

Patient experiences of being cared for by nursing students in a psychiatric education unit

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Abstract

Patients are vital for student learning. However, research has primarily focused on student nurse learning from a student or supervisor perspective; few studies have investigated patient perspectives. This study examines student care practice for patients in acute psychiatric day care. The aim was to describe patients' experiences of care by student nurses in a psychiatric education unit, a collaboration between the clinic and academia. Data were collected through 17 lifeworld interviews with patients, of which 10 also included observations. Data have been analysed for meanings using reflective, lifeworld research (RLR). The findings reveal that the encounters involve an interactive process of giving and receiving, providing students with both health opportunities and risks. The findings can further be described by the following constituents: *exposed and vulnerable; responsibility to support; the importance of accessibility; reciprocity; and engagement that evokes the desire to live a life with dignity*. In a patient–student community, there are prerequisites for proper caring. Patient health seems to be positively affected when patients are involved in both their own care and student learning.

Keywords

caring, learning, lifeworld research, psychiatric care, student–patient relationship

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Introduction

A nurse's education consists of both theory and practice. In clinical and practical training, when student nurses care for patients, their learning process can be characterised as an integration of theoretical knowledge with practical knowledge and skills.^{1,2} These educational periods form an important part of students' education, serving as a means for developing a deeper understanding of patient care and acquiring professional competence.³ Patients play an important role in student learning practice. Students learn the existential meaning of illness and suffering through encounters and relationships with patients. Despite patients being obviously involved in the student learning process, researchers have paid little attention to the patients' views and experiences of this involvement. In this study, we investigated patient experiences of being cared for by nursing students in a psychiatric education unit.⁴ This unit is a collaboration between psychiatric clinic and academia, with the main purpose being to strengthen both the patients' care and the students' learning. In this unit, the students are nursing students in their fourth semester, and there are usually a total of 24 students in the unit at the same time, divided into two wards, over a period of six weeks. As preparation, the students studied two courses: medical psychiatry and psychiatric nursing. We agree with Towle⁵ regarding the importance of highlighting the patient's voice in the education of health

professionals; such an approach has the potential to improve and develop both student learning and patient care.

A central mission in psychiatric care is to decrease patients' existential loneliness, which might hinder health and induce suffering. Therefore, the relationship between the patient and the carer is crucial, thus forming the basis for care.⁶ The fact that psychiatric care is composed of caring relationships has been strengthened by several researchers.^{7–9} Consequently, the challenge for students in this caring and learning context is to learn how to develop caring relationships from encounters with patients who suffer from psychiatric illness. By acquiring the patients' perspectives in this context, strategic learning support in clinical training and safe patient care can be developed.

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Background

Learning in clinical practice means that students are expected to care for patients in a practical context, which is something that they may only have theoretical knowledge of. Research and evaluations have revealed that students experience difficulties in using theoretical knowledge in a practical 'living' context of care; that is, in the encounter with the patient.^{10,11} They acquire the theoretical meaning of caring science concepts; however, they have difficulty using the knowledge as a means of support in encounters with patients.^{1,10,13} Caring science refers here to the science of the human being in relation to health, illness, suffering and caring. Mostly, this knowledge has focused on the patient perspective.¹⁴

To handle this problem and facilitate student learning, both qualified supervisors and suitable learning environments in care practice are required.¹² Educational care units have developed in the 21st century in the United States, Canada, Australia, New Zealand and Sweden as an innovation to develop proper learning environments.^{3,15} These units attempt to work systematically and consciously to integrate theory with practical care in the student learning process;^{1,15} therefore, they have been created partly as an initiative for new thinking and partly to enable favourable conditions for didactics, which support student, supervisor and patient needs. These characteristics are also the principles for the psychiatric education unit in the present study.

Research has shown that patients are usually comfortable with the fact that students are involved in their care.^{16,17} Patients are often prepared to set up for student learning.^{18–21} However, not all patients are comfortable with being cared for by students, and there exists a wide variety of patient experiences. Students are perceived as both supportive and helpful, but also as insufficient in competence and professional ability.^{22–24} Patients might also enjoy extra attention and social activities offered by students, so there is a possibility of mutual social exchange.^{21,25}

For patients, it is important that students learn what is happening in encounters between people. Patients consider this more important than practical and technical elements.²⁶ Eskilsson et al.²⁴ demonstrate that patients can be 'placed' in an education unit without the possibility or power to say no to the students involved in their care. Thus, the need for security and genuine encounters with students becomes important. For encounters to have a genuine character, a mutually reciprocal relationship between the student and patient is required.^{24,27} The opportunity for participation in students' learning and in their own health process is important. Holst et al.²⁸ described the importance of a learning space that supports the interpersonal linkages between patients, students and supervisors. A favourable learning space can create the prerequisites for student learning and also support patients' health if patients become involved in student learning and caring.

