Bridging the Gap between Caring Theory and Nursing Practice
– Learning Experiences of Undergraduate Nursing Students in a Caring Behavior Course

Sophie Mårtensson
Bridging the Gap between Caring Theory and Nursing Practice

Learning Experiences of Undergraduate Nursing Students in a Caring Behavior Course

Sophie Mårtensson
Bridging the Gap between Caring Theory and Nursing Practice

– Learning Experiences of Undergraduate Nursing Students in a Caring Behavior Course

Sophie Mårtensson
Abstract

**Background:** Healthcare providers are obligated to practice with scientific knowledge in order to deliver high quality and safe care based on patients’ needs. Despite this obligation, complaints from care recipients and their significant others regarding healthcare providers’ lack of compassion and competent care in their professional encounters have increased. In the discipline of nursing, theoretical structures of caring, conceptualized as behaviors, have been established as the heart and core value of guidance in all nursing practice. In nursing education, however, caring has tended to be taught as an intangible aspect of nursing practice, described as hidden curricula, thus, focus more on developing knowledge and psychomotor skills instead of learning caring behaviors. Studies that examine how undergraduate nursing students can learn caring behaviors explicitly are rare. Thus, a stronger emphasis on the learning of caring in the context of a caring behavior course that uses a variety of learning didactics is needed. Without adequate theoretical structures for caring-based observational behavioral instruments assessing verbal and non-verbal caring and non-caring behaviors, there is little evidence to help develop the learning of caring behaviors.

**Aim:** The overall aim of this thesis was to study how a caring behavior course in undergraduate nursing education influenced students’ learning of caring behaviors.

**Method:** This thesis was conducted among undergraduate nursing students at a university in Sweden. The participants attended a 7.5-credit (five-week) Caring Behavior Course (the CBC) in semester four during spring and fall 2018 and spring 2019. The CBC was facilitated through a student-centered learning approach intertwined into reflective practice with the learning didactics of narrative pedagogy and simulation; it comprised six voluntary lectures, five mandatory seminars, and two mandatory caring behavior simulation days and examinations. All data were collected from the students participating in the CBC. Two of the four scientific papers constituting this thesis had a qualitative design based on focus group interviews (paper I) and individual written reflections (paper II). Analyses was conducted using qualitative content analysis. One paper had an instrument development design to develop and test an observational behavioral instrument based on
Swanson’s Theory of Caring (paper III). Lastly, one paper had a quantitative observational design using the CBCS on video-recorded observational behavioral data collected in the CBC (paper IV). Analyses was conducted using descriptive statistics and Wilcoxon signed rank test (paper IV).

**Results:** The undergraduate nursing students’ participation in the CBC influenced their learning of caring behaviors. It deepened their understanding and knowledge of caring. The students became aware that learning caring is a task that requires effort because the meaning of caring encompasses nurses’ active engagement in practicing caring behaviors. These findings are also supported through the observational behavioral instrument, through the developed Caring Behavior Coding Scheme based on Swanson’s Theory of Caring; it was found that participation in the CBC influenced the undergraduate nursing students verbal and non-verbal caring and non-caring behaviors.

**Conclusions:** This thesis demonstrated that bridging the gap between caring theory and nursing practice in the CBC using a variety of learning didactics influenced undergraduate nursing students’ learning of caring behaviors. The results contributed to strengthening the knowledge that caring and learning are parallel processes in the undergraduate nursing students’ development into becoming compassionate and competent caring nurses, with the intended outcome of patient healing and well-being.

**Keywords:** Caring, Narrative pedagogy, Observational behavioral instrument, Qualitative method, Quantitative observational method, Reflective practice, Student-centered learning approach, Simulation, Swanson’s Theory of Caring, Undergraduate nursing education
Original papers

This thesis is based on the following papers enclosed as appendices:

Paper I


Paper II


Paper III


Paper IV

Paper I has been accepted for publication by Springer under a creative commons attribution license. Papers II and III are open-access articles also under the terms of a creative commons license, which permits reproduction in any medium.
# Table of Contents

1. **Introduction** ................................................................................. 1  
2. **Background** .................................................................................. 2  
   2.1. Today’s healthcare organizations and healthcare providers .. 2  
   2.2. Complaints from care recipients and their significant others 3  
   2.3. A person-centered approach to care ........................................... 4  
   2.4. Caring in the discipline of nursing ............................................. 5  
   2.5. Undergraduate nursing education ............................................. 7  
      2.5.1. Swedish undergraduate nursing education ......................... 7  
   2.6. The educational learning approach in undergraduate nursing  
       education .................................................................................. 8  
      2.6.1. Learning through a student-centered learning approach ...... 9  
      2.6.2. Learning through reflective practice ................................. 10  
   2.7. Educational learning didactics in undergraduate nursing  
       education .................................................................................. 11  
      2.7.1. Learning through narrative pedagogy ............................... 12  
      2.7.2. Learning through simulation ......................................... 13  
   2.8. Observational behavioral instrument assessing caring  
       behavior .................................................................................. 17  
3. **Theoretical framework** ............................................................. 20  
   3.1. Swanson’s middle range Theory of Caring ............................. 20  
      3.1.1. Practicing caring in Swanson’s Theory of Caring .......... 21  
      3.1.2. Using Swanson’s Theory of Caring in various contexts .. 23  
4. **Rationale** .................................................................................... 25  
5. **Aim** ............................................................................................. 26
5.1. Specific aims of each paper .......................................................... 26

6. Methods ............................................................................................. 27
   6.1. Design ......................................................................................... 27
   6.2. Undergraduate nursing education ............................................ 28
   6.3. The caring behavior course ....................................................... 29
      6.3.1. CBC lectures ....................................................................... 30
      6.3.2. CBC seminars ...................................................................... 31
      6.3.3. CBC caring behavior simulation days .................................. 36
   6.4. Participants ............................................................................... 38
      6.4.1. Description of the participants in papers I–IV ..................... 39
   6.5. Data collection .......................................................................... 41
      6.5.1. Paper I: Focus group interviews .......................................... 42
      6.5.2. Paper II: Individual written reflections ................................. 42
      6.5.3. Paper III: Video recordings ................................................... 43
      6.5.4. Paper IV: Video recordings ................................................... 43
   6.6. Data analyses ............................................................................ 44
      6.6.1. Papers I–II: Qualitative content analysis ............................... 44
      6.6.2. Paper III: Instrument development process ......................... 46
      6.6.3. Paper IV: Descriptive statistics and the Wilcoxon signed rank test 48

7. Ethical considerations ........................................................................ 50

8. Results .............................................................................................. 53
   8.1. Paper I: Undergraduate nursing students’ experiences of learning caring using a variety of learning didactics .................. 53
   8.2. Paper II: Undergraduate nursing students’ experiences of practicing caring behaviors with standardized patients ................ 55
8.3. Paper III: Caring behavior coding scheme based on Swanson’s Theory of Caring–Development and testing among undergraduate nursing students .......................................................... 57

8.4. Paper IV: Assessing the impact of a caring behavior course on undergraduate nursing students’ caring behavior ........................................ 59

9. Discussion .......................................................................................... 61
  9.1. Methodological considerations ...................................................... 61
      9.1.1. Qualitative research .............................................................. 61
      9.1.2. Quantitative research ............................................................ 65
  9.2. Discussion of the results ............................................................... 67

10. Conclusion ....................................................................................... 77

11. Relevance and implications ............................................................. 78

12. Future research .................................................................................. 79

13. Svensk sammanfattning ................................................................. 80

14. Acknowledgements .......................................................................... 83

References .......................................................................................... 84
1. Introduction

Globally, nurses comprise the greatest percentage of human resources in today’s healthcare system and are often the first or sometimes the only healthcare providers whom care recipients and/or their significant others engage with (International Council of Nursing [ICN], 2021; World Health Organization [WHO], 2020). Thus, the professional quality of safe care that nurses provide is essential for care recipients’ healing and well-being (Swanson, 1993). Caring has long been recognized as the heart and core value of nursing practice (Swanson, 1991; Swanson, 1993; Watson, 1979). Although conceptualized as a behavior, caring is also described as an abstract theoretical structure that many find difficult to apply in clinical healthcare practice. For the best outcomes, care recipients and their significant others emphasize the need for nurses to demonstrate compassionate caring behaviors along with competent nursing skills (Swanson, 1993). Despite recognizing the significance of nurses’ learning of caring behaviors, however, nursing education has tended to focus more on teaching knowledge of specific diagnoses and psychomotor skills instead of learning the meaning of caring and the practice of caring behaviors (Gustin, 2021; Sandvik & Hilli, 2022). As a result, undergraduate nursing students report inconsistent opportunities to explicitly practice caring behaviors in nursing education (Akansel et al., 2021; Warshawski et al., 2018). Learning the meaning of caring and how to practice caring behaviors is complex. Thus, nursing students sometimes consider learning caring behaviors to be less important (Akansel et al., 2021). Caring must be acknowledged as more than an intangible aspect of nursing practice, as caring is a fundamental way of being in a relationship with another individual to promote health, healing, and well-being outcomes (Watson, 1979; Watson, 1999). Simultaneously, most of the studies conducted today focus on a specific learning approach and/or a specific learning didactic, resulting in different ways of facilitating undergraduate nursing students’ learning of caring behaviors. Obtaining a deeper understanding and knowledge of this subject is crucial to nurture the development of undergraduate nursing students’ caring behaviors. Therefore, the focus of this thesis is to examine how a caring behavior course (CBC) using a variety of learning didactics may influence undergraduate nursing students’ learning of caring behaviors and be meaningful in nursing education.
2. Background

2.1. Today’s healthcare organizations and healthcare providers

Healthcare organizations are dynamic and constantly evolving as a result of changes in social, political, economic, and demographic forces, technological advancements, and innovations in health science (Leidner et al., 2021; WHO, 2018). Like other healthcare organizations, the Swedish healthcare system has been influenced by the new public management reform, which is associated with efficiency, cost control, and performance evaluation (Sundler et al., 2020). With shorter hospital stays and a decrease in the number of inpatient care facilities, care is increasingly taking place outside hospitals. In addition, people with complex health conditions and care needs are now living longer. These circumstances place higher demands on healthcare providers to collaborate within different healthcare organizations and with care recipients and their significant others (Leidner et al., 2021). Swedish healthcare is struggling with problems of accessibility, quality, finance, and shortage of healthcare providers (Sundler et al., 2020). The Swedish government (2015) has given directives to universities in Sweden to educate a larger number of nursing students, but the Swedish Health and Care Inspectorate (IVO, 2021) reports that nine out of 10 healthcare settings have shortages of both newly graduated and experienced/specialist nurses. This shortage of nurses and other healthcare providers is also seen in other high-income countries. In the US, there are not enough nurses joining the healthcare system to meet the country’s growing demands (Algase et al., 2021), and the same is the case with Great Britain (Glasper, 2021). Griffiths et al. (2018) demonstrated that a low number of registered nurses (RNs) are related to reports of missed nursing care. Koithan et al. (2017) argued that in formal organized healthcare organizations, compassionate and competent nursing care has been pushed to the margins and has detoured from its disciplinary foundation.
2.2. Complaints from care recipients and their significant others

All healthcare providers are obligated to practice scientific knowledge when delivering high-quality and safe care based on care recipients’ needs and regardless of their ages, genders, ethnicities, beliefs, and disabilities (Svensk Sjuksköterskeförening [SSF], 2021; WHO, 2020). Despite this obligation, complaints from care recipients and their significant others regarding healthcare providers’ lack of compassion and competent care in their professional encounters have increased and are pointed out as factors contributing to patients’ vulnerability, suffering, and injuries in healthcare (Råberus et al., 2019; WHO, 2020). The complaints are complex narratives that describe quality and safety failures and poor experiences of healthcare delivery by care recipients and/or their significant others (IVO, 2021; Van Dael et al., 2020). These complaints may not always be identified by internal healthcare systems, such as incident reports and/or retrospective case reviews (Gillespie & Reader, 2021). In Europe and the US, evidence suggests that the complaints submitted by care recipients and their significant others provide valuable information that may help address deficiencies in healthcare (Råberus et al., 2019). The main complaints from care recipients focus on the quality and safety of the medical care received, followed by experiences of inadequate or lack of information and shortcomings in dealing with patients with dignity and respect (IVO, 2021; Råberus et al., 2019; Van Dael et al., 2020).

The nature of the complaints can be affected by the gender of the care recipient and/or their significant others (Eriksson et al., 2018). The gender aspect of complaints is more complex than is often conceptualized (Olsson, 2016). Complaints from women often concern personal aspects of care, such as experiences of dissatisfaction with not being seen, listened to, or trusted in encounters with healthcare providers, whereas complaints from men often focus on dissatisfaction with healthcare organizations as a whole (Eriksson et al., 2018). Wei et al. (2018b) stated that complaints from care recipients that are directed at physicians focus on the quality of treatment and professional competence, whereas complaints that are directed at nurses concern their non-
caring behaviors. Conversely, when care recipients and their significant others are encountered with dignity and respect by healthcare providers, they are more likely to seek care and follow treatment strategies, which are important for their health and well-being (ICN, 2021; WHO, 2020). Sundler et al. (2020) highlighted that healthcare providers need to encounter care recipients and/or their significant others with the compassion needed to balance their vulnerability and dignity. Råberus et al. (2019) stressed that the complexity of vulnerability can be understood within the view of care recipients’ dignity. Therefore, it is important that healthcare professionals try to create trustworthy encounters with care recipients and their significant others, in which dissatisfaction is addressed immediately; this way, formal complaints against healthcare organizations and/or healthcare providers can be avoided (Eriksson et al., 2018).

2.3. A person-centered approach to care

To deliver a person-centered approach to care, healthcare organizations should consider care recipients’ vulnerability, dignity, and needs (Leidner et al., 2021). Briefly, a person-centered approach to care is characterized by a shift in focus from the organization to the person and from illness and diagnosis to the health and wholeness of the patient. This means that the person is understood as a wholeness and is placed in the center within their context, and that the care is safe, individualized, inclusive, accessible, and provided with accurate and clear information (Ekman et al., 2011; McCormack & McCance, 2006; Swedish Society of Nursing [SSF], 2021; WHO, 2020). As awareness of the merits of a person-centered approach to care has increased, this concept has been accepted as a fundamental notion in healthcare organizations (Ekman & SSF, 2021; Swedberg, 2022; WHO, 2020). Evidence of person-centered care has been shown to positively affect care recipients’ health outcomes and economic aspects in relation to healthcare complexity, demands, and limited resources (Ekman & Swedberg, 2022; Leidner et al., 2021). However, although a person-centered approach to care has been widely accepted, challenges remain regarding how it can be applied in clinical healthcare practice (McCormack & Dewing, 2019; Sundler et al., 2020).
Balint (1969) argued that a person-centered approach to care requires that the healthcare provider consider holistically what is known about and attempt to understand the care recipient as a unique human being based on humanistic values before formulating illness diagnoses. Eklund et al. (2019) highlighted that a biological and medical perspective alone is not sufficient to understand care recipients’ needs and experiences of illness. This view corresponds with that of Koithan et al. (2017) that the conventional medical perspective of knowing care recipients’ needs is insufficient to understand their person-centered health and illness experiences. Health and illness are human experiences; the presence of illness does not preclude health, nor does optimal health preclude illness (Ekman & Swedberg, 2022; SSF, 2021). Eisenberg (1977) stressed that knowledge of patients’ objective diseases and their subjective experiences of illness is required to understand care recipients’ needs and experiences of health genuinely. McCormack and McCance (2021) pointed out the significant value of nurses’ in-depth understanding of the inherent humanistic values of a person-centered approach to care. To deliver such an approach, nurses have to identify care recipients’ needs, resources, and experiences and then take a starting point in who the person is, as opposed to what the person is (Dahlberg & Ekman, 2017). Sundler et al. (2020) underlined that a person-centered approach to care encompasses a caring approach based on humanistic values.

2.4. Caring in the discipline of nursing

Caring in the discipline of nursing is based on humanistic values with an existential philosophical approach in which the human being is recognized and understood as an active and capable part of a context. The human being is understood as a wholeness—a unit consisting of body, soul, and spirit, shaped by its experiences and values in the context. The essence of caring is promoting health and well-being, preventing illness, restoring health, alleviating suffering from birth through adulthood, and making the end of life and death as calm and peaceful as possible (Ericsson, 1987; Halldórsdóttir, 1996; Swansson, 1991; Watson, 1979).
Caring in the discipline of nursing has long been recognized as the heart and core value of nursing practice and is conceptualized as a behavior. Watson (1979) asserted that caring behaviors are based on meaning and mindful verbal and non-verbal actions in the moment, in which a caring moment is a heart-centered encounter with another human being. To maintain dignity for the care recipient, nurses need to ensure that the caring encounter encompasses shared trust and respect, characterized by listening to and confirming the wholeness of the human being (Ericsson, 1987; Halldórsdóttir, 1996; Swansson, 1991; Watson, 1979). Halldórsdóttir (1996) stated that uncaring behaviors in caring encounters are characterized by a lack of wholeness, thus promoting feelings of hopelessness, helplessness, vulnerability, and suffering in the care recipient. The overall aim of caring encounters is to alleviate suffering (Eriksson, 2002) and promote patient healing and well-being (Swanson, 1993).

