all levels of care. Another option would be to integrate listening to all types of patients’ life stories throughout every level of the program to reduce other stereotypes and biases. Continuing the use of reflective journaling with elder experiences should also be maintained.
The strong bond some participants had with their grandparents and the positive impact this had on their attitudes toward elders challenged my own views as a nursing faculty member. In the past the gerontology nursing faculty discouraged nursing students from choosing a relative as their elder senior companion. The intent was to provide a new experience for the students. As it turns out, it is beneficial to recommend that nursing students spend time with a grandparent. This would nurture a valuable relationship that has the potential for stories to be shared. Grandparents play a large role in the raising of children and this type of assignment is feasible in the paediatric portion of the program.

The obstacles and challenges participants experienced listening to elders led me to conclude that the ability to communicate with elders with a hearing deficit deserves additional attention. Attention should be paid to how thoroughly communication with elders who have a hearing loss is addressed in nursing courses. It would also be worthwhile to incorporate the scenario of an elder with a hearing deficit into the SimMan simulation exercises in the nursing laboratory (Guimond, Sole, & Salas, 2011.) Other options include having nursing students role-play communicating with an elder with hearing loss in the classroom setting and to listen to hearing loss simulations.

The findings from this research project made me more aware of the ethical concerns of nurses who do not listen to elders. Listening attentively is a nursing action that is not on the list of skills that nursing students must master prior to graduation in this nursing program. Participants’ experiences emphasised the importance of being able to adequately inform and exchange information with an elder with a hearing deficit or experiencing a normal age-related change in cognitive processing. The practice of listening attentively and responding to what was said should be addressed and practised in nursing programs.

The expansion of the use of story in nursing education has the potential to improve attitudes and the care of older adults. One idea that resulted from this study was to utilise more case stories than case studies when teaching gerontology nursing. Case studies tend to objectify the elder as a case to demonstrate a certain disease or condition while a case story personalises the situation portraying the client as an individual. The
use of the term case story varies in interpretation but is as used here, the story about a person told by them or from their perspective (Clark, 2002). A case story ought to include what the elder wanted to tell such as their background, highlights of their life, what is important to them, and their understanding of their health. This teaching strategy addresses the elder’s thoughts and personal circumstance and would be less likely to promote the stereotype that disease or infirmity is due to ageing.

The findings from this research project also have implications for the growing trend toward distance and online education. Using audiovisual materials, which can include stories, has become commonplace in a virtual reality of digital storytelling with podcasts, webinars, videos (Haigh & Hardy, 2011) and virtual worlds such as Second Life (Skiba, 2007). Digital storytelling becomes interactive when technology is integrated with narration, photos, audio and video recordings and music. The images add emphasis and meaning to the stories being told (Gazarian, 2010). The accessibility of digital stories lends itself to both online and face-to-face venues of nursing education. Having nursing students create digital stories of their interactions with elders will promote interpretation and reflection on their lived experiences (Christiansen, 2011). Students can benefit from each other’s experiences with discussion and collaborative reflection after viewing the digital stories (Schwartz, 2012). This educational strategy has the capability of inspiring nursing students to examine their views of elders (Christiansen, 2011; Gazarian, 2010).

Digital stories are also available to watch or listen to online through the American Folklife Center at the US Library of Congress with StoryCorps (2013) and the Veterans History Project (2013). StoryCorps preserves elders’ stories by providing community-based on-site recording sites throughout the US. Nursing students can participate by assisting elders to record their life stories. The Veterans History Project is an intergenerational education program that records wartime experiences of veterans to enhance the understanding of the realities of war and to honour veterans (McCulloch-Lovell, 2003). Stories of elders of World War II and the Korean Wars include collected memorabilia such as letters, diaries and maps of their experiences. Nursing students can
obtain specialised Tool Kits with guidelines to conduct interviews and recordings of older veterans. In addition to benefiting from hearing elders’ stories, students can contribute to the collection and preservation of elders’ oral histories.

Opportunities to utilize technology are essential in nursing education. However, virtual venues cannot replace the experience of a nursing student drawing their chair up to a real live elder and listening to their story. In a virtual experience there is little possibility of establishing a relationship with elders that leads to transformation, reduced stereotypes, and a renewed vision of care. Even if other stories are used in a nursing program, personal one-on-one experiences with elders should also be included. These experiences would be enhanced if the elders were active and independent.