Patients are regarded as an obvious integrative part of students' learning during clinical training.²⁹ However,

research has primarily examined nursing student learning from a student or supervisor perspective. Some early research investigating the patient perspective of student learning in care practice emphasises the importance of studying more from this perspective.^{18,30–32} However, it seems that this has been achieved only to a limited extent. According to Towle et al.³³ and Manninen et al.,²³ it is crucial to learn more about patient involvement in student learning within clinical practice. In psychiatric care, this area has hardly been investigated. Therefore, the aim is to describe patients' experiences of being cared for by student nurses in a psychiatric education unit.

Methods

Research design

The current research was carried out using a reflective life-world research (RLR) approach, based on the work of Dahlberg, Dahlberg and Nyström.³⁴ The RLR approach has been developed and adjusted to caring science. It is characterised by meaning-related and phenomenon orientation, and seeks to describe people's lived experiences to develop knowledge on human existence in different contexts. In the present study, the purpose was to describe and develop knowledge of patients' experiences of being involved in nursing students' learning in practice.

The RLR approach has an epistemological foundation in Husserl's lifeworld theory³⁵ and intentionality theory.³⁶ Dahlberg et al. further consider – with support from Husserl – that it is the task of phenomenology to describe the phenomenon as it is experienced by people. This description entails being phenomenon oriented. RLR is an approach that is characterised by a phenomenological perspective with the following methodological principles: openness, flexibility and bridled understanding.³⁴ These methodological principles are seen as foundational for research credibility in terms of validity, and the possibility to practice the principles in multiple contexts.

Context, participants and setting

The current study was conducted at a psychiatric education unit consisting of two general wards in a hospital in the southwest of Sweden. In total, 17 patients participated in the study: 13 women and four men. The patients were aged between 19 and 61 years, and their psychiatric care experience ranged from 3 weeks to 40 years. Fifteen patients were cared for voluntarily, and two were under compulsory care. The patients in the present study were strategically selected with the aim of obtaining a large spread in terms of age, gender and experiences of being cared for by students. Even variations of being cared for voluntarily or according to the Compulsory Psychiatric Care Act (in Swedish, LPT) were sought. Twenty-three patients were invited to take part in an interview. Twenty-one gave their consent to participate in the life-world interview, and all were selected. Two of the

interviews were cancelled because these patients had reached the end of treatment and had returned home from the hospital. Two more of the interviews had to be cancelled because the patients were unable to attend because of health and medical reasons. To ascertain interest in participation, first, a nurse asked the patients if they were interested in participating in the study. They received both verbal and written information about what the interviews, as well as the observations, would entail, and they then received opportunities to ask the nurse questions. This occurred when the patient had been cared for by students several times. Verbal information about the nature of participation, in the interviews and in the observations, was also given by the first author before data collection started.

Data collection

Data were collected through 17 lifeworld interviews that lasted between 20 and 80 minutes. Ten of these interviews started with an observation where the first author participated in an encounter between the patient and the student. The author's role was passive and silent, which means being attentive but not participating in the conversation. An interview was then conducted close in time to the observations. These 10 interviews lasted between 5 and 25 minutes. The remaining eight interviews lasted between 20 and 80 minutes. One of the patients participated in both a lifeworld interview and an observation. All interviews were included in the analysis, and all of the data collection was conducted by the first author using a reflective attitude, according to the principles of RLR.³⁴

Ethical approval and considerations

The current study was reviewed and approved by the Regional Ethical Review Board of Gothenburg (D.nr.358-10), and the principles of the Declaration of Helsinki were adhered to.³⁷ The patients were given verbal and written information about the purpose of the study, including about the confidentiality of their responses, the voluntary nature of their participation in the study and the protection of their privacy and identity. All the participants provided both verbal and written consent before data were collected. It is obvious that the patients were in a vulnerable position, depending on their health situation. Here, it was important to be aware of where and how the patients could be affected during the data collection process. As a form of support, the first author maintained close collaboration with the responsible physician and nurse for the patients' care.