Caring—the root of professional growth

Regardless of the complexity or abstraction of caring theory, Smith (2019) emphasized that caring knowledge in the discipline of nursing informs the growth of professional identity. Eriksson (2002) stated that understanding and valuing caring theory should be the guidance of the moral compass used by nurses to frame their understanding, values, and behaviors in caring encounters with care recipients and their significant others, as well as with their colleagues, other healthcare providers, and students. Watson (2017) described caring theory as the direction of the global ethical covenant with humanity to maintain human beings’ caring, healing, and person-centered health–illness experiences. At the same time, Råberus et al. (2019) stressed that more is needed beyond present attempts to apply a person-centered approach to care. They highlighted that to gain a more person-centered care development of and changes in healthcare providers understanding, values and behaviors are needed, in order to decrease the care recipients’ vulnerability and suffering, similar to IVO’s (2021) conclusion. This places a greater demand on higher professional education. In a study by Ghane and Esmaeili (2020), undergraduate nursing students describe the lack of a person-centered approach to care in their nursing education. Warshawski et al. (2018) reported that undergraduate nursing students have difficulty understanding the
meaning of caring and the practice of caring behaviors in nursing practice. Similarly, Wei and Watson (2019) asserted that caring-based scientific knowledge in nursing education is the root of the growth in students’ caring behaviors, as caring explains what nurses should do, how they do what they do, and why they do what they do, thus contributing to the foundation of delivering high-quality and safe care. Moreover, the SSF (2021) emphasized that undergraduate nursing education needs to develop nurses who stand up for caring-based scientific knowledge in nursing practice.

2.5. Undergraduate nursing education

Nurses represent nearly 50% of the global healthcare workforce (WHO, 2020). With nurses comprising the largest health professional group, nursing education seeks to educate and provide students with scientific knowledge and sufficient qualifications to practice nursing in a variety of healthcare settings (Taylor et al., 2020; WHO, 2020). Nursing is a legitimate profession, meaning that it guarantees nurses’ qualifications, which are promulgated by the country where a nurse works. Becoming a legitimate nurse with a Bachelor of Science in Nursing degree requires three to four years (depending on the country of education) of higher professional educational studies within the main area of caring in nursing, integrated in medical, pharmacology, sociology, and behavioral scientific knowledge. The nursing profession is responsible for both independent and collaborative clinical decisions that promote care recipients’ health and well-being, prevent illness, and alleviate suffering in accordance with applicable laws (SSF, 2021; WHO, 2020).

2.5.1. Swedish undergraduate nursing education

In Sweden, nurses started applying for professional nursing degrees in 1958, and nursing became part of higher professional education in 1977 during the higher education reform (SSF, 2021). In 1999, Swedish undergraduate nursing education adopted the European higher education standard for nursing education via the Bologna Process (European Commission, 2013). The Bologna Process is a collaboration between European countries with the aim of bringing greater coherence and inclusiveness to higher professional
educational institutions across Europe and the world. Descriptions of competencies to strengthen the quality of professional nursing education learning outcomes, progression, and level determination of bachelor’s, master’s, and doctoral studies are stipulated in European Commission Directive 2013/55.

Along with the European Qualification Framework and the European Credit Transfer and Accumulation System, European Commission Directive 2013/55 stipulates that an undergraduate nursing education program leading to a Bachelor of Science in Nursing degree must have 180 credits (European Commission, 2013).

Distinction between learning and teaching

Within the educational discipline, there is a distinction between learning and teaching (Gage, 1972). European Commission Directive 2013/55 provides recommendations for higher professional education to adopt an educational learning approach that places students’ learning at the center of educational learning processes (European Commission, 2013). Similar recommendations were made in North America and Australia (Miettinen, 2000). Silén (2000) emphasized that learning and teaching can be seen as opposites. When teaching is the focus, the person who teaches the subject is at the center of educational planning, decisions, and implementation. When learning is considered the opposite of teaching, students’ learning is placed at the center of educational processes (Rogers, 1983; Silén, 2000). Nevertheless, it can be argued that teaching is the usual dominant focus (Oliver & Luther, 2020).

2.6. The educational learning approach in undergraduate nursing education

The educational learning approach in this thesis follows the recommendation of European Commission Directive 2013/55 to facilitate students’ learning processes within a student-centered learning approach.
2.6.1. Learning through a student-centered learning approach

In a student-centered learning approach, the student is an active learner, whereas in the traditional teacher-centered learning approach, the student is a passive learner. The main difference is that, in a student-centered learning approach, there is respectful co-creation of knowledge between the educator, the student, and the learning environment (Dewey, 1933; Rogers, 1983), whereas in a teacher-centered learning approach, the teacher possesses the knowledge and transfers this to the students (Gage, 1972; López-Alvarado, 2016). In this sense, the students have active responsibility in their own learning experiences in a student-centered learning approach, as the control of the learning process has been passed from the educator to the students (Deslauriers et al., 2019; Mingorance et al., 2019). Deslauriers et al. (2019) argued that it is educators’ knowledge and ways of interpreting and implementing a student-centered learning approach that determine the opportunities for students to take charge of their own learning process. Students need to learn and develop competencies in taking on responsibilities for their own learning, thus enabling the satisfaction of their learning process (Oliver & Luther, 2020; Silén & Uhlin, 2008).

Therefore, educators are one of the key factors that help students develop competencies in being responsible for and successful in their own learning processes (Pivač et al., 2021). Educators’ primary roles are facilitating and guiding students toward an understanding and sense of professional responsibility (Hilli & Sandvik, 2020). Educators described that a student-centered learning approach facilitates higher student engagement, and students can experience the learning outcomes that are more relevant for their learning processes in this approach (Kaput, 2018). Students’ interactions and co-creation of learning with educators in student-centered learning environments positively affect their learning experiences (Murray, 2018). Villarroel et al. (2020) emphasized that students value the opportunity to apply their knowledge to specific learning outcomes together with their educators. Similarly, educators have positive experiences with the learning processes within student-centered learning environments (Hamlin, 2022; Villarroel et al., 2020). However, educators also reported that facilitating students’ learning
processes in a student-centered learning approach is highly time consuming (Barbagallo, 2019). This corresponds to the finding of Miller and Parlett (1974) that when students experience their learning processes to be important to educators, they take on more responsibilities to make their own decisions. By contrast, if the students feel abandoned and left alone, their behaviors will be characterized by dependence and seeking strategies to find the right answers (Miller & Parlett, 1974). Thus, the primary role of educators is to support a learning environment that engages students’ learning processes (Gustin, 2021). As Silén (2000) emphasized, an educator who supports and challenges their students’ inquiry approach through a student-centered learning approach that is intertwined into reflective practice fosters their students’ learning processes.

2.6.2. Learning through reflective practice

A student-centered learning approach is intertwined into reflective practice, which is derived from John Dewey’s theory of learning (Dewey, 1938). According to Dewey (1933), learning occurs when past experiences are related to future experiences. Reflection is not just a rational intellectual act; but also an act that implies to understand the meaning of our experiences (Dewey, 1938). Gärdénfors (2010) stated that students cannot attain a full understanding of a field of knowledge only by learning facts, as they also need to reflect on the underlying patterns involved and distinguish how the field of knowledge is linked. Sandvik et al. (2015) stressed that understanding is not the same as gaining knowledge because understanding entails thinking, acting, and applying knowledge in various ways in different situations and events; in short, understanding transforms knowledge into observable behaviors and actions. Reflective practice is an instrument in the learning process, in which one’s knowledge and skills in a situation become tools of understanding (Dewey, 1938; Gadamer, 1995; Horton-Deutsch & Sherwood, 2017).

Reflective practice is also an enduring process of growth and change, as it transcends empirical knowledge by exploring and questioning perceptions, values, and behaviors based on what we know from earlier experiences (Greenberger et al., 2022; Horton-Deutsch & Sherwood, 2017). Dewey (1938) emphasized that a prerequisite for growth to occur is an awareness of the
consequences of one’s perceptions, values, and behaviors. In other words, the person needs to develop their own judgments. Reflective practice may lead to enhanced awareness, empathy, and responsibility, thus nurturing more mindful decisions about responding to others, to situations, and to events in a more respectful and non-judgmental manner (Greenberger et al., 2022; Horton-Deutsch & Sherwood, 2017). This means that the person understands the self as part of a larger process in relation to a social context (Dewey, 1920). Watson (2012) underscored that reflective practice is consistent with caring theory, meaning that reflective practice affects students’ abilities to step back and view the social context of any specific situation and event from a unique individual perspective.

Stepping back and learning from earlier experiences take time and require knowledge and engagement from both educators and students (Sandvik & Hilli, 2022). Greenberger et al. (2022) underlined that experiences are not merely personal acts but that they occur through shared interactions between people, situations, and events; reflective practice cannot occur on its own. Gostelow and Gishen (2017) stated that reflective practice needs intentional learning outcomes provided by educators, in contrast to assuming that students will understand the difference between reflective practice and the everyday sense of reflection. Silén (2006) reported that this assumption and an instrumental handling of reflective practice may jeopardize the whole meaning of a student-centered learning approach. Thus, facilitating students’ learning processes should be focused on understanding the underlying principles of reflective practice (Greenberger et al., 2022). Mingorance et al. (2019) stressed that reflective practice should be intertwined into a variety of learning didactics that hold purposeful and structured learning outcomes.

2.7. Educational learning didactics in undergraduate nursing education

The educational learning didactics in this thesis follow Marton and Booth’s (2000) definition of a learning didactic as a learning act that aims to lead to change. This means that the learning process involves a how, and a what. Marton and Booth (2000) defined the how as the way in which students learn
and the what as the objectives that should be achieved in the learning process. The authors stated that the foci of the how and the what are not separable. Silén and Uhlin (2008) stressed that the central educational learning questions of how, what, and why, as well as the learning objectives, influence students’ learning processes. However, as highlighted by Mingorance et al. (2019), reflective practice ought to be intertwined into a variety of learning didactics.

### 2.7.1. Learning through narrative pedagogy

Within nursing education, narrative pedagogy (Diekelmann, 1995; Diekelmann, 2001) is a learning didactic and an important instrument of reflective practice (Horton-Deutsch & Sherwood, 2017). Choperena et al. (2019) wrote that people use multiple perspectives to make sense of the world and themselves by creating stories that have the characteristics of narratives. Every narrative has its own theme, with a beginning, a middle, and an end. Each nurse gets glimpses into each care recipient’s healthcare story, thus facilitating the nurse’s learning of how to understand narratives is of highly importance (Greenberger et al., 2022; Roberts & Leigh, 2020).

Ironside (2015) described narrative pedagogy as a co-created learning experience in which educators and students share healthcare stories and communally seek new ways to understand experiences in situations and events. They do so by reflecting on and questioning the experiences from multiple perspectives e.g., those of the nurse, the care recipients, and the patients’ significant others and by asking the central educational learning questions of how and what e.g., How do I make sense of the situation? What happened? How can I integrate caring into my everyday nursing practice? What do I have to learn more in order to become a nurse? (Ironside, 2015).

When educators share their personal experiences and co-create healthcare narratives, students can learn the professional language (Attenborough & Abbott, 2020; Roberts & Leigh, 2020). However, Greenberger et al. (2022) noted that educators tend to forget the professional language when retelling their personal healthcare experiences. Therefore, educators need to explore their awareness of their personal values and behaviors in the context of those within their own profession (Greenberger et al., 2022).
Reflective writing

Reflective writing is a well-recognized learning didactic in facilitating students’ learning of the professional language. It is often used after a learning experience, as it allows students to self-reflect (Bjerkvik & Hilli, 2019). By practicing reflective writing, students look back at their lived experiences, relate these experiences to present situations and events, and look forward to how such experiences can be applied (Jaastad, 2022). Barbagallo (2019) emphasized that using reflective writing may lead to enhanced awareness, thus nurturing more mindful decisions in relation to perceptions, values, and behaviors. Bjerkvik and Hilli (2019) stressed that learning outcomes should have purposeful and clear instructions (e.g., How did the event unfold? What feelings emerged?) to facilitate students’ learning processes through reflective writing. Furthermore, Jackson (2018) emphasized that to learn something new, students need to open themselves to being vulnerable. In reflective writing, vulnerability implies that students have to be transparent with their pre-understanding of their own perceptions, values, behaviors, and emotions about the objectives that are explored; vulnerability in reflective writing may lead to uncomfortable or even shameful emotions (Jackson, 2018). Choperena et al. (2019) stressed that instead of just facilitating students’ learning processes through verbal reflective practice, reflective writing enables them to deepen their understanding. Showing one’s vulnerability in reflective writing is a way to allow students to examine a situation holistically (McLeod et al., 2020). Reflective writing can contribute to students’ development of a deeper understanding of the care recipient as a person (Benner et al., 2010). Jarden et al. (2021) emphasized that facilitating students’ learning experiences can be done through the learning didactic of simulation.

2.7.2. Learning through simulation

The learning didactic of simulation intertwined into reflective practice is a prerequisite in and an integral part of today’s undergraduate nursing education (Alden & Durham, 2017; SSF, 2021). In simulations, students begin to experience and apply learned theory from lectures (Jarden et al., 2021; Pivač et al., 2021). In this thesis, the learning didactic of simulation conforms to the guidelines of the International Nursing Association of Clinical and Simulation
Learning (INACSL). The INACSL describes simulation as an educational learning didactic in which authentic situations and events that could happen in real life are practiced in a safe learning environment with no possibility of harming real care recipients (INACSL Standards Committee, 2016).

When educators facilitate students’ learning process through simulation, students have to experience the simulation learning environment as safe and the learning outcomes as meaningful (Pivač et al., 2021). The combination of the simulation learning environment, learning outcomes, and simulation instruments is a vital component of students’ learning (Roberts & Leigh, 2020). When designing simulation learning outcomes, educators have multiple options of instruments to choose from, such as the fidelity of mannequins (i.e., the degree to which a mannequin replicates human physiology and the technology of the mannequin), standardized patients (i.e., a real person trained to portray the characteristics of a real patient), role play (i.e., the use of drama techniques), and virtual reality (McMahon et al., 2021).

Today’s healthcare systems are characterized by technological advancements and innovations, which increase our reliance on and use of technologies (Galetz, 2019). This was also noted by Meerdink and Khan (2021); simulation in higher education has become more or less equal to the use of high-fidelity technological mannequins, regardless of the simulation learning outcomes. These outcomes mostly involve students’ medical knowledge and psychomotor skills for hospitalized patients with specific diagnoses (Powers et al., 2021; Zhang et al., 2022). By contrast, simulation learning outcomes focusing on verbal and non-verbal caring behavioral skills are mostly applicable in psychiatric contexts (Donovan & Mullen, 2019). Although the use of mannequins in simulation learning outcomes has multiple benefits for practicing medical knowledge, psychomotor skills, and behaviors that are crucial for becoming a nurse (Meerdink & Khan, 2021), it is not sufficient (Sandvik & Hilli, 2022). Nursing education is challenged with engaging students in finding meaningful connections between caring theory and nursing practice (Gustin, 2021; Persaud & Thornton, 2018), which may be due to caring often being hidden curricula in nursing education and thus possibly affecting the learning of caring behaviors (Rossillo et al., 2020). Furthermore, undergraduate nursing students have reported difficulties in overcoming
artificial interactions with mannequins, as mannequins cannot mimic the full human-to-human connection (Barber & Kardong-Edgren, 2019; Meerdink & Khan, 2021).

Simulation with a standardized patient

The human-to-human connection remains unchanged, with caring as the heart and core value of nursing practice (Galetz, 2019; Létourneau et al., 2021). Facilitating simulation learning outcomes with the use of standardized patients has been shown to enhance undergraduate nursing students’ initiation of verbal interactions with care recipients in clinical practice (Cantrell et al., 2017; Donovan & Mullen, 2019); when healthcare providers interact with standardized patients in simulations, they perform more similarly to how they would in clinical practice (Coffey et al., 2016). Nevertheless, the use of standardized patients, regardless of the simulation learning outcomes in undergraduate nursing education, varies greatly (Barber & Kardong-Edgren, 2019; Meerdink & Khan, 2021).

Simulation with role play

Another alternative use in simulation in undergraduate nursing education that varies greatly is role play (Okenwa-Emegwa & Eriksson, 2020). An advantage of using role play is that it can include several participants in a simulation context by assigning students different roles, such as the care recipient, the healthcare provider, the significant other, and/or the observer (Arveklev et al., 2015; Billings & Halstead, 2019). Given the different role perspectives, students are encouraged to see and feel other perspectives, which may facilitate their learning processes in becoming nurses (Billings & Halstead, 2019; Ter Beest et al., 2018). Håkansson Eklund et al. (2019) suggested that role play is a successful part of practicing the theoretical concept of empathy in caring, as role play involves practicing with real encounters, referring to the whole human-to-human connection. Kuntarti et al. (2018) reported that the learning didactic of role play enhances students’ learning of caring behaviors. On the other hand, students may experience vulnerability during role play; it is a drama technique, so they may be reluctant to engage in role play simulation (Billings & Halstead, 2019; Ter Beest et al., 2018).
Reflective practice in simulation

Regardless of the simulation learning outcomes and the simulation instruments used, educators need to be aware of students’ vulnerability as a predictor of their learning processes during simulation (McMahon et al., 2021). There is strong evidence in the simulation literature regarding the need for educators to actively engage in facilitating simulation learning outcomes in order to enable students’ learning processes (INACSL Standards Committee, 2016; Lewis et al., 2017). Schön (1983) referred to educators as reflective practitioners and presented the concepts of *reflection in action* and *reflection on action*. Reflection in action means that reflection occurs during a learning activity in a current situation. Students reflect on their previous understanding, the decisions to make, and what they need to do next. Reflection on action involves proceeding with the learning activity or changing the situation. The students also reflect on what occurred and attempt to make sense of it, which may enhance their understanding and new knowledge (Schön, 1983). Schön’s (1983) concepts of reflection in action and reflection on action were further developed by Durham and Alden (2013) in the reflective practice model.

In this thesis, the reflective practice model by Durham and Alden (2013), which combines the concept of reflective practice and the learning didactic of simulation, was used. Durham and Alden (2013) emphasized that reflective practice and simulation should occur simultaneously. The reflective practice model acknowledges that students are active learners, and it comprises four phases. The first phase is *reflection before action*, which entails that the educator create a safe learning environment, assign roles, and present the simulation scenario learning outcomes to the students. The students reflect on theory, knowledge, psychomotor skills, emotions, and behavior in preparation for the environment and simulation scenario. The second phase, *reflection in action*, means that the students reflect during the simulation, and they have the opportunity to pause the acting, if needed. If the educator observes that the students are struggling in the learning activity, the educator can call for a pause to reflect on the actual situation. The third phase, *reflection on action*, involves reflection on individual and group performance within the simulation activity and should be led by one and/or several educators. In the fourth phase,
reflection beyond action, written reflection assignments and/or reviews of video recordings, if used in the simulation, are needed. The students reflect on the knowledge they gained and how to use it in clinical nursing practice (Alden & Durham, 2017; Durham & Alden, 2013).