The stories of the participants made a valuable contribution to nursing knowledge with the use of narrative inquiry to learn the perspectives of nursing students as they listened to elders. Concepts that informed this study and emerged from the findings strengthened its contribution to knowledge. Cultural safety, talk story, and threshold concept are absent or rarely found in gerontology nursing literature and research. Examining gerontology nursing through the lens of cultural safety is unique in nursing research. As mentioned in Chapter Two, this may be the first time that cultural safety has been applied to independent elders as a group marginalised due to ageism and who would benefit from care that is culturally safe. Cultural safety informed the implementation and the interpretation of the study.

Through this study it became evident that cultural safety can effectively inform gerontology nursing education and practice. Cultural safety addresses the power differential that is present when nursing students care for elders. By applying the principles of cultural safety (e.g., power, protection, participation, partnership), relationships with elders can be established and elders can be treated with dignity and respect and become active participants in their own care. Incorporating cultural safety into gerontology nursing education and practice enhances the care of elders.
The concept of talk story is a means of communication common in Hawai`i and second nature for many of the participants who were interviewed. The nursing students showed that talk story significantly impacted the manner in which they communicated with elders and developed relationships. Talk story provided an example of how an informal and local style of communication can contribute to the nurse-patient relationship. These findings supplement the limited writings addressing the subject of talk story as mentioned in Chapter Two. Lastly, threshold concept is a relatively new term with few writings applying it specifically to the field of nursing (Andrew & Ferguson, 2008; Billay, 2010; Dearnley & Matthew, 2007). This study is the first to identify a threshold concept specific to gerontology nursing. Other threshold concepts need to be identified as gerontology nursing continues to expand and broaden to encompass elders in both institutional and community settings.

7.5 Implications for research

Implications of this study support the use of narrative inquiry research to learn from nursing students about their educational experiences. Most importantly would be the continued use of narrative inquiry to research the meaning of experiences of gerontology nursing students. Many of their misconceptions and fears create obstacles that faculty need to address in order to promote effective teaching and learning. Additionally, by incorporating cultural safety with gerontology nursing in research, the issue of the imbalance of power in relationships with elders can be addressed.

The experience of interpreting the narrative texts of participants brought to mind new questions for future research. Which of the elders’ stories best engage nursing students? Would there be new findings if the participants’ reflective journals from their clinical experiences with elders were analysed along with their interviews? Answers to these questions would bring more clarity to the findings.

Implications for future research include investigating digital and online education experiences with elders’ stories and their effect on nursing students. A retrospective
approach studying nursing students’ attitudes and experiences after graduation would be helpful to learn the long-term effects of experiences in nursing school.

The findings of this study led me to question what the impact would be on nursing students who listened to the stories of other types of patients who have been marginalised or stereotyped due to their ethnicity, religion, sexual orientation, gender or other situation. Examples of situational stereotypes would include patients who were under arrest, homeless, or unwed mothers.

In addition, this study has made me wonder what meanings are gleaned from the various activities nursing students experience in nursing school. Do they serve the purpose for which they were intended? Do they create outcomes unknown to nurse educators? Researching with narrative inquiry has made me realise that there is much more to learn from the perspective of nursing students. It is thrilling to think of the possibilities as I conclude with my final thoughts.

7.6 Final Reflections

This research study was a journey that afforded me the opportunity to explore the life stories of 15 nursing students. Their contributions helped me understand nursing education from their point of view. Listening to their stories energised me and opened my eyes to new ideas. The findings confirmed and strengthened my commitment to continue the use of stories in nursing education and to integrate the principles of cultural safety in my teaching.

I learned that gerontology nursing content does not have a satisfactory context if nursing students do not have a relationship with elders who personify healthy age ing. Listening to elders’ stories is one way to provide context and promote relationship in nursing education.

I began to think about the value of liminal spaces as those instances when we feel unsettled and uncertain about what we are doing. Now I recognise moments of liminality to be sources of growth and change. The impromptu conversations that spark new ideas in the hallways outside offices are liminal spaces. When the unexpected
happens, when emotions are high, when there is an element of uncertainty or wonder, or as I also learned, when an elder tells their story, these are all liminal spaces. Liminal spaces have the potential to provide tremendous teaching and learning opportunities to bring forward what is known from the past and integrating it with experiences of the present into new transitions.