Data analysis

The data analysis was carried out by all the authors. The interviews were audiotaped and transcribed verbatim and then analysed in accordance with RLR.^{34,38,39} The analysis began with a search for the meaning of the phenomenon observed in the transcribed interviews. The intention was

to describe the essential structure of the phenomenon – namely, to be cared for by nursing students – as the patients experienced it. Throughout the entire analysis process, the intent was to maintain an open and bridled approach to the data. Related meanings were grouped in clusters based on their similarities and differences. These clusters were further scrutinised to identify the patterns that described the essential meaning of the phenomenon. The analysis resulted in an essential description, or essence, of the phenomenon and its variations and nuances, which can be described as the constituents of the phenomenon.

The presentation of the findings below follows the principles of RLR; consequently, it starts with the essential meaning of *to be cared for by nursing students*, as patients experienced it. This means that what we provide is a general description of the phenomenon, an essence. Then, this is followed by five constituents that illuminate the variations and nuances of the phenomenon. Quotations exemplify and clarify the variations and nuances.

Findings

The essential meanings of the phenomenon, *to be cared for by nursing students* in a learning environment in psychiatric care entails encounters with students, where the patient's own mental illness and the student's learning meet in a mutual process. When patients get the opportunity to tell students about their illness and vulnerability, they experience a sense of well-being. The students need to listen to the patients' narratives to acquire lived experiences in the learning process. Encounters with students entail giving and receiving, which means both opportunities and risks to their own health. The opportunities for well-being, though, make it worth the risks.

Mental illness can be exacerbated in non-caring encounters and in expectations and requirements of being available to students' learning. However, the patients understand that learning must take place in a caring context. This understanding helps them feel responsible, even careful, regarding student opportunities in learning to care. The patients can thus contribute to the training of competent nurses for the future, which they can benefit from. In an open and honest dialogue with students, the patients acquire the courage to show their vulnerability, while at the same time listening to and being open to the students' need to learn. Encounters between students and patients are characterised by a common endeavour to understand more about the patient's mental illness, which creates a sense of community.

Living with mental illness can also mean a weakened sense of joy in life. In encounters with students, however, patients gain power and can experience well-being through the students' commitment to wanting to understand the patient and his or her situation. Becoming aware of mental illness through the students' questions can evoke and stimulate emotions of joy of life; this also creates a feeling of being important, which in turn creates a sense of dignity. The students' presence provides the conditions for meaningful participation both in the caring process and in

the student's learning process. It also puts a golden edge on the patients' existence. This little extra extends beyond the usual care frames. When the students are not present, the patients experience a lacking or an emptiness.

The phenomenon is further described by the following constituents: *exposed and vulnerable*; *responsibility to support*; *the importance of accessibility*; *reciprocity*; and *engagement that evokes the desire to live a life with dignity*.

Exposed and vulnerable

Through their mental illness, the patients are both exposed and vulnerable in the presence of others because their power and energy are impaired. This difficulty can be reinforced by the fact that they feel the demands and expectations of both healthcare professionals and students in terms of being available for student learning. Setting up the student's learning needs might feel like a demanding commitment. Reduced strength can also make them incapable of coping with students' questions. According to one patient:

When there have been three conversations in one day, I can get very tired when the fourth comes. I can feel like, though you have the freedom to say no, at the same time you might not be able to do so the third time, even if you had wanted to say no to them.

The patients perceive these problems as the students not having sufficient knowledge and experience to realise the patients' needs and determine what is best for individual patients. They argue that the supervisor must be on hand to ensure that the care is adequate. However, the patients miss the students when they are not in the unit. Then, they are completely deserted, left to psychiatric care that several of them have negative experiences of: 'After a few years, the regulars can't be bothered to be involved any more'. They feel that their experience there is rigid and routine. There are regulations that govern behaviour, and there is insufficient engagement and motivation among caregivers. This feeling makes patients even more exposed and vulnerable. One patient expressed this as, 'A lot of regular carers have probably heard these stories, fifty thousand times. It seems that they may not always be, what you say, so seriously anymore'.

Responsibility to support

Although the students' presence can be stressful for the patients, they feel responsibility for supporting the students in their learning. The patients understand that the students must ask questions and seek answers to what they do not understand. According to one patient, 'Of course, just like any other staff, they must search for information and find out more about things that they are uncertain about'.