Regarding the fourth phase, reflection beyond action (Durham & Alden, 2013), Levett-Jones et al. (2014) emphasized that the major advantage of using video recording for learning is that video playback reduces memory biases, as both students and educators can see how the students actually performed rather than how they thought they performed. Regardless of which learning didactics are used in reflection beyond action (Durham & Alden, 2013), there is strong evidence supporting the prerequisite for facilitated reflection (Madsgaard et al., 2022). Furthermore, when reflecting beyond action, Alden and Durham (2017) stressed that the reflection should be designed around well-known concepts and frameworks, such as caring in the nursing process. Doing so may enhance students’ assimilation of caring theory, psychomotor skills, emotions, perceptions, values, and behaviors that are translated into practice (Alden & Durham, 2017). Schön (1983) stressed that students’ reflections on their experiences may hinder their learning process if they do not engage in such experiences fully. Rueda-Medina et al. (2021) found that students’ learning experiences are enhanced when the reflection is facilitated by educators. On the other hand, some studies found that the main disadvantage of facilitated reflection in the simulation context is the amount of time devoted to it by educators (Mariani et al., 2014; Murray, 2018).

2.8. Observational behavioral instrument assessing caring behavior

Observational instruments that are framed in caring theories to assess healthcare students’ and/or healthcare providers’ behaviors are limited (Akansel et al., 2021; Persaud & Thornton, 2018). Robinson Wolf and France (2017) stated that most studies framed by caring theories focus on describing the intersubjective nature of caring in nursing practice from the perspectives of the care recipients and their significant others, nurses, and nursing students.
In general, studies related to caring behaviors examine the feeling of being cared for by nurses in a variety of healthcare contexts and from the perspectives of the care recipients and/or their significant others (Wei et al., 2018a). Nishizawa et al. (2006) argued that understanding the kind of behavior that is occurring is important for achieving learning outcomes that enhance undergraduate nursing students’ verbal and non-verbal behaviors in their encounters with care recipients. Thus, analyzing video recordings rather than questionnaires is needed to clearly understand which caring behaviors undergraduate nursing students demonstrate during interactions with care recipients (Dyer et al., 2018).

Despite the existence of observational behavioral instruments developed to assess healthcare students and/or healthcare providers’ verbal and non-verbal competencies of caring behaviors in a variety of healthcare contexts, most of these are framed in communication theories and generally focus on verbal behavior only (Asan & Montague, 2014). An example is one of the most cited coding schemes in the medical literature, the Roter interaction analysis system, which codes healthcare provider–patient verbal dialogues in the medical context (Roter & Larson, 2002). Another example of a well-cited coding scheme is the Four Habits Model, which codes physicians’ communication skills associated with patient-centered care (Krupat et al., 2006). Another observational behavioral instrument is the caring behaviors instrument (McDaniel, 1990), which codes nurses’ caring and non-caring behaviors during patient interactions. In a systematic literature review by Higham et al. (2019) on non-technical skills observational behavioral instruments that assess healthcare students’ and/or healthcare providers’ non-verbal behavior in a simulated or clinic healthcare context, they concluded that no preeminent instruments for the assessment of non-verbal behavior could be recommended. Concurrently, Lavoie et al. (2018) found that most observational behavioral instruments used during simulation focus on knowledge, psychomotor skills, and behavior as separate components. Furthermore, none of the above-mentioned observational behavioral instruments are based on a specific caring theory that portray the fully theoretical dimensions of verbal and non-verbal caring and non-caring behaviors. Chorney et al. (2015) emphasized that when there are no
established observational behavioral instruments assessing the phenomenon of concern, the option is to create adaptations of existing instruments or to develop new observational behavioral instruments. As stated by Watson (2008), creating instruments framed in caring theories is highly important for understanding the wholeness of healthcare providers’ caring behavior interactions in all contexts in which caring occurs, such as in educational and/or clinical healthcare contexts. Thus, there is a need to assess the complexity of caring behaviors in the explanations of caring theories (Robinson Wolf & France, 2017).
3. Theoretical framework

The theoretical framework of this thesis is grounded in Swanson’s Theory of Caring (Swanson, 1991; Swanson, 1993). Varpio and Ellaway (2021) defined a theory as an abstraction of experiences, explanations, and/or predictions with the intent of making meaning of a phenomenon or experience. To understand and observe a phenomenon in different ways, a theory should promote a conceptual framework of the complex phenomenon and have different explanatory capabilities of abstraction (Hodges & Kuper, 2012). A middle range theory has a lower abstraction than the grand theory it evolves from so it has a higher descriptive value in understanding a variety of behaviors (Smith & Liehr, 2018). Swanson’s middle range Theory of Caring (Swanson, 1991; Swanson, 1993) is informed by Watson’s Grand Theory of Human Caring (Watson, 1979; Watson, 1999).

3.1. Swanson’s middle range Theory of Caring

Fully appreciating Swanson’s middle range Theory of Caring (Swanson, 1991; Swanson, 1993) requires understanding Watson’s Grand Theory of Human Caring (Watson, 1979; Watson, 1999). Inspired by the philosophers and thinkers Abraham Maslow, Carl Rogers, and Pierre Teilhard de Chardin, Watson sought to balance the cure orientation in the discipline of medicine, giving nursing its own scientific and professional discipline (Smith & Liehr, 2018). Watson’s Grand Theory of Human Caring (Watson, 1979; Watson, 1999) defines a human being as a spiritual wholeness that cannot be divided into body and soul. She developed 10 caritative factors that define the concepts of the theory (Table 1).
Table 1. Description of the 10 Caritative Factors in Watson’s Grand Theory of Human Caring

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sustaining humanistic-altruistic values through the practice of loving, kindness, compassion, and equanimity with the self/others</td>
</tr>
<tr>
<td>2</td>
<td>Being authentically present, enabling one’s faith/hope/belief system, and honoring the subjective inner lifeworld of the self/others</td>
</tr>
<tr>
<td>3</td>
<td>Being sensitive to the self and others by cultivating one’s own spiritual practices; going beyond one’s ego-self toward transpersonal presence</td>
</tr>
<tr>
<td>4</td>
<td>Developing and sustaining loving, trusting-caring relationships</td>
</tr>
<tr>
<td>5</td>
<td>Allowing for the expression of positive and negative feelings, authentically listening to another person’s story</td>
</tr>
<tr>
<td>6</td>
<td>Creatively engaging in problem solving–solution seeking through a caring process; fully using the self and the artistry of caring–healing practices through all ways of knowing/being/doing/becoming</td>
</tr>
<tr>
<td>7</td>
<td>Engaging in transpersonal teaching and learning within the context of caring relationships</td>
</tr>
<tr>
<td>8</td>
<td>Creating a healing environment at all levels, a subtle environment for energetic, authentic caring presence</td>
</tr>
<tr>
<td>9</td>
<td>Reverentially assisting with basic needs as a sacred act, touching the mind, body, and spirit of the other, and sustaining human dignity</td>
</tr>
<tr>
<td>10</td>
<td>Opening the spiritual, mysteries, and unknowns, allowing for miracles</td>
</tr>
</tbody>
</table>

The 10 caritative factors embrace altruistic values; they instill loving, kindness to the self and others, faith and hope, honor, and trust of oneself and of others by nurturing individual beliefs, personal growth, and practice. Watson’s Grand Theory of Human Caring (Watson, 1979; Watson, 1999) is considered a philosophical and ethical base for professional nursing practice (Alligood, 2017; Robinson Wolf & France, 2017).

### 3.1.1. Practicing caring in Swanson’s Theory of Caring

Grounded in Watson’s Grand Theory of Human Caring (Watson, 1979; Watson, 1999), Swanson developed her theory of caring (Swanson, 1991; Swanson, 1993) from three empirical studies in a perinatal context.

The theory offers clear explanations of what it means for nurses to practice caring. Swanson (1993) formulated an overall definition of caring: “Caring is a nurturing way of relating to a valued other towards whom one feels a
personal sense of commitment and responsibility” (p. 165). The key words in this definition include *nurturing*, referring to growth and health; *way of relating*, which occurs in encounters; *to a valued other*, meaning that the one cared for matters; *toward whom one feels a personal sense*, referring to personalization; *sense of commitment*, such as a bond or passion; and *responsibility*, such as accountability and duty (Swanson, 1993).

Swanson’s Theory of Caring is characterized by the caring encounter and is operationalized in five caring domains: *maintaining belief*, *knowing*, *being with*, *doing for*, and *enabling*. Each of these domains is further explained in five sub-domains (Figure 1) (Swanson, 1991; Swanson, 1993).

Although Swanson’s Theory of Caring has been developed over the years with more specific descriptive elements of each domain, the five conceptual domains have remained stable and are consistent with Watson’s Grand Theory of Human Caring (Kalfoss & Owe, 2015).

Swanson (1993) stated that the domain of *maintaining belief* is the core construct of the theory, meaning that the nurse believes that the care recipient
can find strength and meaning in health and illness and can envision a meaningful future for themselves. In the domain of knowing, the nurse strives to understand an event and its meaning in life for the one being cared for by acknowledging the care recipient’s bio-psycho-social and spiritual well-being. Swanson (1993) emphasized that the domain of being with goes a step beyond knowing, as the nurse needs to be emotionally present and share in the care recipient’s experiences of health and illness. In the domain of doing for, the nurse preserves the care recipient’s dignity by performing knowledgeable actions that the one being cared for cannot currently perform for themselves. In the domain of enabling, Swanson (1993) remarked that the nurse aims to help the care recipient heal by supporting and informing them about their realities. She also emphasized that the nurse needs to know their boundaries so that they do not negatively affect the provision of care.

Although the five domains are presented separately, Swanson (1993) stated that the caring process is an iterative process grounded in a culture of maintaining belief. The caring process combines the qualities of the compassionate healer in the domains of knowing and being with and those of the competent practitioner in the domains of doing for and enabling, aiming toward the overall outcomes of patient healing and well-being (Swanson, 1993). To experience well-being is to live the subjective meaning of being filled with wholeness. Thus, healing becomes the process of reestablishing well-being, which means releasing inner pain, creating, or restoring meanings, and developing a sense of renewed wholeness (Swanson, 1993).

3.1.2. Using Swanson’s Theory of Caring in various contexts

Although Swanson’s Theory of Caring was generated from phenomenological studies of women who miscarried, the caring process provides a conceptual framework for transferability beyond the clinical context it evolved from (Alligood, 2017; Andershed & Olsson, 2009; Kalfoss & Owe, 2015). At the same time, Swanson (1991) stated that caring as a nurturing way of relating to another human being is not a sole domain for nursing, meaning that nurses alone do not provide care, but all healthcare providers do. Therefore, the five conceptual domains itemized in Swanson’s Theory of Caring are the core
values of every patient encounter aimed at healing and well-being (Swanson, 1991; Swanson, 1993).

Reynold (1971) stated that a useful theory provides a sense of understanding and applicability in practice. Globally, Swanson’s Theory of Caring (Swanson, 1991; Swanson, 1993) has been embraced as a framework and applied to practice for different healthcare organizations, providers, and educators (Alligood, 2017). An example of a healthcare organization that has implemented Swanson’s Theory of Caring is the University of North Carolina Hospitals through its professional practice model (Tonges & Ray, 2011). Another example is McKelvey (2018), who applied the five conceptual domains in Swanson’s Theory of Caring in nursing education, particularly in educators’ encounters with students. The Parent Caring Response Scoring System, which is an observational behavioral instrument that focuses on the interactions between parent and child during cancer-related port starts, is also based on Swanson’s Theory of Caring (Bai et al., 2018).
4. Rationale

Healthcare providers are obligated to practice scientific knowledge when delivering high-quality and safe care based on patients’ needs. Despite this obligation, complaints from care recipients and their significant others regarding healthcare providers’ lack of compassion and competent care in their professional encounters have increased. These complaints demonstrate the need for learning strategies that enhance healthcare providers’ awareness of their own caring behaviors and thus maintain care recipients’ dignity, health, healing, and well-being.

To strengthen healing and well-being in the discipline of nursing, theoretical structures of caring have been established as the heart and core value of guidance of nursing practice. However, the learning outcomes of undergraduate nursing education have tended to focus more on developing knowledge and psychomotor skills than on learning caring behavior. Some studies have examined specific learning approaches and learning didactics about caring behavior. One challenge identified is engaging students in finding the connection between the meaning of caring and how to practice caring behavior. If undergraduate nursing students are going to learn caring, a stronger emphasis on learning caring using a variety of learning didactics is essential. Furthermore, without adequate caring theory-based observational behavioral instruments that assess caring behavior, there is little evidence to nurture the development of the learning of caring behaviors. The influence of learning caring in the context of a caring behavior course founded on caring theory has not been sufficiently explored using a student-centered learning approach intertwined into reflective practice, narrative pedagogy, and simulation. Thus, the focus of this thesis was to study how a caring behavior course in undergraduate nursing education could influence students’ learning of caring behaviors.
5. Aim

The overall aim of this thesis was to study how a caring behavior course in undergraduate nursing education influenced students’ learning of caring behaviors.

5.1. Specific aims of each paper

Paper I
The aim was to describe undergraduate nursing students’ experiences of participating in a Caring Behavior Course (CBC) using a variety of learning didactics.

Paper II
The aim was to describe undergraduate nursing students’ experiences of practicing caring behaviors with a standardized patient.

Paper III
The aim was to develop and test a caring behavior coding scheme based on Swanson’s Theory of Caring.

Paper IV
The aim was to describe undergraduate nursing students’ learning of caring behaviors while participating in a caring behavior course.
6. Methods

6.1. Design

This thesis comprised four papers (Table 2) that aimed to generate new knowledge from empirical research within undergraduate nursing education. Different designs using both qualitative and quantitative methods were used to meet the aims of the thesis. A qualitative design was the best choice to achieve the aims for papers I and II, as these focused on interpreting different forms of collected narratives from the individuals being studied. An instrument development design was used to develop an observational behavioral instrument based on a caring theory and thus meet the aim for paper III. For paper IV, a quantitative observational design was used, as this paper statistically described the collected data from observed individuals’ behaviors.

Table 2. Description of the study designs

<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Design</th>
<th>Data Collection</th>
<th>Data Analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The aim was to describe undergraduate nursing students’ experiences of participating in a Caring Behavior Course (CBC) using a variety of learning didactics.</td>
<td>Qualitative design</td>
<td>Focus group interviews</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>II</td>
<td>The aim was to describe undergraduate nursing students’ experiences of practicing caring behaviors with a standardized patient.</td>
<td>Qualitative design</td>
<td>Individual written reflections</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>III</td>
<td>The aim was to develop and test a caring behavior coding scheme based on Swanson’s Theory of Caring.</td>
<td>Instrument development design</td>
<td>Video recordings</td>
<td>Descriptive statistics</td>
</tr>
<tr>
<td>IV</td>
<td>The aim was to describe undergraduate nursing students’ learning of caring behaviors while participating in a caring behavior course.</td>
<td>Quantitative observational design</td>
<td>Video recordings</td>
<td>Descriptive statistics Wilcoxon signed rank test</td>
</tr>
</tbody>
</table>
6.2. Undergraduate nursing education

This thesis was conducted among undergraduate nursing students who were attending semester four at a university in Sweden during spring and fall 2018 and spring 2019. Each spring and fall semester, approximately over 100 students are admitted to the undergraduate nursing program. Upon entering semester four, students would have completed 45 credits in nursing science (e.g., out of 120 credits), 30 credits in medical science (e.g., out of 30 credits), 15 credits in social behavior science (e.g., out of 22.5 credits), and 0 credit in the elective scientific field (e.g., out of 7.5 credits) out of the total of 180 credits required to obtain a Swedish legitimate nursing degree and a Bachelor of Science in Nursing degree (European Commission, 2013; Table 3).

Table 3. Overview of the courses in nursing education

<table>
<thead>
<tr>
<th>Semester 1</th>
<th>Semester 2</th>
<th>Semester 3</th>
<th>Semester 4</th>
<th>Semester 5</th>
<th>Semester 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Caring</td>
<td>Medical-microbiology and Immunology</td>
<td>Basic Anatomy and Physiology</td>
<td>Basic Psychology</td>
<td>Basic Gerontology</td>
<td>Basic Pathology, Diagnostics, and Treatments</td>
</tr>
<tr>
<td>7.5 credits</td>
<td>7.5 credits</td>
<td>7.5 credits</td>
<td>7.5 credits</td>
<td>7.5 credits</td>
<td>7.5 credits</td>
</tr>
<tr>
<td>Nursing Science</td>
<td>Medical Science</td>
<td>Medical Science</td>
<td>Social Behavior Science</td>
<td>Medical Science</td>
<td>Medical Science</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Basic Pharmacology</td>
<td>Basic Scientific Methods</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.5 credits</td>
<td>7.5 credits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical Science</td>
<td>Nursing Science</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semester 3</td>
<td>Semester 4</td>
<td>Semester 5</td>
<td>Semester 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Health Promoting in Nursing</td>
<td>Person-centered Nursing I</td>
<td>Person-centered Nursing II</td>
<td>Applied Person-centered Nursing in Complex Situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 credits</td>
<td>15 credits</td>
<td>15 credits</td>
<td>15 credits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Science</td>
<td>Nursing Science</td>
<td>Working Life and Organizations</td>
<td>Bachelor of Nursing Degree Project</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 credits</td>
<td>15 credits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Behavior Science</td>
<td>Nursing Science</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Advanced Scientific Methods</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7.5 credits</td>
<td>7.5 credits</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nursing Science</td>
<td>Nursing Science</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In spring and fall 2018 and spring 2019, the students had the opportunity to apply to one of three on-campus elective five-week courses with 7.5 credits each. These elective courses were as follows: Cardiovascular Nursing from a Person-Centered Perspective, Healthcare Improvement, and the Caring Behavior Course.