Narrative inquiry, dialogue, and listening to stories all shared the characteristic of ongoing transitions. As I was in the midst of recruiting participants and immersed in narrative inquiry and life story, I wrote a poem in my research journal about how I understood these processes entitled, ‘Dialogue.’ Much later when I was examining the findings, I reread the poem and found similarities to the participants’ experiences. This prompted me to write another poem entitled ‘Listening to Elders’ that paralleled ‘Dialogue’ to express what I learned from this journey.

*Dialogue (October 18, 2009)  Listening to Elders (June 28, 2011)*

- *Ebb and flow of the sea*  
  *Give and take as we talk*

- *Turtles peek out*  
  *An amazing story*

- *Crash of the surf*  
  *Shocking tale*

- *Wash of the wave*  
  *The intimacy of tears*

- *Sand shifts and moves*  
  *Thoughts to ponder*

- *Reformation of the shells*  
  *Transformation*

- *Creating an ongoing,*  
  *Again and again,*

- *Everlasting process of change.*  
  *Making something new.*

These two poems reflect the depth of dialogue, change and listening that was experienced during this study and in the writing of this thesis. The experiences and the findings reemphasise the essence of caring as relational and that listening to the stories of elders is a valuable activity to experience relationship with elders. Applying cultural
safety as an interpretive lens helped make visible the ugliness of ageism and the beauty of the experiences of the participants as they became transformed by their experiences.

My hope is that this study and its three layers of stories; those of the elder shadow participants, the nursing students and my narrative of their stories; will contribute change and offer something new to nursing education.
## Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>Consent form to participate in the research project</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Participant information form</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Memorandum from Convener VUW HEC, 11, April, 2009 re ethical approval to undertake PhD research project</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Memorandum from Chair Hawaii IRB, 15, April, 2011 re ethical approval to undertake PhD research project</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Participant recruitment flyer</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Conversational interview guide</td>
</tr>
</tbody>
</table>
Appendix A

Consent form to participate in the research project

TE WHARE WANANGA 0 TE IKA A MAUI

VICTORIA
UNIVERSITY

Title of the project: Listening to the stories of elders

I have been given and understand an explanation of this research project. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that I may withdraw myself (or any information that I have provided) from this project at any time without having to give reasons or without penalty of any sort.

I understand that there could be potential risks associated with being a participant in the research project. These might include uncomfortable memories surfacing during the research process. The benefit to my participation includes the opportunity to reflect on my nursing school experience.

I also understand that:

- any information or other related materials I provide will be kept confidential to the researcher, her supervisors, and the person who transcribes the audiotapes of the conversations;
- the researcher will negotiate with me as to the number of conversations that will be required to gather information;
- the length of time for each conversation will also be negotiated with me prior to the commencement of each conversation;
- the researcher will keep the audiotapes in a secure place for five years after the completion of the research project;
- I will be offered a summary of the results of this research when it is completed;
- the researcher may use the data in her thesis, presentations at conferences or in articles for national and international refereed journals; and
- the data I provide will not be used for any other purpose than that already stipulated in this consent form, without my further consent.

I agree to take part in this research project.

Signed: ____________________________  Name of the participant: ____________________________

Date: ____________________________
Appendix B

Participant Information Form

TE WHARE WANANGA 0 TE IKA A MAUI
VICTORIA
UNIVERSITY OF
WELLINGTON

Introduction to the research

I am a doctoral student in the Department of Nursing and Midwifery at Victoria University of Wellington. I have chosen to conduct a research project that explores the experiences of senior level baccalaureate nursing students who have listened to the life stories of elders who have are 75 years or older. Approximately 12 nursing students will participate in this project.

Invitation to participate

I would like to invite nursing students to share what it was like for them to listen to the stories of these elders, and what they thought about it. It is hoped that the results of this research will help inform nursing faculty of the student perspective as they determine educational activities for nursing students.

If you are interested in being a participant in this project, I will talk with you at a place and time that is convenient for you. I would like to talk to you for up to 60 minutes each time. I will confer with you to decide if we should meet once or twice.

The conversation will include asking you about the level of nursing education that you have completed in addition to your experience listening to elders.