The responsibility that the patients feel is threefold: they feel responsible for their own health and for the students' learning and even for co-patients. However, this coincides

with the encounters with the students. One patient explained the following:

It is important that you are open when learning something, and it is important to let them in and let them see the innermost. They have to realise that we are all different, regardless of the same diagnosis.

The patients' learning responsibilities appear in their attempts to describe their mental illness in as nuanced a way as possible. One patient said, 'I try to be more clear in how I feel all the time and explain my feelings as accurately as possible'.

Responsibility for supporting the students' learning is even evoked by the ability to follow the students' learning development through the students' body language. For example, the patient can see how a student beams with joy when she or he has succeeded in helping the patients. The patients also found that the students' posture changed gradually, from being tense and stiff to calmer and more relaxed. The patients argued that a clenched and rigid posture is distancing, while an upright posture is more inviting and signals both good learning and good caring.

The importance of accessibility

The students are available because physically, they are in the unit, but also because they have an open and inviting attitude for conversation. Caring dialogues are an important and common care activity in psychiatric care. The patients perceived that the students had time for encounters and different activities in a way that the ordinary healthcare staff did not seem to have. The students are curious: they ask questions, and the patients get opportunities to tell the students about their illness, which makes it appear that the students are caring for them. One patient explained:

The students listen in a completely different way. They listen more thoroughly. And when they become uncertain, they ask a question about what they are told. To clarify. To really make sure they heard right or they understood it right.

The patients seem to prefer to talk and discuss with students who do not know but who want to learn rather than with the regular caregivers. One patient described the students as 'are unwritten sheets, and they are not stuck in stereotypes and have no prejudice and therefore it is better to talk with them instead of the ordinary staff'.

Students are able to carry out activities at short notice beyond the ordinary and routine. For patients, this becomes something that is life confirming and pleasurable, and it gives them the opportunity to gain power in a relieving rest from illness. According to one patient:

So, I think in some way that the students can give the little thing, which the regular staff do not have the opportunity to. It will be a little extra, so you can feel better. So it has been for me. They have helped me in the bad moments to feel better.

Reciprocity

To be cared for by students in a learning context calls for mutual interaction. Patients and students help and support each other to achieve their goals in a mutual exchange. Patients find that when they share their own experiences in encounters with students, they get something back. One patient claimed, 'You feel you are more useful when you are here. You can actually help students in their education'.

Encounters between patients and students foster a common endeavour. Patients strive to feel better, and students strive to understand the patients to learn about their practice. Patients are positively affected by seeing how the students develop as nurses. When the students ask questions, the patients get the opportunity to tell them about their illness, which they perceive as caring. One patient explained this in the following manner:

The more open I have been, the more courageous they become, in asking. Or to get me to tell them more. It helps me in my situation. They are a little more forward, which means that I have to think about my existence and myself.

It is easier to make contact with students when there are common denominators, such as age, life experiences and interests. When togetherness and community are created, mutual interaction is strengthened. One patient explained, 'We are kind of the same age. So they have experienced what I have experienced'. Patients find that they speak the same language: 'they know my values and it then leads to no misconceptions'.

Engagement that evokes the desire to live a life with dignity

To be cared for by students means both health opportunities and risks. Mental illness and suffering can mean a loss of a joy of life and feelings of meaninglessness. If this continues, there are obvious risks that the patients' lives may be in danger. The patients gain power in the students' commitment, vivacity and aspirations. In this way, the joy of life and dignity seem to be awakened. The students are both thoughtful and honest, which shows in conversations where they admit their lack of knowledge but express their desire to understand. A patient expresses his gratitude towards that attitude in the following way:

They are doing their best and I am very grateful for that. When I came to this place, I didn't think I would survive in the first place, however, after having been cared for by the nursing students, I actually managed to get some motivation to realise other things that I didn't understand before I came here.

When the students seem to lack knowledge of diseases and treatments, they instead talk about more general topics. These conversations, which include, for example, common interests, create both togetherness and trust. The patients

can talk with the students about what they have mastered, which is both meaningful and dignified. On these occasions, when the patients' illness and suffering are markedly difficult, students give them the opportunity to retrieve power. These conversations constitute a break, where the patients' thoughts and feelings are directed towards something other than illness and their status as patients. One patient explained the feeling in the following way:

I may have been focusing on something else. Not just my own thoughts and things that you get stuck in. We have talked about other things that you at least know a little about. It has not only been illness and such, but it has been like general things, and you have felt that you are after all good in something.