6.3. The caring behavior course

The context of this thesis is the 7.5-credit elective Caring Behavior Course, (the CBC). In the discipline of nursing, caring is conceptualized as a behavior and has long been recognized as the heart and core value of nursing practice (Swanson, 1991; Swanson, 1993; Watson, 1979). In the spirit of caring philosophy and in accordance with Higher Education Ordinance 1993:100 and European Commission Directive 2013/55, the CBC was developed and designed by the author of this thesis, together with her co-workers who are national and international experts in the field. The first CBC held in the spring semester of 2018 served as a pilot for the two subsequent CBCs in the fall 2018 and spring 2019 semesters. After the completion of the CBC pilot course, an adjustment was made, requiring that the students in the two upcoming CBCs encounter the same standardized patient during the two video-recorded caring behavior simulations in the first and last week’s seminars. The last two CBCs were facilitated by the same educators.

The overall educational learning outcomes in the CBC were to gain a deeper understanding and knowledge of caring theory and to transform the theory into caring behaviors and recognize how one’s and others’ values and behaviors influence patient encounters. The CBC was facilitated through a student-centered learning approach (Dewey, 1933; Rogers, 1983) intertwined into reflective practice (Dewey, 1933) with the learning didactics of narrative pedagogy (Diekelmann, 1995; Diekelmann, 2001) and simulation (INACSL Standards Committee, 2016). The CBC consisted of six voluntary lectures, five mandatory seminars, and two mandatory caring behavior simulation days. Throughout the CBC, the seminars, and the caring behavior simulation days, the students worked together in the same study groups that comprised four to five students. To obtain a passing grade (European Commission, 2013), the
students had to actively participate in all mandatory learning components, submit individual written reflections and study group assignments linked to each seminar and to caring behavior simulation day learning outcomes, and take an individual practical examination and a written exam (Table 4).

Table 4. Overview of the five-week course content of the CBC

<table>
<thead>
<tr>
<th>Week</th>
<th>Course Content of the CBC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Seminar 1: Concepts of caring</td>
</tr>
<tr>
<td></td>
<td>- Video-recorded caring behavior simulation of an encounter with a standardized patient</td>
</tr>
<tr>
<td></td>
<td>• Lecture 1: Concepts of caring in nursing practice</td>
</tr>
<tr>
<td>Week 1</td>
<td>• Lecture 2: Verbal and non-verbal caring behaviors</td>
</tr>
<tr>
<td></td>
<td>• Seminar 2: Learning through the lens of others’ perspectives</td>
</tr>
<tr>
<td></td>
<td>• Submissions related to seminar 1: Individual written reflection and study group assignment</td>
</tr>
<tr>
<td></td>
<td>• Lecture 3: Being present</td>
</tr>
<tr>
<td>Week 2</td>
<td>• Submissions related to seminar 2: Individual written reflection and study group assignment</td>
</tr>
<tr>
<td></td>
<td>• Caring behavior simulation day 1: Integrating the concepts of caring into caring behavior</td>
</tr>
<tr>
<td></td>
<td>• Lecture 4: Recognizing one’s own values and biases</td>
</tr>
<tr>
<td>Week 3</td>
<td>• Lecture 5: Encountering unreasonable demands and aggressive patients</td>
</tr>
<tr>
<td></td>
<td>• Seminar 3: Becoming aware of one’s own biases and practicing being present</td>
</tr>
<tr>
<td></td>
<td>• Submissions related to caring behavior simulation day 1: Individual written reflection and study group assignment</td>
</tr>
<tr>
<td></td>
<td>• Caring behavior simulation day 2: Integrating the concepts of caring into caring behavior</td>
</tr>
<tr>
<td></td>
<td>• Seminar 4: Co-creating the concept of caring in nursing practice</td>
</tr>
<tr>
<td>Week 4</td>
<td>• Lecture 5: Co-creating nursing practice</td>
</tr>
<tr>
<td></td>
<td>• Submissions related to seminar 3: Individual written reflection and study group assignment</td>
</tr>
<tr>
<td></td>
<td>• Submissions related to caring behavior simulation day 2: Individual written reflection and study group assignment</td>
</tr>
<tr>
<td></td>
<td>• Seminar 4: Co-creating the concept of caring in nursing practice</td>
</tr>
<tr>
<td></td>
<td>• Lecture 6: Co-creating nursing practice</td>
</tr>
<tr>
<td></td>
<td>• Seminar 5: Becoming a nurse</td>
</tr>
<tr>
<td>Week 5</td>
<td>- Practical examination</td>
</tr>
<tr>
<td></td>
<td>- Video-recorded caring behavior simulation of an encounter with a standardized patient</td>
</tr>
<tr>
<td></td>
<td>• Submissions related to seminar 4: Individual written reflection and study group assignment</td>
</tr>
<tr>
<td></td>
<td>• Written individual examination</td>
</tr>
<tr>
<td></td>
<td>• Submission related to seminar 5: Study group assignment</td>
</tr>
</tbody>
</table>

6.3.1. CBC lectures

The six two-hour voluntary lectures were developed to introduce and deepen the students’ understanding and knowledge of caring in nursing practice. All six lectures were held in full classes by the same educator. The lectures began
and ended with a co-created open-ended reflection question focusing on each lecture’s learning outcomes (Dewey, 1938; Ironside, 2015). Examples of these co-created open-ended reflection questions were as follows: “How do I become present in a caring encounter?” and “What do I have to learn in order to become a caring nurse?” Each lecture included a PowerPoint presentation with written textbook chapters, quotes, art/pictures, videos, and audio clips that reflected the theoretical concepts of caring in nursing practice from the perspectives of care recipients and their significant others, nurses, and other healthcare professionals.

Content of the lectures

In lecture one, The concepts of caring in nursing practice, the learning outcomes focused on deepening the understanding and knowledge of the theoretical concepts of caring: the meaning of dignity, health, illness, and suffering. In lecture two, Verbal and non-verbal caring behavior, the learning outcomes were centered on being present with the patient in contrast to doing for the patient. In lecture three, Being present, the learning outcomes focused on deepening the understanding and knowledge of how to be present in the moment within the theoretical concepts of warmth, respect, empathy, and humor. In lecture four, Recognizing one’s own values and biases, the learning outcomes involved raising awareness of how one’s own values and behaviors can influence patient encounters within the concepts of gender, culture, and equality. In lecture five, Encountering unreasonable demands and aggressive patients, the learning outcomes centered on deepening the understanding and knowledge of how to address unreasonable demands and deal with aggressive patients. Lastly, in lecture six, Co-creating nursing practice, the learning outcomes were about co-creating nursing practice toward the overall aim of achieving patient well-being. In all six lectures, the educator encouraged and invited the students to actively engage in co-created reflections, with a focus on each lecture’s learning outcomes.

6.3.2. CBC seminars

The five four-hour mandatory seminars aimed to deepen the lectures’ theoretical aspect of learning about caring in nursing practice. The seminars
were held by the same educator who facilitated the lectures. All five seminars began and ended as full classes, with open-ended reflection questions focusing on each seminar’s learning outcomes (Dewey, 1938; Ironside, 2015). Examples of these co-created open-ended reflection questions were as follows: “How do I practice active listening in a manner that shows caring behavior?”, “How do I verbalize caring?”, and “What have I learned in today’s seminar that I did not know before?”

Content of the seminars

In seminar one, Concepts of caring, the learning outcome focused on raising awareness of what the students had to learn within the theoretical concepts of caring in order to become nurses: the meaning of being human, dignity, health, illness, and the environment. In the study group, the students watched a 19 min video clip about a young woman who had lived through a severe accident and reflected upon her experience. Linked to the video clip was a written group assignment with a word limit of 500 words and with the requirements for the course literature and scientific papers focusing on the learning outcomes of the seminar.

Furthermore, the students had to be individually video-recorded in a caring behavior simulation in which they encountered a standardized patient at the clinical training center in the School of Nursing. Linked to the caring behavior simulation with a standardized patient was an individual written reflection with a word limit of 300 words and focusing on the following questions: “What was challenging in encountering the standardized patient?”, “What I know now that I did not know before?”, and “To become a nurse I need to learn more?”

In seminar two, Learning through the lens of others’ perspectives, the learning outcome focused on the meaning of being a person and a patient with the overall aim of patient well-being. Together in, full-class, students watched a biographical movie focusing a successful middle-aged father who suffers a stroke. Linked to the biographical movie was a written group assignment with a word limit of 500 words and with the requirements for the course literature and scientific papers focusing on the learning outcomes of the seminar.
Moreover, related to the learning outcomes was an individual written reflection with a word limit of 300 words and focusing on the following questions: “What I know now that I did not know before?”, “Things I knew before but which I understand differently know are?”, and “To become a nurse I need to learn more?"

In seminar three, *Becoming aware of one’s own biases and practicing being present*, the learning outcome focused on raising awareness of one’s own values and biases within the theoretical concepts of caring—gender, culture, and equality—and how these affect behaviors. Together in, the study-group, students watched four video clips focusing on how people judge one another without realizing it and the power of empathy. Linked to the four video clips was a written group assignment with a word limit of 500 words and with the requirements for the course literature and scientific papers focusing on the learning outcomes of the seminar. Moreover, related to the learning outcomes was an individual written reflection with a word limit of 300 words and focusing on the following questions: “What I know now that I did not know before?”, “Things I knew before but which I understand differently know are?”, and “To become a nurse I need to learn more?"

In seminar four, *Co-creating the concept of caring in nursing practice*, the learning outcome focused on practicing active listening within the theoretical concepts of caring: dignity, trust, meaningfulness, confirmation, support, and hope. Together in, the study-group, students engaged in a role play on how to encounter a patient using the seminar learning outcomes’ theoretical concepts. This role play was presented to the entire class and was followed by a co-created reflection. Linked to the seminar was a written group assignment with a word limit of 500 words and with the requirements for the course literature and scientific papers focusing on the learning outcomes of the seminar. Related to the learning outcomes was an individual written reflection with a word limit of 300 words and focusing on the following questions: “What do I know now that I did not know before?”, “Things I knew before but which I understand differently now are?”, and “To become a nurse I need to learn more?"
In seminar five, *Becoming a nurse*, the learning outcomes were integrated to deepen the understanding and knowledge of becoming a nurse. Together in the study group, the students had to create a picture collage depicting the theoretical concepts of caring and their own developments in becoming nurses, including a scientific paper. This picture collage, together with the related scientific article, was presented to the entire class, followed by a co-created reflection.

In seminar five, as in seminar one, the students had to be individually video-recorded in a caring behavior simulation of an encounter with a standardized patient. This simulation also served as the students’ practical examination. Linked to the caring behavior simulation with a standardized patient was an individual written reflection with a limit of 300 words and focusing on the following questions: “What I know now that I did not know before participating in the CBC?”, “Things I knew before but which I understand differently now are?”, and “How I intend to use what I learned in my future practice as a nurse?”

**Video-recorded caring behavior simulation of an encounter with a standardized patient**

As part of seminars 1 and 5, this paragraph presents the video-recoded (GoPro Hero 5 Session, San Mateo, CA, US) caring behavior simulations of encounters with a standardized patient (INACSL Standards Committee, 2016). In both seminars, the scripts of the simulations for both the student and the standardized patient were the same. The students interacted with the same standardized patient in both simulations.

The caring behavior simulation scenario was set up at the clinical training center in the School of Nursing to replicate a home environment with two chairs and a coffee table. The standardized patient sat on one of the chairs. The acting role of the standardized patient alternated between four women with an age range of 63–68 years and with no prior experience of nursing education. All four women were verbally introduced and handed a script of the simulation scenario and an instruction manual for the acting role (Table 5).
Table 5. Scenario script of the caring behavior simulation for the standardized patient

**Simulation scenario:**
When the student acting as the nurse comes to visit the standardized patient, the latter says, “Hi, I’m Elsa. It’s so nice of you to come and visit me (sounding a bit concerned and worried). I don’t feel well today; I feel dizzy and nauseated, and I have a headache. I’m so worried. Can you please help me?

**Instruction manual:**
**Social situation:** You were born in the house where you live, which is a big countryside house. Before retirement, you ran a garden business. You’ve been divorced for 10 years, and your ex-husband, Hans, has a daughter, Gunilla, from a previous relationship. Gunilla is now 42 years old. She lives in a nearby village with her family, consisting of her partner, Anna, and their two sons, Carl, 8, and Oscar, 10. You have a good relationship with all of them.

**Activities:** You like spending time with family and friends. You like to walk your dog, a Labrador named Nicko, in the forest. You spend a lot of time in your garden.

**Pain:** You have a headache. You have no severe pain in the hip where you have had surgery.

**Sleep:** You’ve not been sleeping well, as you’ve been anxious about the hip surgery and what may happen after it.

**Nutrition:** You’ve not been eating as well as you should in the previous month. This morning, you’ve not eaten at all.

**Elimination:** There’s no problem with elimination.

**Vital parameters:** If the student asks about your blood pressure, you normally have 140/70. Five years ago, you started taking medication for high blood pressure. This is monitored at the healthcare center. You have no fever.

**Medication:** Today, you’ve taken your blood pressure medication.

Prior to the simulation, each student was provided with the same simulation instruction (Table 6) by an educator, who also handed out a handbag containing equipment, such as a blood pressure cuff, wound dressing material, syringes, a mobile phone, pen, and pencil, with the instruction to use what they considered appropriate for their assessment during the simulation.

**Table 6. Scenario script of the caring behavior simulation for the student**

The simulation scenario script depicts a self-independent 70-year-old woman named Elsa. Elsa is living alone in a countryside house with her dog. Before retirement, she ran a local garden business. She has an active lifestyle and has many friends. She medicates for high blood pressure and was recently discharged from the local hospital following hip surgery without complications. Because of the surgery, she receives help from assistant nurses in municipal care. This morning, she told the assistant nurse that she wasn’t feeling well, as she felt anxious, dizzy, and nauseated. The student acting as the nurse was called to care for her.
6.3.3. **CBC caring behavior simulation days**

The two four-hour mandatory caring behavior simulation days (INACSL Standards Committee, 2016) aimed to provide the students with practice regarding the meaning of caring as learned in the lectures and seminars. The caring behavior simulation days were facilitated by the educator, who conducted the lectures and seminars, along with four co-workers. Each caring behavior simulation day began and ended as a full class with open-ended reflection questions (Dewey, 1938; Ironside, 2015). On both caring behavior simulation days, the students worked together in their study groups. Each of the simulation scenarios on both caring behavior simulation days was set up in its own learning environment, such as a room at the clinical training center in the School of Nursing, which replicated the context of the simulation scenario script (i.e., municipal care and hospital care). Each simulation scenario on both caring behavior simulation days was facilitated by one of five educators following the reflective practice model (i.e., the four phases of reflection before actions, reflection in action, reflection on action, and reflection beyond action; Durham & Alden, 2013). Before the role play started, the educators presented the simulation environment and the simulation learning outcome for the specific scenario and assigned each student an acting role (i.e., nurse, patient, significant other, and/or observer). After the simulation, the educator facilitated a co-created reflection related to the simulation learning outcome, focusing on individual and group performance during the simulation activity.

**Content of the caring behavior simulation days**

On both caring behavior simulation days for *embodying the concepts of caring into caring behavior*, the learning outcome focused on the practice of transforming the theoretical concepts of caring into caring behaviors. On caring behavior simulation day 1, the students role-played in five contrasting caring and non-caring behavior simulation scenarios: 1) *to listen*, 2) *to be assertive in verbal behavior*, 3) *to demonstrate empathy*, 4) *to be present*, and 5) *to demonstrate warmth in non-verbal behavior*. Each simulation started with the non-caring behavior simulation, followed by the caring behavior
simulation. Tables 7 and 8 show the non-caring and caring behavior simulation role plays for to be assertive in verbal behavior.

Table 7. Description of the non-caring behavior simulation role play for to be assertive in verbal behavior

| The educator: | Anna is visiting her mother, Astrid, at the hospital. Astrid is 65 years old and has been admitted to the medical ward for presumed pneumonia. Astrid is tired. Yesterday, Astrid underwent an X-ray of her lungs, and Anna wants to know the results and the future care plan for her mother. |
| Student acting as the daughter: | You’re standing beside the bed. You talk constantly about how you want to know the X-ray results. You’re worried about Astrid’s future care plan. |
| Student acting as the patient: | You’re lying down in bed. You’re quiet and very tired. |
| Student acting as the nurse: | You encounter Anna in a vague way and a non-caring manner. You don’t know the results of the X-ray. |

Table 8. Description of the caring behavior simulation role play for to be assertive in verbal behavior

| The educator: | Anna is visiting her mother, Astrid, at the hospital. Astrid is 65 years old and has been admitted to the medical ward for presumed pneumonia. Astrid is tired. Yesterday, Astrid underwent an X-ray of her lungs, and Anna wants to know the results and the future care plan for her mother. |
| Student acting as the daughter: | You’re standing beside the bed. You talk constantly about how you want to know the X-ray results. You’re worried about Astrid’s future care plan. |
| Student acting as the patient: | You’re lying down in bed. You’re quiet and very tired. |
| Student acting as the nurse: | You encounter Anna in a vague way and a caring manner. You don’t know the results of the X-ray. |

On caring behavior simulation day 2, the students role-played in five caring behavior simulations scenarios: 1) to encounter difficult situations, 2) to ask specific questions, 3) to co-create care with the patient, 4) to encounter an angry patient, and 5) to encounter a dissatisfied patient. Table 9 presents the caring behavior simulation role play for to ask specific questions.
Table 9. Description of the caring behavior simulation role play for to ask specific questions

**The educator:** Harry is an old man living at the nursing home you are working at. The assistant nurse has asked you to visit him, as his appetite has drastically decreased. Harry is quiet and seems depressed.