I will audiotape the conversations on a tape recorder. This will be used to create a transcript of our conversations. The audiotapes and transcripts will be kept securely stored during the project and for a period of up to five years following completion of the project, at which time they will be destroyed. No one else will have access except for the person who will transcribe the tapes. The transcriber will sign an agreement of confidentiality. Your personal contact information will be kept in a separate place other than the tapes and transcripts.

The potential risk of participating in this project is that if recounting your experience listening to an elder’s story is emotional or distressing to you, it may trigger uncomfortable memories.

If at any stage during the conversation you become distressed because of uncomfortable memories, then I would stop the conversation and ask you if you would like to take a short break, continue at another time or date, or withdraw from the project. At your request I would also give you referral information if needed for any distress.
As part of the project requirements I will be submitting a written thesis and excerpts from your conversation with me would appear in the text. Confidentiality will be maintained and your name and identifiers will not appear in the text. I will also honor any requests if you would prefer that certain portions of the conversation be excluded from the text.

My supervisors Rose McEldowney and Chris Walsh, will be reading and critiquing the drafts of the thesis as part of their role as supervisors. A summary of the research results or full research report will be made available to you. I will also be keeping a reflective journal throughout the research process.

Your participation in this project is entirely voluntary. If you decide to participate, I will ask you to sign a written consent form. A copy of the consent form is attached. Should you decide to discontinue as a participant at any time, you may do so without having to give any reasons or without any sort of penalty.

**Contact Information**

If you have questions or would like to receive further information about the project:

Please contact me, Jeanine Tweedie, at School of Nursing, phone 808-XXX-XXXX or at my home, 95-1013 Luaehu Street, Mililani, Hawai`i, phone 808-626-1993.

Email: jtweedie@xxx.edu

Or you may contact my primary supervisor, Rose McEldowney. She is Associate Professor of Graduate School of Nursing, Midwifery & Health, Victoria University of Wellington, Wellington, New Zealand; and Professor & Head of School of Health Sciences, Charles Darwin University, Australia, rose.mceldowney@cdu.edu.au, phone 0061-8-894-6148.

Questions regarding the project may also be asked of XXX XXXX, chair of the Hawaii university Institutional Review Board at 808-XXX-XXXX.

**TO INDICATE INTEREST IN PARTICIPATING IN THIS STUDY, PLEASE EMAIL ______________, or phone______________ ______________.

She will give me your contact information to set up a time to meet with you.

Sincerely,

Jeanine Tweedie

Assistant Professor of Nursing

Hawai`i
Appendix C  Human Ethics Approval

TO: Jeanine Tweedie
COPY TO: Associate Professor Rose McEldowney, Supervisor
FROM: Dr Allison Kirkman, Convener, Human Ethics Committee
DATE: April 11, 2009
PAGES: 1
SUBJECT: Ethics Approval: No 16392, Elders tell their stories: The impact on nursing students.

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 30 April 2011. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

(Electronic signature)

Allison Kirkman
Convener
Appendix D Institutional Review Board Approval

Hawaii XXXXXXXXXX Institutional Review Board
Project Application

Please complete, save as Word file and send to xxx@.xxx.edu.

Study Title: Elders Tell Their Stories: The Impact on Nursing Students

Investigator
Name: Jeanine Tweedie
(Please check one) X Faculty
Phone: 808-xxx-xxxx
Email: jtweedie@XXXXXX

Sponsoring Faculty Member: (if Investigator is not a XXX faculty member)

Please attach a brief summary of the project. This should contain an explicit statement of the methods of data collection, including questionnaire (if any); who subjects will be and how they will be chosen; and how confidentiality of subjects will be protected. For questionnaires/surveys that will be returned anonymously, a statement that participation is voluntary should appear at the beginning of the form. For other studies, a copy of the informed consent form should be included with this package.

Category for Review:

Check on level of review (Exempt, Expedited, Full) for which you believe the project qualifies, as each criterion that your project meets.

Exempt from review (nil or minimal risk study, or already reviewed by an IRB)

☒ Research involves ONLY investigation into or comparison of normal instructional strategies.

☒ Tests, interview, and surveys are unlikely to elicit emotion or place subjects at risk of civil/criminal liability or damage to their reputation, financial standing, employability, etc. AND information will not be recorded in such a way that subjects can be identified.