Discussion

Methodological considerations

As described earlier in the methods section, lifeworld interviews were used, which also included some observations as a starting point and support for the interviews. The challenge in the present study was to successfully capture the current phenomenon in a flexible and nuanced way. Using a combination of lifeworld interviews and observations can increase the ability to acquire meaningful data and the possibilities to describe the phenomenon's variations and nuances.^{34,40} During the interview, this also gave a chance for the first author to ask directed questions about the observed encounters between the patient and the student, which supported patients in giving rich descriptions of the phenomenon in focus during the interview. This approach has the potential to increase the current study's credibility.

The RLR approach³⁴ was chosen because with its solid ontology, epistemology and methodology, it was judged capable of responding to the complexity of describing patient experiences of being cared for by students. Specifically, this means that a research approach characterised by an open and reflective attitude was required. The phenomenon that was studied necessarily had to manifest itself in all its diversity without being subjected to interpretations or prejudices, because the research was conducted with openness, responsiveness and adherence to the phenomenon and with a bridled, reflective attitude. Consequently, this approach strengthened the credibility of the current study. The weaknesses of RLR stem from the fact that a phenomenon-oriented and meaning-seeking approach can be both complex and challenging. The pitfalls are many, and great demands are made on the researcher's approach. It is not possible to ignore the risk that researchers, with their experiences and (pre)understanding, can influence the results in an undesirable manner.

Reflection on the findings

The results reveal that the patients' health and recovery are positively affected when they are cared for by students.

In accordance with some other studies,^{16,17,24} the current study showed that patients feel the demands and expectations of being available for student learning, both from healthcare professionals and from students. It seems that encounters with students can be seen as opportunities and risks for the patients' own health. However, the opportunities for well-being probably make it worth the risks, and here, the patients can be seen and confirmed in their suffering. The patients' vulnerability and objectification seem to decrease in the students' presence. Mental illness can mean that life is threatened, and meetings with students enable patients to regain a joy of life and their dignity. The patients seem to prefer to meet a student who does not have all the knowledge but who wants to learn instead of a regular carer who believes they know everything. The patients are thus willing to make themselves available to students' learning although this includes risks for their own health. The fact that patients want to get involved in student learning has also been demonstrated by Stockhausen,²⁰ who emphasises that it is through patient experiences that students can learn through care practice. In a study by Twinn,¹⁸ it was shown that patients were anxious about the students' learning situation in healthcare practice, and the patients would sometimes express anxiety that the healthcare staff were burdening the students with too heavy a workload. It is probably not uncommon that patients' motives to give consent to being cared for by students originate from bad experiences with carers. Therefore, it can be assumed that the patients believe that by participating in student learning, they can contribute to educating better nurses; a conclusion which has been supported by Forrest et al.⁴¹

The patients' positive experiences of being cared for by students can be explained by the fact that they have a mutual interaction in the relationship, which shows a good caring relationship. They can support and strengthen each other by taking part in each other's stories, a dynamic that Holst et al.²⁸ and Manninen et al.²³ highlight as an important factor for both good nursing and as important for a good learning space. Indeed, interest in the patient's questions, thoughts and experiences are important elements for creating a mutual caring relationship.

From a patient perspective, there is a mutual vulnerability in the relationship between the student and patient. The patient is vulnerable in his or her illness and in the need for care; the student is vulnerable in his or her uncertainty and learning needs. Both the patient and the student are at a disadvantage against the caring staff because they are both exposed to assessment: the patient, regarding his or her illness and ill health, and the student, regarding her or his caring ability and skill. From an existential perspective, the relationship between the patient and student is characterised by the fact that they share a sense of belonging when they are faced with powerlessness and opportunities. By supporting each other, they can achieve freedom and independence, which characterises a caring relationship, as shown by Chow.⁴² However, according to Suikkala and Leino-Kilpi,^{43,44} the relationship with the student can take both destructive and constructive forms.