**Student acting as the patient:** You’re sitting on a chair. You have no appetite. You’re quiet and don’t want to talk about feeling depressed.

**Student acting as the nurse:** You encounter Harry in his room at the nursing home. You try to establish a caring encounter with him by listening to him and using open clarifying questions.

Linked to each of the caring behavior simulation days was an individual written reflection with a word limit of 300 words and focusing on the learning outcomes of the caring behavior simulation days: “What I know now that I did not know before?”, “Things I knew before but which I understand differently now are?”, and “To become a nurse I need to learn more?”

### 6.4. Participants

A total population sample was used, which, according to Polit and Beck (2016), means that all attending students in each of the three CBCs were asked to participate. The students were provided the same oral and written information (i.e., the research aims, methods, presentation of findings, and data storage) by the researcher’s co-workers. Furthermore, all the students were assured that participation in this research project was voluntary and confidential and that it would not impact their grades in any way. After having had the opportunity to ask questions and think about their participation, the students gave their written informed consent.

In the CBC pilot (paper III), one out of 20 students declined participation in the study. In the CBC during the fall semester (papers I, II, and IV), all 22 eligible students agreed to participate. Lastly, in the CBC during the spring semester (papers I, II, and IV), 12 out of the 38 eligible students declined participation (Table 10).
Table 10. Overview of the participants in the CBCs

<table>
<thead>
<tr>
<th>CBC</th>
<th>Eligible Students</th>
<th>Students who Declined</th>
<th>Total Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC pilot (paper III)</td>
<td>20</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>CBC, fall semester (papers I, II, and IV)</td>
<td>22</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>CBC, spring semester (papers I, II, and IV)</td>
<td>38</td>
<td>12</td>
<td>26</td>
</tr>
</tbody>
</table>

6.4.1. Description of the participants in papers I–IV

Paper I

In paper I, from the total population sample (Polit & Beck, 2016), all 22 participants in the CBC during the fall semester and all 26 participants in the CBC during the spring semester were asked to participate in focus group interviews (Krueger & Casey, 2015). During the fall semester, 13 participants agreed to participate in one out of three focus group interviews. During the spring semester, 12 participants agreed to participate in one out of two focus group interviews (Table 11), for a total of 25 participants.

Table 11. Demographic characteristics of the participants in paper I

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>24</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Age ranging (Years)</td>
<td>21–51 (mean: 28)</td>
</tr>
<tr>
<td>Previous experience from healthcare as a</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare provider</td>
<td>18</td>
</tr>
<tr>
<td>Patient</td>
<td>13</td>
</tr>
<tr>
<td>Significant other</td>
<td>15</td>
</tr>
</tbody>
</table>

Paper II

In paper II, from the total population sample (Polit & Beck, 2016), the narratives from individual written reflections focusing on the video-recorded caring behavior simulations of encounters with a standardized patient were
collected from all 22 participants in the CBC during the fall semester and all 26 participants in the CBC during the spring semester (Table 12), for a total of 48 participants.

Table 12. Demographic characteristics of the participants in paper II

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>44</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Age ranging</td>
<td>Years</td>
</tr>
<tr>
<td></td>
<td>20–52 (mean: 26)</td>
</tr>
<tr>
<td>Previous care experience as a</td>
<td></td>
</tr>
<tr>
<td>Healthcare provider</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Patient</td>
<td>15</td>
</tr>
<tr>
<td>Significant other</td>
<td>25</td>
</tr>
</tbody>
</table>

Paper III

In paper III, from the total population sample (Polit & Beck, 2016), 19 participants’ video-recorded observational data depicting the caring behavior simulations of encounters with a standardized patient were collected from the CBC pilot (Table 13).

Table 13. Demographic characteristics of the participants in paper III

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>15</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Age ranging</td>
<td>Years</td>
</tr>
<tr>
<td></td>
<td>21–31 (mean: 26)</td>
</tr>
<tr>
<td>Previous care experience as a</td>
<td></td>
</tr>
<tr>
<td>Healthcare provider</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Patient</td>
<td>10</td>
</tr>
<tr>
<td>Significant other</td>
<td>12</td>
</tr>
</tbody>
</table>

Paper IV

In paper IV, out of the 22 participants in the CBC during the fall semester, 13 participants’ video-recorded observational data depicting the caring behavior simulations of encounters with a standardized patient were randomly selected,
meaning that each participant had an equal probability of being included (Polit & Beck, 2016). Out of the 26 participants in the CBC during the spring semester, 12 participants’ video-recorded observational data depicting the caring behavior simulations of encounters with a standardized patient were randomly selected, for a total of 25 participants’ video-recorded observational data (Table 14).

Table 14. Demographic characteristics of the participants in paper IV

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>22</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Age ranging</td>
<td>Years</td>
</tr>
<tr>
<td></td>
<td>21–52 (mean: 26)</td>
</tr>
<tr>
<td>Previous care experience as a</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare provider</td>
<td>18</td>
</tr>
<tr>
<td>Patient</td>
<td>8</td>
</tr>
<tr>
<td>Significant other</td>
<td>15</td>
</tr>
</tbody>
</table>

6.5. Data collection

The data collection for papers I–IV was conducted in the context of the three CBCs. An overview of the collected data is presented in Table 15.

Table 15. Overview of the entire data collection

<table>
<thead>
<tr>
<th>CBC</th>
<th>Data Collection I</th>
<th>Data Collection II</th>
<th>Focus Group Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC pilot</td>
<td>Video recordings n = 19</td>
<td>Video recordings n = 19</td>
<td></td>
</tr>
<tr>
<td>CBC, fall semester</td>
<td>Video recordings n = 22</td>
<td>Video recordings n = 22</td>
<td>Focus group interviews n = 3</td>
</tr>
<tr>
<td></td>
<td>Written reflections n = 22</td>
<td>Written reflections n = 22</td>
<td></td>
</tr>
<tr>
<td>CBC, spring semester</td>
<td>Video recordings n = 26</td>
<td>Video recordings n = 26</td>
<td>Focus group interviews n = 2</td>
</tr>
<tr>
<td></td>
<td>Written reflections n = 26</td>
<td>Written reflections n = 26</td>
<td></td>
</tr>
</tbody>
</table>
6.5.1. **Paper I: Focus group interviews**

To meet the aim in paper I, all the participants in the CBCs during the fall and spring semesters were invited to participate in one focus group interview (Krueger & Casey, 2015) three weeks after the completion of each CBC. As described by Krueger (1994), focus group interviews are used to explore the ways in which participants collectively construct the meanings of a phenomenon. Focus group interviews allow the participants to interact and gain insight into one another’s experiences, thus providing rich verbal data about their experienced similarities and differences that would not have probably been obtained in one-to-one interviews (Krueger & Casey, 2015).

Krueger and Casey (2015) stated that limiting each focus group interview to six to eight participants is adequate to obtain a variety of experiences and small enough not to become disorderly or fragmented. Therefore, the participants were randomly selected into a focus group of five to six participants. Each of the five focus group interviews was carried out by two researchers, who are experienced in conducting interviews, in a room at the School of Nursing. One of the two researchers acted as the moderator, and the other served as the assistant. For each interview, an interview guide was used. The interview began with the opening question, “Tell me about your experiences of participating in the CBC,” and then follow-up questions were posed, such as “Tell me more” and “How did that feel?” At the end of each focus group interview, the assistant presented a summary of what was brought up during the focus group interview (Krueger & Casey, 2015). Each of the five focus group interviews lasted between 48 and 68 min, and all were audio recorded and transcribed verbatim.

6.5.2. **Paper II: Individual written reflections**

To meet the aim in paper II, narratives in the form of individual written reflections (Ironside, 2015) focusing on the individual video-recorded caring behavior simulations of encounters with a standardized patient (INACSL Standards Committee, 2016) were collected from all the participants in the CBCs during the fall and spring semesters. Each individual written reflection contained a maximum of 300 words and focused on the participants’ review
of their own verbal and non-verbal caring behaviors with the following reflection questions: “What was challenging in encountering the standardized patient?”, “What I know now that I did not know before?” “To become a nurse I need to learn more?”, “What I know now that I did not know before participating in the CBC?”, “Things I knew before but which I understand differently now are?”, and “How I intend to use what I learned in my future practice as a nurse?” In total, 96 written reflections were gathered.

6.5.3. **Paper III: Video recordings**

To meet the aim in paper III, video-recorded observational behavioral data (Bakeman & Gottman, 1997) depicting the caring behavior simulations of encounters with a standardized patient (INACSL Standards Committee, 2016) were collected from all the participants in the CBC pilot. Bateson and Martin (2021) emphasized that video-recorded observational behavioral data are useful when self-reports are not practical, for example, during an ongoing interaction. In total, 38 video recordings were collected.

6.5.4. **Paper IV: Video recordings**

To meet the aim in paper IV, video-recorded observational behavioral data (Bakeman & Gottman, 1997) depicting the caring behavior simulations of encounters with a standardized patient (INACSL Standards Committee, 2016) were collected from all eligible participants in the CBCs during the fall and spring semesters. Out of the 22 eligible video recordings from the first simulation during the fall semester, 13 were randomly selected, followed by the same participants’ video recordings from the last simulation. Out of the 26 eligible video recordings from the first simulation during the spring semester, 12 video recordings were randomly selected, followed by the same participants’ video recordings from the last simulation. In total, 50 video recordings were collected.
6.6. Data analyses

Different analyses were carried out to answer the aims of each of the four papers. Papers I and II used qualitative content analysis (Graneheim & Lundman, 2004). Paper III used an instrument development process for the observational behavioral instrument (Chorney et al., 2015), as well as descriptive statistics (Siegel & Castellan, 1981). In paper IV, descriptive statistics and the Wilcoxon signed rank test (Siegel & Castellan, 1981) were run.

6.6.1. Papers I–II: Qualitative content analysis

In papers I and II, qualitative content analysis as outlined by Graneheim and Lundman (2004) was used to analyze the transcribed focus group interviews (paper I) and the individual written reflections (paper II). Lindgren et al. (2020) stated that qualitative content analysis is a well-recognized and established data analysis method in nursing research. Qualitative content analysis seeks to describe a phenomenon systematically and objectively; it entails a search for both concrete and abstract patterns among data similarities and differences (Lindgren et al., 2020).

Data were read through several times to obtain a sense of the overall meaning in the collected narratives from the transcribed focus group interviews (paper I) and individual written reflections (paper II). After reading and having discussions among the authors, a sense of the whole emerged. Thereafter, meaning units (Graneheim & Lundman, 2004) that uncovered something related to the aim in each of the papers were extracted from the text. Meaning units can be one or several sentences. Lindgren et al. (2020) highlighted that the process of selecting meaning units ought to be done with mindful consideration, as there may be a risk of a loss of context and meaning if the sentences are too broad or too fragmented. The selected meaning units were copied and pasted into a document separate from the original narratives. For each paper, the process of analyzing data continued by condensing each meaning unit. Graneheim and Lundman (2004) described condensation as the process of shortening while preserving the core. Each meaning unit was labeled with a code, representing a shortened description of the content of the
condensed meaning unit (Graneheim & Lundman, 2004). In each of the papers, the codes were grouped and abstracted into sub-themes and thereafter themes based on the relationships and underlying meanings between their similarities and differences. One main theme emerged in both analyses. This process was done by moving back and forth between the whole and the parts. A theme is a thread of underlying meaning that answers the question of how at an interpretative level and can be built up on or divided into sub-themes (Graneheim & Lundman, 2004). The analytic process was done through continued discussions among the authors until consensus was reached. An example of the process for each paper is presented in Tables 16 and 17. In paper I, one main theme emerged with nine sub-themes and three themes. In paper II, one main theme emerged with eight sub-themes and four themes.

Table 16. An example of the analysis process in paper I

<table>
<thead>
<tr>
<th>Meaning Unit</th>
<th>Condensed Meaning Unit</th>
<th>Code</th>
<th>Sub-theme</th>
<th>Theme</th>
<th>Main Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in the CBC made me realize that I often wanted to use a checklist in order to solve the patients’ needs.</td>
<td>Wanting to use a checklist in order to solve the patients’ needs.</td>
<td>Recognizing patients’ needs</td>
<td>Daring to be present with the patient</td>
<td>Learning to guard the patient’s well-being and alleviate suffering</td>
<td>An insightful and sudden awakening that caring is not only theoretical words</td>
</tr>
<tr>
<td>I realized that it takes courage to stay in a situation that made me feel insecure.</td>
<td>Recognizing that it takes courage to stay in a situation.</td>
<td>Recognizing courage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I realized that I focus only on how to apply my psychomotor skills, such that I forget patients’ experiences.</td>
<td>Focusing on psychomotor skills and forgetting patients’ experiences.</td>
<td>Separating wholeness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in the CBC made me realize that patients’ wholeness is not recognized.</td>
<td>To recognize patients’ wholeness.</td>
<td>Recognizing wholeness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 17. An example of the analysis process in paper II

<table>
<thead>
<tr>
<th>Meaning Unit</th>
<th>Condensed Meaning Unit</th>
<th>Code</th>
<th>Sub-theme</th>
<th>Theme</th>
<th>Main Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>I thought it was difficult to know what questions I needed to ask in order to deliver safe care.</td>
<td>Difficult to know what questions to ask.</td>
<td>Knowledge to ask questions</td>
<td>Realizing the need for knowledge and courage in spoken words</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was very challenging to keep the conversation flowing with my existing medical knowledge.</td>
<td>Challenging to keep the conversation flowing with existing medical knowledge</td>
<td>Challenging with existing knowledge</td>
<td>Recognizing the complexity of verbal behavior</td>
<td>The challenge of being mindfully present in patient encounters</td>
<td></td>
</tr>
<tr>
<td>I thought it was difficult to ask questions not based on my own assumptions about the patient’s needs.</td>
<td>Difficult to ask questions not based on own assumptions.</td>
<td>Asking without assuming</td>
<td>Increasing understanding of how to ask inclusive questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I thought I was asking open-ended questions; I was not aware of that I was not.</td>
<td>Awareness of asking open-ended questions.</td>
<td>Asking open-ended questions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.6.2. **Paper III: Instrument development process**

In paper III, an instrument development process for an observational behavioral instrument, as outlined by Chorney et al. (2015), was performed. This process involved four steps and included video-recorded observational data depicting a caring behavior simulation with a standardized patient and that were collected from the CBC pilot.

Although the four steps are progressively structured, Chorney et al. (2015) stated that the process is iterative. The first step, refining the research question, involves what behaviors of interest to code and who, when, and how to observe them. The second step, developing the coding manual, means the
creation of the manual and includes a list of operational definitions for each code, the sampling strategy, and an instruction guide for the coding scheme. The third step, piloting and refining the coding manual, requires the application of the coding scheme to a sample of observations. The fourth step, implementing the coding scheme, involves defining the coder requirements, training the coder, coding the data, checking for agreement, examining validity, analyzing the data, and reporting the results.

Before testing the CBCS based on Swanson’s Theory of Caring, the author of this thesis trained a coder who holds a PhD in nursing. The training period consisted of an orientation to Swanson’s Theory of Caring (Swanson, 1991; Swanson 1993), the CBCS, and INTERACT® (Mangold International, Arnstorf, Germany) software. During the training period, the coder applied the CBCS to the same nine video recordings used in the development and refining of the CBCS. A gold standard video randomly extracted from the 38 video recordings was developed by the author of this thesis and a co-worker using a consensus process when coding it (Bateson & Martin, 2021). When the training period neared the end, the coder used the CBCS to code the gold standard video and obtained a Cohen’s kappa coefficient of 0.87; the coder was then considered credentialed to conduct coding. This aligns with the statement of Bakeman and Gottman (1997) that a coder is considered credentialed when the gold standard video observation requirement is met, with a Cohen’s kappa coefficient of 0.80 or above. Each video recording was coded for 6 min using the timed-event sequential continuous coding method. This method provides an exact record of the occurrence of a behavioral code in the stream of behavior and provides data on the frequency, duration, and order of behaviors (Bateson & Martin, 2021).

Cohen’s kappa was performed in INTERACT® for 50% of the 14 coded video recordings with a mean value of \( k = 0.82 \) (range: 0.77–0.88) to estimate the inter-rater reliability (IRR) between the coder and the author of this thesis. A random sampling for IRR observer agreement is 10%–25% of the observational data and is at an adequate level when the value of Cohen’s kappa is above 0.80 (Bakeman & Gottman, 1997; Bateson & Martin, 2021). The 14 coded video recordings were run with descriptive statistics in INTERACT®.
6.6.3. **Paper IV: Descriptive statistics and the Wilcoxon signed rank test**

In paper IV, the developed observational behavioral instrument in paper III, the CBCS based on Swanson’s Theory of Caring, was applied to code the collected video recordings of the caring behavior simulations of encounters with a standardized patient from the CBCs during the fall and spring semesters.

Before applying the CBCS to the collected video-recorded observational data, the author of this thesis trained a coder who is an RN with a master’s degree diploma. The training of the coder consisted of an orientation to Swanson’s Theory of Caring (Swanson, 1991; Swanson, 1993), the CBCS, and INTERACT® software. During the training period, the coder applied the CBCS to the same nine video recordings used during the development and refining of the CBCS in paper III. When the training period neared the end, the coder became credentialed to conduct coding on the 50 video recordings after coding against the same gold standard video recording developed in paper III, with an excellent Cohen’s kappa coefficient above 0.80. The coding of each single video recording started when the undergraduate nursing student initiated the interaction with the standardized patient and stopped after 6 min using the timed-event sequential continuous coding method (Bateson & Martin, 2021). This aligns with the statement of Nishizawa et al. (2006) that a suitable interaction period allowing verbal and non-verbal expression to be described is about 5 min.

IRR was estimated in INTERACT® for 25% of the 50 coded video recordings, with a mean value of k = 0.84 (range: 0.79–0.86) in accordance with Bakeman and Gottman (1997).