☒ Research involves only the study or analysis or existing data, documents, records, or specimens that are publicly available or recorded in such a way that subjects cannot be identified.

☒ If study involves ingestion of food: only wholesome food without additives in excess of USDA recommended levels is consumed.

☒ Brief informed consent will be done (except in the case of existing data, etc.)

☒ No use of vulnerable subjects (children, prisoners, pregnant women, mentally ill, etc.)

☒ Has already been approved by IRB at Victoria University of Wellington (Include copy of signed IRB approval form) April 11, 2009
☐ Expedited review (minor risk study)
  ☐ Research and data collection methods are unlikely to elicit strong emotion and deception is not involved.
  ☐ Research involves only noninvasive, painless, and non-disfiguring collection of physical samples, such as hair, sweat, excreta.
  ☐ No use of vulnerable subject (children, prisoners, pregnant women, mentally ill, disabled, etc.).
  ☐ Data are recorded using noninvasive, painless, and non-disfiguring sensors or equipment, such as EKG, weighing scales, voice/video recording.
  ☐ Research involves only moderate levels of exercise in healthy volunteers.
  ☐ Research does not involve ingestion or drugs or use of hazardous devices.
  ☐ If existing data, documents, records, or specimens with identifiers are used, procedures are in place to ensure confidentiality.
  ☐ Informed consent process will be done (attach copy of informed consent form).
  ☐ Data will be kept confidential and not reported in identifiable fashion.
☐ Full review required (more that minor risk)
  
  Attach a statement that describes the use of vulnerable subjects or the study procedures and conditions that place subjects at risk. Describe the precautions that will be taken to minimize these risks. Attach a copy of the informed consent form that will be used.

Certification by Principal Investigator:
The above represents a fair estimate of risks to human subjects.

Jeanine Tweedie  
Name  Assistant Professor  April 12, 2009

FOR IRB USE ONLY

Certification by IRB Chair: I have read this application and believe this research qualifies as: Z Exemption from IRB review
  ☐ Appropriate for expedited review, and
    ☐ Approved
    ☐ Disapproved
  ☐ Appropriate for review by the full IRB
VUW approval expires 2011. XXX approval is good for one year.

Chair, XXXXXXXXXX  (electronic signature) Date 4/15/09
Appendix E Recruitment Flyer

FALL 2009

LEVEL 3, 4 & 5 NURSING STUDENTS

YOU!

Are Invited to Participate In Nursing Research

| Tell about your experience listening to an elder over 75 years old tell a story about their life |

Conversational interviews will be conducted by

Jeanine Tweedie, Assistant Professor of Nursing

IF YOU WOULD LIKE TO KNOW MORE:

Contact (name) at , (email), (phone #), Office #.

She can give you the Participation Information.

Or, if you are already interested in participating: Contact Jeanine Tweedie directly at XXX-XXXX for voicemail to computer email, or 388-9267 cell

9am-4pm weekdays, or at jtweedie@XXXXXX

*Refreshments will be provided*

(POSTED BY PERMISSION 2009)
Appendix F Conversational Interview Guide

Demographic Content:

Gender

Current level in nursing school

Semester/s when listened to elder/s’ life story

Date/time of conversation

Location of conversation

Tell me about your experience listening to the life story of an elder, 75 years old or older.

What life story did the elder tell you?

What were your expectations prior to listening to the elder tell their story?

What are your feelings toward the elder after hearing their story?

How was the experience of hearing an elder’s story?

What did you think of the experience?

What was the highlight of the experience?

What did you learn?

What are your thoughts about the elder who told you the story?

What do you remember most about the experience?

Was there a benefit to hearing the elder’s story?

Any negative aspect to the experience?

In retrospect, what did you get out of the experience?

Did it have any impact on your practice as a nursing student?

Do you think other nursing students would benefit from listening to a life story of an elder?
References


Kant, I. (2002). Prolegomena to any future metaphysics that will be able to come forward as science. (J. Ellington, Trans.). Indianapolis, IN: Hackett. (Original work published 1783).


gerontologists. *Gerontology and Geriatric Education, 30*(1), 17-60. doi: 10.1080/02701960802690274


Wright, L. (2007). Life lessons from Mr. S. *Alberta RN, 63*(8), 12-14.