Recommended by patients is what is referred to as a 'facilitative' relationship, which is a form that takes into account the needs of both the patients and the students. This form of relationship has many positive consequences for both the student and patient.⁴⁵

The results showed that both the patients and students appeared to have questions about mental illness. Thus, the patients and students shared a common endeavour to understand more. From a caring perspective, the endeavour to understand plays an important role, but according to Galvin and Todres,⁴⁶ the nurse can never fully understand and know how it is to live when health and existence are threatened; this means that nurses, in a position of not having the knowledge but wanting to gain knowledge, can be an important part of caring humanity,⁴⁶ which also appears in the research by Michel, Valach and Gysin-Maillart.⁴⁷ The results in the present study demonstrate that the students' endeavours to know and understand entail a type of caring that the patients appreciate. Bornemark⁴⁸ claimed that an attitude of not knowing is an important prerequisite and starting point for learning. When persons encounter a question that they do not understand and when the issue has no context, there are several possibilities: they get to experience something new and foreign, or they get to know what this knowledge is and how it is created.⁴⁸

It seems that patients' stories about what it is to live with mental illness and health disabilities can have good consequences for both the patient and the student; they can both understand more. The importance of listening to the other's unique story for achieving insights and new knowledge is highlighted by several health researchers.^{49–51} Understanding as a phenomenon should not, of course, be understood as 'knowing', but more as an endeavour to 'try to understand'.⁵² Such an understanding starts when the students ask, 'What is it like to live with mental illness and disease?' The question gives patients the opportunity to tell their experiences and the students the opportunity to listen to these and learn, but here, it appears that the patients also seem to listen to their own narratives when they are given the opportunity to tell them to students on repeated occasions.

The significance of reflection for developing understanding¹¹ for both one's own and other's situations clearly appears in the results. The patients proceed from themselves when they try to understand and help the students. It can be understood that the patients try to understand the students' inner worlds by trying to understand themselves; a form of self-reflection. Indeed, self-reflection plays an essential role in understanding the other,¹¹ and it is necessary to master the skill of looking into your own inner world to become open to others.

The students' need to learn and acquire knowledge promotes a sense of responsibility and caring in the patients. This can be interpreted as the patients carrying a basic set of values or ethos. According to Eriksson,⁵³ this means that human beings possess an inner core, where the compass needle is directed towards doing the best for others. This is, according to Eriksson,^{53–55} the basic motive of the

caregiver and stands for compassion and mercy. The patients' caring attitude can be understood as an interpersonal love and consideration for the students; in other words, the patients wish the students well. There is also a vision for the future that, under their responsibility and care, the patients contribute to the training of competent nurses who can eventually provide qualified nursing.

Conclusions

In conclusion, based on a patient perspective, the current study shows that patients experience well-being in encounters and relationships with student nurses. In a community of patients and students, there are prerequisites for both favourable learning and good caring. Thus, encounters with students seem to be important for psychiatric care. However, this requires interactions that can create security and affinity. In the student's presence, the patient provides the opportunity to make his or her voice heard. The patient achieves this by explaining what it is to live with mental illness for a listening student. On the other hand, students' appreciation may depend on the carer's attitude of knowing what is best for the patients.

Patients' health can be positively affected when they are involved in their own care and in the students' learning. From this perspective, caring and learning coincide, and they enrich and strengthen each other. Through the influence of reflection, reflected caring and learning can be accomplished, which has the potential to improve and strengthen both caring and learning in future psychiatric care.

Relevance for clinical practice

The present study contributes with knowledge that can be implemented in healthcare practice to develop and improve psychiatric care and the learning environment. An important aspect for supervisors and leaders in clinical practice is developing different forms of learning and nursing activities where the patient's voice is heard. Furthermore, learning strategies that enable encounters between patients and students, which are favourable for both learning and care, need to be developed. These strategies include caring conversations, team meetings and individual nursing planning; activities which require awareness among supervisors in order to plan clinical studies, and this awareness includes significant knowledge that can constitute an important starting point for good nursing. If the caregivers, supervisors and students have an attitude of 'not knowing' but with a clear endeavour to understand, learning environments in psychiatric care can be problematised and better understood. 'Not knowing' is therefore not an obstacle to learning in psychiatric care. It is rather a prerequisite.

Suggestions for further research

The current study was conducted at a psychiatric education unit where patients meet many students. It would be interesting to study the phenomenon *to be cared for by nursing students* in psychiatric clinical practice that receives

fewer students. This could be useful to investigate whether there are differences related to learning environments.

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Declaration of conflicting interests

The authors declare that there is no conflict of interest.

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