Descriptive statistics were run for each of the CBCS sub-domains for the first and last simulations. Separate variables for each of the sub-domains were created in SPSS (Version 28.0), to assess the proportion of caring behaviors and they consisted of the caring behaviors divided by the total of caring and non-caring behaviors (verbal or non-verbal). All variables were assessed for normality, and none met the assumption of normal distribution. The Wilcoxon
signed rank test (Siegel & Castellan, 1981) was performed for each behavioral observational code to test whether the learning was statistically significant. Statistical significance was set with a p value (exact, two tailed) of 0.05.
7. Ethical considerations

As stated in the World Medical Association (WMA)’s Declaration of Helsinki (2018), the goal of generating new knowledge must never take precedence over the human rights of the participating persons in research projects (WMA, 2018). Ethical considerations are important (Beauchamp & Childress, 2001). In the initial step of this research project, the ethical reflections became clear, as undergraduate nursing students participating in a higher professional educational course would be involved, and data about their experiences and observational data would be collected with video recordings. This research followed the ethical principles of respect for autonomy, beneficence, nonmaleficence, and justice in the Declaration of Helsinki (WMA, 2018), as well as the Swedish Research Council’s regulations when including students in research (Vetenskapsrådet, 2017). Ethical approval for this research was granted by the Regional Ethical Review Board in Linköping, Sweden (DNR 2017/503-31) and the dean at the nursing school where data were collected approved the students’ participation.

The principle of respect for autonomy

The principle of autonomy means respect for the self-determination of adults who have a decision-making capacity (WMA, 2018). This principle was met in the research by ensuring that on the first day of the course, all attending students in the CBCs were provided the same written and oral information by two well-versed researchers who were not involved in facilitating the students’ learning. The written and oral information explained the research project’s aims, methods, presentation of findings, and data storage so that the students could decide on their participation. Furthermore, all attending students were assured that their participation was voluntary and confidential and that they could withdraw at any time. After this, the students were given time to think about their participation and ask the researchers questions before providing their written informed consent. The signed written informed consents were then collected by the two researchers. The WMA (2018) stipulates that informed consent should be received by a well-versed person who does not possess a dual role in the research. Included in the informed
consent were the names and contact details of the researchers to be contacted if the students had any questions during and after their participation in the research. To date, none of the participants has withdrawn or contacted the researchers in charge after the CBC courses.

The principle of respect for beneficence

The principle of respect for beneficence means acting for the benefit of others (WMA, 2018). This was met in the research by ensuring that all learning outcomes in the CBCs, caring behavior simulation days, and examinations were mandatory for the students regardless of their participation or non-participation in the research. Boileau et al. (2018) emphasized that using mandatory learning outcomes when participating in research remains optional. Nevertheless, regardless of participation or non-participation, all the students were fairly and equally treated with dignity and respect. By being aware of students’ vulnerability in undergraduate healthcare educational research, researchers can offer them protection as research subjects (Walsh, 2014). Thus, no research activities involving the analysis of the collected data were conducted before grading. This meant that the students’ participation did not impact the students’ grades. Furthermore, as the author of this thesis had the dual role of being both the researcher and an educator of the CBC, the students were graded by another educator involved in all the three CBC occasions.

The principle of respect for nonmaleficence

The principle of respect for nonmaleficence involves the obligation not to inflict harm on others (WMA, 2018). This was met in this research by ensuring that all the collected data (i.e., audio, and transcribed interviews, individual written reflections, video recordings, and demographic data forms) were stored in accordance with the General Data Protection Regulation (Official Journal of the European Union, 2016) and the university’s data management regulations. The collected and coded research material was archived so that only those researchers involved in this research project had access to the stored data. Furthermore, to reduce the risk of leaking the video-recorded data during the coding periods, the author of this thesis provided the credentialed coders in person with a set of five unidentified (demographic data) video recordings downloaded to a USB stick. This meant that the credentialed coders had no
access to the storage of the collected data and that no video recordings were posted online or sent via email. When the coding period ended, all downloaded video recordings were deleted from the USB stick. The recommended storage period of 10 years will be followed.

As the participants were from a well-defined sample, the principle of respect for nonmaleficence (WMA, 2018) was further met because all the participants were assured of confidentiality. This meant that no presented findings in the collected data can be linked to specific individuals.

The principle of respect for justice

The principle of respect for justice means the equal distribution of benefits, risks, costs, and resources (WMA, 2018). This was met in the research by ensuring that all the participants were given time to fill out the demographic data forms during the first day in the CBCs. Furthermore, as participating in the video-recorded caring behavior simulations of encounters with a standardized patient and writing individual reflections were mandatory learning outcomes in the CBCs, these may not be considered to entail a time cost for the participants. Instead, a time cost for them was the time they spent joining the focus group interviews that were performed three weeks after the CBC completion.

The benefit for the participants was gaining a deeper understanding and knowledge of the meaning of caring and its transformation into caring behaviors. Another contribution of this thesis is that they may have developed understanding and knowledge of learning caring behaviors.
8. Results

This section begins with a summary of papers I and II, which present the undergraduate nursing students’ experiences of learning caring behaviors. Paper III provides a summary of the development and testing of the CBCS based on Swanson’s Theory of Caring, followed by a summary of paper IV on the undergraduate nursing students’ assessed verbal and non-verbal caring and non-caring behaviors through the CBCS based on Swanson’s Theory of Caring. For a more detailed description of the results of each paper, please see each article.

8.1. Paper I: Undergraduate nursing students’ experiences of learning caring using a variety of learning didactics

The first paper described undergraduate nursing students’ experiences of participating in a CBC using a variety of learning didactics. The qualitative content analysis of the transcribed focus group interviews resulted in one main theme—an insightful and sudden awakening that caring is not only theoretical words—with three themes and nine sub-themes (Table 18).

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>An insightful and sudden awakening—– that caring is not only theoretical words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
<td>Sub-theme</td>
</tr>
<tr>
<td>Encountering an active learning environment</td>
<td>Co-creating knowledge with the teachers</td>
</tr>
<tr>
<td></td>
<td>Allowing and trusting each other’s knowledge within the study group</td>
</tr>
<tr>
<td></td>
<td>Learning caring through caring behavior simulations</td>
</tr>
<tr>
<td></td>
<td>Learning caring through writing</td>
</tr>
<tr>
<td>Deepening the understanding of themselves</td>
<td>Learning about yourself</td>
</tr>
<tr>
<td></td>
<td>Becoming aware of your own biases</td>
</tr>
<tr>
<td>Learning to guard the patient’s well-being and alleviate suffering</td>
<td>Recognizing each patient as a person</td>
</tr>
<tr>
<td></td>
<td>Daring to be present with the patient</td>
</tr>
<tr>
<td></td>
<td>Developing into a competent and compassionate nurse</td>
</tr>
</tbody>
</table>
The undergraduate nursing students emphasized that participating in the CBC was a novel and beneficial learning experience for them to learn caring behavior, which piqued their curiosity and desire to know more deeply about caring behavior. They described that the educators facilitated a trustworthy, safe, and co-created learning environment; they were able to freely express their uncertainties of not knowing and felt encouraged to ask questions, as they realized that their learning to become a nurse was important to the educators. They described that the clarity of the structured learning outcomes deepened their learning of caring behaviors and that the consistent membership in the study groups helped promote a more honest learning environment. The undergraduate nursing students also stated that participating in a variety of learning didactics deepened their awareness of caring being more than just theoretical words, and they realized that being present in patient encounters requires the practice of caring behaviors. They expressed that the caring behavior simulations and individual written reflections were new learning experiences for them. At the same time, they described that writing individual reflections was challenging for them and sometimes repetitive. Still, they said that engaging in this learning didactic deepened their awareness that a caring encounter is more than just about learning medical knowledge and psychomotor skills.

Concurrently, the undergraduate nursing students realized that a caring encounter implies more than learning about caring and practicing caring behavior, as it also requires courage to stay in the encounter and ask questions outside a formal checklist of questions. They also expressed feelings of vulnerability and insecurity because they were video-recorded during the caring behavior simulations with a standardized patient, but they said that reviewing their own actions and reactions helped them realize that these were not at all times in line with what they thought they did.

The undergraduate nursing students also stated that recognizing each patient as a person, as a wholeness, and not merely as a predominantly ill or diseased person brought on a different meaning of caring for them. This awareness challenged their pre-understanding of themselves, so participating in the CBC became both a personal and a professional learning experience. They came to recognize the responsibility each nurse has when delivering care to care
recipients. Concurrently, the undergraduate nursing students stated that the subject of the learning outcomes (i.e., caring) cannot be quantitatively graded. Nevertheless, they emphasized the desire to take on more responsibility for their own learning process as they develop into becoming compassionate and competent nurses.

8.2. Paper II: Undergraduate nursing students’ experiences of practicing caring behaviors with standardized patients

The second paper described the undergraduate nursing students’ experiences of practicing caring behaviors with a standardized patient. The qualitative content analysis of the individual written reflections identified one main theme—the challenge of being mindfully present in patient encounters—with four related themes and eight related sub-themes (Table 19).

Table 19. Main theme, themes, and sub-themes

<table>
<thead>
<tr>
<th>Main theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>The challenge of being mindfully present in patient encounters</td>
<td>Deepening understanding and knowing caring behaviors</td>
</tr>
<tr>
<td></td>
<td>Exposing vulnerability and insecurity</td>
</tr>
<tr>
<td></td>
<td>Gaining awareness of one’s own bodily behavior</td>
</tr>
<tr>
<td></td>
<td>Centering on the patient’s outward expressions</td>
</tr>
<tr>
<td></td>
<td>Realizing the need for knowledge and courage in spoken words</td>
</tr>
<tr>
<td></td>
<td>Increasing understanding of how to ask inclusive questions</td>
</tr>
<tr>
<td></td>
<td>Listening to understand the patients’ needs</td>
</tr>
<tr>
<td></td>
<td>Developing awareness of patient’s vulnerability</td>
</tr>
</tbody>
</table>

The undergraduate nursing students described that participating in the video-recorded caring behavior simulations in which they encountered a standardized patient was a complex yet beneficial learning experience. They said that the educators communicated clear learning outcomes in a safe learning environment. Despite this, knowing that the simulation was video-recorded made some students feel more exposed and vulnerable. They also
described how interacting with the standardized patient took on a different meaning as they came to realize that being with the patient and doing for the patient had different meanings.

This awareness of learning about caring and practicing caring behavior simultaneously as delivering medical knowledge and applying psychomotor skills was challenging. The students reflected on how difficult it was to listen for understanding. They described that most of their time spent in the simulation was about wanting to solve the current situation based on their own assumptions about the standardized patient’s needs by asking mostly questions related to the diagnosis. Despite their own insecurity about lacking medical knowledge, they realized that a caring encounter implies more than knowing about physical symptoms related to the diagnosis. They described that it required their own willingness and responsibility to dare to ask questions outside a formal checklist of questions. They also emphasized that nursing education should focus more on medical knowledge, as this would help them ask inclusive questions.

This realization deepened their awareness that their own caring behaviors can significantly influence the outcomes of a patient encounter. At the same time, they realized that patients’ verbal and non-verbal behaviors also influence these outcomes. They said that a caring encounter implies being mindfully present in the moment, which entails more than practice and knowledge in verbal and non-verbal caring behaviors. It requires awareness of one’s own values and behaviors as one develops into becoming a compassionate and competent nurse; more importantly, sharing patients’ vulnerabilities is paramount.
8.3. **Paper III: Caring behavior coding scheme based on Swanson’s Theory of Caring—Development and testing among undergraduate nursing students**

The third paper described the development and testing of the CBCS. The development of the observational behavioral instrument followed the four steps outlined by Chorney et al. (2015):

- Step one: Refining the research question
- Step two: Developing the coding manual
- Step three: Piloting and refining the coding manual
- Step four: Implementing the coding scheme

**Developing the caring behavioral coding scheme**

*Step one:* Verbal and non-verbal caring and non-caring behavioral codes were developed to respond to the question of how to best capture caring in healthcare providers’ caring and non-caring behaviors through Swanson’s Theory of Caring (Swanson, 1991; Swanson, 1993).

*Step two:* During the development of the list of operational definitions (e.g., behavioral codes), the literature on caring theory and behavioral psychology was reviewed. In parallel, healthcare narratives, movies, art, and literature depicting the caring and non-caring verbal and non-verbal behaviors of care recipients, their significant others, and healthcare providers were reviewed. The verbal and non-verbal caring and non-caring behavioral codes created were assembled and structured in accordance with the five conceptual domains itemized in Swanson’s Theory of Caring (i.e., *maintaining belief*, *knowing*, *being with*, *doing for*, and *enabling* with related sub-domains; Figure 1). The derived observational behavioral coding scheme, the CBCS, was piloted using the timed-event sequential continuous coding method on nine video-recorded observational data depicting a caring behavior simulation involving an undergraduate nursing student and a standardized patient.
Step three: During the piloting of the CBCS, it was found that some of the developed behavioral codes could be categorized under more than one domain with related sub-domains in Swanson’s Theory of Caring. In discussion with Dr. Swanson, the decision to combine the domain of maintaining belief with its related sub-domains and the other domains of knowing, being with, doing for, and enabling with their related sub-domains was made (Figure 2). Thus, the domain maintaining belief is not mutually exclusive (Swanson, 1991; Swanson, 1993).

![Diagram showing the combination of domains and sub-domains in the CBCS](image)

Figure 2. Description of how maintaining belief with its related sub-domains is combined with the other domains and their related sub-domains in the CBCS

The developed observational behavioral coding scheme, the CBCS based on Swanson’s Theory of Caring, was examined and approved by Dr. Swanson herself. The CBCS contains 17 verbal and eight non-verbal behavioral codes categorized into caring and non-caring behaviors. Examples of these are presented in Table 20.
Table 20. An example of verbal and non-verbal caring and non-caring behavioral codes in the CBCS

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-domain</th>
<th>Verbal Caring Behavior</th>
<th>Verbal Non-Caring Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing</td>
<td>Avoiding assumptions</td>
<td>Gathering information by asking mostly open clarifying questions</td>
<td>Asking question based on assumptions Judging the person’s experience</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-domain</th>
<th>Non-verbal Caring Behavior</th>
<th>Non-verbal Non-Caring Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing</td>
<td>Engaging oneself and others</td>
<td>Being at eye level or at the same height whenever possible or appropriate</td>
<td>Not being at the eye level or at the same height (looking up or down) whenever possible or appropriate</td>
</tr>
</tbody>
</table>

Testing the caring behavioral coding scheme

*Step four:* The testing of the CBCS showed that all domains were represented with codes. In the domain of *knowing*, all sub-domains were represented, with the sub-domain of *centering on the one being cared for/believing in or holding in esteem* having the most occurring verbal behavioral codes, followed by *assessing needs*. In the domain of *being with*, the sub-domain of *sharing feelings* had the most occurring behavioral codes. Most verbal behavioral codes were found in the sub-domain of *performing competently/skillfully* under the domain of *doing for*. The domain of *enabling* had the least verbal behavioral codes. In the non-verbal behavioral codes, no non-caring behavioral code was found.

8.4. **Paper IV: Assessing the impact of a caring behavior course on undergraduate nursing students’ caring behavior**

The fourth paper described the undergraduate nursing students’ learning of caring behaviors while participating in caring behaviors assessed through the lens of the CBCS. The findings demonstrated that all domains in Swanson’s Theory of Caring were represented with codes.
Verbal caring behavior

Verbal behaviors were mostly observed in the sub-domains of *avoiding assumptions, centering on the one being cared for/believing in or holding in esteem* under the domain of *knowing*. In the sub-domain of *avoiding assumptions* under the domain of *knowing* and in the sub-domain of *performing competently/skillfully* under the domain of *doing for*, there were statistically significant differences between the first and last simulations, indicated as an increase in caring behaviors and a decrease in non-caring behaviors. The domain of *enabling* had the least caring and non-caring behaviors in both the first and last simulations.

Non-verbal caring behavior

Non-verbal caring behaviors were often observed in the domain of *knowing* with its sub-domain of *seeking cues*, followed by *centering on the one being cared for/believing in or holding in esteem*. The domain of *doing for* and its sub-domain *anticipating* had the least non-verbal caring behaviors in both the first and last simulations.

The compassionate healer and the competent practitioner

The most commonly observed caring behaviors demonstrated the qualities of a *compassionate healer*. In both *compassionate healer* and *competent practitioner*, there was an increase in caring behaviors, contrary to a decrease in non-caring behaviors between the first and last simulations. Significant differences were found in the qualities of the *competent practitioner*, with a greater proportion of caring behaviors between the first and last simulations.
9. Discussion

9.1. Methodological considerations

Different methodological approaches were used in the four papers constituting this thesis to provide a more comprehensive understanding of how the CBC influenced the undergraduate nursing students learning of caring behaviors. Although different methods were used, the papers were linked through the theoretical framework of Swanson’s Theory of Caring. Papers I–II used a qualitative methodology to describe how learning about caring behavior in the CBC was a complex yet beneficial learning experience that influenced the students’ learning processes. Paper III used both qualitative and quantitative methodologies to develop the CBCS. Paper IV, which used a quantitative methodology, to describe undergraduate nursing students’ learning of caring behaviors while participating in the CBC.

In the four papers constituting the thesis, several steps were taken to ensure the trustworthiness of the research. Lincoln and Guba (1985) argued that the value of qualitative research, trustworthiness, or truth value can be assessed with a combination of dependability, credibility, confirmability, and transferability, as established by Lincoln and Guba (1985). In quantitative research, validity and reliability can be used (Polit & Beck, 2016).

9.1.1. Qualitative research

Dependability
Dependability refers to the conditions of a study and the stability of the data over time (Lincoln & Guba, 1985). As a PhD student, the author of this thesis had the opportunity to help develop and design the CBC together with her co-workers, which contributed to her own learning process as she developed knowledge of the conditions of the data. Nevertheless, this can also be viewed as a limitation of the thesis. Some co-workers involved in the research did not participate in developing, designing, or facilitating the CBCs to strengthen the dependability of the study. Nevertheless, their contributions to constructive
questioning from an outsider’s point of view deepened the author’s understanding of the conditions of the data, which enhanced the trustworthiness of this thesis.

The first CBC served as a pilot, meaning that it was a preparation (Polit & Beck, 2016) for the two upcoming CBCs to further strengthen dependability. After the completion of the CBC pilot, an adjustment was made, requiring that the students in the two upcoming CBCs encounter the same standardized patient during the two video-recorded caring behavior simulations. The adjustment between the CBC pilot and the two upcoming CBCs involved no changes in learning outcomes, which strengthened the research dependability.

To further ensure dependability during the CBCs, the author of the thesis kept a reflective journal diary to limit the threat of change in the data over time. Although Lincoln and Guba (1985) described a reflective journal diary as a private instrument, the author had dialogues with her co-workers if something was unclear during the CBCs to limit the threat of change in the data over time. In the reflective journal diary, the author wrote down a summary of each learning moment (i.e., lectures, seminars, and caring behavior simulation days) and her own experiences. One consideration that must be raised as a limitation is the author’s dual role as both the researcher and a CBC educator; however, the author’s understanding of the collected data over the period of the CBCs strengthened the paper dependability. As emphasized by Graneheim and Lundman (2004), qualitative research requires an understanding and co-creation between the researcher and the participants.

A total population sample was used, meaning that all attending students had equal chances of participating in the paper’s (Polit & Beck, 2016). This can be argued as a limitation, as it may overrepresent participants with an interest in the research. To date, no participant has withdrawn from this research project, which attests to its dependability and trustworthiness, as attrition or loss of participants over time is a threat in research (Polit & Beck, 2016).

Credibility

Credibility refers to confidence in the truth of the findings (Lincoln & Guba, 1985). Lincoln and Guba (1984) described a series of techniques to strengthen
credibility; one of these is peer debriefing, which aims to uncover the researcher’s pre-understanding and biases in the collected data. To strengthen the credibility of the thesis, the author had close peer debriefing discussions with senior researchers to identify her own pre-understanding and biases in the collected data throughout this research. Furthermore, the diversity in the senior researchers’ expertise in the phenomenon studied in each paper strengthened credibility, as the peer debriefing discussion involved reflections from different points of view.

Two researchers with expertise in the phenomenon conducted the five focus group interviews to ensure credibility. The author of the thesis was considered biased because of her dual role of being both the researcher and an educator in the CBCs. Other approaches were considered but focus group interviews were deemed appropriate to answer the research question on understanding the participants’ differences and similarities in learning experiences in the CBCs. As a PhD student, the author listened to the audio recordings while reading the verbal transcriptions of the interviews to deepen her own learning of how to conduct focus group interviews. This strengthened the paper credibility and reinforced its trustworthiness.

The questions used to collect individual written reflection were the same throughout all CBCs and were stated from a first-person perspective to strengthen the paper credibility. Greenberg et al. (2022) stated that writing reflections from a first-person point of view allows the writer to be more vulnerable to the reader, allowing the written reflection narratives to offer a rich explanation drawn from personal experiences.

Furthermore, pictures were taken together with notes on the props in the simulation environment, and cameras were positioned consistently throughout all CBCs to strengthen the credibility of the video-recorded observational behavioral data. A standardized manual for both the educators and the standardized patient was followed.

Confirmability
Confirmability refers to a researcher’s degree of neutrality and ability to arrive at similar conclusions drawn from the participants rather than from researcher
bias (Lincoln & Guba, 1985). Qualitative content analysis, as described by Graneheim and Lundman (2004), was used to explore the qualitative papers constituting this thesis. Although different qualitative approaches could have been used, qualitative content analysis was deemed appropriate to meet the aim of describing the participants’ experiences. Furthermore, as a PhD student, the author of the thesis took this as an opportunity to learn one qualitative method in depth.

Confirmability was further strengthened by the co-authors’ reading of the transcribed data during the analysis (Graneheim & Lundman, 2004). Their participation in the analysis contributed to the author’s learning process of systematically and objectively describing the similarities and differences in the data. The co-authors confirmed that the phenomenon was the focus of the study, and they facilitated the author’s reflection by critically examining the analysis process.

Quotations in the papers constituting this thesis were also presented to make the text visible to readers and to further ensure the research confirmability. The quotations demonstrated that the abstraction of underlying meanings in the data was drawn from the participants and not from researcher bias, thus strengthening the research confirmability and reinforcing its trustworthiness.

Transferability
Transferability refers to the extent to which the results can be transferred to other contexts and groups (Lincoln & Guba, 1986). Including information about the context and participants means that readers can determine or come up with their own conclusions about the transferability of the results to other contexts (Amankwaa, 2016). The findings in this thesis can be argued to be limited to a single course in a Swedish undergraduate nursing program, and the majority of the participants were also women. Nevertheless, the development and implementation of the CBC followed the European standard for nursing education, European Commission Directive 2013/55 (European Commission, 2013), to strengthen transferability, and the fact that the participants in this research were overrepresented by females characterized Swedish undergraduate nursing education well. In 2020, 90% of those who
obtained a licensed nursing degree in Sweden were female (Socialstyrelsen, 2022). Thus, the results presented in this thesis are homogenous, as a similar group of participants in a similar context was studied, adding to the trustworthiness of the thesis.

Attempts were also made in semester four to include a comparison group of undergraduate nursing students who were enrolled in a course on person-centered nursing and thus neutralize any threats to trustworthiness in the overall design of the thesis. This was found to be practically difficult, as the course included five weeks of clinical practice. Furthermore, the design did not allow for the assessment of the long-term effects of participating in the CBC, so the future use of a longitudinal design is recommended. Nevertheless, the methodological approaches used are considered appropriate for generating new knowledge from empirical research with undergraduate nursing students. Thus, the clear phenomenon orientation in the results enables the transferability of the findings to other contexts.

9.1.2. Quantitative research

Observational behavioral data were collected from the undergraduate nursing students’ encounters with a standardized patient in caring behavior simulations to complement the narrative data collected. The use of observational behavioral data can reduce bias and obtain information that cannot be gathered through narratives (Polit & Beck, 2016). Bakeman and Gottman (1997) emphasized that the observational method can be considered a qualitative method but observing behaviors can also be considered a quantitative method, as the significant value of studying behavior depends on the ability to measure it.

Although there are existing validated observational behavioral instruments assessing verbal and non-verbal behavior, none is considered appropriate to meet the aim of assessing the participants’ verbal and non-verbal caring and non-caring behaviors. This provided a valuable opportunity for the author, as a PhD student, to learn how to develop an observational behavioral instrument based on a caring theory, the CBCS based on Swanson’s Theory of Caring.
Validity

Validity refers to the ability of an instrument to measure what it claims to measure (Polit & Beck, 2016). Polit and Beck (2016) described various techniques to assess validity, such as face validity, content validity, and concurrent validity. Face validity refers to whether an instrument measures the appropriate construct. Although face validity is not considered strong evidence of instrument validity, it is valuable when other techniques to assess validity are used (Polit & Beck, 2016). This thesis showed that the CBCS reflected caring behaviors in nursing practice, as face validity was ensured by an evaluation done by two experienced nurses working clinically in different clinical healthcare organizations and who were not part of this research project. Moreover, to strengthen validity in the CBCS in this thesis, Dr. Swanson examined its content validity, which refers to the degree to which an instrument’s sample of items for the construct being measured adequately includes the construct domain (Polit & Beck, 2016). Dr. Swanson confirmed that the CBCS adequately included the construct of the domains within the theory (Swanson, 1991; Swanson, 1993).

This thesis further showed that the CBCS represented caring behaviors in all domains itemized in Swanson’s Theory of Caring, thus strengthening the validity of this thesis. However, the CBCS needs to be compared in the future with other observational behavioral coding schemes, such as the Caring Behaviors Inventory (Wu et al., 2006), in order to further strengthen its concurrent validity, which refers to an instrument’s capacity to distinguish human beings who differ on a specific criterion (Polit & Beck, 2016).

Reliability

Reliability is the degree to which an instrument can produce consistent results from one test to another (Polit & Beck, 2016). To strengthen the reliability of an instrument, Polit and Beck (2016) described key aspects of equivalence, internal consistency, stability, and equivalence reliability. Internal consistency, which refers to the design of the scale that measures a phenomenon, and stability, which refers to consistent results produced by the instrument.
Equivalence reliability, referring to the degree to which two or more independent observers agree about the scoring of an instrument, was also strengthened (Polit & Beck, 2016). The assessment of undergraduate nursing students’ caring behaviors in observational behavioral studies is important. Although the CBCS based on Swanson’s Theory of Caring is a macro socially based observational behavioral instrument, it may need more human judgment from the coder than a physically based observational behavioral instrument does (Chorney et al., 2015). This thesis demonstrated that a random sample of 25% (paper IV) and 50% (paper III) of all coded observational data was in excellent agreement, with a mean IRR above Cohen’s kappa $k = 0.80$. This is consistent with the results of Bakeman and Gottman (1997), who emphasized that 10%–25% of all coded observational data is at an adequate level when the measured value of Cohen’s kappa is near 0.80.

The reliability of an instrument is also related to the composition of the sample; this means e.g., that a homogeneous sample provides a more homogeneous result (Polit & Beck, 2016). This thesis established the CBCS’ similarity in the distribution of coded caring behaviors in the CBCs. Taken together, this thesis provides support that the CBCS is a reliable observational behavioral instrument to assess undergraduate nursing students’ verbal and non-verbal caring and non-caring behaviors. However, one consideration must be made regarding the amount of coded observational behavioral data in this thesis; more coded video-recorded observational data would add to the transferability and further validation of the CBCS. The amount of coded observational behavioral data was due to time constraints in the author’s PhD studies, which aligns with the statement of Chorney et al. (2015) that coding video-recorded observational data is a time-consuming method.

9.2. Discussion of the results

The starting point of this research project derives from increased number of complaints from care recipients and their significant others’ about healthcare providers’ lack of compassionate and competent care (Råberus et al., 2019; WHO, 2020), with the intended outcome of supporting healthcare organizations to improve. Other studies have emphasized that care recipients
and their significant others do not believe that the complaints they make can lead or contribute to changes in the healthcare organization (Gillespie & Reader, 2021; IVO, 2021). A shift in emphasis from efficiency in healthcare organizations to compassionate caring is needed (Ekman & Swedberg, 2022; McCormack & Dewing, 2019). Treating each patient with compassion and care as the heart and core value of nursing practice is the responsibility of every single healthcare provider in all healthcare organizations in which care is provided. As nurses comprise the greatest percentage of human resources in today’s healthcare organization (ICN, 2021; WHO, 2020), this thesis seeks to address the undergraduate nursing educations part of this chain of complaints. As behaviors may be challenging to become aware of (Prochaska & DiClemente, 1983), it is important to start focusing on learning the meaning of caring and the practice of caring behaviors in undergraduate nursing educations.

Learning caring behavior begins within nursing education curricula

Although the idea of creating caring behavior curricula is not a new one, nursing education has tended to focus more on teaching knowledge of specific diagnoses and psychomotor skills instead of learning the meaning of caring and the practice of caring behaviors (Gustin, 2021; Sandvik & Hilli, 2022). Undergraduate nursing students report inconsistent opportunities to explicitly practice caring behaviors (Akansel et al., 2021; Warshawski et al., 2018) and consider learning caring behaviors to be less important (Akansel et al., 2021). The CBC was based on the philosophy of caring and the results in this thesis show that the use of a student-centered learning approach intertwined with reflective practice, narrative pedagogy, and simulation founded on caring theory influenced the students learning of caring behaviors. The results in this thesis show that, while attending in the CBC the undergraduate nursing students gained an insightful and sudden awakening that caring is not only theoretical words. This shows that caring ought to be acknowledged as more than an intangible aspect of nursing practice. As noted by Watson (1999) and Benner (2000), describing caring practice as the intangible aspect of nursing practice is inaccurate, as caring is the heart and core value of nursing practice. The nursing education curricula needs to change towards a deeper caring perspective containing both the theoretical concepts of caring and practice of
caring behaviors. More attention is needed to how caring, concrete, could be practiced and simulated at a clinical training center.

This thesis demonstrates that if undergraduate nursing students are to be successfully helped in the development of caring within the nursing discipline, a stronger emphasis on learning the meaning of caring and applying caring behaviors needs to begin within the nursing education curricula. This reorientation to facilitate undergraduate nursing students’ learning of caring behaviors through knowing, acting, and being aligns with Sandvik and Hilli’s (2022) emphasis that such a reorientation strengthens nursing students’ development as caring nurses. Furthermore, other studies have shown that learning to practice caring behavior has a highly beneficial effect on graduated nurses’ well-being and work satisfaction (Swanson & Wojnar, 2004; Wei et al., 2019). By contrast, graduated nurses who struggle to practice caring behaviors are likelier to suffer from stress and burnout and may ultimately leave the nursing profession (Wei et al., 2018b). To ensure undergraduate nursing students’ competencies when learning about caring and applying caring behavior, nursing education must embrace the need for change (Gustin, 2021). Bridging the gap between caring theory and nursing practice cannot be done through a single learning approach or a single learning didactic; every nurse educator will need to engage in this change whenever they facilitate learning.

**Caring and learning are parallel processes**

The CBC was, as mentioned above, based on the philosophy of caring and a student-centered learning approach (Dewey, 1933; Rogers, 1983) used to facilitate learning. Christopher et al. (2020) emphasizes that intertwining caring into a student-centered learning approach is the heart and core value in nursing education. Swanson’s Theory of Caring (Swanson, 1991; Swanson, 1993) is informed by Watson’s caritative Grand Theory of Human Caring (Watson, 1979; Watson, 1999) and the caring substance in these theories are, in this thesis, intertwined into a student-centered learning approach (Dewey, 1933; Rogers, 1983). The caring manner the student needs to show the care recipients in order for them to receive healing and well-being, the same manner needs to be shown the students in order for them to learn. The learning substance, such as, see the student as a reflective, active learner taking
responsibilities for their own learning and to see to their past experiences should also be showed towards the care recipients. This can be seen in the light of Ekeberghs (2018) description about that caring and learning are parallel processes which she grounds in the lifeworld caring theory and in phenomenology. A parallel can also be drawn to Eriksson (2018) when she describes that caring and learning have the same foundations and by that she refers to the caritative caring theory (Eriksson, 2018) and hermeneutics (Gadamer, 2013).

The results in this thesis show that, the undergraduate nursing students experienced a safe learning environment marked by co-created respect and mutual trust. This aligns with the statement by Halldorsdottir (1996) that a caring encounter is characterized through mutual trust. The students also experienced participating in the CBC as a beneficial experience, which influenced their motivation to take on more responsibility for their own learning processes. Nurse educators who use a student-centered learning approach support the students’ willingness to take on more responsibility for their own learning of the nursing skills required to deliver safe care (Rossillo et al., 2020; Suliman & Warshawski, 2022).

Wei et al. (2021) reported that a significant predictor for students’ learning of caring behaviors is their perceptions of how nurse educators co-create a safe learning environment and role-model caring behaviors, which are similar to the findings of Inocian et al. (2022). Moreover, nurse educators who role-model caring behaviors help enhance students’ willingness to take on more responsibility for their own learning of the nursing skills required to deliver safe care (Rossillo et al., 2020; Suliman & Warshawski, 2022). The undergraduate nursing students in this thesis experienced that the educator’s presence, engagement and knowledge were of importance. As caring and learning have the same foundation, it is important for the educator to be open-minded, reflective and possess a caritative caring approach for the students to learn. The educator needs to bear and radiate the caring approach and in addition to that, the culture around, the environment, also needs to be caring (Eriksson, 2018).
This thesis emphasizes that, while heeding the call towards a more student-centered learning approach, nurse educators ought to be keenly aware of the need to step away from teacher-centered learning curricula and an over-emphasis on lecture-based knowledge and psychomotor skills acquisition. As shown in this thesis, participating in the CBC was a novel and complex experience compared with the students’ earlier learning experiences in the undergraduate nursing education. They may not have had adequate learning opportunities in the past for caring and applying it as caring behavior. This thesis also shows that the undergraduate nursing students came to realize that safely catering to care recipients’ needs implies learning the meaning of caring. Aligned with Sandvik et al. (2014), there is a need to change focus from mainly developing knowledge and psychomotor skills, referred to as doing, to the process of becoming a caring nurse, referred to as being with.

Learning compassionate and competent care

As emphasized in this thesis, participating in the CBC influenced the undergraduate nursing students’ understanding and knowledge, thus informing their growth toward becoming compassionate, competent, and caring nurses. This thesis shows that participating in the CBC influenced the undergraduate nursing students’ understanding of the obligations and professional responsibilities of nurses to deliver safe care based on care recipients’ needs. Chinn and Kramer (2018) asserted that integrating the meaning of caring into nursing practice enables nurses to deliver safe care based on care recipients’ needs. The thesis further demonstrates that undergraduate nursing students’ experiences of learning caring deepened their understanding of it in such a way that they wanted to learn more about it so that they could become proficient in delivering safe care. Watson (1999) and Swanson (1993) describes that the nurse needs to be compassionate, they mean that compassion is vital for sustaining humanistic-altruistic values and for patients healing and well-being. This thesis shows that the most commonly observed caring behaviors was demonstrated in the qualities of the compassionate healer. Furthermore, it was also found an increase in caring behaviors in both the qualities of the compassionate healer and the competent practitioner, between the first and last simulations. Watson’s (1999) 10 caritative factors that embrace humanistic-altruistic values such as instill
loving—kindness to the self and others, faith and hope, honor, and trust of oneself and of others by nurturing individual beliefs, personal growth, and practice are in line with all four studies in this thesis. They are an ethical base for professional nursing practice (Alligood, 2017; Robinson Wolf & France, 2017). Eriksson (2018) means that compassion is the source of all true caring, and that it is the motive for one's actions. These actions presuppose courage, a courage to take responsibility for another human being.

In this thesis the undergraduate nursing students’ experienced a lack of knowledge, for example, as they reached an understanding of that a caring encounter required their own willingness and responsibility to ask questions outside a formal checklist of questions. As noted by Gadamer (2013), what is challenging is asking the right questions and not finding good answers. Furthermore, Ekman and Swedberg (2022) wrote that the right questions may be marked by the truth, to which we do not know the answers. In the light of Benner’s theory, from novice to expert (1984), the undergraduate nursing students in this thesis possess the needed knowledge and psychomotor skills, but understanding is required to know which and when knowledge matters. Swanson (1993) describes that in the quality of the *competent practitioner*, *doing for* stands for, to do for the other’s as he/she would do for themselves by; comforting, anticipating, performing competently/skillfully, protecting, and preserving dignity. The quality of the *competent practitioner* also stands for *enabling*, which means to facilitate the other’s passage through life transitions and unfamiliar events by; informing, explaining, supporting/allowing, focusing, generating alternative/thinking it through and validating giving feedback. Benner (1984) defined the *novice* as a beginner with no or little experience of the situation in which they are expected to perform and to develop their skills, nurses need to be placed in new nursing practice situations. Furthermore, the *competent* level is developed when the nurse begins to recognize and plan their actions in terms of long-term goals, meaning that the actions are based on pertinent aspects of the situation instead of including all aspects that help the nurse become efficient and organized. This means, that the nurse has coped with clinical situations and thereby recognizes the important aspects of the situation and begins to use their experiences to guide their actions (Benner, 1984). This thesis demonstrates
that the undergraduate nursing students, at the beginning of the CBC could be seen as the novice, and that they during the CBC gained understanding and knowledge thus became more competent. At the end of the CBC, the students used their prior care experiences to recognize the vital aspects of the care situation and cater to their care recipients’ needs while improving their own learning processes along the way. However, this thesis shows that the undergraduate nursing students have a long path to walk before reaching a level of in-depth understanding, knowledge, and intuitive sense of the total care situation and taking actions, accordingly, as emphasized in the level of the expert. Benner (1984) describes that the proficient nurse understands the situation as a whole instead of its separate parts and has learned from experience; therefore, they know how to respond to situations more holistically. She means that the expert nurse has a deep understanding and knowledge of the situation and does not solely rely on analytic principles.

Learning to be mindfully present in the caring moment

The undergraduate nursing students in this thesis experienced how difficult it was to listen for understanding. Listening for understanding can be understood through the concept of insider which refers to gaining insight into care recipients’ lives, in which nurses use their humanity to understand their care recipients’ humanity (Todres et al., 2015). Eriksson and Lindström (2003) wrote that the heart of listening involves having the courage to be vulnerable as a nurse and, at the same time, having the courage to see the care recipients’ longing and expectations to be cared for. Nurses need to have the courage to show compassion and their own vulnerability by being emotionally and physically present in the caring moment, as these are common and important qualities (Eriksson & Lindström, 2003; Watson, 2018). This thesis emphasizes that participating in the CBC deepened the students’ understanding of how to practice and express caring by being mindfully present in the caring moment with the person receiving care.

This thesis also shows that when assessing the students’ participation in the CBC with the CBCS based on Swanson’s Theory of Caring it was found that the undergraduate nursing students’ verbal and non-verbal caring behaviors were influenced. Furthermore, the undergraduate nursing students’
experienced that participating in the CBC had facilitated their ability to turn the theoretical concepts of caring into caring behaviors. This is in line with Eriksson and Lindström’s (2003) idea that, when theory and practice, with the assistance of reflection, are integrated through appropriation, which means absorbing what one has understood, caring becomes visible in verbal and non-verbal behaviors. Without understanding, knowledge becomes insufficient (Sandvik et al. 2015). Thus, learning becomes understanding, and knowledge becomes incorporated in the body as a way of being (Hilli & Sandvik, 2020).

The result of this thesis shows one way to start bridging the gap between caring theory and practicing caring behaviors to reach appropriation. This thesis can provide nursing educators with a variety of learning didactics to facilitate learning around both the theoretical concepts of caring and the practice of caring behaviors in simulation situations, which may strengthen students’ ability to be mindfully present in the caring moment. The CBCS could be used in various learning didactics such as, narrative pedagogy and simulation.

Respecting undergraduate nursing students’ vulnerability and dignity

The thesis further depicts the importance of genuinely facilitating caring with respect for students’ vulnerability and dignity; this is especially important because as the undergraduate nursing students experienced caring as a subject that hold the characteristics of not being gradable. This could be understood in the light of Li et al. (2020) and Sandvik et al. (2015) who stress that the understanding and knowledge of caring are influenced and shaped by both professional and interpersonal qualities. Bowman and Addyman (2014) stressed that being genuinely honest about one’s own caring experiences in the reflection of being graded is challenging.

Developing into a nurse with an accurate understanding and knowledge of delivering safe care based on care recipients’ needs is a vulnerable and demanding emotional challenge. Similar to Kuntarti et al.’s (2018) finding, the students hoped that educators would appreciate their learning processes rather than merely evaluate the material on final exams. This thesis demonstrates that participating in the CBC brought to light a spectrum of patterns among the student, constituting both positive and negative emotions.
Clark (2016) argued that nurse educators must learn to genuinely value students’ reflective efforts by using the grading process to deepen awareness. Doing so guides the students in their professional growth toward becoming caring nurses (Jaastad et al., 2022), as it is not only what the students know but rather what and who they are becoming that is important (Sandvik & Hilli, 2022). This thesis shows that recognizing and valuing the undergraduate nursing students’ reflective efforts influenced their learning of caring, as they deepened their understanding to use the caring behaviors defined in caring.

Educators’ caring approach

This thesis constitutes an example of how caring and a student-centered learning approach intertwined with reflective practice can be used as parallel processes. Guided by Swanson’s Theory of Caring (Swanson, 1991; Swanson, 1993), an attempt to illustrate how this thesis can guide educators to facilitate undergraduate nursing students’ learning of caring behaviors (Figure 3).

![Diagram of the educators’ caring approach based on Swanson’s Theory of Caring](image)

Figure 3. Illustration of the educators’ caring approach based on Swanson’s Theory of Caring

The figure 3, describing the educators’ caring approach illustrates how a safe and co-created learning environment occurs by maintaining beliefs in each
student as a person. This is achieved by actively engaging in the students’ learning experiences through the qualities of the *compassionate healer* (i.e., *knowing*–striving to understand an event as it has meaning in the life of another person; *being with*–being emotionally present for the other person), as well as by preserving the students’ dignity through facilitating and believing in their learning processes via the qualities of the *competent practitioner* (i.e., *doing for*–doing for the other as the other would do for themself; *enabling*–facilitating the other’s passage through life transitions and unfamiliar events). The undergraduate nursing students in this thesis described that they felt that the learning environment in the CBC was safe and reflective; as the educators were engaged and cared for their learning experiences and learning processes with a co-created learning environment based on respect and mutual trust. A significant predictor for students’ learning of caring behaviors is their perceptions of how nurse educators co-create a safe learning environment and role-model caring behaviors (Wei et al. 2021; Inocian et al. 2022). As caring and learning have the same foundation, it is important for the educator to be non-judgmental and possess a reflective caritative caring approach for the students to learn. The educator needs to bear and radiate the caring approach and in addition to that, the culture around, the environment, also needs to be caring (Sandvik et al. 2015). Both the qualities of the *compassionate healer* and the *competent practitioner* need to be embraced when facilitating the intended outcomes of students’ learning of caring behaviors. The students’ learning experiences can be personalized into their preferences in the present learning moment by listening to and sharing their learning experiences through the quality of the *compassionate healer*. Based on the quality of the *competent practitioner*, educators need to possess an understanding and knowledge of the meaning of caring to be able to facilitate and believe in the students’ learning of caring behaviors.
10. Conclusion

This thesis may facilitate current and future improvements in learning the theoretical concepts of caring and the practice of caring behaviors in nursing education, which are focused on meeting each patient as a person based on the humanistic values of caring, with the intended outcome of patient healing and well-being.

- Learning caring behavior implies the need to change the nursing education curricula towards an explicitly caring perspective.

- Caring and learning are shown to be parallel processes where the meaning of caring is intertwined into a student-centered learning approach, reflective practice, narrative pedagogy, and simulations.

- Learning compassionate and competent care entails the need for the educators’ to role-modeling the meaning of caring.

- Learning to be mindfully present in the caring moment implies the need to deepen the students’ understanding and knowledge of how to practice and express caring behaviors within the caring moment.

- Respecting undergraduate nursing students’ vulnerability and dignity entails to respect and facilitate mutual trust in a co-created safe learning environment.

- The CBCS based on Swanson’s Theory of Caring illustrates the wholeness of caring in caring behaviors and seems to be a promising observational behavioral instrument that assesses verbal and non-verbal, caring, and non-caring behaviors.
11. Relevance and implications

This thesis provides the following implications for nurse educators who aim to facilitate students’ learning of caring behaviors.

- A change of the nursing education curricula towards an explicitly caring perspective ought to contain both the theoretical concepts of caring and the practice of caring behaviors.

- A usage of caring and learning as parallel processes where the meaning of caring and the practice of caring behavior is intertwined into a student-centered learning approach, reflective practice, narrative pedagogy, and simulations.

- A usage of role-modeling caring behavior is a prerequisite for co-creating a safe learning environment and mutual trust to protect the undergraduate nursing students’ vulnerability and dignity.

- Enhance the possibility for the undergraduate nursing students’ to be mindfully present within the caring moment.

- The CBCS that illustrates the wholeness of caring can be used as an observational behavioral instrument that assesses verbal and non-verbal, caring, and non-caring behaviors in a variety of learning didactics.
12. Future research

This thesis provides the following future research suggestions.

- Using a national survey to investigate which educational learning approaches and educational learning didactics educators use to facilitate the students’ learning the theoretical concepts of caring and the practice of caring behaviors in different semesters.

- With various explorative research designs, both qualitative and quantitative, describe students learning needs of caring and caring behaviors in different semesters.

- With various research designs, both qualitative and quantitative, explore how educators perceive students learning needs, knowledge, and values of caring and caring behaviors in different semesters.

- With a quantitative design compare values and behaviors among students and educators regarding their perceptions of caring and caring behaviors as well as their perceptions of suitable educational learning approaches and educational learning didactics in different semesters.

- With a co-design of a golden theme focusing caring and caring behavior (based on educators, undergraduate nursing students and newly graduated nurses perspectives) adapted to students learning needs in different semesters; by a quasi-experimental design with a large sample size, examine the effect of such an intervention after graduation, by using a validated instrument for example, the CBCS based on Swanson’s Theory of Caring.

- With various research designs, both qualitative and quantitative, explore care recipients satisfaction of received care at a student-based learning unit that is founded on the philosophy of caring.
13. Svensk sammanfattning


Det övergripande syftet med denna avhandling var att studera hur en omvårdnadskurs influerar sjuksköterskestudenter lärande gällande vårdande förhållningsätt.

Detta avhandlingsarbete genomfördes bland sjuksköterskestudenter i en omvårdnadskurs i termin fyra vid en högskola i Sverige; under våren och hösten 2018 och våren 2019. Alla sjuksköterskestudenter som deltog i omvårdnadskursen blev muntligt och skriftligt informerade om att deltagandet

I enlighet med Högskoleförordningen 1993:100 och EU-kommissionens direktiv 2013/55, skapades omvårdnadskursen av författaren till denna avhandling tillsammans med nationella och internationella experter. Pedagogiken i omvårdnadskursen hade sin grund i det student-centrerade lärandet integrerat i reflektion och i didaktikerna narrativ pedagogik och simulering. I det student-centrerade lärandet är studenten en aktiv del i samskapandet av kunskap mellan läraren och lärmiljön; och därmed aktivt ansvarig för s sin egen lärprocess. Integrerat i det student-centrerade lärandet är reflektionen där lärprocessen sker när tidigare erfarenheter relateras till framtida erfarenheter; reflektion är därmed en handling som innebär att förstå innebörden av våra erfarenheter. I reflektionen är narrativ pedagogik en didaktik där lärare och studenter delar berättelser och tillsammans söker förståelse i upplevelser och situationer genom att ifrågasätta erfarenheterna från flera olika perspektiv (tex. sjuksköterska, vårdtagare, närstående). I didaktiken simulering börjar studenten praktisera lärd teori i en säker lärmiljö utan risk för att skada vårdtagare.

Omvårdnadskursen (7,5 hp/fem veckor) omfattades av sex två timmars frivilliga föreläsningar, fem fyra timmars obligatoriska seminarier och två fyra timmars obligatoriska simuleringsdagar. Kopplade till de obligatoriska seminarierna och simuleringsdagarna var individuella skriftliga reflektioner och inlämningsuppgifter i grupp. Omvårdnadskursen examinerades genom en individuell skriftlig tentamen och en individuell praktisk examination.

Alla data som utgör de fyra delstudierna i denna avhandling samlades in från deltagare i omvårdnadskursen. Två av de fyra delstudierna hade en kvalitativ design baserad på fokusgrupp intervjuer (studie I) och individuella skriftliga reflektioner (studie II); dataanalys utfördes med kvalitativ innehållsanalys. En studie hade en instrumentutvecklings design för att utveckla och testa ett
obserbeteendeinstrument baserat på Swansons teori om vårdande (studie III). En studie hade en kvantitativ observationsdesign baserad på den utvecklade obserbeteendeinstrumentet i studie III (studie IV); dataanalys utfördes med beskrivande och jämförande statistik.

Sjuksköterskestudenterna beskrev att deltagandet i omvårdnadskursen var en utmanande och komplex lär-upplevelse. De beskrev att deltagandet i omvårdnadskursen fördjupade deras förståelse i att ge evidensbaserad vård utifrån vårtagarens behov kräver både medicinska och praktiska kunskaper tillsammans med kunskaper i ett vårdande förhållningsätt. Sjuksköterskestudenterna beskrev en fördjupad förståelse i att mötet med vårtagare och/eller deras närstående influeras av det vårdande förhållningsättet; där ett vårdande förhållningsätt kräver ett aktivt lyssnande och en egen vilja och ansvar i att våga ställa frågor. Detta kräver teoretiska kunskaper och praktisk träning i vårdande förhållningsätt. Samtidigt beskrev sjuksköterskestudenterna att ett vårdande möte består av mer än att lära sig ett vårdande förhållningsätt då det krävs ett eget mod i att våga dela vårtagarens och/eller närståendes sårbarhet. Denna fördjupade medvetenhet utmanade sjuksköterskestudenternas förförståelse om sig själva. Sjuksköterskestudenternas beskrivna upplevelser av att delta i omvårdnadskursen styrktes av det utvecklade obserbeteendeinstrument baserat på Swansons teori om vårdande; vilket visade att sjuksköterskestudenternas verbala och icke-verbala vårdande förhållningsätt påverkades.

Denna avhandling visar hur sjuksköterskestuderer kan lära sig ett vårdande förhållningsätt i en omvårdnadskurs; vilket kan bidra till att stärka redan befintlig kunskap inom ämnet. Denna avhandling visar också att det utvecklade obserbeteendeinstrument baserat på Swansons teori om vårdande förefaller vara ett lovande instrument för att observera verbala och icke-verbala vårdande och icke-vårdande beteenden.

**Nyckelord:** Kvalitativ metod, Kvantitativ observationsmetod, Narrativ pedagogik, Observationsbeteendeinstrument, Omvårdnad, Reflekterande praktik, Simulering, Sjuksköterskeutbildning, Student-centrerad lärande, Swansons teori om vårdande

82
14. Acknowledgements

This thesis would not have been possible without the support and assistance of several individuals. I express my sincerest gratitude to all of you who have been involved in this research project.

My special thanks go to Maria Björk and Susanne Knutsson for introducing me to this research project. You have been my solid foundation throughout my academic journey, and without your support, this journey would have taken a different path. I am here now because of you. Thank you, Anders Broström, Eric A. Hodges, and Gwen Sherwood, for selflessly sharing your knowledge and for providing inspiration and encouragement. You have immensely contributed to my learning and the completion of my studies.

Thank you also to the School of Health and Welfare at Jönköping University, the research group CHILD, and the Skaraborgs Institute for Research for the excellent research environments.

My gratitude goes to all my fellow students for the time and experiences we shared. My special thanks go to my “zoom-fika” students for the discussions, laughter, and support. I hold these moments dearly, which will always be very special and valuable to me.

Lastly, my heartfelt thanks go to my family, especially my mother, Anita Johansson, for introducing me to the academic world, as well as to my beloved friends, Maria Mangerao Cepeda and Karin Ohlin, for all the support during these last years. Above all, I thank my children, Stina and Eric. You are my inspiration. Now that I have completed my thesis, let us celebrate!
References


https://www.vr.se/download/1.2412c5311624176023d25b05/1555332112063/God-forskningssed_VR_2017.pdf


Complaints from care recipients and their significant others regarding healthcare providers’ lack of compassion and competent care in their professional encounters have increased. These complaints indicate the need for learning strategies that enhance healthcare providers’ awareness of their own caring behaviors and thus promote patients’ healing and well-being. In-depth knowledge of undergraduate nursing students’ learning of caring behaviors contributes to a better understanding of caring and its transformation into caring behaviors. The overall aim of this research project was to enhance knowledge of how a caring behavior course (CBC) in undergraduate nursing education influenced the students’ learning of caring behaviors. The findings showed that participating in the CBC influenced the undergraduate nursing students’ learning of caring behaviors. This research project contributed to strengthening the knowledge that caring and learning are parallel processes in nursing education.

Sophie Mårtensson is a registered nurse with a postgraduate diploma in specialist nursing–medical care. She has over seven years of experience working with facilitating nursing students in a variety of clinical healthcare settings. Sophie’s research is focused on the learning of caring behaviors in undergraduate nursing education.